BYLAWS OF THE MEDICAL STAFF
OF
CHANDLER REGIONAL MEDICAL CENTER
MERCY GILBER MEDICAL CENTER

PREAMBLE

These Bylaws provide a structure to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care. These Bylaws describe the activities of the Medical Staff and relations between applicants and members of the Medical Staff. These bylaws, along with the Bylaws of the Board, provide a structure for Medical Staff activities and document the relationship between the Medical Staff and the Board.

ARTICLE I. NAME AND CERTAIN DEFINITIONS

1.1 Name. The name of this organization shall be the Medical Staff of Chandler Regional Medical Center (CRMC).

1.2 Definitions. Unless otherwise specifically defined herein, those words set forth and defined in Exhibit “A” hereto shall have the meanings ascribed to them therein.

ARTICLE II. PURPOSES, RESPONSIBILITIES AND NATURE OF THE MEDICAL STAFF

2.1 Purposes. The purposes of the Medical Staff are:

2.1.1 Professional Body. To constitute a self-governing professional body that is accountable to the Board, providing mutual educational, consultative and professional support;

2.1.2 Organizational Structure. To provide a structure through these Bylaws, Rules and Regulations, and related manuals which define the responsibility, authority, and accountability of each organizational component and individual Member of the Medical Staff;

2.1.3 Clinical Privileges and Peer Review. To provide a mechanism for appropriate delineation of Clinical Privileges and a means for the ongoing evaluation of performance of all Practitioners authorized to practice in the Hospital; and

2.1.4 Policy Communication. To provide a means by which the Medical Staff can participate in the Hospital’s policy making and planning processes and through which such policies and plans are communicated to Members.

2.2 Responsibilities. The primary function of the organized medical staff is to provide oversight for the quality of care, treatment and services provided by practitioners with privileges. To accomplish the above purposes, it is the obligation and responsibility of the Medical Staff:

2.2.1 Quality Management. To participate in the quality management program by:

2.2.1.1 Providing leadership for the process measurement, assessment and improvement of patient care processes, patient safety, and evaluating Practitioner and institutional performance through sound measurement systems in the hospital and its off-site facilities;

2.2.1.2 Monitoring patient care practices and enforcement of Medical Staff and Hospital policies;

2.2.1.3 Assisting in the evaluation of Practitioners’ credentials for initial and continuing Medical Staff appointment and for the delineation of Clinical Privileges in a manner that is thorough, effective and timely;

2.2.1.4 Assisting in the development of a sound system of utilization management;

2.2.1.5 Providing leadership in activities relating to patient safety;

2.2.1.6 Providing oversight in analyzing and improving patient satisfaction.

2.2.2 Staff Recommendations. To make recommendations to the Board regarding appointments, reappointments to the Medical Staff, including Staff category, Department assignments and Clinical Privileges of all Practitioners;
2.2.3 Community Needs. To participate in the Board's planning activities, to assist in identifying community health needs and to suggest to the Board appropriate policies and programs to meet those needs; and

2.2.4 Bylaws Administration. To develop, administer, recommend amendments to and enforce compliance with these Bylaws, its supporting manuals and the Rules and Regulations of the Staff, and with the Hospital Bylaws and policies. These documents shall be consistent with the Board Bylaws.

2.3 Nature of Medical Staff Membership

2.3.1 Appointment to the Medical Staff may be granted to fully licensed Physicians and Other Licensed Individuals who are permitted by law and the Hospital to provide patient care services independently in the Hospital. Membership on the Medical Staff may not be granted to Allied Health Professionals or Ancillary Staff Professionals.

2.3.2 Medical Staff membership is recommended by the Medical Executive Committee and granted by the Board and is a privilege extended only to those professionally competent Practitioners who continuously meet the qualifications standards and requirements set forth in these Bylaws.

2.3.3 All Medical Staff Members must have delineated Clinical Privileges that allow them to provide patient care services independently, with the exception of those practitioners who hold staff appointment only.

2.3.4 Medical Staff membership does not automatically confer Clinical Privileges to Practitioners.

2.3.5 Members of the Medical Staff, Allied Health Professionals and Ancillary Staff Professionals are subject to Medical Staff Bylaws, Rules and Regulations, and Departmental Rules & Regulations and are subject to review as part of the Hospital quality management program (non-privileged Members are exempt from the quality review process).

2.3.6 All Members of the Medical Staff, Allied Health Staff and Ancillary Professional Staff are deemed to be members of the Medical Staff Organized Healthcare Arrangement (MSOHCA) with the Hospital under the Health Insurance Portability and Accountability Act (HIPAA). The Hospital will issue a joint notice of privacy practices (JNPP) to its patients. This JNPP will fulfill HIPAA requirements for both the Hospital and MSHCA members who see patients at the Hospital. When members of the MSHCA see patients at the Hospital, they must not issue another notice or privacy practices to that patient while the patient is in the Hospital. MSHCA member's use of protected health information of the Hospital is restricted to those listed in the JNPP and the JNPP does not fulfill practitioners' obligations when seeing patients outside of the Hospital or in their private offices. Further, MSHCA members remain responsible for issuing their own notice of privacy practices (NPP) outside of the Hospital.

