



Medical Staff

Bylaws

Rules and Regulations

Organization and Functions Manual

Credentialing Policy and Procedures Manual

Corrective Action and Fair Hearing Plan

Revised: 12/2013

Additions/Changes:

- Residents
- ICU Committee
- Consultations
- Anesthesia Services

TRIOS HEALTH MEDICAL STAFF BYLAWS

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ARTICLE I. MEDICAL STAFF MEMBERSHIP

SECTION 1. PURPOSE

The purpose of this organization is to bring the physicians, dentists, and podiatrists that practice at the hospital together into a cohesive body to promote good medical, osteopathic, podiatric and dental care. It will screen applicants for medical staff membership, review privilege requests from all licensed independent practitioners permitted to practice in Trios Health (or Hospital), scrutinize work done by the staff, educate and offer advice and input to the Administrator and the Board of Commissioners. It will provide a mechanism for accountability through defined organizational components and positions.

SECTION 2. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the medical staff is a privilege that shall be extended only to professionally competent physicians, dentists, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and Provisional policies of the medical staff and Trios Health.

SECTION 3. QUALIFICATIONS FOR MEMBERSHIP

A. Only physicians with Doctor of Medicine/Doctor of Osteopathy degrees, dentists (DDS or DMD) or podiatrists (DPM) holding a current Washington State license, and current state and/or federal drug enforcement registration(s) who can document the following criteria will be considered for staff membership. Certified and/or qualified Allied Health Professionals (AHPs) will also be considered:

1. Experience, education, training and judgment,
2. Demonstrated clinical performance and competence,
3. Professional ethics and conduct, including malpractice history,
4. Ability to perform privileges or specified services requested/health status,
5. Communication skills and the ability to read, write and understand the English language and to prepare medical records entries and other required documentation, and
6. Professional liability insurance (issued by a recognized company) of a type and in an amount established by the Board of Commissioners.

Qualifications for membership in the medical staff and the criteria entitling a practitioner to exercise clinical privileges in the Hospital include demonstrated competence and judgment, satisfactory current physical and mental condition, and ability to work harmoniously with others, sufficient to assure the medical staff and the Hospital's Board of Commissioners that any patient treated by the practitioner in the Hospital will receive quality care and that the Hospital and the medical staff will be able to operate in an orderly manner. For those situations where this is questioned, please refer to the *"Practitioner Health Policy"*, *"Disruptive Physician Policy"*, or the *"Corrective Action & Fair Hearing Plan"*, dependent on the situation.

No physician, dentist, podiatrist, or AHP shall be entitled to membership on the medical staff or to exercise particular clinical privileges merely by virtue of licensure to practice in this or in any other state, or of membership in any professional organization, or of privileges at any other hospital.

- B. Completion of an accredited residency programs (i.e. Accreditation Council of Graduate Medical Education, American Osteopathic Association or American Podiatric Medical Association). Dentists and oral surgeons must have graduated from an approved school of dentistry and satisfactorily completed an approved postgraduate training program of at least one year fro dentistry or oral surgery.
- C. In lieu of the requirement of section B, evidence of at least five years of relevant clinical experience in a hospital approved by the Joint Commission on Accreditation of Health Care Organizations or the American Osteopathic Association may be submitted, together with documentation as to fields of work, duties, and responsibilities.
- D. Exceptions to the above may be made only by the Board of Commissioners after a joint conference with the medical staff.

SECTION 4. NONDISCRIMINATION

Trios Health will not discriminate in granting staff appointment and/or clinical privileges on the basis of ancestry, race, gender, faith, or age.

SECTION 5. CONDITIONS AND DURATION OF APPOINTMENT

- A. Initial appointments and re-appointments to the medical staff shall be made by the Board of Commissioners. The Board of Commissioners shall act on appointments and re-appointments only after there has been a recommendation from the Medical Executive Committee in accordance with the provisions of these bylaws and related manuals.
- B. Appointments to the staff will normally be for no more than twenty-four calendar months.
- C. Appointment to the medical staff shall confer on the appointee only such clinical privileges as have been granted by the Board of Commissioners.
- D. Dentists and podiatrists who are members of the medical staff may admit patients if a physician member of the medical staff agrees to conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry). The physician member will assume responsibility for problems, present at the time of the co-admission or which may arise during hospitalization, which are outside the podiatrist's or dentist's lawful scope of practice.

SECTION 6. STAFF DUES

- A. Annual medical staff dues shall be governed by the most recent action, which has been approved by the Medical Executive Committee. The medical staff office shall notify each staff member in writing of any contemplated change in medical staff dues at least twenty-one (21) days before the Medical Executive Committee meeting at which voting on such proposed changes is to take place.
- B. Honorary staff members will not be required to pay dues.

- C. Dues shall be due and payable upon request. Failure to pay dues shall be construed as a voluntary resignation from the staff.

SECTION 7. ETHICAL REQUIREMENTS

A person who accepts membership on the medical staff agrees to act in an ethical, professional, and courteous manner in accordance with the Medical Staff Bylaws, Rules & Regulations and other policies and procedures of the hospital and the medical staff. For those situations where this is questioned, please refer to the "Practitioner Health Policy" or the "Corrective Action & Fair Hearing Plan", dependent on the situation.

SECTION 8. RESPONSIBILITIES OF EACH MEMBER (APPOINTEE)

Each staff member agrees to:

- A. Provide appropriate and continuous care of his patients. He or she is responsible to report to Quality Management Committee chair the inappropriate actions of other physicians, dentists, allied health professionals, hospital employees under his supervision, and licensed independent practitioners.
- B. Abide by the bylaws, rules, and regulations and other policies and procedures of the hospital and the medical staff, and JCAHO and other pertinent regulatory bodies.
- C. Disclose professional liability action, either of a finalized or pending nature including previous judgments and/or settlements, to the medical staff office of the hospital when requested.
- D. Disclose immediately any successful challenges to licensure or registrations or voluntary or involuntary relinquishment of such licensure or registration to the medical staff office or administrator of the hospital.
- E. Disclose immediately voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction, suspension or loss of clinical privileges at another institution.
- F. Disclose any current criminal charges pending, any past charges and any convictions of misdemeanors or felonies when requested.

SECTION 9. PRACTITIONER RIGHTS

- A. Each MD, DO, DMD, DDS and DPM on the medical staff who is not a member of the Medical Executive Committee has a right to an audience with the Medical Executive Committee provided that:
 - 1. The issue has been discussed with the department/section chair, and;
 - 2. The issue has been discussed with the Medical Staff President, and;
 - 3. The issue has been discussed with the practitioner or party involved, and;
 - 4. Copies of relevant documents are to be made available to the members of the Medical Executive Committee and those in attendance prior to discussion of the Issue.

It is the intent of these provisions that the Medical Executive Committee is determined to be the appropriate forum for such discussion and that the issue can be discussed in a rational and well thought out fashion.

- B. Each MD, DO, DMD, DDS, and DPM has the right to initiate a recall election of a medical staff officer provided that twenty percent (20%) of the active staff signs the petition (see III.7 of the bylaws). Upon presentation of a valid petition, the Medical Executive Committee will schedule a special general medical staff meeting for the purposes of discussing the issue and (if appropriate) to entertain a no confidence vote which will be held by mail-in ballots, as described below.

Recall elections of medical staff officers will be held by mail-in random numbered secret ballot. In the case of mail-in ballots, the ballots will be sent to the offices of record of the members of the active staff with a stamped self-addressed envelope to return the ballot. Ballots will be tabulated by the medical staff services office and validated by the parties concerned within ten (10) days of the initial mailing.

An affirmative vote may be cast by marking the ballot "yes" and returning it to the medical staff office. A negative vote may be cast by marking the ballot "no" and returning it to the medical staff office. A change will be recommended by the active staff, for approval by the Medical Executive Committee and Board of Commissioners providing that a simple majority of active medical staff members indicate "yes" for recall on the returned ballot.

- C. Any MD, DO, DMD, DDS and DPM can call a general Staff meeting, with twenty percent (20%) of the active medical staff signing the petition. The Medical Executive Committee will schedule a special general medical staff meeting for the specific purpose addressed by the petitioners. No business other than that stated in the petition may be transacted (see "Special Meetings").
- D. Any practitioner has a right to a hearing/appeal pursuant to the institution's "Corrective Action & Fair Hearing Plan" in the event any of the following actions are taken or recommended as the result of an investigation and corrective action (see *Credentialing Policy & Procedure Manual*).
1. Denial of initial staff appointment,
 2. Denial of reappointment,
 3. Suspension of appointment,
 4. Revocation of appointment,
 5. Denial of requested appointment to, or advancement in, staff category if the denial will result in a termination or restriction of clinical privileges,
 6. Special limitation on the right to admit patients,
 7. Denial or restriction of requested clinical privileges,
 8. Reduction or restriction of clinical privileges,
 9. Suspension of clinical privileges,
 10. Revocation of clinical privileges,
 11. Individual application of, or individual changes in, a requirement of mandatory concurring consultation or any significant limitation on the exercise of clinical privileges, except for a suspension or observation requirement in connection with the exercise of new privileges or reinstatement of a practitioner after a leave of absence.

12. Any other action which requires a report to be made to the Washington State Medical or Disciplinary Boards under RCW 70.41.210 or other applicable law.

Provided, however, that there shall be no right to a hearing/appeal pursuant to the fair hearing plan for those matters set forth in Part VI of the Medical Staff "*Corrective Action & Fair Hearing Plan*".

E. Communications Regarding Practitioners:

1. Whenever a complaint, letter or report concerning a Trios Health practitioner is received and is deemed serious by the receiving party (CEO, any official of the Hospital or a practitioner) the complaint letter or report will remain in the Hospital and be treated as a quality assurance document until otherwise classified. Within thirty (30) days of submission, cases that are coded based on Hospital-wide Indicators is produced by the Quality Department on a monthly basis, screened and referred for clinical review.
2. All formal complaints including patient problem reports, incident reports or complaint/letter/report concerning practitioners will always require notification of the practitioner. The notice to practitioner and any response from the practitioner will be routed through normal quality assurance channels, i.e. Quality Management Committee or Department. Cases which require additional committee review or peer review will be subject to the timelines set forth in the Medical Staff Peer Review Policy.
3. All reported complaints, letters, or reports will be treated seriously and investigated under the following guidelines: All events will be kept confidential to the fullest extent possible. This means disclosure only to witnesses and others as necessary to allow investigation and response to the complaint and as may be required by law.

SECTION 10. DISCIPLINARY PROCEDURES

Corrective Action, Summary Suspension and Automatic Suspension: (see the *Corrective Action / Fair Hearing Plan*).

ARTICLE II. CATEGORIES OF THE MEDICAL STAFF

SECTION 1. THE ACTIVE CATEGORY

QUALIFICATIONS: Appointees to the category (MD, DO, DDS, DMD, or DPM) must:

- A. Admit or otherwise be involved in a minimum of 25 patient contacts at the hospital per year except as expressly waived for practitioners who document their efforts to support the hospital's patient care mission to the satisfaction of the Medical Executive Committee and Board of Commissioners. A patient "contact" includes an inpatient or outpatient activity defined as an admission, an invasive procedure or a consultation.

In the event an appointee to the active category does not meet the qualifications for reappointment to the active category, and if the appointee is otherwise abiding by all bylaws, rules, regulations and policies of the staff, the appointee will be appointed to the Courtesy category.

- B. Live within 30 miles of Trios Health and be able to respond within 30 minutes when on call for ER and/or his patients.

PREROGATIVES: Appointees to this category may:

- A. Exercise clinical privileges as are granted by the Board of Commissioners;
- B. Vote on all matters presented by the medical staff and by the appropriate department and committee of which (s)he is a member;
- C. Hold office and sit on or be the chairperson of any committee, unless otherwise specified elsewhere in these bylaws;
- D. Participate in hospital and medical staff education programs as appropriate.

RESPONSIBILITIES: Appointees to this category must:

- A. Contribute to the organizational and administrative affairs of the medical staff;
- B. Actively participate in recognized functions of the staff appointment including quality/performance improvement, risk management and monitoring activities, including monitoring of new appointees during the Provisional period, and in discharging other staff functions as may be required from time to time;
- C. Participate in the emergency service and other specialty coverage programs as determined by the department chair or by the Medical Executive Committee;

WAIVER: The appropriate department may, by a majority vote of members present, relieve members of the active staff from selected types of call when the following occurs:

- Provider submits request in writing stating one of the following reasons:
 - o Age (greater than 65 years)
 - o Fulfillment of call obligations are being met at another local hospital and is documented and submitted to the Medical Staff Services Office on a quarterly basis
 - o Hardship/health situation.
- D. Pay all medical staff dues and assessments promptly.
- E. Complete the appropriate Provisional time period.

SECTION 2. THE COURTESY CATEGORY

QUALIFICATIONS:

- A. The Courtesy category is reserved for practitioners (MD, DO, DDS, DMD, or DPM) who admit or otherwise are involved in a maximum of 50 patient contacts at the hospital per year except as expressly waived for practitioners who document their efforts to support

the hospital's patient care mission to the satisfaction of the Medical Executive Committee and Board of Commissioners. A patient "contact" includes an inpatient or outpatient activity defined as an admission, an invasive procedure or a consultation.

In the event an appointee to the Courtesy category has more than 50 patient contacts, and if the appointee is otherwise abiding by all bylaws, rules, regulations and policies of the staff, the appointee will be appointed to the Active category.

- B. Must live within 30 miles of Trios Health, and be able to respond within 30 minutes when on call for ER and /or his patients.

PREROGATIVES: Appointees to this category may:

- A. Exercise clinical privileges as are granted him by the Board of Commissioners.
- B. Attend meetings of the staff and department of which (s)he is an appointee and an staff or hospital education programs;
- C. Not vote or hold office.

RESPONSIBILITIES: Appointees to this category must:

- A. Pay all dues and assessments promptly;
- B. Participate in the emergency services and other specialty coverage programs to cover the practitioners own patient panel;
- C. Admit or provide services to patients in the hospital.
- D. Participate in recognized medical staff functions including quality/performance improvement, risk management, and other monitoring activities including monitoring initial appointees during the Provisional period and in discharging other staff functions as may be required from time to time.
- E. Complete the appropriate Provisional time period.

SECTION 3. CONSULTING

QUALIFICATIONS: The Consulting category is reserved for specialist practitioners (MD, DO, DDS, DMD, DPM) of recognized professional ability who are ineligible for membership in other medical staff categories. This would be a practitioner with training and skill, not available locally. Eligible practitioners requesting such privileges must meet current standards for training and/or experience as established by the Medical Executive Committee. Privileges granted will be limited to those not currently provided by Active and Courtesy Trios Health medical staff members.

PREROGATIVES: Appointees to this category may:

- A. Exercise clinical privileges as are granted by the Board of Commissioners.
- B. Not admit patients to the hospital.

