

Arizona State
Civil and Forensic
Hospital
Medical Staff
BYLAWS
2015-2017

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DEFINITIONS

In these bylaws, unless the context otherwise requires:

1. **"A.R.S."** means Arizona Revised Statutes.
2. **"ACTIVE MEDICAL STAFF"** means Physicians, Nurse Practitioners, Dentists, Podiatrists and Physician Assistants who are appointed as members and privileged to attend patients or to provide other diagnostic, therapeutic, medical or surgical services at the Arizona State Hospital. Save when otherwise indicated, the use of the term Medical Staff will include both these members and members of the Associate Medical Staff. The Medical Staff is a self-governing organization.
3. **"ASSOCIATE MEDICAL STAFF"** means Pharmacists, and Registered Dieticians who are credentialed to perform ancillary patient care duties by the Medical Staff under these bylaws and the Credentialing Manual. Associate Medical Staff are exempt from the attendance requirements for Medical Staff meetings and do not have voting privileges within the Medical Staff.
4. **"CHAIRPERSON"** or **"CHAIR"** means the chairperson of a Medical Staff Committee.
5. **"CHIEF MEDICAL OFFICER," "CMO" OR "CHIEF"** means the Chief Medical Officer of the Arizona State Hospital. The CMO has the alternative title of "Medical Director of the Arizona State Hospital."
6. **"CHIEF EXECUTIVE OFFICER"** or **"CEO"** has the alternative title of the Superintendent of the Arizona State Hospital.
7. **"CLINICAL PRIVILEGES"** or **"PRIVILEGES"** means the permission granted to a Medical Staff member or Visiting Staff member to provide those diagnostic, therapeutic, medical or surgical services specifically delineated to him/her.
8. **"DENTIST"** means a person licensed under the provisions of A.R.S. §§ 32-1201, et seq.
9. **"DEPARTMENT"** means the Department of Health Services.
10. **"DEPUTY DIRECTOR"** means the Deputy Director of the Division of Behavioral Health in the Department of Health Services.
11. **"DIVISION"** means the Division of Behavioral Health in the Department of Health Services.
12. **"EMPLOYEE"** means an officer or employee of the State Hospital.
13. **"EX-OFFICIO"** means serves as a member of a body by virtue of a position and means

without voting rights.

14. **“GOVERNING AUTHORITY”** means the Director of The Department of Health Services or the DIRECTOR’S designee.
15. **“GOVERNING BODY” OR “BODY”** consisting of the Deputy Director of the Division of Behavioral Health, an Arizona State Hospital physician and a community representative. This Body is responsible for the overall direction of the Hospital.
16. **“HOSPITAL”** or **“STATE HOSPITAL”** means Arizona State Hospital.
17. **“LICENSED INDEPENDENT PRACTITIONER”** is any individual permitted by law and by the organization to provide care and services without direction and supervision within the scope of the individual’s license and consistent with individually-granted clinical privileges.
18. **“MEDICAL DIRECTOR”** of the Arizona State Hospital has the alternative title of Chief Medical Officer.
19. **“MEDICAL STAFF”** will be used to identify all members of the medical Staff, including Associate and Active Medical Staff members. The Medical Staff is a self-governing organization.
20. **“MEDICAL STAFF EXECUTIVE COMMITTEE”** or **“MEC”** means a committee comprised of the officers of the Medical Staff and two elected members.
21. **“MEDICAL STAFF YEAR”** means the twelve-month period commencing July 1 of each year and ending on June 30th of the following year (state fiscal year).
22. **“NURSE PRACTITIONER”** means a person licensed under ARS §§ 32-1601 et seq. to practice as a Registered Nurse Practitioner.
23. **“PERFORMANCE IMPROVEMENT”** means the system outlined in the Performance Improvement Plan and associated department plans.
24. **“PHARMACIST”** means a person who holds either a Rh.P. or Pharm.D degree who is also licensed under the provisions of ARS §§ 32-1901 et seq.

“PHYSICIAN” means a person licensed under the provisions of A.R.S. §§ 31-1801 et seq. and 32-1401 et seq.
25. **“PHYSICIAN ASSISTANT”** means a person licensed under the provisions of A.R.S. §§ 32-2501 et. seq. and who has in place a signed agreement with a supervising physician, in accordance with these bylaws and the requirements as outlined in the above referenced statutes.

26. **"PODIATRIST"** means a person licensed under the provisions of A.R.S §§ 32-801 et seq.
27. **"PRESIDENT"** means the elected President of the Medical Staff.
28. **"QUALITY IMPROVEMENT, QUALITY MANAGEMENT, QUALITY ASSURANCE"** means the system outlined in the Hospital's Performance Improvement Plan and associated departments.
29. **"REGISTERED DIETICIAN"** means an individual who holds certification as a Registered Dietician (R.D.) from the Commission on Dietetic Registration, and who meets the educational and training requirements of the American Dietetic Association.
30. **"R.B.H.A."** means Regional Behavioral Health Authority.
31. **"STAFF MEMBERSHIP** or **"MEMBERSHIP"** means appointment of an individual to the Active Medical Staff or the Associate Medical Staff. This is separate from clinical privileging.
32. **"SUPERINTENDENT"** means the Superintendent of the State Hospital. The Superintendent has the alternate title of Chief Executive Officer.
33. **"VISITING STAFF"** mean practitioners who are privileged to consult on or manage patients on a limited basis. These individuals are not considered to be members of the Medical Staff as covered under these bylaws. Rather, these are professionals who have applied for, and granted, privileges through the credentialing process.

PREAMBLE

- A. These bylaws are promulgated in accordance with A.R.S. §§ 36-445 et. seq.
- B. There is established a Department of Health Services (Arizona Revised Statutes A.R.S. § 36-101, et seq.), under a Director who is responsible for direction, operation and control of the Department, pursuant to A.R.S. § 36-102(B) and who is appointed by the Governor, pursuant to A.R.S. § 36-102(C).
- C. There is established a Division of Behavioral Health in the Department of Health Services, pursuant to A.R.S. § 36-3402, which shall be under the direction, operation and control of the Deputy Director who shall be appointed by and report to the Director of the Department of Health Services. The Deputy Director shall administer unified mental health programs to include the functions of the State Hospital and community mental health, and appoint the Superintendent of the Arizona State Hospital, subject to the approval of the Director of the Department of Health Services, pursuant to A.R.S. § 36-3403(B),(D).
- D. The Arizona State Hospital is a hospital established by statutes within the Department of Health Services and shall be maintained for the care and treatment of persons with mental disorders, and persons with other personality disorders or emotional conditions who will benefit from care and treatment. Admissions to the State Hospital shall be in accordance with law. A.R.S. §§ 36-202(A). The Hospital shall be under the charge and control of the Deputy Director of the Division of Behavioral Health, pursuant to A.R.S. § 36-202(D). There is a Superintendent of the Arizona State Hospital who shall be appointed by and be under the supervision of the Deputy Director, pursuant to A.R.S. §§ 36-3403 (D) and 36-205.

The Superintendent shall supervise and direct the activities of the Arizona State Hospital and be directly responsible to the Deputy Director for carrying out the purposes for which the Hospital is maintained. The Superintendent may deputize, in writing, subject to the approval of the Deputy Director, any qualified officer of the State Hospital to do or perform in his/her stead, any act the Superintendent is empowered to do or charged with the responsibility of doing by law. A.R.S. § 36-206(A). The Deputy Director may employ or contract with physicians to provide the necessary Medical Staff upon recommendation of the Superintendent.

The Deputy Director may permit members of Associate Medical Staff, the Medical Staff, or Visiting Staff to act as consultants in psychiatry, pharmacy and other areas of the healing arts as long as they are privileged members of the Associate Medical Staff, Medical Staff, or Visiting Staff and possess a current valid license.

- E. The Governing Authority of the Arizona State Hospital is the Director of the Department of Health Services or the Director's designee. The Superintendent functions as the Chief Executive Officer, appoints the Chief Medical Officer with approval of the Deputy Director, pursuant to A.R.S. § 36-205(E), and serves as chief spokesman for the Arizona

State Hospital with the Governing Authority.

- F. The Chief Medical Officer shall have not less than three years of experience in the treatment of psychiatric disorders and shall be certified in psychiatry by the American Board of Psychiatry and Neurology. A.R.S. § 36-205(E).

The Chief Medical Officer is responsible for the clinical administration of the Hospital including diagnosis and all medical care and treatment and shall report directly to the Superintendent. A.R.S. § 36-205(E). In order to discharge these responsibilities, the Chief Medical Officer delegates such duties and responsibilities to those Physicians, Dentists, Pharmacists, Registered Dieticians, Nurse Practitioners, Podiatrists and Certified Physician Assistants (as defined in the Arizona State Hospital Medical Staff bylaws as the Associate or Active Medical Staff) who are employed by or contracted with and granted privileges to engage in practice at the Arizona State Hospital.

The Superintendent is responsible for a process designed to assure that all individuals who provide patient care services, but who are not subject to the Medical Staff privilege delineation process, are competent to provide such services. Subject to the laws of this State governing State personnel administration, the Superintendent may discharge an employee for cause. A.R.S. § 36-208(B). In order to provide such reports as requested by the Deputy Director or required by statute, the Superintendent shall delegate such responsibilities to employees, committees and service areas within the Hospital as appropriate. The Superintendent, on request, shall provide to the Deputy Director a clinical assessment of the Hospital's programs pursuant to A.R.S. §§ 36-206 et seq. and a comprehensive annual report of the activities of the Arizona State Hospital pursuant to A.R.S. § 209(A). The Superintendent shall maintain a method of communication between the Governing Authority and the Hospital in conformity with the rules and regulations of the department.

- G. Personnel employed by or contracted with the Department of Health Services, including those employees who are exempt under A.R.S. § 41-771, are subject to the Arizona conflict of interest statutes, A.R.S. §§ 38-501 et seq. Amendments and revisions of these bylaws may be made at any time under Article XIII and in conformity with the Rules and Regulations of the Arizona Department of Health Services. Amendments and revisions so declared shall be effective on the date of approval by the Superintendent of the Arizona State Hospital, or the Deputy Director of the Division of Behavioral Health to the extent required under applicable law.
- H. The Arizona State Hospital Medical Staff Rules and Regulations are incorporated in these bylaws by reference in their entirety as if fully set forth herein.

