MEDICAL STAFF ORGANIZATION MANUAL

Deer Valley Medical Center
John C. Lincoln Medical Center
Scottsdale Osborn Medical Center
Scottsdale Shea Medical Center
Scottsdale Thompson Peak Medical Center

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Horty, Springer & Mattern, P.C.

MEDICAL STAFF ORGANIZATION MANUAL

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ARTICLE 1

GENERAL

1.A. DEFINITIONS

The definitions that apply to terms used in the Medical Staff documents are set forth in the Credentials Policy.

1.B. TIME LIMITS

Time limits referred to in this Manual and related policies are advisory only and are not mandatory, unless it is expressly stated.

1.C. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Hospital Administration, by a Medical Staff Leader or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

(2) When a Medical Staff or Allied Health Staff member is unavailable or unable to perform an assigned function, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

ARTICLE 2

CLINICAL DEPARTMENTS

2.A. DEPARTMENTS

The Medical Staff will be organized into the following Network clinical departments and Division clinical departments and sections:

(1) Network Clinical Departments

- Department of Pediatrics
- Department of Obstetrics and Gynecology
- Department of Pathology

(2) Division Clinical Departments and Sections

Each Division will have the following clinical departments and sections:

- Department of Anesthesia
- Department of Emergency Medicine
- Department of Medicine
  - Hospital Medicine Section
  - Ambulatory Medicine Section
- Department of Radiology
- Department of Surgery
  - Trauma Section (at Deer Valley Medical Center, John C. Lincoln Medical Center, and Scottsdale Osborn Medical Center)

2.B. FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS, DEPARTMENT CHAIRS AND VICE CHAIRS, AND SECTION CHIEFS

The functions and responsibilities of departments and sections, department chairs and vice chairs, and section chiefs are set forth in Article 4 of the Medical Staff Bylaws.

2.C. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND SECTIONS

(1) Subject to the approval of the Board, Network clinical departments will be created and may be consolidated or dissolved by the Network Executive Committee, and Division clinical departments and sections will be created and may be consolidated or dissolved by the relevant Division Executive Committee.

(2) The following factors will be considered in determining whether a clinical department or section should be created (not every factor must be present in every case):

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department or section (this number must be sufficiently large to enable the department or section to accomplish its functions as set forth in the Bylaws);

(b) the level of clinical activity that will be affected by the new department or section is substantial enough to warrant imposing the responsibility to accomplish departmental or section functions on a routine basis;

(c) a majority of the voting members, with membership determined by the Credentials Committee, of the proposed department vote in favor of the creation of a new department or section under the department;

(d) it has been determined by the Network Executive Committee (for Network clinical departments) or the Division Executive Committee (for Division clinical departments and sections) that there is a clinical and administrative need for a new department or section; and

(e) the voting Medical Staff members of the proposed department or section have offered a reasonable proposal for how the new department or section will fulfill the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors will be considered in determining whether the dissolution or consolidation of a clinical department or section is warranted (not every factor must be present in every case):

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department or section to enable it to accomplish the functions set forth in the Bylaws and related policies;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department or section;

(c) the department or section fails to fulfill designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as department chair or vice chair or section chief; or

(e) a majority of the voting members of the department vote for the dissolution or consolidation of the department (or a section under the department).

ARTICLE 3

MEDICAL STAFF COMMITTEES

3.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Manual outlines the Network and Division Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board. This Manual also specifies Network Hospital Committees and Network Best Care Council Committees which will have representation from the Medical Staff.

(2) Unless otherwise specified in this Manual, the procedures for the appointment of members and chairs of the committees set forth in Article 5 of the Medical Staff Bylaws will apply.

(3) This Manual details the composition of each Network and Division Medical Staff committee. In addition to the membership composition outlined in this Manual, other Medical Staff members or Hospital personnel may be invited to attend a particular Medical Staff committee meeting (as guests, without vote) in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. Such individuals are an integral part of the credentialing, quality assurance, and peer review process and are bound by the same confidentiality requirements as the standing members of such committees.

(4) In accordance with Article 5 of the Medical Staff Bylaws, the Division Executive Committee may establish additional Division committees and the Network Executive Committee may establish additional Network committees.

3.B. MEETINGS, MINUTES, REPORTS, AND RECOMMENDATIONS

(1) Except as otherwise provided, Medical Staff committees will meet as necessary to accomplish their functions.

(2) Medical Staff committees will maintain minutes, which include their findings, proceedings, and actions.

(3) Unless otherwise specified, Division Medical Staff committees will make timely written reports to the appropriate Division Executive Committee and Network Medical Staff Committees will make timely written reports to the Network Executive Committee. The Division Executive Committees will also make regular reports on the performance and execution of their duties to the Network Executive Committee. Minutes of meetings will be kept and maintained under the supervision of the Medical Staff Office.

(4) Medical Staff Committees will comply with the confidentiality requirements outlined in the Credentials Policy.

ARTICLE 4

DIVISION MEDICAL STAFF COMMITTEES

The following Medical Staff committees will exist at each Division:

4.A. CRITICAL CARE COMMITTEE

4.A.1. Composition:

(a) The Chief of Staff, in consultation with the Division Chief Medical Officer, will appoint the Critical Care Committee members and the chair of the Critical Care Committee, subject to the approval by the relevant Division Executive Committee.