- C. Not hold office or vote in medical staff affairs.

RESPONSIBILITIES: Appointees to this category must:

- A. Provide service to patients as requested.
- B. Limit activity to the rendering of consultations, procedures and ramifications thereof.
- C. Participate in performance improvement activities when a case involving a Consulting staff member is presented for review at a general staff, department, or committee meeting and further follow-up or action is requested. The Consulting staff member involved shall be notified in writing at least one week in advance and will be required to attend.

SECTION 4. AFFILIATE STAFF CATEGORY

QUALIFICATIONS:

The Affiliate Category is reserved for those practitioners who desire to be Provisional with, but do not intend to practice at the Hospital. It is a membership category with no clinical privileges being granted. The primary purpose of the Affiliate Category is to promote professional and educational opportunities, including continuing medical education collegial association and/or to establish and maintain a referral network.

PEROGATIVES:

Appointees to this category may:

- A. Visit hospitalized patients and review medical records but MAY NOT: admit patients, attend patients, exercise any clinical privileges, write orders or progress notes, perform consultations, assist in surgery, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients at the Hospital;
- B. Attend educational activities of the Hospital and Medical Staff.
- C. Attend meetings of the Medical Staff and applicable department.
- D. Not exercise a vote.
- E. Not hold office.

RESPONSIBILITIES:

- A. Pay all dues and assessments promptly.

SECTION 5. PROVISIONAL STAFF

QUALIFICATIONS:

Membership in the Provisional category is reserved for practitioners (MD, DO, DDS, DMD, or DPM) who have applied for initial appointment to Active or Courtesy Staff. Provisional category members must meet and maintain the qualifications for the category for which they initially applied, i.e. Active or Courtesy. Provisional staff members will be monitored closely as delineated in the “*Credentialing Policy and Procedure Manual*”, determined by the Medical Executive Committee for a period of time established by the Medical Executive Committee.

PREROGATIVES: Appointees to this category may:

- A. Exercise clinical privileges as are granted by the Board of Commissioners.
- B. Attend meetings of the staff and department of which s/he is an appointee and any staff or hospital education programs.
- C. Not vote.
- D. Not hold office.
- E. Not serve on the Medical Executive Committee.

RESPONSIBILITIES: Appointees of this category must:

- A. Pay all dues and assessments promptly;
- B. May participate in the emergency services and other specialty coverage programs as determined by the department chair or the Medical Executive Committee;
- C. Admit or provide services to patients in the Hospital in sufficient numbers for meaningful review of practitioner’s patient care. Failure to do so by end of the Provisional period will result in relinquishment of privileges and/or staff membership.
- D. Participate in recognized medical staff functions including quality/performance improvement, risk management, and discharging other staff functions as may be required from time to time.
- E. Satisfactorily complete proctoring review as required (see the *Credentialing Policy & Procedure Manual*) to advance to medical staff category initially requested

SECTION 6. ALLIED HEALTH PROFESSIONALS AND LICENSED INDEPENDENT PRACTITIONERS

There shall be additional categories of the Medical Staff consisting of individuals credentialed in their respective professions and permitted to perform specific functions within the Hospital. These categories shall consist of:

QUALIFICATIONS:

- A. LICENSED INDEPENDENT PRACTITIONER ("LIP") – Those professionals who are authorized by State law and recognized by the Board of Commissioners at the recommendation of the Medical Executive Committee to provide medical care to patients without immediate supervision by a physician, to assume responsibility for care of patients, and exercise their own judgment. LIPs shall have a written agreement with physician member(s) of the medical staff listed who will provide primary back-up for those patient care situations falling outside the scope of their Hospital privileges; back-up physician(s) members are to have appropriate privileges.
- B. The practitioners must live within 30 miles of Trios Health and be able to respond within 30 minutes when on call for ER and/or his patients.

PREROGATIVES:

- A. These practitioners will be assigned to the department most closely related to their specialty. These practitioners are subject to the corrective action and fair-hearing procedures outlined in the medical staff documents.
- B. ALLIED HEALTH PROFESSIONALS ("AHP") – Those professionals who are required by State law and/or the Hospital to provide medical care to patients under the supervision of a physician. These professionals shall be employed by and under the direct supervision of a physician staff member and will be assigned to the department of their supervising physician. AHPs are not subject to and have none of the rights available under the corrective action and fair hearing procedures outlined in the medical staff bylaws and accompanying manuals.

The initial granting of privileges to LIPs and AHPs shall be accomplished in a manner consistent with the overall procedure established for the Medical Staff as detailed in the "*Credentialing Policy and Procedure Manual*" portion of these medical staff documents. Clinical privileges may be extended to LIPs and AHPs after consideration of the applicant's education, training, experience, competence, ethical standards, ability to work with others and health status.

All AHPs and LIPs are subject to re-evaluation and re-appointment on a biennial basis in a manner consistent with that detailed in the "*Credentialing Policy & Procedure Manual*" of these medical staff documents.

All AHPs and LIPs shall carry out their activities subject to departmental policies and procedures, and in conformity with the Medical Staff Bylaws and related documents, and other policies and procedures of the Hospital and the medical staff. No AHP or LIP shall be entitled to vote or hold office, but may serve on committees. They are required to pay dues, fees and other assessments as determined elsewhere in these medical staff documents.

SECTION 7. TELEMEDICINE PRIVILEGES

Telemedicine is the exchange of medical information from one site to another via electronic communications for the purpose of improving patient care, treatment, and services.

Individuals applying for telemedicine privileges are not considered members of the medical staff and do not have the rights or benefits of membership and do not have access to the Fair

Hearing process. Telemedicine privileges granted in conjunction with a contractual agreement will be incident to and coterminous with the agreement.

Licensed Independent Practitioners (LIP) are credentialed and privileged to perform telemedicine through one of the following mechanisms:

- 1) The hospital fully privileges and credentials the LIP according to the medical staff bylaws and credentialing policies, or
- 2) The hospital privileges the LIP using credentialing information from a CMS accredited organization and approved through the hospital process. This information shall include a list of privileges granted to the LIP and information indicating that the applicant has exercised such privileges in a competent manner.

All individuals granted telemedicine privileges will be subject to the hospital's performance improvement, OPPE, and peer review activities.

SECTION 8. RESIDENTS

The Resident Staff shall consist of those practitioners at Trios Health in the Graduate Medical Education Program. The residents will have a full or limited license from the State of Washington to practice medicine. Residents in training at Trios Health shall not hold membership on the medical staff and do not have the rights or benefits of medical staff membership and do not have access to the Fair Hearing process. Residents shall at all times, when performing duties and services related to post-graduate education, be under the supervision of an attending (supervising) physician member. The Supervising Physician shall be an appropriately credentialed and privileged member of the Medical Staff in good standing.

Residents shall be permitted to function clinically in accordance with the written training protocols developed by the residency training program with oversight by the Graduate Medical Education Committee (GMEC). The *Resident Policies for Medical Staff* (KGH003785) outlines residency program policies that relate to medical staff including the delineation of roles, responsibilities, and patient care activities of residents. Supervision guidelines for medical staff overseeing residents are outlined in this policy.

As per AOA requirements, Residents may be allowed to participate in hospital and medical staff committees but shall have no voting rights. Residents may not serve as Medical Staff Officers.

While Residents must first abide by AOA rules and regulations for training, unless otherwise defined by the AOA Residents shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff Policies and Procedures. Residents shall be subject to limitation or termination from their ability to function as Residents at any time as per the disciplinary and remediation policies in the Resident Handbook.

The residency program leadership and/or GMEC must communicate on an annual basis or as needed, with the medical staff and hospital leaders about the performance of its residents, patient safety issues, and quality of patient care per the *Communication Between GMEC and Medical Staff Policy* (KGH003786).

SECTION 9. TEMPORARY PRIVILEGES

Temporary clinical privileges may be granted by the administrator, with written concurrence of the departmental chairperson and chairperson of Medical Executive Committee upon completion of a written application.

A signed acknowledgment will be obtained for receipt of copies of the Medical Staff Bylaws, Rules and Regulations and that he agrees to be bound by the terms thereof in all matters relating to his temporary clinical privileges.

Special requirements of supervision and reporting may be imposed by the chairperson of the department concerned on any practitioner granted temporary privileges. Temporary privileges shall be immediately terminated by the administrator upon notice of any failure by the practitioner to comply with such special conditions.

The administrator may at any time, for just cause, upon the recommendation of the chairperson of the Medical Executive Committee, terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) then under his care in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination shall be immediately effective and the chairperson of the Medical Executive Committee shall assign a member of the medical staff to assume responsibility for the care of such patient(s) until discharge from the Hospital. The wishes of the patient(s) shall be considered in the selection of such substitute practitioner. An applicant for temporary privileges shall not be entitled to the rights afforded by Article I Section 9 of these bylaws or the procedural rights afforded by the Medical Staff *"Corrective Action and Fair Hearing Plan"*.

Credentialing of Temporary Staff shall be conducted the same as for any other category, and per the *"Credentialing Policy & Procedure Manual"*.

Types of Temporary Staff

A. Locum Tenens:

Shall be granted to a practitioner serving as a Locum Tenens for a member of the medical staff, or when there is a need, to attend patients without applying for membership on the medical staff for a period of one year, but may not work more than sixty (60) days in a calendar year. However, a Locum Tenens Radiologist may work no more than one hundred twenty (120) days in a calendar year.

B. Specified Patient Consultation:

The administrator may permit a practitioner to serve as a consultant on a specified patient for a member of the medical staff, providing all of his or her credentials have been reviewed and approved by the Chair of the Medical Executive Committee.

C. Provisional/Temporary:

Provisional/Temporary privileges may be granted to an applicant with a complete Type I application (see *Credentialing Policy & Procedure Manual*) following review and approval by the appropriate Department Chair, the Medical Staff President and the Administrator.

SECTION 10. DISASTER PRIVILEGES

Privileges will be granted only in the instance of which an emergency management plan is activated and the hospital is unable to meet patient's needs. Disaster privileges may be granted at the discretion of the hospital administrator, departmental chairperson, or hospital supervisor. Privileges granted should be consistent with those currently in place in the appropriate department and specialty as the physician's "home" hospital. The physician requesting disaster privileges must provide the following forms of identification.

- A. A current picture identification card.
- B. A current license to practice and a valid picture identification issued by the state, federal or regulatory agency.

The following information may be requested at the time of granting privileges but may not be used as a form of identification.

- C. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)
- D. Presentation by current hospital or medical staff member(s) with personal knowledge regarding the practitioner's identity.

Verification of the above information shall be considered a high priority and completed as soon as possible (feasible), by the Medical Staff Office, utilizing Appendix A. Disaster privileges will be effective immediately. A decision to continue the Disaster privileges initially granted will be determined within 72 hours. The physician shall document in all medical records that they were working under disaster privileges and a list of patient encounters will be obtained. In addition, all patient encounters will be reviewed by a Medical Staff member prior to discharge.

Primary source verification of licensure will be conducted through the Medical Staff Office within 72 hours of granting Disaster privileges.

SECTION 11. THE HONORARY CATEGORY

Honorary category is restricted to those individuals the staff wishes to honor. Such staff appointees are not eligible for clinical privileges. They may attend medical staff and department meetings, continuing medical education activities, and may be appointed to committees as a consultant or nonvoting member.

SECTION 12. LEAVE OF ABSENCE

A. Leave Status

A staff member may obtain a voluntary leave of absence not to exceed twelve (12) months by submitting written notice to the Chairperson of the Medical Executive Committee stating the exact period of time of the leave. During the period of a leave, the staff member's privileges and prerogatives shall be suspended.

B. Termination of Leave

As soon as possible prior to the termination of the leave the staff member may request reinstatement of his privileges and prerogatives by submitting a written notice to that effect to the Medical Executive Committee. The Staff member shall submit a written summary of his relevant activities during the leave.

1. The Medical Executive Committee shall make a recommendation to the Board of Commissioners concerning the reinstatement of the member's privileges and prerogatives. Failure to request reinstatement or to provide a requested summary of activities as above provided shall be deemed a voluntary withdrawal of staff membership, privileges and prerogatives by the practitioner without the right of hearing or appellate review. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.
2. A staff member placed on medical leave status shall also provide a medical clearance from his attending physician prior to return to staff privileges.
3. If a member requests leave of absence status for the purpose of obtaining further medical training in his own or another field of medical practice, reinstatement will become automatic upon request for same, with an accompanying activities summary from the program director. However, any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.
4. Reinstatement will be automatic if leave of absence is for serving armed services commitment, with an accompanying summary of activities from the military.
5. If leave of absence occurs with no medical activity for the period of the leave, the Medical Executive Committee may require proof of continuing competency by either further education (a refresher course, etc.) and/or appropriate monitoring for a period of time.

ARTICLE III. OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

The officers of the medical staff shall be:

- A. President
- B. Vice President
- C. Past President

SECTION 2. QUALIFICATIONS OF OFFICERS

Officers must have been members of the Trios Health Active category for the previous four (4) years at the time of nomination and election and must remain members of the Trios Health Active category in good standing during their terms of office. Officers may not simultaneously hold leadership positions on another hospital medical staff and shall not simultaneously hold an elected department leadership position.

SECTION 3. ELECTION OF OFFICERS

- A. A nominating committee shall consist of four individuals appointed by the Medical Executive Committee. This committee shall offer one or more nominees for each office.
- B. Officers shall be elected by written ballot provided they are mailed to all Active staff members with at least 50% returned, and a successful candidate is appointed by a simple majority of those returned ballots. If no simple majority is obtained, another vote will be taken at the direction of the Medical Executive Committee. Only members of the Active category shall be eligible to vote. The Board of Commissioners will confirm all officers.
- C. Nominations may also be made by petition signed by at least 10% of the members of the active staff. Such petition must be submitted to Medical Executive Committee at least thirty (30) days prior to the annual medical staff meeting.
- D. Nominations must be announced, and the names of the nominees distributed to all members of the active medical staff at least twenty-one (21) days prior to the annual meeting(s). Nominations will not be announced unless accepted by the nominee.

SECTION 4. TERM OF OFFICE

All officers serve a term of two (2) years. Officers shall take office on the second day of the calendar year.

SECTION 5. VACANCIES OF OFFICE

Vacancies in office during the medical staff year, except the office of the president, shall be filled by the Medical Executive Committee. If there is a vacancy in the office of the president, the vice president shall serve the remainder of the term.

SECTION 6. DUTIES OF OFFICERS

- A. **President** – The president shall serve as the chief medico-administrative officer of the Hospital and will fulfill duties specified in the organization and functions manual or rules and regulations.
- B. **Vice President** – In the absence of the president, the vice president shall assume all the duties and have the authority of the president. (S)he shall perform such further duties to assist the president as the president may from time to time request. (S)he shall also chair the quality management committee. The vice president shall serve as the secretary and treasurer of the Medical Staff and in those capacities will see to the safeguarding of staff funds, the administration of staff expenditures, the collection of dues, make appropriate periodic reports of status of same to the staff and keep the minutes of all medical staff meetings.
- C. **Past president** – Attends the Medical Executive Committee meetings, with vote, and Serves as a consultant to the current medical staff officers.