**ARTICLE I
NAME**

The name of this body shall be the "Medical Staff of the Arizona State Hospital," hereinafter referred to as the "Medical Staff."

**ARTICLE II
PURPOSE AND RESPONSIBILITIES**

A. THE PURPOSE OF THE MEDICAL STAFF SHALL BE:

1. To make reasonable efforts to see that the quality of patient care provided by the Hospital is maintained at the generally recognized community standard, and to help ensure Patient safety.
2. To provide a means whereby problems of a medical-administrative nature may receive effective discussion and action; and to create a mechanism designed to provide for effective communication among the Medical Staff, Hospital Administration and the Governing Body.
3. To initiate and maintain these bylaws, Credentialing Procedures and Rules and Regulations for governance of the Medical Staff, subject to and consistent with the standards of the community and the policies of the Governing Authority.
4. To monitor and evaluate clinical Hospital activities of each Medical Staff member in order to promote maintenance of quality performance.
5. To provide Continuing Medical Education programs that will assist in maintaining and advancing professional knowledge and skill for the Medical Staff in compliance with requirements of professional societies and medical licensing bodies.
6. To provide for a mechanism for appropriate delineation of clinical privileges for members of the Medical Staff.
7. To provide a framework within which Medical Staff members can act with a reasonable degree of freedom and confidence in the provision of patient care services.
8. The organized Medical Staff provides oversight in the process of analyzing and improving patient satisfaction.

B. THE RESPONSIBILITIES OF THE MEDICAL STAFF SHALL BE:

1. To participate in the Hospital's Performance Improvement Program.

2. To make recommendations to the Chief Medical Officer (Medical Director) and the Governing Body regarding appointments and reappointments to the Medical Staff, including clinical privileging and to make recommendations regarding the delivery of quality medical care for patients and to help ensure Patient safety.
3. To maintain, administer, recommend amendments to and enforce these bylaws, supporting manuals and the Rules and Regulations of the Medical Staff and the relevant Policies and Procedures of the Hospital.
4. To establish, maintain and support sound professional practices and initiate corrective action when warranted.
5. To provide clinical leadership in assuring that quality patient care is provided for all Arizona State Hospital patients and that Patient care is provided in an effective and efficient manner, which helps to ensure Patient safety.

ARTICLE III MEMBERSHIP

A. ELIGIBILITY FOR MEMBERSHIP ON THE MEDICAL STAFF:

1. Membership on the Medical Staff or Associate Medical Staff shall extend only to professionally competent, physically and mentally capable Physicians, Nurse Practitioners, Dentists, Podiatrists, Physician Assistants, Pharmacists, and Registered Dietitians who are employed by or contracted with the Arizona Department of Health Services who continually meet the qualifications, standards and requirements set forth in these bylaws, the provisions of their contractual agreements and the Arizona Revised Statutes.
2. Only Physicians, Nurse Practitioners, Dentists, Podiatrists, Physician Assistants, and Pharmacists licensed to practice in the State of Arizona, or Registered Dietitians in good standing with the American Dietetic Association, who can document their background, experience, training, current competence, physical and mental capability, their adherence to the ethics of their profession, and their good reputation with sufficient adequacy to assure the Medical Staff and the Governing Authority that any patient treated by them in the Hospital will be given quality patient care, shall be qualified for membership of the Medical Staff or Associate Medical Staff.
3. All applicants for Medical Staff or Associate Medical Staff membership shall satisfy such additional training and clinical experience requirements as may be established by the Medical Staff Executive Committee.
4. Membership may not be denied on the grounds of gender, age, race, religion,

color, national origin, political affiliation or sexual preference.

5. All applicants for Medical Staff or Associate Medical Staff membership, if not otherwise employed by the Arizona Department of Health Services, must maintain professional liability insurance coverage with limits of coverage not less than those that may, from time to time, be established by the Director of the Department of Health Services.
6. Acceptance of membership on the Medical Staff or Associate Medical Staff shall constitute the Staff member's agreement that the member will abide by the principles of medical and professional ethics as adopted or amended by the American Psychiatric Association, the American Medical Association, the American Osteopathic Association, The American Dietetics Association, The American Pharmacists Association, the American Dental Association or the American Podiatric Association.
7. No applicant may apply for Medical Staff or Associate Medical Staff membership more than once per Medical Staff year if the applicant's application has been denied for clinical reasons. This does not apply if an applicant has resigned his/her membership.

B. TERMS AND CONDITIONS OF APPOINTMENT:

1. All appointments to the Medical Staff shall be made by the Governing Body upon recommendation of the Chief Medical Officer and the Medical Staff Executive Committee as outlined in these bylaws and the Credentialing Procedures Manual. The term of Medical Staff appointment shall be for no more than two years.
2. Initial appointment to the Active Medical Staff as defined in Article IV shall be provisional and shall be made for a minimum period of six (6) months and not to exceed one year. Failure to be advanced from provisional status within one year will result in expiration of appointment. Recommendation for change in provisional status shall be made by the Medical Staff Executive Committee (MEC) when the member has met the performance requirements for advancement. Change in provisional status shall be recommended by the Chief Medical Officer with the advice of the Medical Staff Executive Committee. The Governing Body makes the final determination for advancement, as outlined in the Credentialing Procedures Manual.
3. Appointment to the Medical Staff does not, in itself, confer clinical privileges on the appointee. Privileges are separately requested and granted by the Governing Body upon recommendation by the Medical Staff Executive Committee.
4. Reappointment and re-privileging shall be made at two-year intervals.
5. Medical Staff or Associate Medical Staff membership and clinical privileges of

employed or contracted Medical Staff categories, will automatically terminate upon termination of the employment or contract by the Governing Body or at the end of the contract period in the event that no new contract has been entered into between the Medical Staff member and the Department of Health Services.

6. The CMO or other administrative physicians must go through the same appointment and reappointment process as other Medical Staff if providing clinical services.

C. RESPONSIBILITIES OF STAFF MEMBERSHIP:

Members will:

1. Provide their patients with care at a generally recognized community standard for quality and efficiency of medical care.
2. Provide for continuity of patient care, insuring that another member of the Medical Staff provides coverage for assigned patients. They will seek consultations when necessary.
3. Agree to abide by the Medical Staff bylaws, Rules and Regulations and Policies and Procedures of the Arizona State Hospital, including all pertinent provisions of state and federal laws.
4. Be responsible for the preparation and the timely completion of medical records and other accreditation and licensing requirements, quality assurance reviews and clinical practice requirements.
5. Abide by the ethical principles of the profession.
6. Participate in meetings, peer review, committee work, and other functions of the Medical Staff.
7. Agree that quality and appointment-related discussions, deliberations, records and other information of the Medical Staff, clinical services and their committees, shall be confidential to the fullest extent of the law. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff, or where no officially adopted policy exists, only with the express approval of the Medical Staff Executive Committee or the Chief Medical Officer.

**ARTICLE IV
MEDICAL STAFF CATEGORIES**

A. PROVISIONAL STATUS:

All initial appointments to the Active and Associate Medical Staff shall be made to the Provisional Status category. Provisional Status members may admit and provide patient care consistent with provisionally granted privileges under the general direction of the Chief Medical Officer or designee where the applicants' performance and clinical competence can be observed and evaluated; may be eligible to serve on Medical Staff committees and vote on matters before such committees; may vote on matters before the Medical Staff and hold office of the Medical Staff; are required to attend Medical Staff meetings and honor emergency service assignments according to provisionally granted privileges; and may fulfill consultation requirements.

B. ACTIVE STAFF:

Active Staff shall consist of those Medical Staff member Physicians, Nurse Practitioners, Dentists, Podiatrists and Physician Assistants who have been employed or contracted either part time or full time, and who admit patients and participate independently in the care and treatment of patients consistent with clinical privileges granted at the Arizona State Hospital. Only a Pharmacist, who holds a Pharm.D and possess advanced qualifications in Psychopharmacology, will be eligible for membership in the active Medical Staff. All applicants for membership on the Active Staff shall first have satisfactorily completed service as members on Provisional Status. Active Staff members shall have been members on Provisional Status for no less than six (6) months and for no longer than twelve (12) months from the date of initial appointment.

Active Staff members may vote on committee matters and matters before the Medical Staff, hold an office of the Medical Staff, serve on Medical Staff committees and must attend assigned committee meetings except as provided in these bylaws.

C. ASSOCIATE MEDICAL STAFF:

Associate Medical Staff shall consist of Pharmacists or those Registered Dieticians who request privileges to write orders, which are employed by or contracted with the Arizona State Hospital on at least a part time basis. Associate Medical Staff members participate independently in patient care consistent with clinical privileges granted at the Arizona State Hospital. All applicants for membership on the Associate Medical Staff shall first have satisfactorily completed service as members on Provisional Status. Associate Medical Staff members shall have been members on Provisional Status for no less than six (6) months and for no longer than twelve (12) months from the date of initial appointment.

Associate Medical Staff members may not vote on matters before the Medical Staff, may not hold an office of the Medical Staff, may not admit patients, are not required to attend general Staff meetings, and may be assigned to chair or serve on Medical Staff committees and may vote on matters before such committees.

D. TEMPORARY STAFF:

Temporary Staff appointment shall exist when appointment to the Medical Staff is pending and a request for clinical privileges is in progress. Applicants to the Visiting Staff may be appointed to Temporary status when the CMO believes that the delay in processing the request for clinical privileges will result in a potential loss of service to patients. Temporary Staff members may participate independently in the care and treatment of patients consistent with temporary clinical privileges granted at the Arizona State Hospital. If the Temporary Staff member is awaiting appointment to the Active Staff, then they may chair or serve on Medical Staff committees, and vote on matters before such committees, and may vote on matters before the Medical Staff, but may not hold an office of the Medical Staff.

Temporary Staff applicants shall act under the supervision of the Chief Medical Officer or a delegated Medical Staff member who is not on provisional status. Temporary Staff may be granted by the CMO for an initial period of 90 days, with one 30-day renewal. Temporary privileges may not be granted for more than 120 days.