(b) The Critical Care Committee for each Division will include the Intensive Care Unit ("ICU") Medical Director.

(c) When appointing other members to the Critical Care Committee, consideration will be given to the multidisciplinary aspect of the committee and include a broad representation of Medical Staff members who care for patients in the ICU.

4.A.2. Duties:

The Critical Care Committee is responsible for the following:

(a) providing a forum for discussion and proposed action with respect to opportunities to improve patient care and problems, issues, and concerns in the ICU;

(b) monitoring and reviewing all clinical activities relating to the care of critical care patients;

(c) maintaining continuing surveillance of the professional performance of all Medical Staff members involved in the care of critical care patients and addressing concerns through the appropriate review channels;

(d) developing and maintaining a process improvement program for critical care patients; and

(e) developing and maintaining rules and regulations, policies, procedures, guidelines and educational activities relating to critical care.

4.B. DIVISION EXECUTIVE COMMITTEE

The composition, duties, and meeting requirements for the Division Executive Committee are addressed in Article 5 of the Medical Staff Bylaws.

4.C. DIVISION LEADERSHIP COUNCIL

4.C.1. Composition:

(a) The Division Leadership Council will be comprised of the following voting members:

(1) Chief of Staff, who will serve as chairperson;

(2) Vice Chief of Staff; and

(3) Immediate Past Chief of Staff.

(b) The following individuals will serve as *ex officio* members, without vote, to facilitate the Division Leadership Council's activities:

(1) Division Chief Medical Officer;

(2) Chief Executive Officer;

(3) Director of Medical Staff Services;

(4) Chairpersons of the Professional Practice Evaluation Committees; and

(5) Quality Department representative(s).

(c) Other Medical Staff members or Hospital personnel may be invited to attend a particular Division Leadership Council meeting (as guests, without vote) in order to assist the Division Leadership Council in its discussions and deliberations regarding an issue on its agenda. These individuals will be present only for the relevant agenda item and will be excused for all others. Such individuals are an integral part of the Division Leadership Council review process and are bound by the same confidentiality requirements as the standing members of the Division Leadership Council.

4.C.2. Duties:

The Division Leadership Council will perform the following functions:

(a) review and address concerns about professional conduct as outlined in the Medical Staff Professionalism and Code of Conduct Policy;

(b) review and address possible health issues that may affect an individual's ability to practice safely as outlined in the Practitioner Health Policy;

(c) review and address issues regarding clinical practice as outlined in the Professional Practice Evaluation Policy;

(d) meet, as necessary, to consider and address any situation involving an individual that may require immediate action;

(e) serve as a forum to discuss and help coordinate any quality or patient safety initiative that impacts any or all services within the Hospital;

(f) cultivate a physician leadership identification, development, education, and succession process to promote effective and successful Medical Staff Leaders at present and in the future and serve as the nominating committee for the Division as follows; and

(1) convene not less than 60 days prior to the annual meeting of the Medical Staff and prepare a slate of qualified nominees for each Medical Staff office vacancy. In selecting a candidate(s) for office, the Division Leadership Council will consider the qualifications for the office set forth in the Bylaws and may consult with members of the Medical Staff and Hospital administration concerning the qualifications and acceptability of prospective nominees;

(2) submit its recommended slate so that notice of the nominees can be provided to the Medical Staff at least 45 days prior to the election; and

(3) if an additional nomination is submitted, by written petition of the voting members of the Medical Staff, evaluate the proposed candidate to ensure that he or she meets the qualifications for the office as set forth in the Medical Staff Bylaws and provide notice of any qualified proposed candidate in accordance with the Bylaws; and

(g) perform any additional functions as may be requested by the Professional Practice Evaluation Committee, the Division Executive Committee, the Network Executive Committee or the Board or as set forth in any Medical Staff policy.

4.C.3. Meetings, Reports, and Recommendations:

The Division Leadership Council will meet as often as necessary to perform its duties and will maintain a permanent record of its findings, proceedings, and actions. The Division Leadership Council will report to the Professional Practice Evaluation Committee, the Division Executive Committee, the Network Executive Committee, as applicable, and others as described in the policies noted above.

4.D. JOINT CONFERENCE COMMITTEE

4.D.1. Composition:

The Joint Conference Committee will be comprised of three representatives appointed by the Chair of the Network Executive Committee and three representatives appointed by the Chair of the Board.

4.D.2. Duties:

(a) The Joint Conference Committee is responsible for attempting to resolve any dispute or disagreement between the Medical Staff and the Board, including instances in which the Board is contemplating a decision that is inconsistent with the recommendation of the Network Executive Committee. The Joint Conference Committee will not be convened for matters already reviewed by the Contract Evaluation Subcommittee and presented to the Board.

(b) At the request of any three members of the Committee, the Hospital Chief Executive Officer will furnish such documentation and information as may be relevant to the matter under consideration. The Committee may also request the attendance of any person with knowledge of the matter under consideration. Compliance with all such requests will not be unreasonably withheld. All requests and information will be furnished in sufficient time and detail to enable the Committee to thoroughly evaluate the issue under consideration.