SECTION 7. REMOVAL FROM OFFICE

Removal of an officer from their position shall be for failure to conduct those responsibilities assigned within these bylaws or other policies and procedures of the medical staff or hospital or failure to satisfy and maintain the qualifications for office. The Board of Commissioners may remove from office any officer on its own initiative, but only after a joint conference with a majority of the Medical Executive Committee representatives. The affected individual will not be present for such a joint conference. An officer may be removed from their position consistent with the process described in Article I, Section 9.b.

ARTICLE IV. MEDICAL STAFF ORGANIZATION

SECTION 1. ORGANIZATION OF DEPARTMENTS

The medical staff of the hospital shall be departmentalized into a medical department and a surgical department. Each department shall be responsible for the promotion of quality care at Trios Health and for reviewing the professional performance of members rendering care at Trios Health. Each department shall have a chair with overall responsibility for the supervision and satisfactory discharge of the functions of the department.

SECTION 2. OPTIONAL CLINICAL PRACTICE GROUP(S)

The Medical Executive Committee may recognize any group of physicians/dentists/podiatrists who have organized themselves into a clinical practice group (CPG). Any CPG, if organized, will not be required to hold regularly scheduled meetings, nor will attendance be required. CPGs are completely optional and may exist to perform any of the following activities:

- A. Continuing education;
- B. Grand rounds;
- C. Discussion of policies;
- D. Discussion of equipment needs;
- E. Development of recommendations for department chairs or Medical Executive Committee;
- F. Participation in the development of criteria for clinical privileges (when requested by a department chair or Medical Executive Committee);
- G. Discussion of a specific issue at the request of a department chair or the executive committee; and
- H. Clinical pathways

Except in extraordinary circumstances, no minutes or reports will be required reflecting the activities of the CPG. Only when CPGs are making formal recommendations to a department will a report be required to the department chair documenting the CPG specific position.

NOTE: CPG meetings will not be staffed by the representatives of the medical staff office. Attendance will not be taken.

SECTION 3. QUALIFICATIONS, SELECTION, AND TENURE OF DEPARTMENT CHAIRPERSON

- A. Each chair shall be a member of the active medical staff, willing and able to discharge the functions of the office, and be either certified by an appropriate specialty board or have been determined to possess equivalent qualifications by the Medical Executive Committee.
- B. Department chairs will be elected by their department to serve a 2-year term. The Board of Commissioners must approve all chairs.
- C. Removal of a department chair from their position shall be for failure to conduct those responsibilities assigned within these bylaws or other policies and procedures of the medical staff or hospital. The Board of Commissioners may remove from position any department chair on its own initiative, but only after a joint conference with a majority of the Medical Executive Committee representatives. The affected individual will not be present for such a joint conference.

Each department member has the right to initiate a recall election of a department chair provided that twenty percent (20%) of the active staff department members sign the petition. Upon presentation of valid petition, the Medical Executive Committee will schedule a special department meeting for the purposes of discussing the issue and (if appropriate) to entertain a no confidence vote which will be held by mail-in ballots, as described below.

Recall elections of department chairs will be held by mail-in random numbered secret ballot. In the case of mail-in ballots, the ballots will be sent to the offices of record for active medical staff department members with a stamped self-addressed envelope to return the ballot. Ballots will be tabulated by the medical staff services office and validated by the parties concerned within ten (10) days of the initial mailing.

An affirmative vote may be cast by marking the ballot "yes" and returning it to the medical staff office. A negative vote may be cast by marking the ballot "no" and returning it to the medical staff office. Removal will be recommended by the department, for approval by the Medical Executive Committee and Board of Commissioners providing that a simple majority of active medical staff members of the department indicated "yes" for recall on the returned ballot.

SECTION 4. FUNCTIONS OF DEPARTMENT

- A. Each department, through the department chair, shall recommend criteria for the granting of clinical privileges to the Credentials Committee.
- B. Each department, through the department chair, shall make recommendations for granting of clinical privileges, per the *"Credentialing Policy & Procedure Manual"*.
- C. Each department shall systematically evaluate the care of patients by its members.
- D. Each department shall be responsible for the determination of the call schedule for emergency services and other specialty coverage for each of its members.

SECTION 5. ASSIGNMENT TO DEPARTMENTS

The Medical Executive Committee will, after consideration of the recommendations of the chair of the appropriate clinical departments and the Credentials Committee, recommend department assignments for all members in accordance with their qualifications.

ARTICLE V. COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee and such other standing and special committees of the staff responsible to the Medical Executive Committee as may from time to time be necessary and desirable to perform the staff functions listed in these bylaws. Those functions requiring participation of, rather than direct oversight by, the medical staff may be discharged by the medical staff representation on such hospital committees as are established to perform such functions.

Whenever these bylaws require that a function be performed by, or that a report or recommendation be submitted to the Medical Executive Committee or a department, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

COMPOSITION: The Medical Executive Committee shall consist of the president, past president, vice president, and chair of each department. In addition, representatives from each department shall be elected annually by their assigned department from the active medical staff as follows:

Medicine: Internal Medicine or Medicine sub-specialty
Emergency Medicine
Pediatrics
Family Medicine

Surgery: General Surgery or Surgery sub-specialty
Anesthesiology
Pathology
Obstetrics/Gynecology
Radiology

The administrator (or his designee) and chief nurse executive shall be ex-officio members without vote. The chairperson will be the president of the medical staff.

DUTIES: The duties of the Medical Executive Committee shall be to:

- A. Receive or act upon reports and recommendations concerning patient care quality and appropriateness reviews, evaluation and monitoring functions, and the discharge of their delegated administrative responsibilities; and recommend to the Board of Commissioners specific programs and systems to implement these functions;
- B. Coordinate the activities of and policies adopted by the Board of Commissioners;

- C. Oversee the credentialing process and submit (with or without comment) recommendations to the Board of Commissioners concerning all matters relating to appointments, reappointments, staff category, department, assignments, clinical privileges and corrective action;
- D. Account t the Board of Commissioners and to the staff for the overall quality and efficiency of patient care in the hospital and the participation of the medical staff in organization performance improvement activities;
- E. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of staff appointees, including initiating investigations and initiating and pursuing corrective action, when warranted;
- F. Make recommendations on medico-administrative and hospital management matters;
- G. Keep the medical staff up-to-date concerning the licensure and accreditation status of the hospital;
- H. Consistent with the mission and vision of the hospital, the Medical Executive Committee will participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;
- I. Represent and act on behalf of the staff, subject to such limitations as may be imposed by these bylaws;
- J. Formulate and recommend medical staff rules, policies and procedures to the Board of Commissioners;
- K. Make recommendations concerning the structure of the medical staff, the mechanism by which medical staff membership may be terminated, and the mechanisms for fair hearing procedures;
- L. Establish medical staff dues, fees and/or other assessments as necessary and/or appropriate; and
- M. Make quarterly reports to the Board of Commissioners regarding the functions and activities of the Medical Staff.

MEETINGS: The Medical Executive Committee shall generally meet monthly but, at least ten times per year and hold special meetings whenever called by the president of the medical staff. Permanent records of its proceedings and actions will be maintained.

SECTION 3 QUALITY MANAGEMENT COMMITTEE

A. Purpose and Meetings

The Quality Management Committee:

- (1) Coordinates the systematic and ongoing review of the appropriateness and quality of: blood, drug use, surgery and invasive procedures, timeliness of completion of medical records, and physician related infection data;

- (2) Reviews and approves blood usage review plan;
- (3) Coordinates, prioritizes and monitors the medical staff data gathering and analysis components of the hospital's quality review program and coordinates the medical staff's activities in this area with those of the other professional and support services in the hospital.
- (4) Serves as a liaison for quality review issues with the medical staff, the hospital staff and the committee(s) responsible for accreditation and licensure.
- (5) Develops an annual strategic plan, in coordination with the director of the quality and risk management services, for the staff's performance improvement activities, and annually reviews the effectiveness and cost efficiency of the medical staff's performance improvement activities.
- (6) Establishes:
 - (a) Formats for the aggregation, display and reporting of data and findings;
 - (b) Systems for follow-up to determine that action taken results in problem resolution; and
 - (c) Formats and schedules for submission of data and findings, committee minutes, and special reports.
- (7) Receives and synthesizes information submitted by medical staff and/or hospital departments and committees, and performance improvement teams, as appropriate.
- (8) Supervises the maintenance of a quality review profile on each staff member and transmits, via the quality and risk management department, the same to be used in connection with the periodic reappraisal of each staff member.
- (9) Implements a system for screening and evaluation of clinical risk management issues including unexpected patient care management events, morbidity concerns, analyzes aggregate data on significant high risk events by identifying possible patterns, and communicating same to the professional staff and hospital groups with related responsibilities.
- (10) The committee shall analyze trends of hazardous and risk management events reported, and attempt to determine effective solutions; and implement appropriate systems or suggest action to enhance the quality and safety of patient care.
- (11) The Quality Management Committee meets at least ten times per year and reports to the Medical Executive Committee.

The specific procedures for obtaining information to achieve the above-listed functions are outlined in other hospital and departmental policies and procedures such as hospital wide Performance Improvement (PI) Plan.

B. Composition

The Quality Management Committee includes:

- (1) Six physicians appointed by the President of the medical staff;
- (2) Vice president of the medical staff will chair and report to the Medical Executive Committee;
- (3) Representatives from Administration, Clinical Quality Department, Risk Management, and nursing, (ex officio), without vote; and
- (4) Others may be invited to report as needed.

SECTION 4. JOINT CONFERENCE COMMITTEE

A. Purpose and Meetings

The joint conference committee shall conduct itself as a forum for the discussion of matters of medical center policy and practice, especially those pertaining to peer review activities and shall act as a liaison between the medical staff, administration, and the Board of Commissioners. The joint conference committee shall meet at least annually and transmit a report of activities to the Medical Executive Committee and to the Board of Commissioners.

B. Composition

The joint conference committee shall be a duly authorized peer review and standing committee and shall be composed of the three (3) officers of the medical staff and three (3) officers of the Board of Commissioners, the hospital administrator and the assistant administrator for patient care service. The Board of Commissioners president will chair the joint conference committee.

SECTION 5. CREDENTIALS COMMITTEE

A. Composition and Term

The Credentials Committee shall be a duly authorized peer review and standing committee and shall consist of not less than three and no more than ten members of the active medical staff. The members shall consist of, but are not limited to, the Past President, Past Chairman of Medicine Department and the Past Chairman of the Surgery Department. Members shall serve a two year term or until replaced by an outgoing Department Chairman.

B. Duties

The duties of the Credentials Committee shall be:

- (1) to review the credentials of all applicants and to make recommendations for membership and delineation of clinical privileges in compliance with Article 1, Sections 2,3,4 and 5 of these bylaws;
- (2) to make a report to the Medical Executive Committee on each applicant for medical staff membership or clinical privileges, including specific consideration of

the recommendations from the departments in which such applicant requests privileges; and

- (3) to review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of physicians to the various departments or services.

C. Meetings

The Credentials Committee shall meet at least monthly and shall maintain a permanent record of its proceedings and actions.

SECTION 6. PERINATAL COMMITTEE

A. Purpose and Meetings

B. Composition

The Perinatal committee shall consist of OB/GYN physicians, Certified Nurse Midwives, Pediatricians, and Family Medicine physicians that deliver newborns.

C. Responsibilities

1. Through the committee chair, shall recommend criteria for the granting of clinical privileges to the Surgery Department.
2. Through the committee chair, shall make recommendations for granting of clinical privileges, per the *"Credentialing Policy & Procedure Manual"*.
3. The committee shall systematically evaluate the care of patients by its members and report this to the Surgery Department.
4. The committee shall be responsible for the determination of the call schedule for emergency services and other specialty coverage for each of its members.

SECTION 7. STAFF FUNCTIONS

Provision shall be made in these bylaws or by resolution of the Medical Executive Committee approved by the Board of Commissioners, either through assignment to the departments, to staff committees, to staff officers or officials, or to interdisciplinary hospital committees, for the effective performance of the staff functions specified in this section and described in the current organization and functions manual, and of such other staff functions as the Medical Executive Committee or the Board of Commissioners shall reasonably require. These are to:

- A. Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as intensive or coronary care units, and all hospital sponsored services;
- B. Conduct or coordinate quality and appropriateness and improvement activities, including invasive procedures, blood usage, drug usage reviews, medical record, and other reviews;

- C. Conduct or coordinate utilization review activities;
- D. Conduct or coordinate credentials investigations regarding staff membership and granting and renewal of clinical privileges and specified services;
- E. Provide continuing education opportunities responsive to quality assessment/improvement activities, new state-of-the-art developments and other perceived needs, and supervise the hospital's professional library services;
- F. Develop and maintain surveillance over drug utilization policies and practices;
- G. Investigate and control nosocomial infections, and monitor the hospital's infection control program;
- H. Plan for response to fire and other disasters, for the hospital's growth and development, and for the provision of services required to meet the needs of the community;
- I. Direct staff organizational activities, including staff bylaws review and revision, staff officer and committee nominations, liaison with the Medical Executive Committee and hospital administration, and review and assist in achieving hospital accreditation;
- J. Coordinate the care provided by members of the medical staff with the care provided by the nursing service and with the activities of other hospital patient care and administrative services; and
- K. Engage in other functions reasonably requested by the Medical Executive Committee and Board of Commissioners;
- L. Develop and maintain surveillance over quality cancer care within the hospital through participation in a standing, multi-disciplinary Cancer Committee which meets the cancer program standards set forth by the American College of Surgeons Commission on Cancer. This may be achieved through a joint committee with other local organizations;
- M. Develop and maintain surveillance over quality trauma care within the hospital through participation in a joint, multi-specialty Trauma Oversight Committee with the other Tri-City hospitals which meet standards set by the Washington State WAC's for trauma care.

ARTICLE VI. MEDICAL STAFF MEETINGS

SECTION 1. ANNUAL AND QUARTERLY MEDICAL STAFF MEETINGS

The annual meeting of the medical staff shall be held during the last quarter of each year to elect officers as necessary. Written notice of the meeting shall be sent to all medical staff members and conspicuously posted. The medical staff will meet quarterly in a social environment to bolster collegiality and communication within the medical staff, i.e. President's Report.

SECTION 2. SPECIAL MEETINGS

- A. The president may call a special meeting of the medical staff at any time. The president shall call a special meeting within twenty (20) calendar days after receipt of a written

request thereof signed by not less than 20% of the voting members of the medical staff, or upon a resolution by the Medical Executive Committee. Such request or resolution shall state the purpose of the meeting. The president shall designate the time and place of any special meeting.