E. VISITING STAFF:

Visiting Staff members are those practitioners with clinical privileges to provide specific services to patients, but who are either not requesting appointment to, or would qualify on the basis of less than part time employment, the Medical Staff. In general, applicants to the Visiting Staff category would be practitioners who are contracted either with the Arizona State Hospital or an outside agency who provide either a time limited service, or an ongoing service in a limited specialty area occupying less than 10 hours per week. Physicians who are contracted or employed solely for the purposes of providing after hours "on call" coverage would also be eligible for this category. Applicants to the Visiting Staff must undergo the same credentialing process as applicants to the Active Medical Staff.

Visiting Staff may not admit or discharge patients from the hospital and may not write orders in the medical records unless privileged to do so (as would be the case for physicians providing after hours call coverage). Visiting Staff should only document in the medical record using the medical records forms appropriate to the service being provided.

ARTICLE V DELINEATION OF CLINICAL PRIVILEGES

A. EXERCISE OF PRIVILEGES:

A Physician, Dentist, Podiatrist, Registered Dietician, Pharmacist, Nurse Practitioner, or Certified Physician Assistant providing clinical services at the Arizona State Hospital

may exercise only those clinical privileges granted by the Governing Body upon recommendation of the Medical Executive Committee and the Chief Medical Officer. In addition to those responsibilities noted in Article IV, the duties and privileges of each medical Staff are delineated in the Application for Medical Staff Appointment. Furthermore, Medical Staff members in the Temporary, Provisional, or Active categories will follow the documentation requirements outlined in ClinSvsDocument004, "Physician's Documentation Responsibilities in the Health Records".

B. DELINEATION OF PRIVILEGES:

1. REQUESTS:

- a. Each application for appointment or reappointment to the Medical Staff or the Visiting Medical Staff must contain a request for specific clinical privileges desired by the applicant. Specific requests must also be submitted for temporary privileges and for modifications of privileges.
- b. Each application for Visiting Staff privileges must clearly state those clinical privileges which are being requested by the applicant. Specific requests must also be submitted for temporary privileges and for modifications of privileges.

2. BASIS FOR DETERMINATION:

- a. Requests for clinical privileges will be evaluated on the basis of education, training, experience, references, demonstrated current competence, ability and judgment. This decision is not based solely upon certification, fellowship, or membership in a specialty body or society. The basis for all privilege determination in connection with periodic reappointment or a requested change in privileges must include documented clinical performance, references and results from the Staff's Performance Improvement Peer Review activities. Participation in continuing education is necessary for reappointment to membership on the Medical Staff or renewal or revision of individual clinical privileges. Privilege determinations will also be based on pertinent information from other sources, especially from other institutions and health care settings where a professional exercises clinical privileges as well as from the National Practitioner Data Bank. This information will be added to and maintained in a Visiting or Medical Staff file established for the Visiting or Medical Staff member or be available through files kept by the Medical Staff Coordinator or by the discipline/department chief or the Quality Risk Management department. Requests for initial, renewed, or revised clinical privileges will include, but are not limited to, consideration of: previously successful or current pending challenges to any license or registration or

the voluntary relinquishment of such license or registration; voluntary or involuntary termination of Medical Staff membership; voluntary or involuntary limitation, reduction, or loss of clinical privileges at another hospital; and involvement in professional liability actions resulting in final judgments or settlements. Gender, race, creed, and national origin are not used in this process.

- b. The CMO and other administrative physicians are subject to the same privileging process as other Staff members if exercising Clinical privileges.

3. 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 provided in the Credentialing Procedures Manual and are incorporated herein by reference.

C. TEMPORARY PRIVILEGES:

1. GENERAL PROVISIONS:

Temporary privileges may be granted by the Chief Medical Officer, only in the circumstances described in Section C.2 of this Article to an appropriately licensed Physician, Pharmacist, Registered Dietician, Nurse Practitioner, Dentist, Podiatrist, or Certified Physician's Assistant, and only when available information reasonably supports a favorable determination regarding the requesting professional's ability and judgment to exercise the privilege requested. Circumstances such as a current challenge or a previously successful challenge to licensure or registration, involuntary termination of medical Staff membership at another organization, involuntary limitation, reduction, denial, or loss of clinical privileges at another institution, or a pattern of liability actions will be considered in the decision to allow temporary privileges. In addition, if the person is not employed by the State, there must be documentation of professional liability insurance as required in these bylaws. Special requirements for consultation and/or reporting may be imposed by the Chief Medical Officer. These bylaws, Rules and Regulations and policies shall control all matters relating to clinical privileges, whether or not the Physician, Pharmacist, Registered Dietician, Nurse Practitioner, Dentist, Podiatrist, or Certified Physician's Assistant has signed an agreement to abide by the bylaws.

2. CASES WHEN THE CMO MAY GRANT TEMPORARY PRIVILEGES:

- a. Care of Specific Patients: Upon receipt of a request, either written or by telephone, specific, temporary privileges may be granted for the care of

one or more specific patients. Such privileges shall be granted on a per-patient basis and be restricted to the treatment of not more than four patients in twelve months.

- b. Application in Process: After the receipt of a complete application for Medical Staff appointment, including a request for specific temporary privileges, the applicant may be granted temporary privileges for an initial period of ninety days, with one 30 day. Temporary privileges may not be granted for more than 120 days.
- c. Locum Tenens: Upon receipt of a written request for specific temporary privileges, an appropriately licensed physician of documented competence who is Locum Tenens for a member of the Medical Staff may, without applying for membership on the Staff, be granted temporary privileges for a period of no longer than thirty days. Any privileges beyond thirty days will require receipt of a full application for Staff membership and privileges.

D. TERMINATION OF TEMPORARY PRIVILEGES:

The Chief Medical Officer, in consultation with the Chief Executive Officer, may terminate all temporary privileges upon the discovery of information that raises serious questions about the Visiting or Medical Staff member's professional qualifications or abilities to appropriately exercise any of the privileges that have been granted. Any termination of temporary privileges will be effective immediately. Temporary privileges can be revoked for any reason. Article X does not apply to the termination of temporary privileges.

E. EMERGENCY PRIVILEGES:

In case of an emergency that would result in serious harm to a patient, or where the life of the patient is in immediate danger, any licensed Physician, Physician's Assistant, or Nurse Practitioner may render emergency assistance, regardless of privilege status, until an appropriately privileged member of the Medical Staff can assume care of the patient or the patient can be transferred to another hospital for care.

F. DISASTER PRIVILEGES:

Disaster privileges may be granted to A Physician, Certified Physician's Assistant, or Nurse Practitioner when the Hospital's Emergency Management Plan has been activated at the Hospital and the current Medical Staff is unable to handle the immediate patient needs. The CEO, CMO or either of their designees can grant disaster privileges on a case-by-case basis. The verification of privileges will be a high priority and accomplished through the CMO office once the disaster is under immediate control. The process for privileging is identical to the routine process and procedures described in these bylaws. It may also be accomplished through the human resources department, depending upon the acuity of the disaster and Staff availability. The CMO or his/her designee shall be responsible for any Medical Professional who has been granted disaster privileges and shall direct and/or supervise them throughout the delivery of all patient

services. The Medical Professional who has been granted disaster privileges shall wear an appropriate badge to identify them as such.

Presentation of one of the following is necessary for the Medical Professional to be granted disaster privileges:

1. A current picture Hospital ID card.
2. A current license to practice and a valid picture ID issued by a state, federal or regulatory agency.
3. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
4. Identification indicating that the individual has been granted authority to render patient care, treatment and services in disaster circumstances (such authority having been granted by a federal, state or municipal entity).
5. Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's identity.

G. PROVISIONAL PERIOD:

All initial clinical privileges are granted on a provisional basis and the provisional period must last at least six months. During that period the Physician, Pharmacist, Registered Dietician, Nurse Practitioner, Dentist, Certified Physician's Assistant, or Podiatrist will have a specified number of records reviewed as outlined in the CREDENTIALING PROCEDURES MANUAL.

H. SPECIAL CONDITIONS REGARDING PHYSICIAN'S ASSISTANTS AND SPONSORS:

An attending Physician will, in all cases, maintain responsibility for the admission, overall physical and mental health status, and discharge of the patient. Certified Physician Assistants are limited to privileges, which are provided under the supervision of the Physician with supervision privileges. That Physician will be responsible for insuring that the Certified Physician Assistant limits his/her practices to the privileges granted to the Certified Physician Assistant. Certified Physician Assistants must have in place a signed agreement with a Supervising Physician in accordance with these bylaws and the requirements of the Arizona Board of Licensure for Physician Assistants. The supervising physician must be a member of the Active Medical Staff.

The supervising physician may, in adherence to the requirements imposed by the Arizona Board of Licensure for Physician Assistants, appoint other members of the medical Staff as Agents for supervision of a Certified Physician Assistant. A copy of the signed agent agreement filed with the Arizona Board of Licensure for Physician Assistants must be retained in the files of both the Physician Assistant and the appointed agent.

**ARTICLE VI
OFFICERS OF THE MEDICAL STAFF**

The officers of the Medical Staff shall be: (1) MEDICAL DIRECTOR (CMO)
(2) PRESIDENT
(3) REPRESENTATIVE OF THE GOVERNING BODY

A. SELECTION OF OFFICERS:

1. The Medical Director is an appointee of the state who also functions as an officer of the Medical Staff.
2. The President of the Medical Staff shall be elected by a majority vote of the Medical Staff.
3. The Medical Staff Representative to the Governing Body shall be elected by a majority vote of the Medical Staff and shall be a voting member of the Medical Staff.
4. Election shall be made by simple majority of the votes cast. In the event that there are three or more candidates and no candidate receives a majority, there shall be successive voting such that the name of the candidates receiving fewest votes is omitted from each successive slate until a simple majority vote is obtained between two candidates. If two candidates have the same number of least votes, both shall be omitted from the successive slate.
5. If a representative is no longer able to serve, one or more replacements will be nominated at the next scheduled full Medical Staff meeting, and an election shall be held within fifteen (15) days following the meeting.

B. Terms of office shall be for two Medical Staff years. Officers must be active or provisional active members of the Medical Staff at the time of selection and must remain members in good standing during their term of office. Failure to maintain such status shall automatically result in forfeiture of the office.

C. DUTIES OF OFFICERS:

1. MEDICAL DIRECTOR (CMO)

The Medical Director shall serve as the Chief Medical Officer of the Medical Staff to:

- a. Represent the Medical Staff before the Superintendent, the Governing Body and others in all matters of mutual concern regarding the Arizona State Hospital.