4.D.3. Meetings and Reports:

(a) The Joint Conference Committee shall meet and issue a report, as described in this Section, expeditiously.

(b) Any report of the Joint Conference Committee will state the basis of the findings, conclusions and recommendation reached by the Committee. The report will be furnished to both the Network Executive Committee and to the Board.

(c) The entity whose action or decision is the subject of consideration will refrain from taking final action until such time as the Joint Conference Committee has rendered a report with its findings and recommendation and should give great weight to the findings, conclusions, and recommendations of the Joint Conference Committee.

4.E. PERIOPERATIVE SERVICES COMMITTEE

4.E.1. Composition:

(a) The Perioperative Services Committee and Committee chair will be appointed by the Chief of Staff, in consultation with the Chief Medical Officer.

(b) The Perioperative Services Committee will consist of the following voting members:

(1) two Active Staff members from the Department of Anesthesia and the department chair;

(2) an Active Staff member from the Trauma Section, where applicable;

(3) two Active Staff members from the Department of Surgery and the department chair;

(4) an Active Staff member from the Department of Obstetrics and Gynecology;

(5) a representative from Hospital administration;

(6) two nursing managers (one from inpatient and one from outpatient);

(7) two members from non-managerial support staff (e.g., scrub techs, staff nurses); and

(8) a Medical Staff member elected by the core members.

(c) The Perioperative Services Committee will also include the following ad hoc, non-voting members who will be invited to attend meetings as needed:

(1) schedulers, central supply technicians, and others as determined necessary by the voting Committee members; and

(2) individuals invited based on specialty or particular issue at hand.

(d) The Clinical Director of Perioperative Services, the Division Perioperative Managers and additional representation will be invited to attend meetings as needed.

(e) Members who are unable to complete a membership term will be replaced by a representative from the same department or discipline as outlined above.

(f) The Perioperative Services Committee shall elect co-chairs for its division, one from the Department of Surgery and one from the Department of Anesthesia.

4.E.2. Duties:

The Perioperative Services Committee is responsible for the following:

(a) providing a collaborative forum for Medical Staff and perioperative services leadership to address efficiency and quality of perioperative services;

(b) maintaining continuing surveillance of the professional performance of all members of the Medical Staff involved in the care of surgical patients. Concerns regarding individual physician performance shall be reviewed at Perioperative Services Committee meetings and, if no resolution is reached, may be referred to the respective department for formal review;

(c) reviewing the perioperative services operations and the capital, supply and new technology budgets and making recommendations on issues related to budget development, implementation, strategic planning and data-based decision-making;

(d) reviewing staffing, ancillary services, and other resource issues that affect performance or satisfaction;

(e) developing and maintaining a process improvement program. Conflict resolution will initially be between the Perioperative Services Committee and the involved Department. Any unresolved conflicts will be forwarded to the appropriate Division Executive Committee;

(f) developing and maintaining policies and guidelines relating to perioperative service efficiency; and

(g) maintaining written or electronic minutes of conclusions, recommendations, actions taken and the results of such actions.

4.F. PROFESSIONAL PRACTICE EVALUATION COMMITTEES

There will be two Professional Practice Evaluation Committees, one that functions at the Osborn, Shea and Thompson Peak Divisions and one that functions at the Deer Valley and John C. Lincoln Divisions. The composition, duties, and meetings and reports provisions of the Professional Practice Evaluation Committees are set forth below.

4.F.1. Composition:

(a) The Professional Practice Evaluation Committees will each consist of at least seven members of the Active Staff who will be: (i) broadly representative of the clinical specialties on the Medical Staff; (ii) experienced or interested in credentialing, privileging, peer review, or other Medical Staff affairs; and (iii) supportive of evidence-based medicine protocols.

(b) The Division Chiefs of Staff for the particular Professional Practice Evaluation Committee will appoint the chair of that Professional Practice Evaluation Committee, with the approval of the Network Executive Committee. The vice chair of the committee will be elected by the voting members of the committee.

(c) Half of the members of a Professional Practice Evaluation Committee will be appointed by the Network Executive Committee and half of the members of the committee will be elected by the Division Medical Staffs for that particular Professional Practice Evaluation Committee following the nomination process set forth in the Bylaws.

(d) The chair of the Trauma Committee, and the chair of any department or section peer review committee, as authorized by the Professional Practice Evaluation Committee, will serve *ex officio*, without vote.

(e) The Chief Physician Executive, the Chief Quality Officer (or his or her successor), the Division Chief Medical Officers as needed, and administrative staff as needed will all serve *ex officio*, without vote.

(f) To help foster consistency and uniformity within the Network, each Professional Practice Evaluation Committee will designate one of its members to serve, *ex officio*, without vote, on the other Professional Practice Evaluation Committee.

(g) Before any Professional Practice Evaluation Committee member begins serving, the member must understand the expectations and requirements of the position and affirmatively accept them. Members will participate, as required, in periodic training on peer review, with the nature of the training to be identified by the Network Executive Committee and the Professional Practice Evaluation Committee.