- B. Written or printed notice stating the time, place and purposes of any special meeting of the medical staff shall be conspicuously posted and shall be sent to each member of the medical staff at least seven (7) days before the date of such meeting. The attendance of the medical staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

SECTION 3. QUORUM

Medical staff, Medical Executive, and Quality Management committee meetings: Simple majority of the voting members. Excused absences do not count in determining the quorum. All other department and committee meetings: Those present and voting, as long as there is greater than one person.

SECTION 4. ATTENDANCE REQUIREMENTS

Members of the medical staff are encouraged to attend meetings of the medical staff. Meeting attendance will not be used in evaluating members at the time of reappointment.

Members of the Medical Executive Committee and Medical Staff Quality Management Committee are expected to regularly attend the meetings held and represent their departments.

SECTION 5. SPECIAL MEETING REQUIREMENTS

When a suspected deviation from standard clinical or professional practice is identified, the medical staff president or the applicable department chair may require the practitioner to confer with him or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the conference at least five (5) days prior to the conference, including the date, time and place, and a statement of the issue involved, and that the practitioner's appearance is mandatory.

Failure of the practitioner to appear at any such conference, unless excused by the Medical Executive Committee chair upon showing good cause, may result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the Medical Executive Committee may direct. A suspension under this section will remain in effect until the matter is resolved by subsequent action of the Medical Executive Committee and the Board of Commissioners. Such resolution shall be made in a timely manner.

SECTION 6. PARTICIPATION BY ADMINISTRATOR

The Administrator and any representative assigned by the Administrator may attend any committee or departmental meetings of the medical staff.

SECTION 7. ROBERT'S RULES OF ORDER

When needed, the latest edition of Robert's Rules of Order shall prevail at all meetings of the general staff, Medical Executive Committee, and department meetings, except that the chairperson of any meeting may vote.

SECTION 8. NOTICE OF MEETINGS

Routine meetings will be held on the day, time and place, as agreed upon, unless the meeting is canceled. Members will be notified as soon as possible.

SECTION 9. ACTION OF COMMITTEE/DEPARTMENT

The recommendation of a majority of its voting members present at a meeting at which a quorum is present shall be the action of a committee or department. Such recommendation will then be forwarded to the Medical Executive Committee for final action.

SECTION 10. RIGHTS OF EX OFFICIO MEMBERS

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

SECTION 11. MINUTES

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding officer shall sign the minutes and copies thereof shall be submitted to the Medical Executive Committee. A file of the minutes of each meeting shall be maintained.

ARTICLE VII. CONFIDENTIALITY, IMMUNITY AND RELEASE

SECTION 1. SPECIAL DEFINITIONS

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

- A. INFORMATION means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any of the subject matter specified in Section 5B of this Article.
- B. MALICE means the dissemination of a known falsehood or of information with a reckless disregard for whether it is true or false, or the absence of a reasonable belief that an action, statement or recommendation is warranted by the facts.
- C. PRACTITIONER means a staff member or applicant.

- D. REPRESENTATIVE means the Board of Commissioners and any member of a committee thereof, the administrator of the hospital, president of the medical staff organization and any member, officer, department, section or committee thereof, and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
- E. THIRD PARTIES mean both individuals and organization providing information to any representative.

SECTION 2. AUTHORIZATIONS AND CONDITIONS

By applying for, or exercising, clinical privileges within this hospital, a practitioner:

- A. Authorizes representatives of the hospital and the medical staff to solicit, provide and act upon information bearing on their professional ability and qualifications.
- B. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative who acts in accordance with the provisions of this Article.
- C. Acknowledges that the provisions of this Article are express conditions of this application for, or acceptance of, staff membership, or their exercise of clinical privileges at this hospital.

SECTION 3. CONFIDENTIALITY OF INFORMATION

Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining quality patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated or used in any way except as provided herein or otherwise provided by law. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records.

SECTION 4. IMMUNITY FROM LIABILITY

- A. For Action Taken

No representative of the hospital or medical staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of their duties as a representative, if such representative acts in good faith and without malice. Regardless of any provisions of state law to the contrary, truth shall be an absolute defense for a representative in all circumstances.

- B. For Providing Information

No representative of the hospital or medical staff, and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative of this hospital or medical or any other hospital, organization of health professionals, or other

health-related or educational institution or organization concerning a practitioner who is or has been an applicant to or member of the staff or who did or does exercise clinical privileges at this hospital, provided that such representative or third part acts in good faith and without malice.

SECTION 5. ACTIVITIES AND INFORMATION COVERED

A. Activities

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other educational or health-related institution's or organization's activities concerning, but not limited to:

1. Applications for appointment and clinical privileges;
2. Periodic reappraisals for re-appointment and clinical privileges;
3. Corrective action;
4. Hearings and appellate reviews;
5. Case management resources functions;
6. Malpractice loss prevention; and
7. Other hospital, department, section, committee, and subcommittee activities related to monitoring and evaluation and maintaining quality patient care and appropriate professional conduct.

B. Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, professional ethics, ability to cooperate with others, economic efficiency or any other matter that might directly or indirectly affect patient care or the efficient functioning of an institution or organization.

SECTION 6. RELEASES

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article, subject to such requirements, including those of good faith, absence of malice and the exercise of a reasonable effort to ascertain truthfulness, as may be applicable under the laws of the State of Washington, and such releases or copies thereof may be submitted to third parties from whom information, as described in Section 5B of this Article is sought. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

SECTION 7. CUMULATIVE EFFECT

Provisions in these bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

ARTICLE VIII. REVIEW, REVISION, ADOPTION, AND AMENDMENT

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The medical staff shall have the responsibility to formulate, review annually, and recommend to the Board of Commissioners medical staff bylaws, policies, and amendments thereto, which shall be effective when approved by the Board of Commissioners.

SECTION 2. METHODS OF ADOPTION AND AMENDMENT

All proposed amendments to the bylaws, or the Medical Staff *“Corrective Action and Fair Hearing Plan”*, whether originated by the Medical Executive Committee, another standing Committee, or by a member of the active category of the medical staff, must be reviewed and discussed by the Medical Executive Committee to develop verbiage prior to a medical staff vote. Such amendment may be recommended to the Board of Commissioners.

- A. By the medical staff after a majority vote, provided that the proposed amendment(s) was first distributed to all members of the active category at least twenty-one (21) days prior to a medical staff vote. Each member of the active category of the medical staff will be eligible to vote on the proposed amendment via printed ballot. An affirmative vote may be cast by marking the ballot “yes” and returning it to the medical staff office. A negative vote may be cast by marking the ballot “no” and returning it to the medical staff office. A change will be approved by the medical staff providing that a simple majority of active medical staff members have returned their ballots to the medical staff office within fourteen (14) calendar days of the medical staff meeting, and providing that 75% of those ballots received have been marked “yes”.
- B. If the bylaws and accompanying documents are not in compliance with the requirements imposed by law, regulation, order of court of law, for accreditation, for tax purposes, or otherwise necessary in the Board's judgment and discretion, the Board of Commissioners may request appropriate amendment. Such amendment as is proposed by the Board of Commissioners shall be deemed adopted by the medical staff unless the medical staff within the time frame designated by the Board of Commissioners takes action that amends these bylaws to conform to such requirements within a reasonable period of time. Such amendments need not be approved by the medical staff.
- C. Any amendment recommended by the Medical Executive Committee after formal active staff vote shall become effective only after approval by the Board of Commissioners or its authorized agent.

SECTION 3. RELATED PROTOCOLS AND MANUALS

The Medical Executive Committee will recommend to the Board of Commissioners credentials and organization and function manuals and other such manuals, rules or regulations as are necessary to further define the general policies contained in these bylaws. Upon adoption by the Board of Commissioners, these manuals and rules/regulations will be incorporated by reference and become part of these bylaws. A vote of the medical staff as provided in Article VIII, Section 2A of these bylaws is not required to adopt, amend or revise the related documents, unless otherwise stated in a specific related document.

SECTION 4. EXTERNAL EFFECTS ON BYLAWS

In the ever-changing healthcare marketplace, transactions may be made which could arguably affect the medical staff bylaws without involvement of the medical staff. To preserve the integrity of the Trios Health medical staff bylaws in certain transactions, successor in interest and affiliation effect provisions are advisable.

A. Successor in Interest

1. These bylaws, and clinical privileges accorded under these bylaws, will be binding upon the hospital and medical staff of any successor in interest in Trios Health.

B. Effect of Hospital's Affiliation

1. Affiliation with other hospitals, healthcare systems or similar entities shall not in and of itself affect these medical staff bylaws.

DEFINITIONS

ADMINISTRATOR	Administrator of Trios Health, and his authorized designee.
APPLICANT	Any practitioner who has applied for appointment, reappointment, privileges, or change in status to the medical staff or AHP.
APPLICATION	The act of applying for appointment, reappointment, privileges, or change in status to the medical staff or AHP.
BOARD OF COMMISSIONERS	Board of Commissioners of Kennewick Public Hospital District, or its designee.
BYLAWS	These bylaws, rules & regulations, Provisional manuals and policies and procedures of the Trios Health medical staff and AHP.
CREDENTIALING	The process whereby a practitioner is accepted to the medical staff or AHP and is granted practice privileges.
DISTRICT	Kennewick Public Hospital District (KPHD).
EX OFFICIO	Serves as a member of a body by virtue of office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.
HE, HIS, HIM	Shall be read as he/she, his/her, him/her respectively in all instances.
HOSPITAL	Trios Health, Kennewick, Washington.
JOINT CONFERENCE	A meeting between representatives of the Board of Commissioners, hospital administration, and the physician members of the Medical Executive Committee.

MEDICAL STAFF	The formal organization of all licensed physicians, osteopaths, dentists, and podiatric physicians who are privileged under these bylaws to attend patients or to provide other diagnostic, therapeutic, teaching, or research services in the hospital.
MEDICO-ADMINISTRATIVE	A practitioner, employed by or otherwise serving the hospital on a full or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care, and it includes the supervision of professional activities of practitioners under his direction.
NOTICE	Except where specific notice provisions are otherwise provided in these bylaws, all such notices, demands, or requests required or permitted to be mailed shall be in writing, properly sealed, and shall be sent through the United States Postal Service, first class postage prepaid. An alternative delivery system may be used if it is reliable, expeditious, and if evidence of its use is obtained. Mailed notices to a member, applicant, or other person shall be to the address that last appears on the official records of the medical staff or the hospital.
PHYSICIAN	Allopathic or osteopathic physicians or dentists.
PODIATRIST	Podiatric physicians and surgeons, as defined by WAC 246-922-010 and RCW 18.22.
PRACTITIONER	Allopathic, osteopathic, or podiatric physician; dentist or allied health professional.
PRIVILEGING	The granting of practice privileges.
PRIVILEGES	The permission granted by the Board of Commissioners to a practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services (applies to scope of practice when used in lieu of privileges or clinical privileges).
RELATED MANUALS	Documents related to these bylaws, including but not limited to the Rules & Regulations, Provisional Manuals Organization and Functions Manual, the Credentialing Policies and Procedures Manual, Medical Staff Corrective Action & Fair Hearing Plan, Practitioner Health Policy, Disruptive Physicians Policy, Medical Staff Policies and Procedures, and Hospital Policies and Procedures which are pertinent to medical staff practices within the hospital.

ORGANIZATION AND FUNCTIONS MANUAL

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ARTICLE I FUNCTIONS OF THE STAFF

SECTION 1. GENERALLY

The required functions of the staff are as described in Section 1.2 below. The staff official(s) and/or organizational component(s) responsible for each of the activities to be carried out in accomplishing a function are identified in parentheses following the description of the activity. If no staff official and/or organizational component is identified, then the function shall be carried out by the Medical Executive Committee or its designee(s).

The current medical staff is organized into two departments: medical and surgical. Each department will meet quarterly each year (more often if needed).

SECTION 2. DESCRIPTION OF FUNCTIONS

A. Governance, Direction, Coordination and Action

1. Receive, coordinate, and act upon as necessary the written reports and recommendations from sections, committees, other groups and officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities. (Medical Executive Committee, certain staff committees)
2. Account to the Board of Commissioners and to the staff by written reports for the overall quality and efficiency of patient care at Trios Health. (President and Medical Executive Committee, jointly)
3. Take reasonable steps to obtain professional ethical conduct and competent clinical performance on the part of staff members, including initiating investigations and initiating and pursuing corrective action, when warranted. (Medical Executive Committee and President)
4. Make recommendations on medico-administrative and hospital management matters. (Medical Executive Committee and President)
5. Inform the medical staff of the accreditation program and the accreditation and licensure status of the hospital. (President and Medical Executive Committee)
6. Act on all matters of medical staff business. (Medical Executive Committee, certain staff committees)

SECTION 3. QUALITY IMPROVEMENT ACTIVITIES

- A. Adopt and modify, subject to the approval of the Medical Executive Committee and the Board of Commissioners, and supervise the conduct of specific programs and procedures for assessing, maintaining and improving the quality and efficiency of the medical care provided in the hospital. (Quality Management Committee)
- B. Develop chain-of-command showing responsibility regarding practitioner concerns, care issues, etc. (Quality Management Committee)

- C. Implement the procedures required under (a) by:
 - 1. developing criteria and identifying data needs for the various activities,
 - 2. identifying patterns of performance within or outside the acceptable range,
 - 3. receiving and evaluating explanations for patterns significantly different from the norm, and
 - 4. reporting these findings and explanations. (Quality Management Committee reporting to Medical Executive Committee)
- D. Formulate and act upon specific recommendations to correct identified improvable (Medical Executive Committee and President)
- E. Follow up on action taken. (For monitoring impact of change, entities identified under (2) above, for further action, those under (3))
- F. Coordinate the staff's performance improvement activities with those of other health care disciplines. (Quality Management Committee, and the President with administration)
- G. Send written reports, when appropriate, to the next higher authority in the organizational structure on the results (including findings, actions taken, and follow-up) and progress of the quality review and risk management activities. (all medical staff committees)
- H. Participate in annually evaluating the overall quality review program for its comprehensiveness, integration, effectiveness and cost efficiency. (Quality Management Committee, Medical Executive Committee, and Board of Commissioners)

SECTION 4. MONITORING ACTIVITIES

- A. Adopt, modify, supervise and coordinate the conduct and findings of the patient care monitoring activities including but not limited to, surgical case review including tissue review, blood usage reviews, drug therapy practices and drug utilization, surveillance, prevention, and control of infection.

Other areas in which patient care review occurs includes cancer care and trauma care. The results of the review activities are reported to the appropriate medical staff departments or committees, the Quality Management Committee, and the Medical Executive Committee.
- B. Conduct ongoing operative and other invasive procedure review, including tissue review, evaluation, and comparison of preoperative and postoperative diagnosis, indications for the procedure, actual diagnosis of tissue removed, and situations in which no tissue was removed.
- C. Conduct periodic blood usage reviews, including evaluation of appropriateness of all transfusions (whole blood and blood components), review of all confirmed transfusion reactions, and review of ordering practices for blood and blood products, including the amount requested, the amount used, and the amount wasted.