- b. Serve as an ex-officio member of all other Medical Staff committees except for those committees that the CMO is the Chair of, is assigned to by these bylaws or has otherwise convened for a specific purpose.
- c. Be responsible for assuring the enforcement of Medical Staff bylaws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been required against a Medical Staff member. The CMO shall also have the authority to extend, for cause, established deadlines for Staff appointment, reappointment and procedures on an individual basis.
- d. Establish, combine or abolish committees not mandated by existing bylaws and appoint members to these committees to meet the goals and objectives of the Medical Staff.
- e. Represent the views, need for policies, and grievances of the Medical Staff before the Governing Body.
- f. Receive and interpret the policies of the Governing Body, and report to the Governing Body on the performance and maintenance of quality with respect to the medical care and treatment provided at the Arizona State Hospital.
- g. Foster activities of the Medical Staff
- h. Be the spokesperson for the Medical Staff in its external professional and public relations.
- i. Prepare with the President items to be placed on the agenda for Medical Staff Executive Committee meetings and Medical Staff meetings.
- j. In the absence of the President, shall automatically assume those medical Staff duties and have the authority that relates to the capacity of the President.
- k. Establish the type and scope of clinical services required to meet the needs of Arizona State Hospital patients.
- l. Be responsible for the orientation and continuing education of Medical Staff.
- m. Participate in selection of resources for needed services not provided by the organization.
- n. Integrate the departments/services into the primary functions of the

Hospital.

- o. Coordinate/integrate interdepartmental/intradepartmental services.
- p. Serve as a Governing Body liaison to the Performance Improvement Committee.

2. **PRESIDENT**

The President shall serve in an advisory capacity to the Medical Director and shall be responsible for:

- a. Assuring compilation of accurate and complete minutes of the Medical Staff Executive Committee.
- b. Monitoring all procedures relating to the applications, appointments and reappointments for membership on the Medical Staff.
- c. Serving as both Chair and Secretary to the Medical Staff Executive Committee to follow up their recommendations and suggest items for their consideration.
- d. Referring appropriate items to the various other committees of the Medical Staff.
- e. Assuring the orderly collection of permanent records of the business of the Medical Staff and its committees.
- f. In collaboration with the CMO, continually assessing and improving Quality of Care and services, including the implementation of a planned and systematic process for monitoring and evaluating the quality and appropriateness of the care and treatment of patients and the clinical performance of all individuals with clinical privileges.
- g. Providing input on Hospital policies and procedures, the Medical Staff bylaws, Rules and Regulations, Medical Staff Executive Committee directives, and departmental policies and procedures.
- h. In collaboration with the CMO, credentialing/privileging function and criteria, and to transmit to the Medical Staff Executive Committee recommendations concerning Staff classification, the appointment, removal from provisional status, reappointment, and delineation of clinical privileges of all Medical Staff members.
- i. Providing leadership in matters affecting patient care, including needs for

personnel, equipment, space, supplies, special regulations and techniques.

- j. Maintaining documentation of monitoring and evaluation activities and communicating relevant information regarding these activities to the Medical Staff Executive and Performance Improvement Committees, as appropriate.
- k. Calling, presiding at, and providing the agenda for all general meetings of the Medical Staff.

3. GOVERNING BODY REPRESENTATIVE

The elected Medical Staff representative to the Governing Body shall:

- a. Be elected to serve by majority vote of the Medical Staff.
- b. Be a voting member of the Medical Staff.
- c. Sit as a member of the Medical Staff Executive Committee.
- d. The President of the Medical Staff may also serve in this role, in the absence of the elected governing Body Representative.

D. REMOVAL FROM OFFICE:

- 1. Any officer is automatically removed when s/he ceases to be a member of the Medical Staff or ceases to have privileges.
- 2. Two-thirds (2/3) of the voting members of the Medical Staff may, by written petition, presented to the Chief Medical Officer, recommend the removal of the President or Governing Body Representative from office. The Chief Medical Officer will, within two weeks, meet with the President and all available members of the Medical Staff before acting on the petition. Within the following two weeks, the Chief Medical Officer will confer with the Superintendent and make a decision on whether to retain the President or Governing Body Representative. The decision will be final and not open to appeal under these bylaws. This is not a decision concerning Staff membership or privileges.

**ARTICLE VII
MEDICAL STAFF MEETINGS**

A. BUSINESS MEETINGS

A meeting open to all members of the Active Medical Staff shall be held monthly (or at least 10 times yearly) to conduct appropriate business. The President of the Medical Staff will set the agenda in conjunction with the CMO. The agenda of such meetings shall include reports of review and evaluation of the work done in the performance of the required Medical Staff functions. These meetings shall be called and chaired by the President.

All Medical Staff meetings shall be closed to persons who are not members of the Medical Staff unless invited in advance by the President. However, the CEO shall be invited to attend all meetings of the Medical Staff. At the discretion of the President, other individuals may be invited as non-voting participants, when their expertise or viewpoint would not otherwise be available.

In the event that an Executive Session is called at a Medical Staff meeting, only members of the Active Medical Staff will be allowed to remain for an Executive Session.

All minutes of the committees and subcommittees of the Medical Staff must be regularly reviewed and action items approved through meetings of the full Medical Staff.

The Medical Staff Executive Committee may hold any additional meetings of the Medical Staff for the purpose of transacting such business as may come before the committee. The Medical Staff Executive Committee is empowered to act for the Medical Staff as a whole, between meetings of the full Medical Staff. All meetings of the MEC shall be held at such date and time as the President shall designate.

B. SPECIAL MEETINGS:

1. The Medical Director or the President may call a special Medical Staff meeting for discussion of general Medical Staff issues at any time after giving five days' notice. (This should not be confused with emergency meetings, which can be called at any time without set notice by the Chief Medical Officer).
2. The President shall call a special meeting within ten (10) working days after receipt of a written request for same stating the purpose of such meeting and signed by not less than 1/3 of the Medical Staff.
3. The President shall designate the time of any special meetings at the Hospital.
4. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. The Governing Body shall attend if this is included in the written request.

C. QUORUM:

The presence of greater than fifty percent (50%) of the Medical Staff shall constitute a quorum. A quorum is required of the Medical Staff in order to conduct official business.

D. ATTENDANCE REQUIREMENTS:

1. Each member of the Medical Staff shall be required to attend 2/3 of monthly business meetings and special meetings of the Medical Staff, unless excused by the President. Members of the Associate and Visiting Medical Staff shall be excused from this requirement.
2. Each member must attend at least 2/3 of the meetings of any Medical Staff committee to which he is appointed or elected except as provided for elsewhere in these Bylaws.

**ARTICLE VIII
MEDICAL STAFF COMMITTEES AND FUNCTIONS**

The Medical Staff committees shall be:

The Medical Staff Executive Committee (MEC), and other such standing committees of the Staff as may be necessary and desirable to perform Medical Staff functions. The MEC may, by resolution, establish Medical Staff committees to fulfill its functions.

A. GENERAL PROVISIONS

1. Except as otherwise provided in these bylaws, all committee chairs shall be appointed by the Chief Medical Officer.
2. Except as otherwise provided in these bylaws, all committee members shall be selected by the Chief Medical Officer. The Chief Medical Officer may delegate his/her authority to select committee members.
3. The Chief Executive Officer and the CMO shall be ex-officio members of all committees and shall serve without vote except in those committees where the Chief Medical Officer is also designated as a "regular" member by virtue of Staff office on appointment or Staff membership.
4. The terms of committee chairs and members shall be two years.

B. SPECIAL PROVISIONS FOR EXECUTIVE SESSIONS OF COMMITTEES:

1. Only members of the Active Medical Staff may attend Executive Sessions.
2. Each committee shall maintain minutes reflecting the proceedings, actions and attendance at each meeting. The original minutes shall be preserved in the Medical Staff Office.
3. During the course of any Medical Staff Committee meeting, an issue may be discussed in Executive Session. The issues under discussion in Executive Session are recorded separately from the general meeting minutes and must contain the following information:
 - a. Time in and out of Executive Session.
 - b. Statement that excuses all non-members from the meeting unless their presence is necessary to the business at hand and identifies members who are present.
 - c. Reference stating the name of any non-member and the reason they are in attendance during Executive Session.
4. The general minutes should document the times (in and out) of the Executive Session and only the topic of discussion, not its content.
5. Any action that is decided upon during Executive Session is recorded in the regular meeting minutes and will note there the action taken, but not the reasons for the Executive Session.
6. Executive Session minutes are not to be duplicated or distributed routinely to anyone. Executive Session minutes will be prepared and approved by the committee and shall remain on file in the Medical Staff Office.
7. The Chief Medical Officer or the Chief Executive Officer may review the Executive Session minutes of any Medical Staff Committee at any time.

C. MEDICAL STAFF EXECUTIVE COMMITTEE:

The Medical Staff Executive Committee shall consist of the officers of the Medical Staff (CMO, President and Governing Body Representative) and two additional elected members. The CEO or designee shall attend each Medical Staff Executive Committee meeting on an ex-officio basis.

1. The President shall be the Chair and Secretary of the Medical Staff Executive Committee.

2. The Chief Medical Officer of the Medical Staff shall be the Vice Chair of the Medical Staff Executive Committee.
3. There will be two elected members to the Medical Staff Executive Committee. One of the elected members must be a licensed physician. An election shall be held every two years at a Medical Staff Meeting.
4. No Medical Staff member actively practicing in the Hospital is ineligible for membership on the Executive Committee solely because of his/her professional discipline or specialty. Associate Medical Staff are ineligible for membership on the Executive Committee.
5. Voting members of the Medical Staff Executive Committee must be Active Medical Staff who are practicing in the Hospital.
6. The majority of voting members shall be fully licensed doctors of medicine or osteopathy.

D. DUTIES OF THE MEDICAL STAFF EXECUTIVE COMMITTEE:

The Medical Staff Executive Committee is the body empowered to act for the Medical Staff in the intervals between meetings of the full Medical Staff.