(h) If additional expertise is required, the Professional Practice Evaluation Committee may request that a practitioner with the necessary expertise attend Professional Practice Evaluation Committee meetings while the matter is under consideration. The practitioner may assist the Professional Practice Evaluation Committee in its deliberations and the appropriate interventions. The practitioner will be present only for the relevant agenda items. Any such practitioner will attend as a guest, without vote, but will be an integral part of the peer review process and will be bound by the same confidentiality requirements as the standing members of the committee.

4.F.2. Duties:

Relative to the Divisions they represent, the Professional Practice Evaluation Committees are responsible for the following:

(a) overseeing the implementation of the Professional Practice Evaluation Policy and providing training and support on the various components of the process;

(b) reviewing and approving specialty-specific criteria (as identified by each department) for focused professional practice evaluation triggered by a concern being raised;

(c) identifying those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an informational letter may be sent to the practitioner involved in the case;

(d) reviewing referred cases as outlined in the Professional Practice Evaluation Policy;

(e) developing, when appropriate, performance improvement plans for practitioners, as described in the Professional Practice Evaluation Policy;

(f) monitoring and determining that system issues that are identified as part of peer review activities (and not identified and addressed through other forums such as Root Cause Analyses) are successfully resolved;

(g) periodically reviewing the effectiveness of the Professional Practice Evaluation Policy and recommending revisions as may be necessary;

(h) reviewing any practitioner-specific reports and/or reviews performed by a department or section; and

(i) performing any additional functions as may be requested by the Network Executive Committee or the Board.

4.F.3. Meetings and Reports:

The Professional Practice Evaluation Committees will meet at least ten times per year and will promptly report their findings to the Network Executive Committee.

ARTICLE 5

NETWORK MEDICAL STAFF COMMITTEES

The following Medical Staff committees will exist at a Network level:

5.A. ALLIED HEALTH COMMITTEE

5.A.1. Composition:

The Network Executive Committee, in consultation with the Chief Physician Executive, will appoint the members and a physician chair of the Allied Health Committee, which will consist of the following:

(a) five members of the Medical Staff with equal representation from each Division when possible;

(b) five members of the Allied Health Staff, with consideration given to representation from the different categories of practitioners which are a part of the Allied Health Staff and representation from each Division when possible; and

(c) representatives from Nursing and Administration.

5.A.2. Duties:

The Allied Health Committee is responsible for the following:

(a) recommending the clinical privileges or scope of practice for each category of practitioner on the Allied Health Staff;

(b) recommending practice guidelines for each category of practitioner on the Allied Health Staff;

(c) reviewing annually the practice guidelines for each category of practitioner on the Allied Health Staff and making recommendations based on this review;

(d) reviewing the competency and performance evaluation activities of members of the Allied Health Staff and making recommendations based on this review; and

(e) conducting an annual review of the credentialing process as it applies to Allied Health Staff and proposing any amendments that are deemed necessary.

5.A.3. Reports:

The recommendations made by the Allied Health Committee will take into account input from the Departments. The Allied Health Committee will report its recommendations to the Credentials Committee.

5.B. BYLAWS COMMITTEE

5.B.1. Composition:

The Network Executive Committee, in consultation with the Chief Physician Executive, will appoint the members and the chair of the Bylaws Committee, which will consist of the following:

(a) the Immediate Past Chief of Staff of each Division; and

(b) five additional members from the Active Staff and/or Active Affiliate Staff with representation from each Division when possible.

5.B.2. Duties:

The Bylaws Committee is responsible for the following:

(a) reviewing the Medical Staff Bylaws, the Credentials Policy, this Manual, and other related documents (including, but not limited to, the Medical Staff Rules and Regulations) at least biannually, or more often as needed or directed by the Network Executive Committee, and making recommendations for appropriate amendments and revisions;

(b) receiving and considering all recommendations for changes in these documents made by any committee or department of the Medical Staff, any individual appointed to the Medical Staff, General Counsel, the Chief Executive Officer, or the Board; and

(c) reviewing Network and Division policies for consistency with these documents and reporting inconsistencies and recommending revisions to the Network Executive Committee.

5.C. CANCER COMMITTEE

5.C.1. Composition:

(a) The Network Executive Committee, in consultation with the Chief Physician Executive, will appoint the chair and members of the Cancer Committee, consisting of Medical Staff members from diagnostic and therapeutic specialties involved in

the care of cancer patients. There will be at least one physician from each of the following specialties:

(1) Diagnostic radiology;

(2) Medical oncology;

(3) Pathology;

(4) Radiation oncology; and

(5) Surgery.

(b) Allied Health Staff members who work with cancer patients may also be appointed as members of the Cancer Committee.

(c) The Cancer Liaison Physician ("CLP") will also serve as a member of this committee. The CLP, a physician of any specialty, can fulfill one additional leadership position within the Cancer Committee such as chair or a designated coordinator and represent one of the required physician specialties.