- D. Periodically review and evaluate drug therapy practices and drug utilization, including review of the appropriateness, safety, and effectiveness of the prophylactic, empirical, and therapeutic use of drugs. The review and evaluation includes the use of antibiotics as well as those drugs which are high risk, high volume, or problem prone in their administration. The review of adverse drug reactions shall include recommendations and actions based on the conclusions of the review.
- E. Periodically review and evaluate the surveillance, prevention, and control of infection to identify and reduce the risks of acquiring and transmitting infections among patients, employees, physicians, and other licensed independent practitioners, contract service workers, volunteers, students, and visitors. The review and evaluation includes those infections acquired in the hospital (nosocomial) as well as those brought into the hospital. Those brought in may be endemic (common cause) or epidemic (special cause). The broad range of activities to conduct surveillance, prevention, and control of infection are coordinated and carried out by the hospital linking with external organizations to reduce the risk of infection from the environment, including food and water sources.
- F. Periodically review and evaluate general indicators of quality of care including, but not limited to, unexpected patient care management events which may include results of autopsies, root cause analysis investigation for sentinel or other serious events, and/or ethical issues resolution.
- G. Enforce and coordinate compliance with medical staff privilege requirements and other established policies and protocols relating to clinical practice in the hospital.
- H. Those responsible for conducting any of these monitoring activities shall submit written reports of results and progress to the appropriate medical staff entity. Summary reports should reflect quarterly and yearly activity.

SECTION 5. UTILIZATION MANAGEMENT

- A. Development a utilization management plans for approval by the Medical Executive Committee, hospital administration, and Board of Commissioners. The plan must apply to all patients regardless of payment source, outline the confidentiality and conflict of interest policy, and include provision for at least:
 - (1) Review of the appropriateness and medical necessity of admissions, continued hospital stays, and the use of clinical support services;
 - (2) Discharge planning;
 - (3) Data collection and reporting requirements; and
 - (4) Use of written, objective, measurable criteria in conduction the reviews. (Quality Management Committee)
- B. Review and monitor that the plan is in effect, known to the staff members, and functioning at all times. (Quality Management Committee)

- C. Analyze utilization profiles on a periodic basis, and prepare written evaluations of the utilization review and management activities on a continuous basis, including a determination of their effectiveness in allocating resources. (Quality Management Committee)
- D. Conduct performance improvement studies, take actions, submit reports, and make recommendations as required by the strategic plan. (Quality Management Committee, other staff individuals/components as defined in the strategic plan)
- E. The Quality Management Committee submits a written report monthly, including at least a summary of the findings of and specific recommendations resulting from various performance improvement activities, to the Medical Executive Committee and for information on utilization patterns to sections, as appropriate, and to any other staff organizational entity or officials, as needed. The Quality Management Committee reports similarly to the Medical Executive Committee and for information to any other staff organizational entity or official as needed. (The Medical Executive Committee and President report to the Board of Commissioners)

SECTION 6. CREDENTIALS REVIEW

- A. See Credentials Policy & Procedure Manual
- B. To expedite the credentialing process, the delegation of authority has been granted as follows:
 - (1) Administrator/designee for the Board of Commissioners;
 - (2) Medical Executive Chair/designee for the Medical Executive Committee; and
 - (3) Credentials committee;
 - (4) Department Chair/designee for respective department.

SECTION 7. INFORMATION MANAGEMENT

- A. Review and evaluate medical records to determine that they:
 - (1) Properly describe the condition and progress of the patient, the therapy and tests provided the results thereof, and the identification of responsibility for all actions taken. (Quality Management Committee)
 - (2) Are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the hospital. (Quality Management Committee)

- B. Develop, review, enforce, and maintain surveillance at least quarterly over enforcement of staff and hospital policies and rules relating to medical records, including completion, preparation, forms, format, filing, indexing, storage, destruction, and availability: and recommend methods of enforcement thereof and changes therein. (Quality Management Committee for review and enforcement of timeliness rules, forms and policy, etc.)
- C. Provide liaison with hospital administration, nursing service, and medical records professionals in the employ of the hospital, on matters relating to medical records practices and information management planning (Quality Management Committee)

SECTION 8. EMERGENCY PREPAREDNESS

- A. Assist the hospital administration in developing, periodically reviewing, and implementing a disaster/fire plan that addresses disasters, both external and internal to the hospital. (Medical staff representation on the hospital safety committee)

SECTION 9. PLANNING

- A. Participate in evaluating on an annual basis existing programs, services and facilities of the hospital and medical staff, and recommend continuation, expansion, abridgment, or termination of each. (Medical Executive Committee, President of staff, department chairs, Board of Commissioners, hospital planning committee)
- B. Participate in evaluating the financial, personnel, and other resource needs for beginning a new program or service, for constructing new facilities, or for acquiring new or replacement capital equipment, and assess the relative priorities or services and needs and allocation of present and future resources. (Medical Executive Committee, President of staff, department chairs, Board of Commissioners, hospital planning committee)
- C. Submit written reports as necessary, or required, to relevant staff organizational components and to the Board of Commissioners or appropriate committees thereof through the President of staff with findings and recommendations for action. (Medical Executive Committee, President of staff, department chairs, Board of Commissioners, hospital planning committee)

SECTION 10. BYLAWS REVIEW

- A. Conduct periodic review of the bylaws and the related manuals and forms promulgated in connection with them. (Medical Executive Committee)
- B. Conduct periodic review of the clinical policies and rules. (Medical Executive Committee)

- C. Submit written recommendations to the Medical Executive Committee and to the Board of Commissioners for changes in these documents. (For bylaws, Medical Executive Committee to staff to Board of Commissioners; for related manuals, policies and rules, Medical Executive Committee to Board of Commissioners)

SECTION 11. NOMINATING

- A. Identify nominees for election to medical staff offices and to other elected positions in the staff organizational structure. (Medical Executive Committee to medical staff, other authorities as identified in various sections of the medical staff bylaws)
- B. In accomplishing (a), consult with members of the staff, the Medical Executive Committee, and administration concerning the qualifications and acceptability of prospective nominees.
- C. Nominating committee to be formed at least 60 days prior to elections.

SECTION 12. RESPONSIBILITIES OF DEPARTMENT CHAIRS

A department chair will be elected by the Provisional department members for two year staggered terms pending subsequent approval by the Medical Executive Committee and Board of Commissioners. Anyone who is willing and able to discharge the below mentioned functions and is either Board of Commissioners certified or shall have been determined to possess equivalent qualifications by the Medical Executive Committee and has been an Active medical staff member for four years at the time of election may be nominated. The responsibilities of the department chairs will be as follows:

- A. Be accountable to the Medical Executive Committee for all professional and administrative activities within the department.
- B. Be a member of the Medical Executive Committee giving guidance on the overall medical policies of the hospital and making specific administrative and clinical activity recommendations regarding the department.
- C. Maintain surveillance of the professional performance of all practitioners with clinical privileges in the department, and report to the Medical Executive Committee when necessary.
- D. Enforcement of the Bylaws, Medical Staff Rules & Regulations, Credentialing Policy & Procedure Manual, Practitioner Health Policy, Disruptive Physician Policy, Corrective Action & Fair Hearing Plan, and other policies and procedures of the hospital and the medical staff.
- E. Be responsible for implementation, within the department of actions taken by the Medical Executive Committee or the medical staff.
- F. Recommend to the Credentials Committee the criteria for clinical privileges that are relevant to the care provided in the department.

- G. Transmit to the Credentials Committee the department's recommendation concerning the staff classification, the reappointment, and the delineation of clinical privileges for all practitioners in the department.
- H. Assure that the quality and appropriateness of patient care provided in the department are monitored and evaluated, and be responsible for implementing action following review and recommendations by the Quality Management Committee.
- I. Be responsible for the teaching, orientation and continuing education for the department.
- J. Participate in every phase of administration of the department through cooperation with nursing services and hospital administration in matters affecting patient care, including recommending off-site services for needed patient services not provided by the department or the organization. Approve and develop criteria for evaluating the quality and effectiveness of out-sourced medical services.
- K. Assist in the preparation of the capital and operating (including staffing) budget for the department.
- L. Promote effective physician/hospital relationships.
- M. Ensure members maintain current status in necessary areas, as delineated by these bylaws, and other medical staff documents, i.e. current, valid Washington State medical license; professional liability insurance limits as established by the Board of Commissioners; and current, valid DEA registration.

ARTICLE II PROFESSIONAL STAFF COMMITTEES

SECTION 1. DESIGNATION

There will be a Medical Executive Committee. The Quality Management is Committee is responsible to the Medical Executive Committee. The following functions will routinely report to the Quality Management Committee their findings, conclusions, recommendations, action and effectiveness of action: medical records, operative and other invasive procedures review, utilization review, drug usage and blood usage. The pharmacy and therapeutics, infection control, special care, cancer, trauma, credentials, perinatal, and ethics functions are reviewed by hospital committees that report quarterly to the Quality Management Committee. Principles that govern committees are provided in the staff bylaws. The manner of and authority for the appointment of members and chairs of committees are set forth in the bylaws.

SECTION 2 MEDICAL EXECUTIVE COMMITTEE

The composition and duties of the Medical Executive Committee are as set forth in the bylaws. In addition, the Medical Executive Committee supervises overall medical staff compliance with accreditation and other regulatory requirements applicable to the medical staff or any of its clinical units.

SECTION 3 QUALITY MANAGEMENT COMMITTEE

The composition and duties of the Quality Management Committee are as set forth in the bylaws.

SECTION 4. JOINT CONFERENCE COMMITTEE

The composition and duties of the Joint Conference Committee are as set forth in the bylaws.

SECTION 5. CREDENTIALS COMMITTEE

The composition and duties of the Credentials Committee are as set forth in the bylaws.

SECTION 6. PERINATAL COMMITTEE

The composition and duties of the Perinatal Committee are as set forth in the bylaws.

SECTION 7. CANCER COMMITTEE

Trios Health shall have a Cancer Committee for the purpose of providing superior care to patients with cancer.

A. Composition of Committee:

The committee shall consist of at least one (1) medical staff member from the required specialties: diagnostic radiology, pathology, general surgery, medical oncology and radiation oncology. The cancer committee/leadership chair is a physician who may fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the cancer committee and fulfill the role of one of the required physician specialties. One physician member representing the hospital's five major cancer sites (breast, prostate, lung, colorectal and bladder) will be invited to attend the meetings.

The committee shall consist of at least one (1) non-physician member from cancer program administration, oncology nursing, social services, cancer registry and quality improvement. Additional physician or non-physician members include hospice, nurse navigator, pharmacy and the American Cancer Society. Other representatives may be assigned when the scope of services determines the need for additional members. Individual members of the committee/leadership body are appointed to coordinate important aspects of the cancer program.

B. Responsibilities:

- 1) Oversee the entire spectrum of care for all cancer patients admitted to the hospital. This includes diagnosis, treatment, rehabilitation, follow-up and end-result reporting.
- 2) Organize, publicize, implement and evaluate regular educational and consultative tumor conferences that are multidisciplinary, hospital-wide and case oriented.
- 3) Advise and assist in the solution of problems concerning cancer care which may arise in the clinical or administrative departments of the hospital.
- 4) Oversee the operation of the Cancer Registry, paying particular attention to the quality control of abstracting, staging and end-reporting.
- 5) Plan and implement quality improvement measures and review and monitor quality of patient care using Commission on Cancer quality reporting tools.
- 6) Fulfill the responsibilities as outlined by the current Commission on Cancer Program Standards including establishing and maintaining policies and procedures to comply with the standards.
- 7) Uphold medical ethical standards through the ethics committee.

C. Meetings:

The committee will meet at least quarterly. Meeting minutes will be maintained in the Medical Staff Office.

D. Committee Reporting:

The committee reports and submits the minutes to the Quality Management Committee.

SECTION 8. PHARMACY & THERAPEUTICS COMMITTEE

- A. COMPOSITION: The Pharmacy and Therapeutics Committee shall consist of at least five representatives from two departments of the Medical Staff, a non-voting representative from the pharmaceutical service, and a non-voting, advisory representative from the nursing service and hospital administration.

B. DUTIES:

- (1) assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage.
- (2) advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs.
- (3) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
- (4) periodically developing and reviewing a formulary or drug list for use in the hospital.
- (5) evaluating clinical data concerning new drugs or preparations requested for use in the hospital.

- (6) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
 - (7) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.
 - (8) reviewing adverse drug events.
 - (9) reviewing of blood and blood components, including whether an informed consent was obtained. This should be reported to the Quality Management Committee for review.
- C. **MEETINGS:** The committee shall meet as often as necessary but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

SECTION 9. INTENSIVE CARE UNIT (ICU) COMMITTEE

- A. **Composition.** ICU shall consist of the Medical Director and up to seven additional medical staff members and ancillary services which may include the Chief Nursing Officer or designee, the ICU Director, and designee from Pharmacy, Nutrition, Social Worker, Nursing, Respiratory, and Quality Improvement.
- B. **Duties/Purpose.** The duties of the ICU Committee shall be:
- 1. To improve the quality of care, treatment and services for KGH, to provide a forum for KGH Medical Staff and employees and to provide oversight and make recommendations to the Medicine Department and administration on issues related to the critical care services to patients in the ICU. In addition the committee is in charge of recommending policies, procedures, and process improvement for appropriate delivery of critical care services. Scope includes the care provided in the ICU. Important issues relating to care in this unit will be evaluated and solutions identified.
- C. **Reporting.** The ICU committee is accountable to the Medicine Department.
- D. **Meetings.** The ICU Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

ARTICLE III MEETING PROCEDURES

SECTION 1. NOTICE OF MEETINGS AND QUORUM

The policy on notice of medical staffs meetings and quorum is as set forth in the bylaws.

SECTION 2. ORDER OF BUSINESS AT MEDICAL STAFF MEETINGS

The order of business at any meeting is determined by the appropriate chair.

SECTION 3. MANNER OF ACTION

Except as otherwise specified, the actions of a majority of the members present and voting at a meeting at which a quorum is present is the action of the group. Such vote shall be binding.

SECTION 4. EXECUTIVE SESSION

A regular or special meeting of the medical staff, a department or a medical staff committee may go into executive session at the discretion of the chairperson upon request by 50% of the members present. Attendance at the meeting will be restricted to the active members of the medical staff, department, or committee and administrator and/or his designee. One physician member will be designated by the chairperson of the meeting to record minutes.

SECTION 5. MINUTES

Minutes are not required unless specified by the bylaws or related procedure manuals. However, when they are taken, they shall include a record of the vote taken and shall be signed by the presiding officer, and copies thereof shall be submitted to the Medical Executive Committee. A permanent file of the minutes taken shall be maintained.