Duties of the Medical Staff Executive Committee shall be:

1. To coordinate the activities and general policies of the Staff.
2. To receive and act on committee reports.
3. To implement policies of the Medical Staff.
4. To assist and support the Chief Medical Officer in providing a liaison between the Medical Staff and Governing Body.
5. To develop and transmit recommendations to the Governing Body via the Chief Medical Officer and/or a physician member of the Governing Body.
6. To fulfill the Medical Staff's accountability to the Chief Executive Officer for the medical care rendered to the patients in the State Hospital.
7. To ensure that the Medical Staff is kept abreast of accreditation, certification and state licensing activities and informed of the accreditation, certification and licensing status of the Hospital.
8. To review the credentials of applicants to the Medical Staff and to review

recommendations for Staff membership and delineation of clinical privileges. In the event there is doubt about an applicant's ability to perform the privileges requested, the committee can request a specific evaluation of the practitioner to be certain that the privileges can be approved. As a result of such reviews, to make recommendations to the Governing Body for appointment and clinical privileges.

9. To review all information available regarding the performance and clinical competence of Medical Staff members with clinical privileges. As a result of such reviews, make recommendations to the Governing Body for reappointment and renewal of and/or changes in clinical privileges.
10. To take all reasonable steps to ensure ethical, professional conduct and competent clinical performance on the part of all Medical Staff members including initiation of and/or participation in Medical Staff corrective or review measures when warranted.
11. To oversee the "Functions" outlined in section "E" of this article and to recommend actions to the Governing Body based on that oversight.
12. To make recommendations to the Governing Body on the structure of the Medical Staff.
13. The Medical Staff Executive Committee shall meet once a month. Additional meetings may be scheduled as needed. It is allowable to skip a single month up to 3 times per year. The meetings shall be closed except that non-members may appear by invitation of the Chair. The Chair may call an Executive Session, which may only be attended by voting members of the Medical Staff Executive Committee and those whose presence is necessary for the business at hand as determined by the Chair.

E. FUNCTIONS OF THE MEDICAL STAFF:

These functions may be carried out by the Medical Staff Executive Committee, Staff committees and/or in combination with Hospital-wide committees as determined by the President and Medical Staff Executive Committee and with the concurrence of the Governing Body.

1. QUALITY IMPROVEMENT AND ASSURANCE
 - a. Adopt, modify, and supervise the conduct of programs and procedures for assessing and improving the quality and appropriateness of medical care and other services provided in the State Hospital.
 - b. Formulate recommendations to correct identified problems.
 - c. Actively follow up to determine whether problems are corrected.

- d. Coordinate with the Hospital-wide Performance Improvement Program.
- e. Participate in the Annual Evaluation of the Performance Improvement Plan.
- f. Maintain and forward documentation of and recommendations from Performance Improvement activities.

2. MONITORING ACTIVITIES

- a. Adopt plans and modify and coordinate the conduct and findings of patient care monitoring activities to improve patient care and patient safety.
- b. Review mortalities, if any, on a monthly basis.
- c. Conduct ongoing Professional Practice Evaluations, and when indicated, initiated Focused Professional Practice Evaluations, as described in the Credentialing Manual.
- d. Review Risk Management Data.
- e. Review the recommendations of the Medical Executive Medical Committee with respect to recommendations regarding privileging, re-privileging, and medical Staff membership.
- f. Maintain and forward documentation of monitoring activities.
- g. Review complex medical cases through ongoing case review committees and identify and provide consultation when appropriate.

3. UTILIZATION REVIEW

- a. Plan, modify and coordinate the conduct of Utilization Review.
- b. Facilitate appropriate placement and discharge of patients in and from the Hospital.
- c. Maintain and forward reports on these activities.

4. CREDENTIAL REVIEW

- a. Review, evaluate and transmit written reports as required on the qualifications of each applicant or member for appointment, reappointment, change in provisional status, change in level of Staff

membership, or initiation or change in privilege.

- b. Initiate, investigate, review and report on corrective action matters and any other matters involving the clinical, ethical or professional conduct of any individual referred by the Chief Medical Officer, President of the Medical Staff, the Medical Staff Executive Committee, or chair of Staff or Hospital-wide committees.
- c. Submit reports to the Medical Staff Executive Committee on the status of pending applications.
- d. Maintain a credentialing and privileging file for each member of the Medical Staff including records of participation in Staff activities and results of quality improvement activities.

5. EDUCATION AND RESEARCH

- a. Develop, plan and implement continuing education programs that are relevant to the scope of patient care and responsive to quality improvement issues.
- b. Maintain a written record of education activities.

6. MEDICAL RECORDS

- a. Review and evaluate records to determine that they properly describe the conditions and progress of the patient and are sufficiently complete so as to facilitate continuity of care and communications between those providing patient care services.
- b. Develop, review, enforce and maintain surveillance over enforcement of Staff and Hospital Policies and Rules and Regulations relating to completion, confidentiality, preparation, format, forms, filing, storage, destruction and availability of records.
- c. Coordinate with Hospital administration and employees in matters relating to medical records.
- d. Submit reports, at least quarterly, to the Medical Staff on the medical records function.

7. PHARMACY AND THERAPEUTICS

- a. Assist in the formulation of broad professional policies regarding the evaluation, appraisal selection, procurement, storage, distribution, use, safety and all other matters relating to medications used in the Hospital.

- b. Advise the Staff and pharmacy department on matters pertaining to developing and monitoring the formulary.
- c. Review unexpected drug reactions.
- d. Establish standards for the use of controlled or investigational drugs.
- e. Maintain surveillance over drug usage.
- f. Report at least quarterly to the Medical Staff.

8. INFECTION CONTROL

- a. Maintain surveillance over the Hospital Infection Control program.
- b. Develop and implement a preventative and corrective program designed to minimize infection hazards.
- c. Report at least quarterly to the Medical Staff and/or Hospital-wide Quality Improvement Committee.

9. BYLAWS

At least every two years, conduct a review of the bylaws and Rules and Regulations, and submit reports to the MEC recommending changes in these documents.

10. PLANNING

Participate with the Hospital administration in the evaluation of the resources needed, and Staff organization changes needed to provide optimum services.

11. BIOETHICS

Establish and maintain a system, in cooperation with other treatment disciplines, to provide consultation for treatment providers (to aid in decision making in situations where ethical dilemmas exist).

12. MORBIDITY AND MORTALITY

To evaluate significant patient care events for morbidity and mortality and recommend follow up actions to improve patient care.

**ARTICLE IX
MANDATORY REPORTING/
CORRECTIVE ACTION**

A. MANDATORY REPORTING:

The Arizona State Hospital will comply with all Federal and State reporting requirements including, but not limited to, the Federal Health Care Quality Improvement Act of 1986.

B. GROUNDINGS FOR CORRECTIVE ACTION:

1. Non-compliance with Medical Staff bylaws, Rules and Regulations. This shall include, but not be limited to, failure to disclose information pertinent to and necessary in the evaluation of a member's qualifications for appointment or reappointment to the Medical Staff.
2. Violation of specific rules of the Hospital or this Medical Staff. This shall include, but not be limited to, persistent and repeated failure to complete medical records, failure to adhere to approved admitting and discharge policies, failure to discharge attending Staff responsibilities relative to consultation and call.
3. Causes for dismissal or discipline of an employee in the State service.
4. Misconduct. This shall include, but not be limited to, violations as indicated in number 2 above, abandonment of a patient, disruptive behavior, falsification of records, violation of the Principles of Ethics of the American Psychiatric Association, American Pharmacist Association, American Medical Association, American Osteopathic Association, the American Dental Association, or the American Podiatric Association.
5. Care Below Applicable Standards. This shall include, but not be limited to, incompetence, unprofessional conduct, failure to adhere to patient care policies of the Hospital, clinical performance below the standards of practice established by the clinical department, provision of substandard care, recurrent misdiagnosis, and/or a demonstrated lack of clinical competence.
6. Inability to Work With Others. This shall include, but not be limited to, the inability to work in harmony with others or evidence of conduct detrimental to patient care.

C. PROCEDURES FOR CORRECTIVE ACTION:

1. Any person may provide information to the Chief Medical Officer, the President of the Medical Staff or the Governing Body about the conduct, performance or competence of Medical Staff members.

2. Any member of the Medical Staff, the Chief Medical Officer, the President of the Medical Staff or the Governing Body must notify the Medical Staff Executive Committee when such person believes there are grounds for investigation against a Medical Staff member as set forth in these bylaws. Such notification, when made by any member of the Medical Staff or the President of the Medical Staff, will be deemed a request for corrective action, shall be made in writing to the President and shall be supported by reference to specific activities or conduct constituting grounds for the request. Requests for corrective action initiated by the Chief Medical Officer or the Governing Body may be in writing to the President and shall be supported by reference to specific activities or conduct constituting grounds for the request. Upon receipt of a request for corrective action from a source other than the Chief Medical Officer, the President shall notify the Chief Medical Officer of the request and the specific activities or conduct constituting grounds for the request.
3. If the President and the Chief Medical Officer determine that a Medical Staff Member is likely to be impaired by a physical, psychiatric or emotional illness that results in the Medical Staff Member engaging in potentially unsafe medical practices that places patients at risk of harm, the President or Chief Medical Officer may, as an alternative to proceeding with corrective action as permitted in the bylaws, refer and allow the affected Medical Staff member to obtain evaluation, treatment, rehabilitation and/or monitoring programs or resources in accordance with the Physician Health Policy attached hereto as Appendix A.
4. Within five (5) business days of receipt of a request for corrective action, the Chief Medical Officer or the President of the Medical Staff shall call a meeting of the Medical Staff Executive Committee (MEC). The MEC shall review the request for corrective action and may (1) determine to take no further action, (2) within five (5) business days of its review meeting, send, by Certified or Registered Mail, Return Receipt Requested, a written communication to any affected Medical Staff member that the MEC has received a request for corrective action and that the affected member is being afforded the opportunity to provide information to the MEC in written form and/or in a face to face discussion with the MEC before the MEC decides whether to refer the matter for investigation, or (3) assign an investigation regarding the request for corrective action to an appropriate Medical Staff member, standing committee or ad hoc committee of the Medical Staff members. If the MEC assigns an investigation, within five (5) business days of the assignment to investigate the request for corrective action, the assigned Medical Staff member or the assigned committee chairperson shall personally send, by Certified or Registered Mail, Return Receipt Requested, a written communication to any affected Medical Staff member that the MEC has receive a request for corrective action and that the affected member is being afforded the opportunity to provide information to the MEC in written form and/or in a face to face discussion with the MEC. Any affected Medical Staff member who is sent a written communication providing the member with the

opportunity to present information to the MEC shall have ten (10) business days from the date the notification is sent to provide information to the MEC in written format or to have a face to face discussion with the MEC. If the affected Medical Staff member provides information to the MEC in written form and/or in a face to face discussion, the MEC may determine to take no further action or may, if it has not already done so, assign an investigation regarding the request for corrective action. The MEC and the assigned Medical Staff member or assigned committee may proceed to make a determination regarding the request for corrective action regarding an affected member if that member fails without good cause to timely provide information in written form or fails without good cause to attend any scheduled face to face meeting with the MEC. If the MEC has assigned an investigation, the assigned Medical Staff member or assigned committee shall complete a full investigation and shall provide the MEC with a report of findings and recommendations within fifteen (15) business days of receipt of the assignment. The MEC may authorize extension of this time period for good cause. If the MEC itself investigates the request for corrective action, the MEC shall have fifteen (15) business days to complete the investigation and prepare its report of findings and recommendations. The MEC may authorize extension of this time period for good cause.