(d) Required non-physician members are:

(1) the Cancer Program Administrator (responsible for the administrative oversight and has budget authority for the cancer program);

(2) an oncology nurse;

(3) a social worker or case manager;

(4) the Certified Tumor Registrar ("CTR");

(5) a palliative care professional, if services are provided on site;

(6) a genetics professional, if services are provided on site; and

(7) the following additional members, which are strongly recommended, but not required: specialty physicians representing the five major cancer sites at the program, a registered dietitian or nutritionist or nutrition services representative, a psychiatric or mental health professional trained in the psychosocial aspects of oncology, and an American Cancer Society representative.

(e) The Network Executive Committee, in consultation with the Chief Physician Executive, will have authority to appoint other individuals to serve on the committee and is expected to select representatives from both the community and

the Divisions. Other individuals will be appointed as needed to comply with the accreditation requirements of the Commission on Cancer of the American College of Surgeons.

(f) Each calendar year, all of the required coordinators (listed below) are appointed for one calendar-year term at a time by the Cancer Committee at the first quarter meeting and are responsible for specific areas of cancer program activity and compliance. An individual cannot serve in more than one coordinator role during a term.

(1) Cancer Conference Coordinator;

(2) Quality Improvement Coordinator;

(3) Cancer Registry Quality Coordinator;

(4) Community Outreach Coordinator;

(5) Clinical Research Coordinator; and

(6) Psychosocial Services Coordinator.

5.C.2. Duties:

The Cancer Committee is responsible for:

(a) generating and evaluating annual events aimed at cancer education, prevention and screening;

(b) promoting a coordinated multidisciplinary approach to the clinical management of patients with cancer;

(c) ensuring that multidisciplinary cancer conferences cover all major sites to ensure high-quality, comprehensive care;

(d) ensuring an active, psychosocial support care system is in place for patients with cancer and their families;

(e) monitoring quality management and improvement of cancer care provided by the Divisions through completion of quality management studies that focus on quality, access to care and outcomes;

(f) providing access to clinical trials and promoting cancer-related clinical research; and

(g) ensuring quality of the cancer registry database.

5.D. CONTINUING MEDICAL EDUCATION COMMITTEE

The purpose, functions, committee membership and structure, and other details associated with the Continuing Medical Education Committee ("CMEC") are outlined in the CMEC charter. To the extent that the provisions of this Section conflict with the CMEC charter, the CMEC charter will govern.

5.D.1. Purpose of Committee:

(a) Primary Functions:

The CMEC develops, coordinates, monitors, and evaluates the HonorHealth continuing medical education program and its individual CME activities to ensure quality and consistency in the content development, design, and delivery of educational activities and to provide oversight for the accreditation of the HonorHealth CME program. A primary role of the CMEC is to ensure that the HonorHealth program remains on the leading edge of continuing medical education. Thus, a critical function of the CMEC is to recommend new directions and initiatives for the HonorHealth CME program in consideration of sound educational practices based on the principles of adult learning theory and the most current and evidence-based CME research.

(b) Approval Responsibilities:

Committee approval responsibilities include granting CME approval for new and ongoing activities, meeting minutes, mission statement, charter, policies, procedures, forms, and budget oversight.

5.D.2. Committee:

(a) Committee Membership and Structure:

The CMEC consists of voting members and non-voting members:

- Physician voting members will be comprised of physician representatives from each HonorHealth hospital, primary care clinic physician, residency program director, Chief Medical Officer, Advisory Board representative, Chief Academic Officer, and committee chair. Note that a physician voting member can provide representation of more than one said title above or any combination thereof.

- Non-physician voting members will include interdisciplinary representation by Leadership from departments such as Nursing, Pharmacy, CME, Library Services, and Quality.

- Non-voting members will represent CME staff, Medical Staff, physician liaisons, at least one resident, and others recommended by the committee chair.

In order to stay active, members must attend at least 50% of meetings, including two in-person quarterly meetings and participate via electronic voting for four electronic monthly meetings. Participation in in-person meetings via conference call is permitted. Membership participation and eligibility will be reviewed by the committee chair annually.

(b) Role of a Committee Member:

- Become familiar with the Arizona Medical Association ("ArMA") CME accreditation requirements and the ACCME Standards of Commercial Support.

- Assist with the interpretation and implementation of the ArMA and ACCME standards and requirements for re-accreditation.

- Ensure alignment of the CME division's goals and activities with the HonorHealth strategic plan and overall mission.

- Recommend new initiatives and directions for CME worthy of further study and possible development.

- Suggest strategies for creating a strong CME presence within HonorHealth's medical education continuum.

- Approve CME applications for *AMA PRA Category 1 Credit™*.

- Identify resources and advocates in support of CME activities and initiatives.

- Provide oversight and guidance for the Conflict of Interest process as required.

- Review drafts of the Self Study Re-accreditation Report and provide input prior to submission to ArMA.

5.D.3. Committee Meetings:

(a) Meeting Schedule and Process:

Meetings will be held monthly on the third Monday. In-person meetings will be held quarterly in January, April, July and October and will be held at Thompson Peak Medical Center. All other monthly meetings will consist of electronic voting.

Quarterly in-person meetings and monthly electronic voting will require a quorum of five voting members and all activities will require a majority vote for approval.