The Hospital will solicit an acknowledgement of the JNPP from its patients and MSHCA members must not solicit a separate acknowledgement from patients at the Hospital. Practitioners remain responsible for obtaining their own acknowledgement of the NPP outside of the Hospital.

ARTICLE III. APPOINTMENT AND REAPPOINTMENT

3.1 General Qualifications. Every Physician or Other Licensed Individual who seeks or enjoys Staff appointment must continuously demonstrate to the satisfaction of the Medical Staff and of the Board at least the following qualifications (Physicians granted Community Affiliate Level Two appointment are exempt from the qualifications set forth in 3.1.3, 3.1.4 and 3.1.6 below):

3.1.1 Licensure. A valid unrestricted license issued by the State of Arizona to practice as a Physician or Other Licensed Individual, and a valid unrestricted Drug Enforcement Administration ("DEA") Certificate, unless specifically excused by the MEC in circumstances where a DEA is not needed to practice the privileges requested (e.g. Pathologists, Teleradiologists). Except as otherwise provided, each Member of the Medical Staff is strongly encouraged to maintain a DEA certificate that includes all drug schedules (2, 2N, 3, 3N, 4 and 5). Any exceptions to the full schedule DEA will be addressed on a case-by-case basis by the Credentials Committee and MEC.

3.1.2 Education/Post-Graduate Training

3.1.2.1 Successfully graduated from an approved school of medicine, osteopathy, podiatry, or dentistry.

3.1.2.2 Successful completion of one of the following:

3.1.2.2.1 For physicians, an allopathic or osteopathic residency program that is approved by the ACGME or the AOA.
3.1.2.2 For podiatrists, a two-year Podiatric Medicine and Surgery residency program (at least one year must be a podiatric surgical residency) approved by the Council on Podiatric Medical Education (CPME).

3.1.2.3 For dentists, at least one year of a hospital-based residency approved by the American Dental Association.

3.1.2.4 For Oral/Maxillofacial surgeons, an American Dental Association-approved residency program.

3.1.2.3 Physicians who are still in a training program (residency or fellowship) may not be granted privileges or begin practicing at the hospital in that particular specialty until completion of the training program (i.e. physicians may not provide patient care services at the Hospital in the specialty for which they are still in training).

3.1.3 Board Certification

3.1.3.1 Be board certified, or be eligible to enter the certification examination system in accordance with the training and/or experience requirements defined by the applicable certifying board. The certifying board must be one of the following: 1) member board of the American Board of Medical Specialties (ABMS), 2) member board of the American Osteopathic Association (AOA), 3) the American Board of Podiatric Surgery (ABPS), 4) the American Board of Oral & Maxillofacial Surgery (ABOMS); 5) certification by the Royal College of Physicians and Surgeons of Canada will be accepted in the following circumstances: (a) the applicable ABMS specialty board recognizes the Canadian post-graduate training as equivalent to the ACGME post-graduate training (i.e. the ABMS specialty board accepts Canadian trained physicians for entrance into the ABMS certification exam process) and, relying on that, (b) the Medical Staff Department has approved acceptance of Canadian Boards for department members. Such board status (eligible or certified) must be in the primary specialty for which privileges are sought (subspecialty certification requirements will be determined at the department level). The applicant must achieve Board Certification within seven (7) years of completion of residency/fellowship training (however, each medical staff department has the authority to require its members to achieve Board Certification within a timeframe that is less than 7 years). A department chairman, the Credentials Committee and/or Medical Executive Committee may, in certain situations, recommend that a practitioner be granted privileges in a specialty other than the specialty in which he is certified if the practitioner otherwise meets the criteria for staff appointment and the training and/or experience criteria for the privileges requested; OR

3.1.3.2 Have been a member of the Medical Staff of Chandler Regional Medical Center since prior to September 1, 1994, without interruption or leave of absence.

3.1.3.3 Physicians appointed to the Medical Staff January 1, 2008 and thereafter are required to continuously maintain Board Certification in the specialty for which privileges have been granted.

3.1.4 Performance.

3.1.4.1 Education, training, and experience demonstrating current clinical competence.

3.1.4.2 Actively engaged in a clinical practice at least six of the last twelve months (residency/fellowship or private practice); exception may be made by the Credentials Committee.

3.1.4.3 Actively practiced in a hospital deemed acceptable by the Credentials Committee for at least two of the past five years (exception may be made by the Credentials Committee, e.g. physician is requesting Community Affiliate appointment only with no clinical privileges, or physicians who limit their practice to urgent care). Twelve months of recent experience in a full-time clinical residency/fellowship will be considered equivalent.

3.1.5 Attitude. A willingness and capability based on current attitude and documented performance, to:

3.1.5.1 Work with and relate to other Practitioners, Hospital management and other Staff, visitors and the community in a cooperative, professional manner;

3.1.5.2 Discharge Medical Staff obligations appropriate to Staff category;
3.1.5.3 Adhere to high standards of professional ethics.