5. If any member of the Medical Staff has a conflict of interest as to the request for corrective action, that member shall not serve as an assigned investigative Medical Staff member nor sit either on the MEC or Investigating Committee when the request for corrective action is being discussed nor shall vote or take an action, formal or informal, which may have a tendency to influence the decision for corrective action. Knowledge of the matter involved shall not by itself be considered conflict of interest nor preclude a member from serving as an assigned investigative Medical Staff member or sitting on either committee.
6. Within five (5) business days of receipt of the report of findings and recommendations or, where the Medical Staff Executive Committee itself investigated the request for corrective action, within five (5) business days of preparation of its report of findings and recommendations, the Medical Staff Executive Committee shall notify in writing personally or by Certified Registered Mail, Return Receipt Requested, any affected Staff member that the investigation is complete, furnish copies of the request for corrective action and the report of findings and recommendations to any affected Staff member. This notification must be completed prior to taking any action, except summary suspension, as provided in these bylaws against any affected Staff.

D. RECOMMENDATIONS FOR CORRECTIVE ACTION:

1. The Medical Staff Executive Committee may recommend to the Governing Body any of the following actions:
 - a. Determining no corrective action be taken, and if the Medical Staff

Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's credentialing and privileging file.

- b. Deferring action for a reasonable time when circumstances warrant.
 - c. Issuing a letter of "concern and instruction" or a letter of "reprimand" to the Member and placing a copy in the member's credentialing and privileging file.
 - d. Requiring the member to undergo a physical and/or mental evaluation at the expense of the Hospital.
 - e. Imposing terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation or monitoring.
 - f. Reducing, modifying, suspending or revoking clinical privileges.
 - g. Returning to provisional status or limitation of any prerogatives directly related to the member's delivery of patient care.
 - h. Suspending, revoking or placing Medical Staff membership on probation.
 - i. Determining that an already imposed summary suspension of privileges be terminated, modified or sustained.
 - j. Taking other appropriate action as determined by the MEC.
2. An action of the Governing Body ordering a corrective action recommended by the Medical Staff Executive Committee shall constitute grounds for a hearing only if that action is listed in Article X A. 1, In the event the member does not request a hearing regarding an action listed in Article X A. 1 within the time period and in the manner specified in Article X, such action shall take effect immediately upon expiration of that time period. If a member requests a hearing, no corrective action(s) shall take effect until the Governing Body approves the recommendation of the Hearing Committee in accordance with Article X E.11 at the time of appeal.
 3. Recommended actions take effect on approval of the Governing Body except as outlined elsewhere in the bylaws in order to protect patients, i.e. summary suspension, or automatic suspension.
 4. Despite the status of any investigation, at all times the Medical Staff Executive Committee shall retain authority and discretion to recommend whatever action may be warranted by the circumstances, including summary suspension.

E. SUMMARY SUSPENSION:

1. Any member of the Medical Staff Executive Committee, the President of the Medical Staff or the Chief Medical Officer may request the Governing Body to suspend summarily all or part of the clinical privileges and/or membership of a Medical Staff member whenever failure to take such action may result in an imminent danger to the health of any individual. Only the Governing Body may

order summary suspension of clinical privileges of the Medical Staff

2. Unless otherwise stated, summary suspension becomes effective immediately upon imposition, and the Governing Body shall promptly give written notice by Hand Delivery or by Certified or Registered Mail, Return Receipt Requested, of the suspension to the member and to the President of the Medical Staff and the Chief Medical Officer. Summary suspension may be limited in duration and shall remain in effect for the period stated or, if unlimited in duration, until otherwise resolved. The Chief Medical Officer or the President shall provide for alternative medical coverage for patient care.
3. The Governing Body shall direct an investigation to be conducted by the Medical Staff Executive Committee. Unless terminated by the Governing Body, summary suspension shall remain in effect until all procedural rights contained in these bylaws have been exhausted. Unless otherwise agreed to by the affected Staff member and the Chief Medical Officer, any hearing after investigation shall begin within the time period outlined in Article X, Section C.
4. A Medical Staff member whose summary suspension has been modified or sustained pursuant to Article IX, SECTION D (I); shall be entitled to request a hearing on the matter according to procedural rights outlined in ARTICLE X.

F. AUTOMATIC SUSPENSION

Automatic suspensions are not considered corrective actions and do not afford access to the fair hearing procedures outlined in Article X.

1. Revocation and Suspension. Whenever a member's license or other legal credential authorizing practice in this State is revoked or suspended by the applicable licensing or certifying authority, Medical Staff membership and clinical privileges shall be automatically revoked or suspended as of the date such action becomes effective and throughout its term.
2. Restriction. Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any clinical privileges that the member has been granted at the Hospital, which are within the scope of said limitation or restriction, shall be automatically limited or restricted in a similar manner and as of the date such action becomes effective and throughout its term.
3. Probation. Whenever a member is placed on probation by the applicable licensing or certifying authority, the membership status and clinical privileges at the Hospital shall automatically become limited or restricted in a similar manner and as of the date such action becomes effective and throughout its term.

4. Insurance. Failure to maintain professional liability insurance with limits of liability required by the terms and conditions of a contract with Arizona State Hospital and the Department of Health Services shall result in automatic suspension of all Clinical privileges and membership on the Medical Staff.
5. Administrative Leave of Absence. Administrative Leave of Absence imposed on any member, whether employed by or contracted, by the Department of Health Services shall result in automatic suspension of all clinical privileges and membership on the Medical Staff.
6. Termination of Contract or Employment. Termination or suspension of a member's contract or employment with the Department of Health Services shall result in automatic suspension of all clinical privileges and membership on the Medical Staff, except as outlined elsewhere in these bylaws.
7. Revocation or Suspension - DEA Certificate. Whenever a member's DEA certificate is revoked, limited or suspended, the member shall automatically be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.
8. Probation - DEA Certificate. Whenever a member's DEA certificate is subject to probation, the member's right to prescribe medications covered by the DEA certificate shall automatically become subject to the same terms of probation as of the date such action becomes effective and throughout its term.
9. Medical Records. Persistent and repeated failure to maintain medical records as outlined in the Rules and Regulations shall result in automatic suspension of all clinical privileges and membership on the Medical Staff.
10. Enforcement. The Chief Medical Officer, President and the Chief Executive Officer shall have the duty of enforcing all automatic suspensions.
11. Reinstatement. Medical Staff Members may apply for reinstatement and shall provide evidence of that condition which was the basis of the automatic suspension has been corrected. The Chief Medical Officer, President and the Chief Executive Officer shall approve any reinstatement of privileges, subject to the approval of the Governing Body.

**ARTICLE X
HEARING AND APPEAL PROCEDURES**

A. INITIATION OF HEARING

1. TRIGGERING EVENTS

The following actions are the exclusive grounds for a hearing upon timely and proper request by the Staff Member:

- a. denial of initial Staff appointment.
- b. denial of reappointment.
- c. suspension of Staff membership.
- d. revocation of Staff membership.
- e. denial of requested appointment to or advancement in Staff category.
- f. reduction in Staff category or return to Provisional status.
- g. denial of requested clinical privileges.
- h. suspension of clinical privileges.
- i. revocation of clinical privileges.

B. REQUEST FOR HEARING:

1. The hearing and appeal procedure is the administrative adjudicatory process for resolution of actions taken against Medical Staff members contracted or employed by the Arizona Department of Health Services. An aggrieved Medical Staff member must follow the applicable procedures set forth in Article IX prior to invoking the process set forth in this Article and must exhaust the remedies set forth in these bylaws before requesting further review or resorting to legal action.
2. Notice of Action. In any case where action taken constitutes grounds for hearing as set forth in this Article, the Chief Medical Officer or his/her designee shall personally deliver or send by Certified Mail, Return Receipt Requested, written communication to the affected Medical Staff member that states:
 - a. The action to be taken against the member.
 - b. The reasons for the action.

- c. That the affected member has the right to request a hearing before a hearing committee on the action at any time not more than thirty (30) days from receipt of the notice of action.
 - d. A list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Staff Executive Committee.
3. The member shall have thirty (30) days following receipt of the notice of action within which to request a hearing before a Hearing Committee. The request for hearing shall be made in writing and either personally delivered by the affected Medical Staff member to the Chief Medical Officer or sent Certified Mail, Return Receipt Requested, to the Chief Medical Officer. In the event the member does not request a hearing within thirty (30) days following receipt of the notice of action in the manner described within this subsection, the member shall be deemed to have accepted the action and to have waived the member's right to a hearing under this Article.

C. HEARING PROCEDURES:

1. Chair of Hearing Committee. If the Chief Medical Officer receives a timely request for a Hearing, he/she shall inform the Medical Staff Executive Committee. The Medical Staff Executive Committee shall thereupon appoint a Hearing Committee, which shall be composed of not less than three members of the Medical Staff not on provisional status, who shall not have actively participated in the consideration of the matter involved at any previous level. Members may not be in direct economic competition with the appellant (employment at or contracting with the State Hospital does not in itself constitute economic competition). A Medical Staff Executive Committee member may participate in the deliberations of the Hearing Committee, but not be entitled to vote. The Hearing Committee shall nominate a Chair from among its members. Knowledge of the matter involved shall not preclude a member from serving on the Hearing Committee.
2. The Hearing Officer. At the request of the Staff member who requested the hearing, the Medical Staff Executive Committee, the Hearing Committee, or, on his/her own motion, the Governing Body shall appoint a Hearing Officer, who may be an Attorney at Law, to preside at the Hearing.
3. Notice of Hearing. Upon notification by the Chief Medical Officer of receipt of a timely request for a hearing, the Medical Staff Executive Committee shall schedule a hearing, which date shall not be less than 30 days nor more than 45 days from receipt of the request for hearing and shall give written notice sent certified mail, return receipt requested, to any affected member of the time, place and date of the hearing. The Hearing Committee may extend the specified time period for cause.