SECTION 6. PROCEDURAL RULES

Meetings of the staff, departments, and committees will be conducted according to the then current edition of Robert's Rules of Order. In the event of conflict between said Rules and any provisions of the medical staff bylaws or any of its related manuals, the latter are controlling.

ARTICLE IV. AMENDMENT

SECTION 1. AMENDMENT

This medical staff organization and functions manual may be amended or repealed, in whole or in part, by one of the following mechanisms:

- A. A resolution of the Medical Executive Committee recommended to and adopted by the Board of Commissioners; or
- B. Action by the Board of Commissioners on its own initiative after notice to the Medical Executive Committee of its intent and pursuant to the procedures outlined in the medical staff bylaws.

SECTION 2. RESPONSIBILITIES AND AUTHORITY

The procedure outlined in Article VIII, Section 3 of the medical staff bylaws shall be followed in the adoption and amendment of this medical staff organization and functions manual, provided that the Medical Executive Committee may act for the staff in making the necessary recommendations.

CREDENTIALING POLICY AND PROCEDURES

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CREDENTIALING

ARTICLE 1. POLICY FOR APPOINTMENT & RE-APPOINTMENT APPLICATION:

SECTION 1. GENERAL

- A. All applications to the medical staff shall be in writing, shall be signed by the applicant, and shall be submitted on a form prescribed by the Governing Body after consultation with the credentials committee and the Medical Executive Committee. The application shall require detailed information concerning the applicant's professional qualification, and shall request the names of at least three (3) persons who have had extensive experience in observing and working with the applicant, and who can provide adequate references pertaining to the applicant's professional competence and ethical character, and shall include information as to whether the applicant's membership status and/or clinical privileges have ever been voluntarily or involuntarily revoked, suspended, reduced or not renewed at any other hospital or institution, and as to whether his or her membership in local, state or national medical societies, or his or her license to practice any profession in any jurisdiction, has ever been, voluntarily or involuntarily, suspended or terminated. The application shall also require detailed information concerning the applicant's involvement in any professional liability action, including but not limited to any claims made by a patient and any pending or final lawsuits, settlements, or judgments including those made against the practitioner (or his/her behalf) through a professional corporation, group or employer. The application shall include information regarding the applicant's mental and physical health. The application shall require authorization including consent for release of information.
- B. Applicant's Burden
- The applicant shall have the burden of producing adequate information for a proper evaluation of his/her experience, professional ethics, character, background, training, demonstrated ability and current competence, and upon request of the Credentials Committee, the Medical Executive Committee, or the Board of Commissioners, physical and mental status, and of resolving any doubts about these or any of the other basic qualifications.
- C. By applying for appointment/re-appointment to the medical staff each applicant thereby signifies his/her willingness to appear for interviews in regard to his/her application, authorizes the hospital to consult with members of medical staffs of other hospitals with which the applicant has been Provisional and with others who may have information bearing on his/her competence, character, and ethical qualifications, consents to the hospital's inspection of all records and documents that may be material to an evaluation of his/her professional qualifications and competence to carry out the clinical privileges s/he requests, as well as, of his/her moral and ethical qualifications for staff membership.

D. Statement of Release and Immunity from Liability

The following are express conditions applicable to any applicant and to any person appointed to the Medical Staff and to anyone having or seeking privileges to practice his or her profession in the Hospital during his/her term of appointment or reappointment. In addition, these statements shall be included on the application form, and by applying for appointment, reappointment or clinical privileges the applicant expressly accepts these conditions during the processing and consideration of his or her application, regardless of whether or not s/he is granted appointment or clinical privileges.

1. To the fullest extent permitted by law, the applicant or appointee extends absolute immunity to, and releases from liability, this Hospital and its representatives and any third party with respect to any and all civil liability which might arise from any act, communication, reports, recommendations, or disclosures involving an applicant or appointee, performed, made, requested or received by this Hospital and its representatives, to, from, or by any third party, including other appointees to the Medical Staff, concerning activities relating, but not limited to:
 - (a) Applications for appointment or clinical privileges, including temporary privileges;
 - (b) Periodic reappraisals undertaken for reappointment or for increase or decrease in clinical privileges;
 - (c) Proceedings for voluntary and involuntary reduction or suspension of clinical privileges, revocation of medical staff appointment, or any other disciplinary sanction;
 - (d) Summary suspension;
 - (e) Hearings and appellate reviews;
 - (f) Medical care evaluations;
 - (g) Utilization reviews;
 - (h) Other hospital and medical staff, departmental, service or committee activities relating to the quality of patient care or the professional conduct of an appointee to the Medical Staff or of any individual granted privileges to practice in the Hospital; and concerning statements, investigations, materials provided, or inquiries, oral or written, relating to an applicant's or appointee's professional qualifications, credentials, clinical competence, previous performance, character, mental or emotional stability, physical condition, ethics, behavior. As well as, the inspection of all records and documents that may be material to such questions, or any other matter that might directly or indirectly have an effect on the individual's competence or on patient care, or on the orderly operation of this Hospital or any other hospital or healthcare facility including otherwise privileged or confidential information provided such information is provided in good faith and without malice.

2. Any act, communication, report, recommendation or disclosure, with respect to such applicant or appointee, made in good faith and at the request of an authorized representative of this Hospital or any other hospital or healthcare facility, anywhere at anytime, for the purposes set forth in (a) above, shall be privileged to the fullest extent permitted by law. Such privilege shall extend to employees of the Hospital and its authorized representatives. And to any third parties that either supply or are supplied information and to any of the foregoing authorized to receive, release or act upon the same.
 3. As used in this section, the term "Hospital and its representatives" means this Hospital, the members of its Board of Commissioners and their appointed representatives, the Chief Administrative Officer and his or her subordinates or designees, consultants for the Hospital, the Hospital's attorney and his or her partners, assistants or designees, and all appointees to the Medical Staff who have responsibility for obtaining or evaluating the applicant's or appointee's credentials and/or acting upon his or her application or conduct in the Hospital and any authorized representative of any of the foregoing.
 4. As used in this section, the term "third parties" means all individuals or government agencies, organizations, associations, partnerships and corporations, whether hospitals, healthcare facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.
- E. The application from shall include a statement that the applicant has read the Bylaws, Rules and Regulations, Credentialing Policy & Procedure Manual, Practitioner Health Policy, Disruptive Physician Policy, Corrective Action & Fair Hearing Plan of the Medical Staff and that s/he agrees to be bound by the terms thereof if s/he is granted membership and/or clinical privileges and to be bound by the terms thereof without regard to whether or not s/he is granted membership and/or clinical privileges in all matters related to consideration to consideration of his or her application.

SECTION 2. APPOINTMENT PROCESS

- A. All applications for hospital privileges shall be submitted to the hospital through the Medical Staff coordinator. This hospital employee shall then begin a file on the applicant. It will be the responsibility of this individual to ensure that the application is complete. It is then the responsibility of the Hospital to verify that the applicant's information is correct and complete. A checklist shall be used to help during the first phase. This list should include, but not be limited to the following:
1. Complete application and privilege request forms.
 2. A valid, verified Washington State license.
 3. Intern and/or Residency certificates.
 4. A valid narcotics license/DEA certificate.

5. Names, addresses and telephone numbers of three (3) professional peer references.
6. Board status verification.
7. Malpractice coverage verification in limits as established by the Board of Commissioners.
8. The name of any hospital or facility with or at which the applicant has or has had any association, employment, privileges, or practice.
9. Information as to whether the applicant's clinical privileges, medical staff appointment, employment or professional association have ever been voluntarily or involuntarily suspended, terminated, diminished, revoked, refused, relinquished, or limited at any hospital or other healthcare facility.
10. Information as to whether the applicant's license or narcotics license/certificate to practice in any state has ever been voluntarily or involuntarily relinquished, denied, limited, suspended, or revoked.
11. Information as to whether any disciplinary actions and/or open or closed complaints have ever been initiated, or are pending against the applicant by any State licensure board, i.e. any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state, the substance of the allegations in the proceedings or actions, and any additional information concerning the proceedings or actions as the physician deems appropriate.
12. A waiver by the applicant of any confidentiality provisions concerning the information required to be provided by or to the Hospital pursuant to this subsection.
13. Verification by the applicant that the information provided is accurate and complete.
14. Statement indicating that there are no physical or mental health problems that could have impact on the applicant's requested privileges, or need for reasonable accommodation.
15. A statement that the applicant will continuously provide quality care to his or her patients.
16. A statement that the applicant agrees to appear for interviews at the Hospital as required by the administration and/or medical staff. Information as to whether the applicant has been charged with or convicted of a felony.
17. Information as to whether the applicant has been excluded from participation in any health care program funded in whole or in part by the federal government.

- B. The Hospital shall query the National Practitioner Data Bank, all information reported about the applicant pursuant to the Health Care Quality Improvement Act, of 1986.
- C. The Hospital shall query professional references, past department chairs and training directors for practitioner evaluations.
- D. The Hospital shall query the Washington State Patrol for background inquiry as specified in the appropriate State Law(s).
- E. If additional information is required before the application can be declared complete, then the applicant must be notified in writing of the need for additional information and that the application will not be further processed until that information is made available. A copy of this letter will be placed in the applicant's file.
- F. When the application has been deemed complete, it is ready for processing. The application request will follow the procedure outlined in the "*Credentialing Procedure Manual*" portion of this document.

SECTION 3. RE-APPOINTMENT PROCESS

- A. At the conclusion of the initial appointment period, all Medical Staff members except Honorary Staff shall undergo a biennial re-appointment. Re-appointment is an evaluation of the applicant's Medical Staff membership qualifications, as well as, the applicant's current competence to maintain the clinical privileges that have been granted.

Medical Staff re-appointments are due no greater than every twenty-four (24) months.

- B. All applications for re-appointment of hospital privileges shall follow the process outlined above in Section II. A, E.

SECTION 4. CLINICAL PRIVILEGES

- A. Every practitioner practicing at this hospital by virtue of medical staff membership shall, in connection with such practice, is entitled to exercise only those clinical privileges specifically granted to him or her by the Board of Commissioners.
- B. Revision to clinical privileges are to be requested in writing by the practitioner, and is to be accompanied by supporting evidence to document current training, experience and competence. Information for additional privileges is to be verified, and processed as a Type I, or Type II request as appropriate (see *Credentialing Procedure Manual*).
- C. Every initial application for medical staff appointment must contain a request for the specific clinical privileges desired by the applicant. The Credentials Committee and the Medical Executive Committee's evaluation of such requests shall be based on the applicant's education, training, experience, demonstrated competence, references, health status, ethical standards, ability to work with others, and other relevant information, including the appraisal by the applicable department(s).

- D. Periodic re-determination of clinical privileges and the increase or curtailment of same shall be based upon the direct observation of care provided, review of the medical records of patients treated in this or other hospitals, and/or review of the records of the medical staff which document the evaluation of the member's participation in the delivery of medical care. In order to obtain additional privileges, a practitioner must make written application which must state the type of clinical privileges desired and be accompanied by documented evidence of current training or clinical competence to support the request. Such application should be processed in the same manner as an initial application under these Bylaws and Appointment/Re-Appointment procedures, and the applicant shall have the rights to notice of and hearings on adverse proposed recommendations as provided.
- E. Privileges granted to dentists and podiatrists shall be based on their training, experience and demonstrated competence and judgment. The scope and extent of surgical procedures that each dentist and podiatrist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Surgery Department chairperson. All dental and podiatric patients shall receive the same basic medical appraisal by a physician as patients admitted to other surgical services. A physician member of the medical staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The physical presence in the hospital of a physician staff member who will accept this responsibility is required during the administration of anesthetic, except when local is administered directly by the practitioner.
- F. Adverse Recommendations; Hearings: When any proposed recommendation of the Medical Executive Committee may adversely affect the practitioner or applicant, the procedures provided in the Corrective Action Fair Hearing Plan shall be followed. When the Board of Commissioners makes any proposed final decision that may adversely affect the practitioner or applicant, the procedures provided in the Corrective Action Fair Hearing Plan shall be followed.

SECTION 5. EMERGENCY PRIVILEGES

In the case of an emergency, any physician member of the medial staff, to the degree permitted by his or her license and regardless of department or staff status or lack of it, shall be permitted and assisted to do everything possible to save the life of a patient, using every facility of the hospital necessary, including the calling for any consultation necessary or desirable. A practitioner providing services in an emergency situation that is outside his/her usual scope of privileges shall obtain all consultative assistance available as deemed necessary, and shall arrange for appropriate follow-up care. For the purpose of this section, an "emergency" is defined as a condition which would result in serious permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

SECTION 6. REVIEW BY OUTSIDE CONSULTANTS

If, during the course of a practitioner's staff membership, the Medical Executive Committee believes that the interests of the practitioner and/or the medical staff would be better served by an audit of the peer review activities or that peer review activities should be performed by outside reviewers due to either conflict of interest, lack of expertise by the medical staff, and/or other reasons, the Committee may, through the Administrator, obtain the services of a qualified consultant(s). Such review shall be advisory to the Committee and, as such, the consultant(s) activities shall be protected under the quality assurance statutes of the State of Washington.

SECTION 7. MODIFICATION OF MEDICAL STAFF CATEGORY

All requests for change in medical staff category are to be submitted in writing to the hospital through the Medical Staff Coordinator. A request for change in medical staff category will be processed as a Type I or II as appropriate (see *Credentialing Procedure Manual*).

SECTION 8. PRIVILEGES IN MORE THAN ONE DEPARTMENT

If a practitioner request privileges in more than one department, processing of requests will be conducted through the appropriate departments, whether a Type I or Type II.

SECTION 9. CONFIDENTIAL NATURE OF PROCEEDINGS

All meetings, proceedings, and deliberations of the Board of Commissioners, the Medical Staff or their staff or agents concerning the granting, denial, revocation, restriction, or other considerations of the Status of the clinical or Staff privileges of a practitioner (as that term is defined in the Medical Staff Bylaw) pursuant to Medical Staff Bylaws, Manuals, and Policies and Procedures of the Hospital shall be confidential and conducted in Executive Session provided, however, that any final action of the Board of Commissioners regarding the same shall be done in public session.

ARTICLE II. CREDENTIALING PROCEDURE

SECTION 1. PURPOSE: To ensure that all qualified medical staff applications are processed in an efficient, timely and consistent manner.

SECTION 2. INITIAL APPOINTMENT PROCEDURE:

- A. When a written request has been received from a prospective applicant for an application, an application packet is assembled within five (5) working days of the request and sent to the prospective applicant. If the applicant is going to pickup the packet, a 48-hour notice should be given to the Medical Staff Services department. This also applies to applicants seeking Temporary clinical privileges.