3.1.6 Professional Liability Insurance. Provide evidence of current and continuous professional liability insurance in the amount of at least $1 million per occurrence and $3 million aggregate in the form required by the Board, and agree to maintain such insurance during the appointment period; physicians in the Community Affiliate Level Two category are exempt from this requirement. The company providing malpractice coverage must be licensed to transact insurance in the State of Arizona and meet the following criteria:

3.1.6.1 Carrier Arizona licensing status: “Admitted” or “Qualified Unauthorized”
3.1.6.2 Financial Rating: AM Best – B+ or better, and Standard & Poors – BBB or better; OR
3.1.6.3 The CHW self-insured Trust will be deemed qualified.

3.1.7 Disability. Freedom from a physical or behavioral impairment that interferes with the qualifications required in 3.1.4 above, such that the practitioner poses a significant risk to the health or safety of others that cannot be eliminated with a reasonable modification of policies, practices or procedures or by the provision of auxiliary aids or services.

3.2 Nondiscrimination. Chandler Regional Medical Center will not discriminate on the basis of age, gender, race, national origin, or creed.

3.3 Basic Responsibilities of Individual Staff Appointment. Each Practitioner, regardless of assigned staff category, exercising any privileges under these Bylaws shall:

3.3.1 Provide his patients with continuous care and supervision at the generally recognized professional level of quality and efficiency.

3.3.2 Abide by the Medical Staff Bylaws, Rules & Regulations, department rules and regulations, and all other standards and policies of the Medical Staff and Hospital, including the Catholic Healthcare West (CHW) Corporate Integrity Program.

3.3.3 Discharge such Staff functions for which he is responsible by appointment, election or otherwise.

3.3.4 Prepare and complete in a timely fashion the medical and other required records for all patients he admits or in any way provides care to in the Hospital.

3.3.5 Promptly inform the hospital of any of the following: 1) revocation or cancellation or reduction of professional liability insurance below the minimum limits required by the Board; 2) health status change which would affect his ability to practice his specialty; 3) voluntary or involuntary termination of staff membership or voluntary or involuntary reduction or loss of privileges at other health care facilities; 4) change in licensing status, including disciplinary actions by a state licensing board; and 5) Medicare/Medicaid sanctions;

3.3.6 Strictly abide by the principles adopted by said Practitioner's profession;

3.3.7 Comply with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended from time to time, and regulations promulgated thereunder by the U.S. Department of Health and Human Services (“HIPAA”) and other laws which protect the privacy, security and confidentiality of a patient’s PHI.

3.3.8 Maintain the qualifications and standards set forth in these Bylaws for Medical Staff membership; and

3.3.9 Pay Medical Staff dues and assessments as established by the Medical Executive Committee from time to time. In all cases, a practitioner’s failure to pay medical staff dues and assessments after thirty (30) days written notice shall be deemed a voluntary relinquishment of staff membership and privileges. Dues are assessed to each new applicant for their first year or part of a year.

3.4 Term of Appointment.

3.4.1 Appointment. All initial appointments (except Community Affiliate appointments) will be for a provisional period of not less than one year. Community Affiliate appointments will be for an initial period of up to two years, based on the practitioners birth date.

3.4.2 Reappointment. Reappointments to any category of the Medical Staff may not exceed two years in duration; and

3.4.3 Procedures for Appointment and Reappointment. The detailed procedures for appointment and
reappointment of the Medical Staff are outlined in the Credentials Manual.

3.4.3.1 The basic steps of the initial appointment/credentialing process include:

3.4.3.1.1 Obtaining an application from the applicant in a format approved by the MEC and the Board.
3.4.3.1.2 Verifying the information provided in the application (and/or determining that certain information cannot be verified).
3.4.3.1.3 Requesting additional information from the applicant as needed.
3.4.3.1.4 Determining whether the application is complete and the applicant meets minimum qualifications to be considered for appointment, and whether the application can continue through the process.
3.4.3.1.5 Submitting the application, if complete and minimum qualifications are met, to the relevant department chairman and Credentials Committee for evaluation and recommendation.
3.4.3.1.6 Submitting the application along with the department chairman and Credentials Committee recommendations to the MEC for review and recommendation.
3.4.3.1.7 Submitting the application along with the MEC’s recommendation to the Board.
3.4.3.1.8 Obtaining a final decision from the Board.
3.4.3.1.9 Notifying the applicant of the Board’s decision and, if applicable, any procedural rights.

3.4.3.2 The basic steps of the reappointment/re-credentialing process include:

3.4.3.2.1 Obtaining a reappointment application from each applicant in a format approved by the MEC and Board.
3.4.3.2.2 Verifying the information provided in the application (and/or determining that certain information cannot be verified).
3.4.3.2.3 Gathering ongoing professional practice evaluation data regarding the applicant, and focused professional practice evaluation data, if any, from the expiring appointment term.
3.4.3.2.4 Requesting additional information from the applicant as needed.
3.4.3.2.5 Determining whether the application is complete and can continue through the process.
3.4.3.2.6 Submitting the application, if complete, to the relevant department chairman and Credentials Committee for evaluation and recommendation.
3.4.3.2.7 Submitting the application along with the department chairman and Credentials Committee recommendations to the MEC for its review and recommendation.
3.4.3.2.8 Submitting the application along with the MEC’s recommendation to the Board.
3.4.3.2.9 Obtaining a final decision from the Board.
3.4.3.2.10 Notifying the applicant of the Board’s decision and, if applicable, any procedural rights.