A new CME activity application packet must be completed and submitted at least two weeks before scheduled committee meetings. The committee will have one week to review and vote on activities. CME staff will provide an additional week for review and voting if necessary. Appendix A in the charter contains the schedule and due dates.

(b) Meeting Agenda:

The agenda is developed by the chair and Director of CME.

(c) Meeting Voting:

Quorum is met with at least one-third of total voting members present with a simple majority for approval. For in-person meetings, a one-third quorum is met as a total of "in-person" attendance and "on the call" attendance via conference phone line. For the electronic voting format, the quorum is met at a one-third response from total voting members.

(d) Meeting Minutes:

Meeting minutes are recorded and provided to the Medical Staff for distribution to the Medical Executive team.

5.D.4. Reporting and Lines of Communication:

The CMEC Chair will report at a minimum quarterly to the Chief Academic Officer and Network Executive Committee.

5.E. CREDENTIALS COMMITTEE

5.E.1. Composition:

The Network Executive Committee, in consultation with the Chief Physician Executive, will appoint the members and chair of the Credentials Committee, which will consist of the following members (with vote unless otherwise specified):

(a) the Vice Chief of Staff of each Division;

(b) three Past Chiefs of Staff selected jointly by the Chiefs of Staff of the Scottsdale Osborn Medical Center Division, Scottsdale Shea Medical Center Division, and the Scottsdale Thompson Peak Medical Center Division;

(c) two Past Chiefs of Staff from the Deer Valley Medical Center and the John C. Lincoln Medical Center selected jointly by the Chiefs of Staff of Deer Valley Medical Center and the John C. Lincoln Medical Center;

(d) an Advanced Practice Clinician member of the Allied Health Staff;

(e) the Chief Physician Executive, *ex officio*, without vote; and

(f) the Network Chief Nursing Officer, *ex officio*, without vote.

5.E.2. Duties:

The Credentials Committee is responsible for the following:

(a) reviewing the credentials of all applicants for appointment, reappointment, and clinical privileges, conducting a thorough review of the applications, interviewing such applicants as may be necessary, and making written reports of its findings and recommendations to the appropriate Division Executive Committee;

(b) reviewing, as may be requested by the Division Executive Committee or other appropriate committee, available information regarding the current clinical competence of individuals appointed to the Medical Staff or the Allied Health Staff and, as a result of such review, making a written report of its findings and recommendations;

(c) recommending (based on input from the relevant department) the numbers and types of cases to be reviewed as part of the initial competency evaluation;

(d) reviewing and approving specialty-specific criteria (as identified by each department) for ongoing professional practice evaluation and focused professional practice evaluation for new privileges; and

(e) recommending to the Division Executive Committee (based on input from the relevant department and ad hoc multidisciplinary committees formed for purposes outlined in this section) appropriate threshold eligibility criteria for clinical privileges, including clinical privileges or new procedures and clinical privileges that cross specialty lines.

5.E.3. Meetings and Reports:

The Credentials Committee will meet at least ten times per year and will make regular reports to the Division Executive Committee on the status of pending applications (including any reasons for delay in processing an application or request) and the execution of its duties.

5.F. GRADUATE MEDICAL EDUCATION COMMITTEE

The purpose, functions, committee membership and structure, and other details associated with the Graduate Medical Education Committee ("GMEC") are outlined in the GMEC charter. To the extent that the provisions of this Section conflict with the GMEC charter, the GMEC charter will govern.

5.F.1. Purpose of the Committee:

(a) Primary Functions:

The GMEC is responsible for the oversight of the Accreditation Council for Graduate Medical Education ("ACGME") accreditation status of the Sponsoring Institution and each of its ACGME-accredited programs; the quality of the GME learning and working environment within the Sponsoring Institution, each of its ACGME-accredited programs, and its participating sites; the quality of educational experiences in each ACGME-accredited program that lead to measurable achievement of educational outcomes as identified in the ACGME Common and specialty/subspecialty-specific Program Requirements; the ACGME-accredited program(s)' annual evaluation and improvement activities; and all processes related to reductions and closures of individual ACGME-accredited programs, major participating sites, and the Sponsoring Institution.

The GMEC must demonstrate effective oversight of the Sponsoring Institution's accreditation through an Annual Institutional Review ("AIR") and demonstrate effective oversight of underperforming programs through a Special Review process.

(b) Approval Responsibilities:

The GMEC is responsible for the review and approval of institutional GME policies and procedures; annual recommendations to the Sponsoring Institution's administration regarding resident/fellow stipends and benefits; applications for ACGME accreditation of new programs; requests for permanent changes in resident/fellow complement; major changes in each of its ACGME-accredited programs' structure or duration of education; additions and deletions of each of its ACGME-accredited programs' participating sites; appointment of new program directors; progress reports requested by a Review Committee; responses to Clinical Learning Environment Review ("CLER") reports; requests for exceptions to duty hour requirements; voluntary withdrawal of ACGME program accreditation; requests for appeal of an adverse action by a Review Committee; and appeal presentations to an ACGME Appeals Panel.