4. Notice of Charges. As a part of, or together with the notice of hearing, the Medical Staff Executive Committee shall state in writing in concise language the acts or omissions, which constitute the grounds for adverse action against the Medical Staff member. The list of charges includes medical records number, if applicable, or the reasons for the denial of the request of the applicant or Medical Staff member.
5. Witnesses. The Notice of Charges received by the affected Staff member may contain a list of witnesses (if any) expected to testify at the hearing on behalf of the Medical Staff Executive Committee. Any affected Staff member shall also have the right to present witnesses. If either party, by notice to the other, requests a list of witnesses, the recipient, within five business days, shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence at the hearing. Such request for notice of witnesses shall be made no less than 10 business days before the date scheduled for hearing. If a party fails to provide names and addresses of witnesses, the Hearing Officer in his/her discretion may preclude the testimony of the witnesses whose names have not been disclosed.

D. PRE-HEARING CONDUCT:

1. No Right to Discovery: While no party to a hearing shall have any right to discovery of documents or other evidence in advance of a hearing, the hearing officer may confer with both sides to encourage an advance mutual exchange of documents, witness interviews or other evidence relevant to the issues to be presented at the hearing. It shall be the duty of any affected Staff member and the Medical Staff Executive Committee to notify the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that the Hearing Officer may make pre-hearing decisions concerning such matters. Requests for Reconsideration of any pre-hearing decisions may be made at the hearing.
2. Postponements and Extensions: Postponements and extensions of time beyond the times expressly permitted in these bylaws in connection with the hearing process may be requested by any party. Requests for postponements and extensions of time may be granted by the Hearing Officer if the Hearing Officer finds the requests to have been made in good faith and for good cause.

E. HEARING CONDUCT:

1. Failure to Appear. If a Staff member who requested a hearing fails to appear and proceed at such hearing without good cause, determined by the Hearing Officer, the Hearing Committee shall notify in writing the Medical Staff Executive Committee, the Staff member who requested the hearing, and the Governing Body, of the Staff member's failure to appear. The written notification will indicate that the Staff member's failure to appear constitutes that member's

voluntary acceptance of any actions involved, and any recommendations or actions will become final and effective immediately.

2. Representations. The hearings provided for in these bylaws are for the purpose of inter-professional resolution of matters bearing on conduct or professional competency. Accordingly, the person requesting the hearings may be represented by the person or legal counsel of his/her choice. However, the person requesting the hearing must notify the Chief Medical Officer, in writing, of his/her intention to be so represented no later than 15 business days prior to the Hearing. The Chief Medical Officer shall disclose information concerning the intention to be so represented to the Arizona Attorney General's Office in order that legal counsel may be appointed for the Hospital.
3. The Hearing Officer. The Hearing Officer shall act to provide that all participants in the hearing have a reasonable opportunity to be heard, to present relevant and non-cumulative oral and documentary evidence, and see that decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for, presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure or admissibility of evidence. If the Hearing Officer determines that either party in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary actions as seem warranted by the circumstances. The Hearing Officer shall not act as a prosecuting officer or as an advocate for the Hospital, Governing Body or the Medical Staff Executive Committee. If requested by the Hearing Committee, the Hearing Officer may participate in the Hearing Committee's deliberations, but is not entitled to vote.
4. Record of Hearing. The Hearing Committee shall maintain a written record of the hearing. Any party may arrange for a stenographic or audiotape record at the party's own expense.
5. Rights of Both Sides. At a hearing, both parties shall have the rights to call and examine witnesses, to introduce exhibits, to cross-examine any witness and to rebut any evidence, all subject to rulings of the Hearing Officer. The hearing shall be confidential and closed to the public.
6. Admissibility of Evidence. Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses and presentation of evidence need not apply to a hearing conducted under this Article. Any relevant, non-cumulative evidence shall be admitted by the Hearing Officer, if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Committee may question any witness or call additional witnesses if it deems appropriate. Any party shall have the right to submit a memorandum to be filed following the close of evidence at such time and in such manner as the

Hearing Officer may establish.

7. Official Notice. The Hearing Officer shall have the discretion to take official notice of any matters relating to the issues under consideration that could have been judicially noticed by the courts of this State. Participants in the hearing shall be informed of the matters to be officially noticed or refute the noticed matters by evidence or by written or oral presentation of authority. Reasonable or additional time shall be granted, if requested, to present written rebuttal of any evidence admitted on official notice.
8. Basis of Decision. The decision of the Hearing Committee shall be based only on the evidence admitted at the hearing.
9. Burden of Proceeding/Burden of Proof. For all actions taken, the person who requested the hearing shall have the burden of going forward to show that the action was not based upon substantial evidence unreasonable or not sustainable. The party having the burden of going forward shall present its evidence first. The other party shall then be given an opportunity to present evidence. The party having the burden of going forward shall then be given an opportunity to present rebuttal evidence. The burden of proof shall be by clear and convincing evidence. The party requesting the hearing shall prevail only if the Hearing Committee determines that the action was arbitrary, capricious or not based upon substantial evidence.
10. Adjournment and Conclusions. The Hearing Officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned and the Hearing Committee shall conduct its deliberations, unless either or both parties file a memorandum, in which case deliberations shall begin following receipt of the memorandum or memoranda. The Hearing Committee shall conduct any deliberations outside the presence of any other person. The Hearing Officer shall be invited to participate in deliberation in accordance with these bylaws.
11. Decision of the Hearing Committee. Within ten (10) business days after the close of evidence or receipt of the memorandum or memoranda, the Hearing Committee shall render a final written recommendation, which shall contain a concise statement of the reasons justifying the decision made. Copies of the decision shall be delivered to the Medical Staff Executive Committee, the person who requested the Hearing and the Governing Body. No corrective action shall take effect until the Governing Body approves the corrective action recommendations of the Hearing Committee. A copy of the decision made by the Governing Body shall be delivered to the person who requested the hearing by Registered or Certified Mail, Return Receipt Requested.
13. The Appeal. The decision of the Governing Body, after considering the findings

of the Hearing Committee shall be final, subject to the right of appeal as outlined in Section F of this Article.

F. APPEAL:

1. Time for Requesting Appeal. Within ten (10) days after receipt of the decision of the Governing Body, either the person who requested the hearing or the Medical Staff Executive Committee may request review by an Appeal Committee. This request shall be delivered either in person or by Certified or Registered Mail, Return Receipt Requested, to the Governing Body. If review by an Appeal Committee is not requested within the ten -day period, the Governing Body's decision shall be final and effective immediately upon expiration of the ten-day period.

G. GROUND FOR APPEAL AND NOTICE:

1. Grounds for Appeal. A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be one or more of the following and only the following:
 - a. Substantial noncompliance with the procedures required by these bylaws or applicable law, which has created demonstrated prejudice.
 - b. The decision was arbitrary, capricious or not based upon substantial evidence.
2. Time, Place and Notice. Upon receipt of a timely request for appeal to an Appeal Committee, the Governing Body or its designee shall, within fifteen (15) days after receipt of such of request for appeal, schedule an appellate review if the Governing Body determines that valid grounds exist for review. The Governing Body shall notify the applicant of the time, place and date of the appellate review by Certified Mail or hand delivery. The date of appellate review shall not be more than thirty (30) days from the date of receipt of the request for appellate review, provided, however, that when a request for appellate review is made from a member who is under suspension that is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made. The time within which appellate review will be held may be extended by the Appeal Committee for good cause.

H. APPEAL COMMITTEE AND PROCEDURE:

1. Appeal Committee. The Appeal Committee shall hear all timely appeals and shall be comprised of the three members from the Medical Staff who have not been

involved in any aspect of the case to be heard and who are selected by the Chief Medical Officer. Knowledge of the matter involved shall not preclude any Medical Staff member from serving on the Appeal Committee provided that the Staff member did not take part in a prior investigation or hearing on the same matter. If the Appeal Committee requests appointment of an attorney to assist it in the proceeding, the Chief Medical Officer shall request representation for the Appeal Committee from the Attorney General's office. The attorney assisting the Appeals Committee shall not have acted as an advocate for the Medical Staff Executive Committee or provide legal advice in connection with the hearing.

2. Appeal Procedure. The proceeding by the Appeal Committee shall be a review of the record before the Hearing Committee. The Appeal Committee may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel in connection with the appeal and to present a written statement in support of his/her position on appeal. In its sole discretion, the Appeal Committee may allow each party or representative to personally appear and make an oral argument. The Appeal Committee shall conduct deliberations outside the presence of the parties and their representatives. However, the Attorney assisting the Appeal Committee may be present during deliberations but may not vote.
3. Final Decision of the Appeal Committee. Within ten (10) business days of the conclusion of the proceedings, or as soon thereafter as reasonably possible, the Appeal Committee shall render a final decision in writing and shall deliver copies to the Medical Staff Executive Committee, the Chief Medical Officer and the Governing Body and Governing Authority.
4. The Governing Authority shall render a written decision to accept, reject or modify the decision of the Appeal Committee. A copy of the Governing Authority's written decision shall be delivered to the person who requested the hearing by Certified or Registered Mail, Return Receipt Requested. The Governing Authority's decision is final and shall be effective immediately and is not further appealable under these bylaws.

ARTICLE XI CONFIDENTIALITY, IMMUNITY AND RELEASES

A. SPECIAL DEFINITIONS:

For purposes of this Article, the following definitions shall apply:

1. INFORMATION: record of proceedings, minutes, interviews, records, reports, forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions, actions, data, and any other form relating to any subject matter specified in Section C. and E. herein.

2. PRACTITIONER: a Medical Staff member
3. REPRESENTATIVE: the Governing Authority director or committee thereof; the Superintendent, Chief Medical Officer, or employees of this Hospital, employees of other organizations, a Medical Staff organization and any member, officer, clinical unit, or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering, analysis, use of other related functions.
4. THIRD PARTIES: both individuals and organizations providing information.