- B. The Appointment Application Packet includes the following:
1. Cover letter
 2. Washington State Practitioner Application
 3. Trios Health Supplemental application
 4. Washington State Patrol Criminal History form
 5. Joint Credentialing letter
 6. Authorization and Release
 7. Delineation of Privileges and Signature Cover page
 8. HIPPA Statement
 9. Confidentiality Statement
 10. Medicare Acknowledgment Statement
 11. Trios Health MS Bylaws/Rules & Regulations, supporting MS Policies and Procedures, etc.
 12. Return envelope
- C. Application Packet is returned to Medical Staff Services department which shall:
1. Stamp date received on all documents
 2. Verify for each applicant:
 - (a) The applicant meets the Medical Staff Bylaws qualifications for medical staff appointment;
 - (b) The Application Packet forms with all questions are answered fully, with accompanying documentation/explanation when required;
 - (c) All signature requirements are met;
 - (d) Copies of current State licenses(s), DEA certification(s) and malpractice insurance in limits as established by the Board of Commissioners, Medical School diplomas, and Board certifications are provided.
- D. Verification Process: Prepare the following/evaluation letters and mail with the enclosures indicated on each letter (keep copy in credentials file).
1. Professional Reference evaluations
 2. License verification(s), including current Washington State licensure

3. Relevant training and/or experience verification(s) and/or evaluation(s)
4. Affiliation verifications, past and present
5. Initiate request for AMA Physician Profile, if appropriate
6. Query the National Practitioner Data Bank according to NPDB Guidebook/User's Manual
7. ECFMG verification, as appropriate
8. Malpractice verification(s)
9. Washington Criminal Background
10. Training verification of:
 - a) Medical School
 - b) Internship
 - c) Residency
 - d) Fellowship/other post-grad training
 - e) Board Certification
11. For Licensed Independent Professionals (LIPs) and Allied Health Professionals (AHPs), request a competency report/evaluation from the appropriate Hospital department manager(s) and/or department chair.
12. For AHPs request a competency report/evaluation from the supervising/sponsoring physician(s).

SECTION 3. RE-APPOINTMENT PROCEDURE:

- A. The re-appointment process shall be initiated by the Medical Staff Services department who will send a re-appointment form to the staff members at least 90 days prior to the expiration of the current appointment. The re- appointment form must be completed and submitted along with all requested information to the Medical Staff Office within thirty (30) days. Absent a showing of good cause by the practitioner, failure to timely complete and submit a re-appointment form will result in voluntary resignation of medical staff membership and clinical privileges without right to a hearing or appeal under the Medical Staff Corrective Action Fair Hearing Plan.
- B. The Re-appointment Application Packet consists of the following:
 1. Cover letter
 2. Trios Health Application for Re-Appointment with authorization/release

3. Delineation of current privileges
 4. Return envelope
- C. Application Packet is returned to Medical Staff Services department
1. Stamp date received on all documents
 2. Verify that the following have been received from the applicant:
Meets Medical Staff Bylaws qualifications for medical staff appointment;
 - (a) Application Packet forms with all questions answered fully, with accompanying documentation/explanation when required;
 - (b) All signature requirements met;
 - (c) Copies of current State license(s), DEA certification(s), malpractice insurance in limits as established by the Board of Commissioner, additional CME certificates and/or board certifications.
 3. Begin confidential Re-Appointment Activity Report form.
- D. If any information is missing, return to applicant for completion.
- E. Verification Process
1. Prepare the following verification letters and mail with the enclosures indicated on each letter (keep copy in credentials file);
 2. Professional reference evaluations
 3. License verification(s), including current Washington State licensure
 4. Relevant training and/or experience verifications(s) and/or evaluation(s)
 5. Query the National Practitioner Data Bank according to NPDB Guidebook/User's Manual
 6. Malpractice verification(s)
 7. Board Certification
 8. Washington State Patrol

SECTION 4. CREDENTIAL FILE

- A. File application information in credentials files.

- B. Requested information returned to the Medical Staff Services department:
1. Stamp date received on each document and log on tracking sheet
 2. Replace document copy in credentials file with completed original
 3. Review response for completeness. If the response contains negative or questionable information, highlight/flag it and contact the appropriate department chair.
- C. If there are missing verification/evaluations:
1. Thirty (30) days following the initial verification request send a "No Response" letter to the applicant. Send a second verification/evaluation after response received from the applicant.
 2. Sixty (60) days following the initial verification request
- D. When all of the above documentation/verifications/evaluations have been received, the application is considered complete.
- E. These time periods are guidelines and are not directives such as to create any rights for a practitioner to have an application processed within these periods. If action does not occur at a particular step in the process within the time frame specified and the delay is unwarranted, the next higher authority may proceed to consider the application and all the supporting information. If the provisions of the Corrective Action Fair Hearing Plan are activated, the time requirements provided therein govern the continued processing of the application.
- F. Failure to adequately complete the application forms, the withholding of required information, or the providing of false or misleading information, may be deemed a voluntary withdrawal of the application without right to a hearing or appeal under the Medical Staff Corrective Action Fair Hearing Plan.

SECTION 5. REVIEW PROCESS

When collection and verification is accomplished, Medical Staff Services and appropriate Department Chair/designee categorizes the application as follows:

A. Appointment

- TYPE I:** A Type I applicant is a practitioner who recently completed training for whom there is no difficulty in verifying the information on the application or obtaining satisfactory responses;
- OR:** A Type I application is from an established practitioner who has had hospital appointments and does not meet any of the Category II screens.

TYPE II: A Type II applicant would be one from a practitioner who had one or more of the following:

1. Three (3) or more practice locations throughout the country over a 5-year period, unless practitioner functioned as a locum tenens
2. Greater than four (4) medical licenses scattered throughout the country, unless practitioner functioned as a locum tenens
3. His/her clinical privileges revoked, diminished or otherwise altered by another healthcare organization
4. His/her license in any state revoked, placed on probation, or suspended
5. Greater than two (2) malpractice claims in five years
6. Disciplinary action taken by a State licensure board, or federal organization, or a criminal conviction
7. Letters of reference that were not returned
8. If some requested clinical privileges vary substantially from those generally Provisional with the specialty, or doesn't match up with training
9. Classified by Department Chair, Credentials Committee, or Medical Executive Committee chair as a Type II
10. Any gaps in application history
11. Any denials from other medical staffs
12. Questionable trends of quality events identified
13. Discrepancy between the applicant and the NPDB report

B. Re-Appointment

TYPE I: All verifications are obtained with no negative information reported

TYPE II: Greater than two (2) malpractice claims in five years, any insurance settlement or judgment (in the current reappointment cycle); any open/closed complaints against the State medical license (in the current reappointment cycle); any delay in return of reference verifications.

Any hospital or license suspensions or revocations, or privileges restricted; any other unusual findings Provisional with the application.

SECTION 6. PROCESSING

TYPE I:

- Step 1: Department Chair(s) reviews and makes a recommendation on the completed application within ten (10) working days of notification from Medical Staff Services.
- Step 2: Department Chair(s) recommendation and completed application are forwarded to the Credentials Committee at their next regularly scheduled meeting.
- Step 3: Credentials Committee recommendation and completed application are forwarded to the Medical Executive Committee at their next regularly scheduled meeting.
- Step 4: Recommendations and completed application are forwarded to Hospital Administrator who presents the application to the Board of Commissioners at its next regularly scheduled meeting. The Board of Commissioners grants or denies membership or clinical privileges as it deems appropriate.
- Step 5: On behalf of the Board of Commissioners, the Administrator will send the applicant a letter regarding results of review and final action by the Board of Commissioners.
- Rights to a hearing/appeal pursuant to the institution's Corrective Action Fair Hearing Plan in the event of an unfavorable action are listed in the Medical Staff Bylaws Article I, Section 9 E.

TYPE II:

Type II applications will be processed through the entire credentialing structured:

1. Department(s)/Department Chair(s)
2. Credentials Committee
3. Medical Executive Committee
4. Review and final action by the Board of Commissioners

On behalf of the Board of Commissioners, the Administrator will send the applicant a letter regarding results of review and final action by the Board of Commissioners. Any practitioner has a right to a hearing/appeal pursuant to the institution's Corrective Action Fair Hearing Plan in the event of an unfavorable action as listed in the Medical Staff Bylaws Article I, Section 9 E.

Action on Application

Credentials Committee Action

1. At its next regular meeting after receipt of the department chairs' reports and recommendations, the Credentials Committee shall consider such reports, recommendations, and such other relevant information as may be available.
2. After review of the reports of the department chairs, the Application and all supporting documentation, the Credentials Committee shall take one of the following actions:
3. Deferral. The Credentials Committee may, choose to defer an action on an application in order to request additional specific information, conduct an interview and/or request further documentation.
4. Favorable recommendation. When the Credentials Committee recommendation is favorable to the applicant, the administrator shall promptly forward it, together with all supporting documentation, to the Medical Executive Committee. For the purpose of this section "all supporting documentation" includes the application form and its accompanying information and the reports of the Credentials Committee.
5. Adverse recommendation. When the Credentials Committee recommendation is adverse (as defined in the bylaws) to the applicant, the entire application is forwarded to the Medical Executive Committee for additional review.

Medical Executive Committee Action

1. At its next regular meeting after receipt of the department chairs' and Credentials Committee reports and recommendation, the Medical Executive Committee shall consider such reports, recommendations, and such other relevant information as may be available.
2. After review of the reports of the department chairs and Credentials Committee, the Application and all supporting documentation, the Medical Executive Committee shall take one of the following actions:
3. Deferral. The Medical Executive Committee may, choose to defer an action on an application in order to request additional specific information, conduct an interview and/or request further documentation.
4. Favorable recommendation. When the Medical Executive Committee recommendation is favorable to the applicant, the administrator shall promptly forward it, together with all supporting documentation, to the Board of Commissioners. For the purpose of this section "all supporting documentation" includes the application form and its accompanying information and the reports of the Credentials Committee and the Medical Executive Committee.

5. Adverse recommendation. When the Medical Executive Committee recommendation is adverse (as defined in the bylaws) to the applicant, the administrator shall give the applicant special notice of the adverse recommendation and of the applicant's right to request a hearing in the manner specified in the Medical Staff Corrective Action Fair Hearing Plan. The applicant shall be entitled to the procedural rights of the Medical Staff Corrective Action Fair Hearing Plan. This recommendation could include a generally favorable application for appointment to the medical staff, but with limitations or denial of one or more requested privileges. No such adverse recommendation need be forwarded to the Board of Commissioners until after the applicant has exercised or has been deemed to have waived his right to a hearing as Medical Staff Corrective Action Fair Hearing Plan. The Board of Commissioners shall be informed of, but not take action on, the pending adverse recommendation until the applicant has exhausted or waived his procedural rights as stated in Medical Staff Corrective Action Fair Hearing Plan.

Appointment Reports

The Department, Credentials Committee, and Medical Executive Committee reports and recommendations shall be submitted in the form prescribed by the Medical Executive Committee. Each report and recommendation shall specify whether Medical Staff, LIP or AHP appointment or privileges is recommended (based on the criteria stated in Article 3 of the Bylaws), and, if so, as may be applicable, the membership category, department affiliation, and clinical privileges to be granted and any special conditions to be required. The reasons for each recommendation shall be stated and supported by reference to the completed Application and all other documentation, which was considered, all of which shall be transmitted with the report.

Action by the Board of Commissioners

1. Action upon Medical Executive Committee's Recommendation.
2. After receipt of the Medical Executive Committee's recommendation, the Board of Commissioners shall act in the matter as follows:
3. Defer action and refer the recommendation back to the Medical Staff President for appropriate action, stating the reasons for such referral back and setting a time limit within which a subsequent recommendation by the Medical Executive Committee shall be made;

Adopt the recommendation; or

1. If the Board of Commissioners' decision is adverse to the applicant in respect to either appointment or clinical privileges, the administrator shall give notice of such adverse decision, and the Board of Commissioner's decision shall be held in abeyance until the applicant has exercised or has been deemed to have waived his rights under the Medical Staff Corrective Action Fair Hearing Plan. The fact that the adverse decision is held in abeyance shall not be deemed to confer privileges where none existed before.

Without benefit of Medical Executive Committee Recommendation:

1. If the Board of Commissioners does not receive a Medical Executive Committee recommendation within a reasonable time period, it may, after notifying the Medical Executive Committee, take action on its own initiative. If such decision is favorable, it shall constitute the final decision of the Board of Commissioners. If the decision is one of those set forth in Medical Staff Corrective Action Fair Hearing Plan, the Administrator shall give the applicant special notice of such adverse decision and of the applicant's right to request a hearing in the manner specified in the Medical Staff Corrective Action Fair Hearing Plan; and the applicant shall be entitled to the procedural rights as provided in the Medical Staff Corrective Action Fair Hearing Plan before any final adverse action is taken.

Final Decision

In the case of an adverse Medical Executive Committee recommendation or an adverse Board of Commissioners decision, the Board of Commissioners shall take final action in the matter only after the applicant has exhausted or has waived his procedural rights as provided in the Medical Staff Corrective Action Fair Hearing Plan. Action thus taken shall be the final decision of the Board of Commissioners, except that the Board of Commissioners may defer such decision by referring the matter back to the Medical Staff President for further reconsideration. Any such referral back shall state the reasons therefore, shall set the time limit within which a subsequent recommendation to the Board of Commissioners shall be made, and may include a directive that an additional hearing be conducted to clarify issues which are in doubt. After receipt of such subsequent recommendation and of new evidence in the matter, if any, the Board of Commissioners shall make a final decision.

Notice of Final Decision

Notice of the Board of Commissioners' final decision shall be given by the administrator to the Medical Executive Committee, the Credentials Committee and the chair of each department concerned, and the applicant. A decision and notice to appoint shall include, if applicable the:

1. Staff category to which the applicant is appointed;
2. Department to which he is assigned;
3. Clinical privileges he may exercise; and
4. Any special conditions attached to the appointment.

ARTICLE III. PROCTORING PROCEDURE**SECTION 1. PURPOSE:**

To ensure that all Provisional medical staff members and existing staff members requesting additional privileges, regardless of specialty or category or membership are assessed in an efficient, timely and consistent manner. Exemptions may be made by the chairperson of a department.

SECTION 2. DEFINITION:

A proctor is a practitioner with unrestricted privileges at the Hospital within department assigned to supervise or monitor another medical staff member. The proctor also assists the Provisional practitioners to become acquainted with the Hospital facilities, policies, rules, regulations, etc.