3.5 Practitioners Providing Contractual Services

3.5.1 Exclusive Contracts. The Hospital may contract exclusively with a practitioner or group for clinical or other services. Examples are, but are not limited to, Emergency Medicine, Anesthesiology, Radiology, Pathology, and Clinical Laboratory/Pathology. A practitioner providing services under such an exclusive contract with the Hospital must meet the same membership qualifications, must be processed for appointment, reappointment, and privilege delineation in the same manner, and must fulfill all of the obligations for his membership category and privileges as any other applicant or member.

The Board may determine that the Hospital’s mission, community service or business interests may be best implemented by closing the membership in a department or section. Only those practitioners who are either employed by or contracted with the Hospital may continue to exercise privileges or provide clinical or non-clinical services in a department or service with a closed membership. The decision to close membership in a department or section may be undertaken by the Board after consultation with the MEC.

Medical Staff membership in such a closed department or service may be contingent upon continued employment by or contract with the Hospital. A practitioner who is no longer contracted with or employed by the Hospital in a closed department or service shall be deemed to have voluntarily resigned from the medical staff and shall not have a right to the fair hearing procedures or other appeal procedures set forth in the Bylaws or Fair Hearing Plan, as long as the Hospital service/department remains closed. Unless a department or service has been closed by the Hospital, practitioners may apply for and exercise clinical privileges they have been granted.
3.5.2 **Telemedicine.** Practitioners who provide patient care services via a telemedicine link must meet the same criteria and their applications will be processed in the same manner and with the same requirements as any other applicant or Member.

3.5.3 **Effect of Staff Appointment Termination.** A contracted or employed Practitioner's right to use Hospital facilities is automatically terminated when his Staff appointment expires or is terminated.

3.5.4 **Effect of Agreement Expiration or Termination.** The effect of expiration or other termination of an exclusive agreement upon a Practitioner's Staff appointment and Privileges will be governed solely by the terms of the Practitioner's agreement with the Hospital. Unless the agreement expressly provides that the termination of the agreement, or the Practitioner's separation from the group that has contracted with the Hospital, does not affect Staff appointment or Clinical Privileges, then the expiration of the agreement or Practitioner's separation from the group shall be deemed a voluntary resignation of medical staff membership, giving no right to the fair hearing procedures or other appeal procedures set forth in the Bylaws or Fair Hearing Plan.

3.6 **Medico-Administrative Officers.** Any Medico-Administrative Officer must apply for and obtain Medical Staff membership and privileges in the same manner as other Members as provided in Article IV. His Clinical Privileges must also be delineated in accordance with Article V. The Medical Staff appointment and Clinical Privileges of any Medico-Administrative Officer shall not be contingent on his continued occupation of that position, unless otherwise provided in an employment agreement, contract or other arrangement. All issues that arise with regard to the administrative performance of a contracted Physician or Other Licensed Individual shall be resolved in accordance with the terms of the contract.

3.7 **Bylaws.**

3.7.1 **Orientation.** The Medical Staff shall provide to its Members and individuals holding Clinical Privileges a complete copy of or electronic access to the Medical Staff Bylaws and of the Rules and Regulations of the Medical Staff.

3.7.2 **Revisions.** To ensure a continued awareness of approved Medical Staff policy and procedure is maintained, the Medical Staff shall provide to its members and individuals holding Clinical Privileges the written text of all significant revisions of the Medical Staff Bylaws, Rules and Regulations and supplemental documents.

**ARTICLE IV. MEDICAL STAFF CATEGORIES & ALLIED HEALTH PROFESSIONALS/ANCILLARY STAFF PROFESSIONALS**

4.1 **Categories.** There are five categories within the Medical Staff: active, provisional, courtesy, community affiliate and honorary. Allied Health Professionals shall not be members of the Medical Staff but may participate in the Staff organization as provided for in Section 4.7.

4.2 **Active Category.**

4.2.1 **Qualifications.** Members to this category must:

4.2.1.1 Regularly admit, consult, perform diagnostic studies or therapeutic interventions (as defined in Appendix A) in the care of an average of at least twenty-five (25) patients per year over the preceding two (2) years in the Hospital, except as expressly waived by the Board after at least twenty (20) years of service in the active category. Members who do not have direct patient contact but are actively practicing at the hospital and are involved in the treatment of patients by virtue of the nature of their specialty (radiologists and pathologists), or Members whose practice is limited to a CHW urgent care facility, will be placed in the Active category upon satisfactory completion of their provisional period.

4.2.1.2 Have completed a minimum of one year of satisfactory performance in the provisional category.

4.2.2 **Prerogatives.** Members to this category may:

4.2.2.1 Admit patients without limitation, except as otherwise provided in the Medical Staff rules and regulations, or by specific Privilege delineation;

4.2.2.2 Vote on all matters presented at general and special meetings of the Medical Staff, or presented via mail ballot, and of the Department and committees to which they are appointed;
4.2.2.3 Hold office and sit on or be the chairman of any committee, unless otherwise specified elsewhere in these Bylaws; and

4.2.2.4 Exercise such Clinical Privileges as are granted to them.

4.2.3 Responsibilities. Members to this category must:

4.2.3.1 Contribute to the organizational and administrative affairs of the Medical Staff;

4.2.3.2 Actively participate in recognized functions of Staff appointment including quality improvement and other monitoring activities, and in discharging other Staff functions as may be required from time to time;

4.2.3.3 Supervise/proctor initial members during their provisional period, as requested by initial members or by the department chairman or President;

4.2.3.4 Participate in the Emergency Department specialty coverage program as determined by their respective Departments.