B. AUTHORIZATIONS AND CONDITIONS:

By submitting an application for Medical Staff, or by applying for or exercising clinical privileges or providing specified patient care services in this Hospital, a practitioner:

- a. authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon any information bearing on his professional ability and qualifications; and
- b. agrees to be bound by the provisions of this Article and that he shall have no claim against any representative who acts in accordance with the provisions of these bylaws.

C. CONFIDENTIALITY OF INFORMATION:

Information with respect to any practitioner submitted, collected or prepared by any representatives of this or any other health care facility, organization or Medical Staff for the purposes of evaluating and improving the quality and efficiency of patient care, reducing morbidity and mortality, contributing to teaching or clinical research and determining that health care services are professionally indicated and performed in compliance with applicable standards of care shall, to the fullest extent permitted by law, be confidential and privileged and shall not be used in any way except as provided by law. Such confidentiality shall also extend to information of the kind that may be provided by Third Parties. That information shall not become part of any particular patient's record or of the general Hospital records. The filing of reports with state licensing agencies or under the Health Care Quality Improvement Act of 1986 shall not be deemed a breach of confidentiality.

D. IMMUNITY FROM LIABILITY:

1. Each member of the Medical Staff and each applicant for each such position, agrees that no Representative of the Hospital or Medical Staff shall be liable for damages or other relief for any decision, opinion, action, statement or recommendation made within the scope of his/her duties as a Representative.
2. FOR PROVIDING INFORMATION

Each member of the Medical Staff, and each applicant for any such position, agrees that no representative of the Hospital or Medical Staff and no Third Party shall be liable for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this Hospital, State of Arizona Risk Management Division, other Hospital or Medical Staff or to an appropriate state or federal regulatory agency concerning a Practitioner who is or has been an applicant to or a member of the Staff or who did or does exercise clinical privileges or provide specific patient care services at this Hospital, provided further that such information will not be provided to any other hospital, health professionals, or individuals without that practitioner's express written consent.

E. ACTIVITIES:

1. The confidentiality and immunity provided by this Article apply to all acts, communications, proceedings, interviews, reports, records, minutes forms, memoranda, statements, recommendations, findings, evaluations, opinions, conclusions or disclosures performed or made in connection with this or any other health care facility or organization's activities concerning, but not limited to:
 - a. application for appointment, clinical privileges or specified services.
 - b. Periodic reappraisals for reappointment, clinical privileges or specified services.
 - c. corrective or disciplinary action.
 - d. hearings and appellate reviews.
 - e. quality assessment or performance improvement program activities.
 - f. utilization and claims reviews.
 - g. profiles and profile analysis.
 - h. malpractice loss prevention.
 - i. other Hospital and Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.
 - j. all materials and information gathered in the privileging credentialing or reapplication process.
2. INFORMATION

The information referred to in this Article may relate to a practitioner's

professional qualifications, clinical ability, judgment, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect patient care.

F. AUTHORIZATIONS

Each practitioner shall, upon request of this Hospital, execute general and specific authorizations in accordance with the tenor and import of this Article. Execution of such authorizations is not a prerequisite to the effectiveness of this Article.

G. CUMULATIVE EFFECT

Provisions in these bylaws and in application forms relating to authorization, confidentiality of information and immunities from liability are, in addition to other protection, provided by law and not in limitation thereof.

**ARTICLE XII
ADOPTION AND AMENDMENT**

Any proposed repeal, amendment or adoption of these Medical Staff bylaws, Rules and Regulations and/or Credentialing and Privileging Procedures shall be accomplished through a cooperative process involving both the Medical Staff and the Governing Body.

Any proposed repeal, amendment or adoption of these Medical Staff bylaws, Rules and Regulations and/or Credentialing and Privileging Procedures shall be in accordance with the following:

- A. Any proposal shall be read or presented in writing at any regular Medical Staff meeting with at least one week's notice.
- B. Approval of such proposal by the Medical Staff shall require a simple two-thirds (2/3) majority, provided a quorum is present. Fifty-one percent (51%) of the members present represent a quorum.

Any proposed repeal, amendment or adoption shall become effective only after such action is approved by the Medical Staff and the Governing Body, approval decisions shall not be unreasonably withheld by either. Neither the Medical Staff nor the Governing Body shall withhold approval if such repeal, amendment or adoption is mandated by law, statute or regulation or is necessary to obtain or maintain accreditation or to comply with fiduciary responsibilities or action to improve the integrity of the membership of the Medical Staff with regard to the ethical treatment of patients.

If either the Governing Body or the Medical Staff submit an approved repeal, amendment or adoption to the Medical Staff bylaws, Rules and Regulations and/or Credentialing and Privileging Procedures to the other and no action is taken within sixty-five (65) days, the

adoption, amendment or repeal action submitted shall be conclusively deemed approved by the Body which failed to act within sixty-five (65) days. Neither the Medical Staff nor the Governing Body may amend these Medical Staff bylaws, Rules and Regulations and/or Credentialing and Privileging Procedures unilaterally.

Any repeal, amendment or adoption to these Medical Staff bylaws, Rules and Regulations and/or Credentialing and Privileging Procedures are subject to the approval of the Chief Executive Officer of the Arizona State Hospital, as well as the Deputy Director of the Division of Behavioral Health Services before they become effective, and such approval shall not be unreasonably withheld.

These Medical Staff bylaws, Rules and Regulations and/or Credentialing Procedures shall be reviewed at least every two years, considered in relationship to the changing needs of patients, the community and the overall goals and objectives of the Hospital, and amended as necessary. If significant changes are made in the Medical Staff bylaws, Rules and Regulations and/or Credentialing Procedures, members of the Medical Staff will be provided with copies of the written changes.

APPENDIX A MEDICAL STAFF HEALTH POLICY

A. INTENT

1. It is the intent of the Arizona State Hospital Medical Staff to assure that each Medical Staff member provides safe and effective care for all patients for whom the member is responsible.
2. It is the intent of this policy to provide assistance to impaired physicians, in order that any affected Medical Staff member has an opportunity to participate in, and benefit from, appropriate rehabilitation services or programs.
3. It is intended that Medical Staff members are provided such assistance, rather than be subjected to formal corrective action as described in Article IX of these bylaws, and as is appropriate to the individual practitioner's situation.

B. GOAL:

The goal of this policy is to prevent physical, psychiatric, or emotional illness of Medical Staff members from placing patients at risk of harm by an impaired physician.

C. POLICY STATEMENT:

1. It shall be the responsibility of each Medical Staff member to report to the Medical Staff leadership, i.e., the President or the Chief Medical Officer, any concerns regarding potentially unsafe medical care practices or potential risks to patient safety, which may be the result of an impairment involving a Medical Staff member's

physical, psychiatric, or emotional health. Medical Staff will discuss at business meetings, as appropriate, the role of the medical Staff in recognizing signs of impairment in colleagues, including the advisability and benefits of self referral if necessary.

2. All matters involving the physical, psychiatric or emotional illness-related impairment of a Medical Staff member shall be treated as confidential, especially and including the diagnosis, treatment, rehabilitation or monitoring program of the affected Medical Staff member.
3. All activities and steps involved in the process of carrying out this Medical Staff Health Policy shall be documented in writing and filed in the affected Member's Credentialing and Privileging file.
4. Employee performance-related corrective and/or disciplinary matters involving state employed Medical Staff members shall be processed in accordance with current applicable Arizona Department of Personnel Policies and Procedures. Similarly, such performance-related matters involving contracted Medical Staff members shall be processed in accordance with applicable Arizona Department of Administration Policies and Procedures.

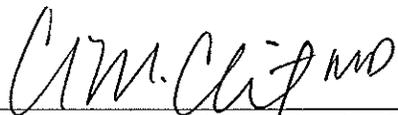
D. PROCEDURES:

1. Any report of possible Medical Staff member's impairment shall be discussed between the President and the Chief Medical Officer as soon as possible following the receipt of such a report in order to assure that patient safety is maintained.
2. It shall be the responsibility of the President and the Chief Medical Officer to review any such report with the person providing a report, and to confer with the affected Medical Staff member.
3. The President and the Chief Medical Officer will then make a determination as to whether or not there is sufficient basis to find that the Medical Staff member is placing patients at risk and/or engaging in unsafe medical practices due to a possible physical, psychiatric, or emotional impairment of the Medical Staff member.
4. If the President and the Chief Medical Officer make a determination that such a possible Medical Staff member impairment issue exists, they shall jointly meet with the affected member and refer the affected member to appropriate evaluation, treatment, rehabilitation, and/or monitoring programs or resources as deemed appropriate to address the identified impairment of the Medical Staff member. The Chief Medical Officer, in consultation with the President of the Medical Staff, will cooperate with the Medical Staff member to design a process to assess the progress of the Member, which might include a Focused Professional Practice evaluation or ongoing medical record review. It is anticipated that this process would continue throughout the period of rehabilitation and for six (6) months thereafter.

5. Should a report of possible physician impairment involve the President or the Chief Medical Officer, the non-involved person shall complete the same process through the inclusion of the elected Governing Body representative to accomplish the same intent and the goal of this policy.

6. If the identified, affected Medical Staff member refuses to accept or follow through with the recommendation of the President and the Chief Medical Officer in a timely manner as identified by them, the matter will be referred to the Executive Committee of the Medical Staff for consideration of Corrective Action in accordance with Article IX of the bylaws.

ARIZONA STATE CIVIL AND FORENSIC HOSPITAL MEDICAL STAFF BYLAWS



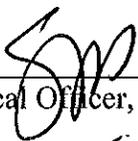
 Assistant Director, Division of Behavioral Health
 (Representing Governing Body)

7/13/15
 Date



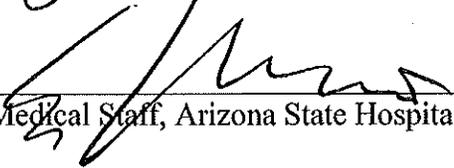
 Chief Executive Officer, Arizona State Hospital

7-13-15
 Date



 Chief Medical Officer, Arizona State Hospital

7/13/15
 Date



 President, Medical Staff, Arizona State Hospital

07/15/15
 Date

BYLAWS 2015-2017 (REVISED)