5.F.2. Committee:

(a) Committee Membership and Structure:

The GMEC must have at least the following voting members: the Designated Institutional Official ("DIO"); a representative sample of program directors (minimum of two) from its ACGME-accredited programs; a minimum of two peer-selected residents/fellows from among its ACGME-accredited programs; a quality improvement or patient safety officer or designee; and pharmacy AVP and/or pharmacy program director(s).

In order to carry out portions of the GMEC's responsibilities, additional GMEC membership may include others as determined by the GMEC. Subcommittees that address required GMEC responsibilities must include a peer-selected resident/fellow. Subcommittee actions that address required GMEC responsibilities must be reviewed and approved by the GMEC.

In order to stay active, members must attend at least 50% of meetings. Participation in in-person meetings via conference call is permitted.

(b) Executive Session:

Executive sessions provide a venue for handling issues that are best discussed in private, for fostering robust discourse, and for strengthening trust and communication. Executive sessions are confidential, create a mechanism for oversight, and enhance relationships.

An executive session will be held immediately following a live GMEC meeting. Attendees include the Chair of the GMEC, Program Directors, Academic Affairs Director, support staff, and invited guests as necessary.

(c) Voting Criteria:

A quorum consisting of the DIO, one program director and one resident must be present in order to conduct business. All agenda items will require a majority vote for approval.

An electronic voting platform may be substituted as an alternate method of voting criteria for the GMEC. Participating in electronic voting is not a substitute for GMEC attendance.

(d) Role of a Committee Member:

- Familiarity with ACGME Institutional, Common and Program Requirements.

- Assist with the interpretation and implementation of the ACGME requirements to assure continued accreditation.

- Ensure alignment of the GME division's goals and activities with the HonorHealth strategic plan and overall mission.

- Recommend new initiatives and directions for GME worthy of further study and possible development.

- Actively participate in the GMEC and its subcommittees as assigned.

- Assign a designee if unable to attend.

5.F.3. Committee Meetings:

(a) Meeting Schedule and Process:

The GMEC must meet a minimum of once every quarter during each academic year. Each meeting of the GMEC must include attendance by at least one resident/fellow member.

(b) Meeting Agenda:

The agenda is developed by the GMEC Chair and Director of Academic Affairs in collaboration with the members.

(c) Meeting Minutes:

The GMEC must maintain meeting minutes that document execution of all required GMEC functions and responsibilities.

(d) Review of Effectiveness of the GME Charter:

Review of the charter occurs annually.

5.F.4. Reporting and Lines of Communication:

The GMEC Chair will report at a minimum quarterly to the Chief Physician Executive and Network Executive Committee.

5.G. MEDICAL STAFF PLANNING AND PARTNERSHIP COMMITTEE

The Medical Staff Planning and Partnership Committee will provide a systematic and effective mechanism for dialogue and information-sharing between members of the Medical Staff, the Board, and HonorHealth Administration.

5.G.1. Composition:

The Medical Staff Planning and Partnership Committee will consist of the following members:

(a) the Chief Executive Officer;

(b) the Chief Physician Executive;

(c) the Hospital Chief Executive Officer/Chief Clinical Officer;

(d) the HonorHealth Medical Group Chief Medical Officer;

(e) the Innovation Care Partners Chief Executive Officer;

(f) the Division Chiefs of Staff; and

(g) three Board members.

Other participants will be invited to attend on an as-needed basis. The Committee will be chaired by a Division Chief of Staff (to be appointed by his/her peers). The Committee chair will be supported by the Chief Physician Executive and Medical Staff Services Officer(s), for the purposes of developing meeting agenda and preparing meeting materials.

5.G.2. Duties:

The Medical Staff Planning and Partnership Committee is responsible for the following:

(a) providing a forum for open, honest, and transparent communication between the Board, administration, and physicians;

(b) presenting and/or developing potential strategic initiatives, and soliciting strategic input from the HonorHealth physician community;

(c) reviewing high level quality, patient safety, patient experience, and clinical efficiency performance;

(d) reviewing and making recommendations related to capital expenditures, operational expenditures, and IT strategy;

(e) providing feedback and insights to potential physician candidates to serve on the Board upon request;

(f) providing the Board with broad-based perspective of the HonorHealth physician community point of view;

(g) promoting physician understanding and "ownership" of HonorHealth initiatives;

(h) engaging and educating current and future physician leaders; and

(i) evaluating major decisions at HonorHealth in relation to the guiding principles established in the HonorHealth – Physician Compact.

5.G.3. Meetings and Reports:

(a) The Committee will meet at least quarterly.

(b) Minutes and action items will be recorded, maintained with attachments, and distributed to all Committee members.

(c) The Committee will allow for roundtable report outs from its membership on any matters deemed important by any member for broad communication. The Committee chair will work collaboratively with the Chief Physician Executive to prepare Committee reports to be shared with the Board, Network Medical Executive Committee, and Division Medical Executive Committees. Report outs (and judgments about what should be reported out and to whom) should be determined by the chair, in collaboration with the Chief Physician Executive, with consideration given to the need for confidentiality of items discussed during Committee meetings and any non-disclosure agreements.

5.H. NETWORK EXECUTIVE COMMITTEE

The composition, duties, and meeting requirements for the Network Executive Committee are addressed in Article 5 of the Medical Staff Bylaws.