4.3 Provisional Category.

4.3.1 Qualifications. Members to this category must:

4.3.1.1 Be advanced to active or courtesy category after serving not less than one (1) year and not more than two (2) years in the provisional category.

4.3.2 Prerogatives. Members to this category may:

4.3.2.1 Admit patients to the Hospital in the same manner as active category Members;

4.3.2.2 Vote only on matters presented at meetings of committees of which they are members; and

4.3.2.3 Exercise such Clinical Privileges as are granted to them;

4.3.3 Responsibilities. Each Member of the provisional category is required to:

4.3.3.1 Discharge the same responsibilities as those specified in Section 4.2.3.1 and 4.2.3.2 for the active category. Failure to fulfill those obligations is grounds for denial of advancement pursuant to Section 4.3.1.1 above or termination of Medical Staff appointment;

4.3.3.2 Participate in the Emergency Department specialty coverage program as determined by the Member’s respective Department.

4.4 Courtesy Category.

4.4.1 Qualifications. Members to this category must:

4.4.1.1 Admit, consult, perform diagnostic studies or therapeutic interventions on an average of at least one (1) patient and fewer than an average of twenty-five (25) patients per year in the Hospital, or be a Practitioner in a “low hospital utilization” specialty or who otherwise meets the criteria described in Section 5.2.5 of the Credentials Committee, or be a member in good standing of the Active Staff of Mercy Gilbert Medical Center.

4.4.2 Prerogatives. Members to this category may:

4.4.2.1 Admit patients in the same manner as active category Members;

4.4.2.2 Attend meetings of the Staff and the Department of which they are Members;

4.4.2.3 Vote on matters presented at meetings of committees of which they are members;

4.4.2.4 Exercise such Clinical Privileges as are granted to them.

4.4.3 Responsibilities. Members to this category must:

4.4.3.2 Participate in the Emergency Department specialty coverage program as determined by their respective Department.
Community Affiliate Category. The Community Affiliate category is comprised of physicians who wish to be affiliated with the Hospital but do not admit, manage, or treat patients in the Hospital. Community Affiliate physicians do not have clinical privileges and may not write inpatient orders, write progress notes, or perform diagnostic studies or therapeutic interventions on inpatients. Community Affiliate physicians are not subject to the Focused Professional Practice Evaluation (FPPE) process or the Ongoing Professional Practice Evaluation (OPPE) process. Community Affiliate physicians may order outpatient diagnostic studies in accordance with Section 6.9 of the Medical Staff Rules & Regulations. The two levels of Community Affiliate physicians are as follows:

4.5.1 Community Affiliate Level One

4.5.1.1 Qualifications.

4.5.1.1.1 Current unrestricted Arizona license
4.5.1.1.2 Current unrestricted DEA
4.5.1.1.3 Board Certification as set forth in Section 3.1.3 of these Bylaws
4.5.1.1.4 Professional liability insurance in accordance with Section 3.16 of these Bylaws
4.5.1.1.5 Eligibility to participate in Medicare/Medicaid, AHCCCS and other federally funded programs
4.5.1.1.6 Demonstrate Professional and ethical conduct

4.5.1.2 Prerogatives. Members granted Level One appointment may:

4.5.1.2.1 Voluntarily participate on E.R. outpatient referral schedule
4.5.1.2.2 Be included on the physician referral network, Resource Link
4.5.1.2.3 Participate in medical staff committee functions as a voting member
4.5.1.2.4 Attend hospital sponsored continuing education programs
4.5.1.2.5 Obtain a CHW network account to access patient information electronically

4.5.1.3 Responsibilities. Members granted Level One appointment must:

4.5.1.3.1 Complete the same credentialing process for initial appointment and reappointment that is required for practitioners granted clinical privileges, including payment of the application fee.
4.5.1.3.2 Pay all dues, fines and assessments as directed by the Medical Executive Committee.

4.5.2 Community Affiliate Level Two

4.5.2.1 Qualifications.

4.5.2.1.2 Current unrestricted Arizona license
4.5.2.1.3 Eligibility to participate in Medicare/Medicaid, AHCCCS and other federally funded programs.
4.5.2.1.4 Demonstrate professional and ethical conduct

4.5.2.2 Prerogatives. Members granted Level Two appointment may:

4.5.2.2.1 Obtain a CHW network account to access patient information electronically
4.5.2.2.2 Attend hospital sponsored continuing education programs

4.5.2.3 Responsibilities. Members granted Level Two appointment must:

4.5.2.3.1 Complete an abbreviated application and credentialing process for initial appointment and for reappointment; no application fee will be assessed.

4.6 Honorary Category.

4.6.1 Qualifications. Honorary category is restricted to those Practitioners whom, upon retirement from practice, the Staff wishes to honor.

4.6.2 Prerogatives. Honorary Members are not eligible to admit patients to the Hospital, or to exercise Clinical Privileges in the Hospital. They may, however, attend, as non-voting members, Medical Staff and Department meetings and serve on Medical Staff Committees. They are not required to pay dues.

4.7 Allied Health Professionals and Ancillary Staff Professionals.
4.7.1 General.

4.7.1.1 The term "Allied Health Professional" refers to an individual, other than a Physician or Other Licensed Individual and not a Hospital Employee, who exercises independent judgment within the areas of said individual's professional competence and the limits established by the Board, the Medical Staff and the State of Arizona, and who is qualified to render direct or indirect patient care independently or under the sponsorship/ supervision (as defined in Appendix A) of a Medical Staff member (as defined in Appendix A) possessing privileges to provide such care in the Hospital. An Allied Health Professional is not eligible for Medical Staff Membership.

4.7.1.2 The term "Ancillary Staff Professional" refers to an individual who is qualified to render medical or surgical care under the direct supervision of a Sponsor/Supervisor who has been granted such privileges to provide such care in the hospital. An Ancillary Staff Professional is not eligible for Medical Staff membership.

4.7.1.3 Based upon the recommendations of the Medical Executive Committee the Board shall delineate: (1) the Allied Health categories eligible to apply for Clinical Privileges; (2) the mode of practice in each category (whether dependent or independent); and (3) the scope of practice or Clinical Privileges, Prerogatives, terms and conditions attended to each category; (4) the Ancillary Staff Professional categories and their scope of practice.

4.7.1.4 The activities of Allied Health Professionals and Ancillary Staff Professionals will be governed by the applicable section of the Credentials Manual.

4.7.1.5 Sponsors/supervisors shall be responsible for overseeing and evaluating the work performance of dependent Allied Health Professionals and Ancillary Staff Professionals at the Hospital and for providing a written evaluation of their performance and competence annually and at reappointment.

4.7.2 Removal Procedures and Status.

4.7.2.1 Allied Health Professionals and Ancillary Staff Professionals are not Members of the Medical Staff and accordingly, have none of the duties and Prerogatives of Members; and

4.7.2.2 The Hospital has the right, either through the administration or upon recommendation of the Medical Executive Committee, to suspend, terminate, revoke or modify any or all of the clinical activities/scope of practice or privileges or functions of any Allied Health Professional or Ancillary Staff Professional without recourse on the part of such person(s) or others to the review and appeal procedures for Medical Staff Members as set forth in the Fair Hearing Plan.

4.7.2.2.1 Independent Allied Health Professionals whose Privileges are suspended, terminated, revoked or modified shall be told in writing the reasons for such action and, if they so request in writing, shall be entitled to the appeal procedures for Allied Health Practitioners described in the Fair Hearing Plan prior to any action by the Board.

4.7.2.2.2 A dependent Allied Health Professional or Ancillary Staff Professional whose clinical privileges are suspended, terminated, revoked or modified shall be told in writing the reasons for such action and, if they so request in writing, shall be entitled to the appeal procedures for Allied Health Practitioners and Ancillary Staff Professionals described in the Fair Hearing Plan prior to any action by the Board.

4.8 Medical Education Programs. Chandler Regional Medical Center is not a participant in a formal medical education program. However, students, interns, or residents may participate in patient care activities at the hospital or off-site facility while serving a clinical rotation under the preceptorship of a Staff Member. The credentialing requirements and guidelines for participation in patient care are described in the Credentialing and Clinical Guidelines established and adopted by the Medical Staff and the Board.

ARTICLE V. CLINICAL PRIVILEGES

5.1 Exercise of Privilege. A Practitioner providing clinical services at the Hospital or outpatient facility may exercise only those privileges granted to him by the Board or specified in Section 5.6 of these Bylaws. The Board has final authority on granting, renewing, revising, reinstating or denying privileges. The Privileges granted to each
Practitioner shall be on file in the office of the Medical Staff and on file or accessible electronically in other appropriate locations in the Hospital.

5.2 Delineation of Clinical Privileges.

5.2.1 Requests. Each application for appointment or reappointment to the Medical Staff (except Community Affiliate appointments) must include a request for specific Clinical Privileges desired by the applicant. Specific requests must also be submitted, in writing, for temporary privileges, locum tenens privileges, and for modification of privileges in the interim between reappointments. The National Practitioner Data Bank will be queried at the time of initial granting of privileges, biennial renewal, and when new or additional privileges are requested.

5.2.2 Basis for Privileges Determinations. Requests for Clinical Privileges will be evaluated on the basis of education, training, experience, demonstrated competence, ability and judgment. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical performance and documented results of the Staff's quality management program activities. Privileges determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises Clinical Privileges. The information will be added to and maintained in the Medical Staff file established for the Member.