5.I. PHARMACY AND THERAPEUTICS COMMITTEE

5.I.1. Composition:

The Network Executive Committee, in consultation with the Chief Physician Executive, will appoint the members and the chair of the Pharmacy and Therapeutics Committee, which will consist of the following:

(a) at least one Active Staff member from each Division; and

(b) additional representatives from each Division, including those from pharmacy, administration, nursing, nutrition/dietary, laboratory, and quality.

5.I.2. Duties:

The Pharmacy and Therapeutics Committee is responsible for the following:

(a) reviewing and making recommendations to the Medical Staff and Hospitals regarding the selection, distribution, handling, use, administration, and stocking of drugs and diagnostic testing materials to meet the most effective therapeutic standards and prevent unnecessary duplication;

(b) developing and keeping a current formulary;

(c) evaluating clinical data concerning new drugs requested for use in the Hospitals;

(d) establishing standards concerning the use and control of investigational drugs used in the Hospitals;

(e) reviewing drug therapy practice and drug utilization within the Hospitals;

(f) considering requests and recommendations from the Medical Staff and the Hospitals relating to formulary items;

(g) evaluating and monitoring adverse drug reactions;

(h) reviewing the appropriateness, effectiveness and safety of the use of antibiotics; and

(i) performing functions that may be necessary to meet accreditation standards.

5.I.3. Meetings and Reports:

The Committee shall meet at least quarterly, maintain permanent records, and make reports of its activities, including conclusions, recommendations, actions taken, and the results thereof, in writing to the Network Executive Committees.

5.J. PRACTITIONER HEALTH COMMITTEE

5.J.1. Composition:

The Network Executive Committee, in consultation with the Chief Physician Executive, will appoint the members and the chair of the Practitioner Health Committee, which will consist of the following:

(a) the Network Chief Medical Officer and five other members of the Medical Staff, including an anesthesiologist and psychiatrist when possible, appointed for their experience in addressing health issues; and

(b) whenever the health of a member of the Medical Staff or Allied Health Staff is under review, the chair of his or her department, joining the committee on an *ad hoc* basis.

5.J.2. Duties:

The Practitioner Health Committee is responsible for the following:

(a) assuming responsibility for the supervision and management of practitioner health issues (defined as any physical, mental, or emotional condition that could adversely affect an individual's ability to practice safely), as requested;

(b) reviewing the performance of any individual who is referred to the committee and assessing whether the individual would benefit from or require treatment, rehabilitation, or other assistance;

(c) assisting in the diagnosis, treatment, and rehabilitation of practitioners who may have a health issue;

(d) developing a process for referrals to the committee (including a self-referral process);

(e) maintaining confidentiality of practitioners reviewed by the committee, unless limited by law, ethical considerations, or concerns about patient safety; and

(f) arranging, in collaboration with the Graduate Medical Education Committee, educational programs for the Medical Staff and the Allied Health Staff on practitioner health issues, including preventive measures designed to promote well-being.

ARTICLE 6

NETWORK HOSPITAL AND BEST CARE COUNCIL COMMITTEES

6.A. NETWORK HOSPITAL COMMITTEES

The following Network Hospital Committees will exist and include representation from members of the Medical Staff selected by the Network Executive Committee, in consultation with the Chief Physician Executive:

(1) Ethics Committee; and

(2) Supply Chain Governance Committee.

6.B. NETWORK BEST CARE COUNCIL COMMITTEES

The BEST Care Council Committees outlined below will include members of the Medical Staff selected by the Network Executive Committee, in consultation with the Chief Physician Executive, who will be charged with reporting to the Network Medical Executive Committee:

(1) Infection Prevention and Control Committee;

(2) Patient and Caregiver Experience Committee;

(3) Patient Safety Committee;

(4) Clinical Efficiency and Effectiveness Committee; and

(5) Other BEST Care Council committees, as identified by the Network Medical Executive Committee in consultation with the Chief Physician Executive.

6.C. MEDICAL STAFF MEMBERS OF NETWORK HOSPITAL AND BEST CARE COUNCIL COMMITTEES

Medical Staff members who have been appointed (by the Medical Staff) and/or have administratively assigned leadership roles in Network BEST Care Council Committees (including Service Lines and Clinical Collaboratives) and Network Hospital Committees will work with Medical Staff officers, department chairs, and section chiefs to ensure appropriate, bidirectional communication and collaboration.

ARTICLE 7

AMENDMENTS AND ADOPTION

(a) The amendment process for this Manual is set forth in the Bylaws.

(b) This Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Medical Staff Rules and Regulations, and Hospital or Medical Staff policies pertaining to the subject matter thereof.

Adopted by the Deer Valley Medical Center Medical Staff:

_____(Date)_____

Adopted by the John C. Lincoln Medical Center Medical Staff:

_____(Date)_____

Adopted by the Scottsdale Osborn Medical Center Medical Staff:

_____(Date)_____

Adopted by the Scottsdale Shea Medical Center Medical Staff:

_____(Date)_____

Adopted by the Scottsdale Thompson Peak Medical Center Medical Staff:

_____(Date)_____

Approved by the Board:

_____(Date)_____