5.2.3 Basis for “Grandfathering”. From time to time, a Department may decide that optimizing patient safety requires it to revise the credentials required for a medical staff member to exercise particular privileges within a Department. Such revision may prospectively render medical staff members who, prior to the revision exercise such privilege, no longer qualifies to exercise the privilege. In such cases, a decision must be made whether to “grandfather” those practitioners who, prior to the revision validly held such privilege. It is the responsibility of each Department, at the time a decision is made to revise the credentials required to exercise a privilege, to make a determination whether medical staff members currently holding the privilege will be granted an exemption from the new requirement. Any decision to disallow grandfather of medical staff members currently holding a privilege should be made based on objective, verifiable data supported by relevant literature and practice in the community, reflecting an underlying desire to maximize patient safety. In no case should subjective or economic factors be used to make the determination. In every case, the criteria for the decision must be consistently applied to every affected member of the Department.

5.2.4 System and Procedure for Delineating Privileges. The procedure by which requests for Clinical Privileges are processed and the specific qualifications for the exercise of privileges are in the Credentials Manual and are incorporated herein by reference.

5.2.5 Focused and Ongoing Evaluations. All practitioners who are granted clinical privileges are subject to the focused and ongoing practice evaluations described in the Professional Practice Evaluation Policy.

5.3 Special Conditions for Dental and Podiatric Privileges. Requests for Clinical Privileges for dentists and podiatrists are processed in the manner specified in this Article. Surgical procedures performed by dentists and podiatrists will be under the overall supervision of the chairman of the Department of Surgery. All dental and podiatric patients will receive a basic medical appraisal by a Member of the Medical Staff who must determine the risk and effect of any proposed surgical or special procedure. This basic medical appraisal form (history and physical) issued by the hospital must be completed by the podiatrist and dentist prior to the procedure and updated 24 hours prior to the procedure. For patients with any pre-existing medical conditions (ASA II or higher), there must be a history and physical or consultation report from an appropriate specialist, in addition to the basic medical appraisal, that indicates the patient is medically stable and optimized for surgery. It is the responsibility of the podiatrist and dentist to make arrangements with a qualified M.D. or D.O. to assume responsibility for medical management of the patient in the event of a complication during the surgical procedure that necessitates further medical intervention or admission.

5.4 Special Conditions for Allied Health Professionals (AHP) & Ancillary Staff Professionals (ASP). Requests to perform specified patient care services from AHPs and ASPs are processed in the manner specified in Section 4.7 and in the applicable section of the Credentials Manual. An AHP or ASP may, subject to any licensure requirements or other limitations, exercise independent judgment within the areas of his professional competence and participate directly in the medical management of patients under the supervision of a Physician (Sponsor/Supervisor) who has been accorded privileges to provide such care.

5.5 Temporary Privileges.

5.5.1 Conditions. Temporary privileges may be granted as described in Section 5.5.2, only to an appropriately licensed Practitioner, when available information reasonably supports a favorable determination regarding the requesting Practitioner’s qualifications, ability, and judgment to exercise
the Privileges requested, and only after the Practitioner has satisfied the professional liability insurance requirement of these Bylaws, if required. Special requirements of consultation and reporting may be imposed by the Department chairman responsible for supervision. Except in unusual circumstances, temporary privileges will not be granted unless the Practitioner has agreed in writing to abide by the Bylaws, Rules and Regulations and policies of the Staff and the Hospital in all matters relating to his temporary privileges. Whether or not such written agreement is obtained, these Bylaws, Rules, Regulations and policies control all matters relating to the exercise of Clinical Privileges.

5.5.2 Circumstances. Upon written concurrence of the Medical Staff President or the Chairman of the Department where the privileges will be exercised, the Administrator, or authorized designee, may grant temporary privileges in the following circumstances:

5.5.2.1 Pendency of Application. After receipt of a completed application for Staff appointment, completion of the verification process, and evidence that the applicant has the items listed below, Category I applicants (no adverse information) are granted temporary privileges, effective with Credentials Committee approval, while awaiting review and recommendation by the MEC and approval by the Board, for a period not to exceed 120 days. Category II applicants may be eligible for temporary privileges as determined by the Credentials Committee on a case-by-case basis, depending on the nature of the adverse information that caused the Category II designation.

5.5.2.1.1 current licensure, with no current or previously successful licensure restrictions;
5.5.2.1.2 current DEA certification (if applicable), with no current or previously successful restrictions;
5.5.2.1.3 evidence of current professional liability insurance;
5.5.2.1.4 relevant training and/or experience and current competence and ability to perform the privileges requested;
5.5.2.1.5 not been subject to involuntary termination of medical staff membership at another organization;
5.5.2.1.6 not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another organization.

5.5.2.2 Care of Specific Patients. Upon receipt of a written request, or via telephone in unusual circumstances, temporary privileges may be granted for an important patient care need for the care of one or more specific patients to a Practitioner who is not an applicant for Staff appointment if there is verification of current unrestricted licensure, current professional liability insurance, current unrestricted and valid DEA certificate, and current competence. Such requests for temporary privileges shall be limited to nine (9) patients in any twelve (12) month period.

5.5.3 Termination of Temporary Privileges. The Medical Staff President or the Administrator, after consultation with the appropriate Department chairman (or his designee), must on the discovery of any information or the occurrence of any event of a nature which raises questions about a Practitioner's professional qualifications or ability to exercise any or all of the temporary Privileges granted, and may at any other time, terminate any or all of a Practitioner's temporary Privileges; provided, however, that where the life or well being of a patient is determined to be endangered, the termination may be effected by any person entitled to impose summary suspension under these Bylaws. In the event of any such termination, the Practitioner's patients then in the Hospital will be assigned to another Practitioner by the chairman responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute Practitioner.

5.5.4 Rights of the Practitioner With Temporary Privileges. A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws and the Fair Hearing Plan because his request for temporary privileges is refused or because all or any part of his temporary privileges are terminated or suspended.

5.6 Locum Tenens. Locum tenens privileges may be granted to a practitioner to provide coverage for a current medical staff member. Locum tenens privileges may not exceed one hundred twenty (120) days and will be granted no more than one (1) time in a 12-month period. Practitioners seeking locum tenens privileges shall provide the items listed below. All information provided by the applicant will be verified prior to locum tenens privileges being granted.

5.6.1 A completed Locum Tenens application
5.6.2 A completed privileges request form
5.6.3 Copy of Medical School diploma, if applicable
5.6.4 Copy of internship/residency/fellowship certifications, if applicable
5.6.5 Three letters of recommendation from peers who are familiar with the applicant’s current clinical skills

Chandler Regional Medical Center
Mercy Gilbert Medical Center
and abilities

5.6.6 Evidence of current Board status (eligibility or certification)
5.6.7 Evidence of current professional liability insurance in the form and amounts prescribed in these bylaws and by the Board for all practitioners
5.6.8 Copy of current Arizona license and/or certification
5.6.9 Copy of DEA certificate, if applicable
5.6.10 An application fee in the amount determined by the MEC

5.7 Disaster Privileges. Disaster privileges may be granted by the Administrator, Chief Medical Officer, or Medical Staff President, or his/her designee, when the disaster plan has been activated and if the organization is unable to handle the immediate patient needs. The decision to grant disaster privilege shall be made by the responsible individual on a case-by-case basis at his/her discretion.

5.7.1 Disaster privileges may be granted to a practitioner on presentation of a valid government-issued photo identification issued by a state or federal agency, and any or some combination of the following items:

5.7.1.1 a current photo hospital ID card
5.7.1.2 a current license to practice
5.7.1.3 identification indicating that the individual is a member of a Disaster Medical Assistance Team;
5.7.1.4 identification indicating that the individual has been granted authority to render patient care in emergency circumstances granted by a federal, state or municipal entity;
5.7.1.5 presentation by a current hospital staff member with personal knowledge regarding practitioner’s identity.

5.7.2 A photo ID badge will be issued by the hospital and must be worn by the practitioner and visible at all times to allow staff to readily identify these individuals.

5.7.3 Oversight of individuals granted disaster privileges shall be accomplished either by direct observation by a member of the medical staff or a review of the records, to the extent possible, based on the nature of the disaster.

5.7.4 As soon as the immediate emergency situation is under control, the process of verifying the credentials and privileges of the individuals granted emergency privileges shall be instituted and completed within 72 hours from the time the volunteer practitioner presents to the organization; this process shall include the following:

5.7.4.1 Current unrestricted licensure;
5.7.4.2 Current unrestricted DEA;
5.7.4.3 Current professional liability insurance as required by these Bylaws;
5.7.4.4 Relevant training/experience;
5.7.4.5 Current competence;
5.7.4.6 Health status/ability to perform privileges;
5.7.4.7 Board status;
5.7.4.8 National Practitioner Data Bank query;
5.7.4.9 No current or previously successful licensure challenges;
5.7.4.10 No involuntary termination of medical staff membership at another institution;
5.7.4.11 No involuntary limitation, reduction, denial or loss of clinical privileges;
5.7.4.12 No OIG sanctions.

5.7.5 The organization will make a decision, based on the information listed in Section 5.5.3.4 above, regarding continuation of the disaster privileges initially granted within 72 hours.

5.8 Emergency Privileges. In the case of emergency, any Practitioner will be permitted to use any Hospital facility and take any action necessary, within the scope of said Practitioner's license, to save a patient's life or to save a patient from serious harm, regardless of the individual's Staff status or Clinical Privileges. When the emergency ceases to exist, such a Practitioner must request, pursuant to the terms of this Article 5, temporary or additional privileges necessary to continue to attend the patient. In the event such temporary privileges are denied or are not requested, the patient shall be assigned to an appropriate member of the Medical Staff. For purposes of this Section 5.6, emergency is defined as a condition in which the patient is in immediate danger of a loss of life or serious permanent harm, and any delay in administering treatment would add to such a danger.

5.9 Provisional Period

5.9.1 Duration. All initial appointments to the Staff (except appointments to the Community Affiliate category) and all grants of Clinical Privileges to new Members are provisional for a minimum period of
one year.

5.9.2  **Purpose.** During the provisional period, a Practitioner's performance will be evaluated and documented as specified in the Professional Practice Evaluation Policy.

5.9.3  **Procedure for Concluding or Extending the Provisional Period.** The mechanism for extending and concluding the provisional period is outlined in the Credentials Manual and incorporated herein by reference.