SECTION 3. PROCEDURE:

- A. Proctored medical staff members shall be proctored for twelve (12) months. The Medical Executive Committee may extend the proctoring period, for a period not to exceed two years total, or until the staff member has treated a sufficient number of patients in the Hospital to adequately assess his/her behavior and clinical competence with respect to all Clinical privileges requested. The Medical Executive Committee and the Board of Commissioners may decide not to extend a practitioner's appointment if no extension is warranted.
- B. The practitioner being proctored is responsible for maintaining a record of all admissions, consultations, outpatient surgeries and other patient care activity at the Hospital during the proctoring period, or until given notice that proctoring requirements have been fulfilled. This list will be provided periodically by the practitioner to the Hospital for reference.
- C. A member of the practitioner's assigned department shall have primary responsibility for evaluating the proctored staff member. Proctors from additional departments may be assigned if requested privileges are outside the normal purview of the assigned department. Proctor responsibility may be exercised on a rotating basis or in any other manner determined by the department or its chairperson. The evaluation may be both retrospective and concurrent.
- D. A proctor shall have sufficient expertise to judge the quality of work being performed. It is not always necessary for a proctor to have the same specialty qualifications as the person being proctored. For example, a surgeon from a different specialty can often adequately review surgical technique in a number of specialties.
- E. If at the end of the Provisional or proctoring period the practitioner has not met the admissions/procedures requirement, the Medical Executive Committee may, after reviewing a recommendation from the involved department(s) and Credentials Committee:
 - 1. Recommend an additional Provisional appointment/proctoring period, or
 - 2. Acknowledge the practitioner's voluntary relinquishment of –
 - a) Provisional medical staff appointment and clinical privileges.
 - b) Additionally requested clinical privileges.
- F. If at the end of any additional appointment or proctoring period the practitioner has still not treated a sufficient number of patients to properly evaluate the requested clinical privileges, he/she is deemed to have voluntarily relinquished his/her appointment and clinical privileges/additionally requested privileges for failure to provide sufficient clinical experience of a satisfactory evaluation.

SECTION 4. RETROSPECTIVE REVIEW/EVALUATION

A retrospective review is useful to evaluate the practitioner's practice patterns and can reveal problems such as incomplete operative notes or unnecessary diagnostic testing, reveals deficiencies in medical records (accuracy, legibility, completeness, timeliness).

- A. Retrospective review/evaluation shall consist of at least the following;
1. Review of the medical record of each patient admitted or treated by the practitioner during the proctoring period. The practitioner must notify the proctor of patient admissions and treatments in a timely fashion, until informed otherwise by the chairperson of the department. The review shall include, but not be limited to, the following:
 - a) History and Physical
 - b) Diagnosis and justification
 - c) Proposed treatment or procedure and indications
 - d) Continuity of care provided to the patient
 - e) Appropriateness of orders, tests and medications prescribed
 - f) Consultants are utilized in an appropriate and timely manner
 - g) Progress notes, operative notes/report, discharge summary (timeliness, adequate content, legible, accurate)
 - h) To extent possible, determine whether the practitioner is establishing a good working relationship with nurses, consultants, and others who are involved in the care of that patient
 - i) Conformance to medical staff Bylaws, Rules & Regulations, and Hospital policies and procedures
 2. Discussions with other individuals involved in the care of patients including consulting physicians, assistants at surgery, anesthesiologists, pharmacists, and nurses, when appropriate.
 3. Discussion with the practitioner about each case, when appropriate.
 4. A written report of the evaluation shall be made to the department chairperson.
- B. If during the course of the retrospective evaluation, the reviewing physician believes intervention by another physician is necessary for the protection of patients that matter shall be taken promptly to the department chairperson who shall initiate appropriate action.

SECTION 5. CONCURRENT REVIEW/EVALUATION

- A. The following principles should be applied to concurrent evaluations of practitioners other than surgeons:
1. The concurrent evaluation can be conducted by the proctor by visiting the practitioner's patients in the hospital, reviewing the practitioner's orders and progress notes, and discussing the patient's course with the attending physician. The practitioners are responsible for notifying their assigned proctor(s) of any procedures, i.e. surgeries and/or other invasive procedures such as Endoscopy, deliveries, etc. in order that the proctor may concurrently observe the procedure(s).
 2. The proctor should note at least the following information:
 - a) History and Physical
 - b) Diagnosis and justification
 - c) Proposed treatment or procedure and indications
 - d) Continuity of care provided to the patient
 - e) Appropriateness of orders, tests and medications prescribed
 - f) Consultants are utilized in an appropriate and timely manner
 - g) Progress notes, operative notes/report discharge summary (timeliness, adequate content, legible, accurate)
 - h) To extent possible, determine whether the practitioner is establishing a good working relationship with nurses, consultants, and others who are involved in the care of that patient.
 - i) Conformance to medical staff Bylaws, Rules & Regulations, and Hospital policies and procedures.
- B. The evaluator has the right and responsibility to directly intervene (even to the extent of taking over the case) at any time during the concurrent evaluation if, in his opinion, such intervention is necessary for the protection of the patient. The evaluator shall report such intervention to the department chairperson with the report proceeding through regular channels.
- C. The following principles should be applied to concurrent surgical evaluations of practitioners:
1. The concurrent evaluator is at all times acting on behalf of and with the authority of the hospital and medical staff.

2. The evaluator must be present in the operating room in which case is being done during the surgical procedure. A concurrent evaluation can be conducted by the proctor by either assisting or observing the surgery of the practitioner, with follow-up of the post-operative course as listed above. The evaluator should note at least the following information whether:
 - a) All necessary information is recorded by the practitioner in a timely manner, i.e. history, physical, progress notes;
 - b) The above information is recorded in a legible manner;
 - c) Entries made in the patient's record by practitioner are informative;
 - d) Entries made in the patient's record by the practitioner are appropriate;
 - e) The practitioner's assessment and use of ancillary services were appropriate, i.e. x-ray, lab, medications;
 - f) The practitioner's surgical technique is appropriate;
 - g) The pro-operative diagnosis coincided with the post-operative diagnosis;
 - h) The post-operative care was adequate
 - i) The operative report was complete, accurate and timely; and
 - j) Complications (if any) were recognized and managed in a timely and appropriate manner.
3. The evaluator has the right and responsibility to directly intervene (even to the extent of taking over the case) at any time during the concurrent evaluation if, in his opinion, such intervention is necessary for the protection of the patient. The evaluator shall report such intervention to the department chairperson with the report proceeding through regular channels.

SECTION 6. LIABILITY OF PROCTORS/MONITORS/EVALUATORS:

- A. A proctor/monitor/evaluator is not assuming any additional liability by evaluating an Provisional appointee on behalf of the medical staff and hospital. The role is not one of sponsorship or preceptorship. The evaluator is not training or guiding the appointee in his or her practice. The evaluator is in no sense of the word a "master" or "employer" or one who might be liable for the acts of the appointee. The evaluator's role is to observe the Provisional appointee and to make an assessment and report regarding that appointee's clinical competence to exercise the privileges that have been granted.

- B. When performing as a proctor, the physician evaluator is acting on behalf of the Hospital in the furtherance of the Hospital's legal obligation to carefully credential and evaluate all those individuals who are permitted to care for patients in the hospital. Therefore, in the unlikely event that a proctor would be named in a lawsuit that arose out of the proctoring activities, the proctor would be entitled to protection by the Hospital as part of its Directors and Officers insurance, as well as through its indemnification policy.
- C. It is most important to stress that a proctor/evaluator has the right and responsibility to intervene at any time during a concurrent evaluation when, in the evaluator's opinion, such an intervention is in the best interest of the patient.

SECTION 7. DEPARTMENT & MEDICAL EXECUTIVE COMMITTEE RECOMMENDATIONS:

- A. The Department Chairperson(s) can and should make a recommendation any time during the Provisional appointment when questions arise regarding the Provisional appointee's competence to perform the clinical privileges granted.
- B. At the end of the Provisional period, the proctor(s) shall submit report(s) to the appropriate department(s), upon which the chairperson(s) shall base a recommendation to the Medical Executive Committee, which shall include:
 - 1. Whether sufficient treatment of patients occurred to properly evaluate the clinical privileges being exercised;
 - 2. If not, whether the Provisional medical staff appointment should be extended for any additional period;
 - 3. If sufficient treatment of patients has occurred to properly evaluate the clinical privileges being exercised, the department chairperson shall make a recommendation concerning the practitioner's qualifications and fitness for these clinical privileges.
- C. After reviewing and assessing the department chairperson assessment(s) and report(s), as well as all appropriate documentation, the Credentials Committee and the Medical Executive Committee shall then make a recommendation with any additional comments to the Board of Commissioners regarding the Provisional appointee's continued medical staff appointment and clinical privileges, who shall make a decision regarding the Provisional appointee's advancement in medical staff category and clinical privileges.

SECTION 8. ADMISSION/ATTENDANCE REQUIREMENTS:

No practitioner is entitled to be granted an ongoing appointment on the basis of paper credentials when he or she fails to use the hospital sufficiently to permit a proper evaluation of his/her clinical skills. An appointee who does not use the hospital is deemed not qualified for continued appointment as there is no basis upon which to determine first hand that the practitioner provides quality care. Thus, an Provisional staff member who does not admit or attend to a sufficient number of patients to allow for a meaningful review relinquishes his/her medical staff appointment and clinical privileges.

SECTION 9. DUE PROCESS PROCEDURES:

- A. If a practitioner's appointment is relinquished for failure to provide sufficient clinical experience for a satisfactory evaluation, the practitioner shall be notified in writing before a report of the relinquishment is made to the Board of Commissioners.
- B. As part of the notice acknowledging the relinquishment and the reason(s) for it, the practitioner shall be given an opportunity to request, within ten (10) days, a meeting with the Medical Executive Committee, the Department Chairperson and the Administrator. At that meeting, the practitioner shall have an opportunity to explain or discuss extenuating circumstances involving his failure to provide sufficient clinical experience for a satisfactory evaluation. At that meeting:
 - 1. None of the parties shall be represented by counsel;
 - 2. Minutes shall be kept;
 - 3. The practitioner may present evidence of extenuating circumstances and why the minimum requirement should be waived or the Provisional medical staff appointment extended; and
 - 4. Any party may ask questions of any other party, relative to the practitioner's proctoring period.
- C. At the conclusion of the meeting, the Medical Executive Committee shall make a written report and recommendation to the Board, with a copy of the recommendation to the practitioner. The report shall include the minutes of the meeting held with the practitioner. If the recommendation of the Medical Executive Committee is one of those outlined in Article I Section 9.D. of the bylaws, the practitioner shall be given notice of his right to request a hearing pursuant to the Medical Staff Corrective Action Fair Hearing Plan.
- D. The Board of Commissioners shall make its decision in accordance with the procedures set forth in the Medical Staff Corrective Action Fair Hearing Plan.

ARTICLE IV. TERMINATION OF APPOINTMENT OR REDUCTION IN CLINICAL PRIVILEGES DUE TO QUESTIONS OF CLINICAL COMPETENCE OR BEHAVIOR PROBLEMS:

- A. If there is a recommendation by the Medical Executive Committee to terminate the practitioner's appointment prior to its expiration due to questions about qualification, fitness, behavior or clinical competence, the practitioner shall be entitled to the hearing and appeal process as set forth in the Corrective Action Fair Hearing Plan.
- A. In the event of any apparent or actual conflict between this guideline and the Bylaws, Rules & Regulations or any other policy of the Hospital or its medical staff, the provisions of the Bylaws, Rules & Regulations or any other policy of the Hospital shall prevail.

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MEDICAL STAFF CORRECTIVE ACTION

SECTION 1. CORRECTIVE ACTION

- A. **Criteria for Initiation:** Any person may provide information to the Medical Staff President, a department chair, the Medical Executive Committee, or the Hospital Administrator about the conduct, performance, or competence of a medical staff member. When reliable information indicates that a member may have exhibited acts, demeanor or conduct reasonably likely to be:

1. Detrimental to a patient's or anyone's safety or to the delivery of patient care within the Hospital;
2. Contrary to the Medical Staff Bylaws or Rules & Regulations; or
3. below applicable professional standards (such as sexual harassment, abusive behavior toward patient or staff, etc.).

A request for an investigation or action against such member may be initiated by the Medical Staff President, the department chair, the Hospital Administrator, the Board of Commissioners or the Medical Executive Committee.

- B. **Initiation:** A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate record of its reasons.

- C. **Investigation:** If the Medical Executive Committee concludes that an investigation is warranted, it shall direct that an investigation be undertaken, with notice to the Hospital Administrator. The Medical Executive Committee will assign the task to an Ad Hoc Committee of the Medical Staff composed of members who are not in direct economic competition with the individual under investigation. The Ad Hoc Committee shall proceed with its investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall promptly be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the Ad Hoc Committee deems appropriate. The Ad Hoc Committee may, but is not obligated to, conduct interviews with persons involved, however, such investigation shall not constitute a "hearing" as that term is used in the "Fair Hearing Plan", nor shall the procedural rules with respect to hearings apply. Despite the status of any investigation, the Medical Executive Committee and the Governing Body shall at all times retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

D. **Medical Executive Committee Action:** As soon as practicable after the conclusion of after the Ad Hoc Committee investigation, the Medical Executive Committee shall, with notice to the Hospital Administrator, take action which may include, without limitation:

1. Determining no corrective action should be taken.
2. Deferring action for a reasonable time where circumstances warrant.
3. Issuing letters of admonition, warning, reprimand or censure, although nothing herein shall be deemed to preclude department chair from issuing informal written or oral warnings outside of the mechanism for corrective action in this Article. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's Credential file.
4. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or the exercise of clinical privileges including, without limitation, requirements for co-admission, mandatory consultation or monitoring.

Recommending reduction, modification, suspension or revocation of clinical privileges.
5. Recommending reduction of membership status or limitation of prerogatives directly related to the member's delivery of patient care.
6. Recommending suspension, modification, probation or revocation of Medical Staff membership.

E. **Subsequent Action:**

1. If corrective action as set forth in Subsections 4 through 7 of Section 1.D. is recommended by the Medical Executive Committee, that recommendation shall be transmitted in writing to the member and, in these cases only, the member shall than be entitled to his rights set forth in the "Fair Hearing Plan".
2. If the member does not exercise his rights under the "Fair Hearing Plan", the Medical Executive Committee shall forward its recommendation to the Board of Commissioners.
3. The decision of the Board of Commissioners shall be deemed final action.

F. **Remediation:** Notwithstanding the foregoing, the Medical Executive Committee may, in the alternative and with notice to the Hospital Administrator, enter into a remedial agreement with the affected member to resolve the problem. If the affected member fails to abide by the terms of the remedial agreement, the member will be subject to the standard corrective action procedures of the Section.

SECTION 2. SUMMARY SUSPENSION

- A. **Criteria for Initiation:** Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of a patient, or wherever the member's conduct presents a danger of immediate and/or serious harm to the life, health, safety of any patient or other person, the Medical Staff President, the Medical Executive Committee, the Hospital Administrator, the Board of Commissioners, or the member's Department Chair (or their designee) may summarily suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Board of Commissioners, the Medical Staff President, the Medical Executive Committee and the Hospital Administrator. The summary suspension shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary suspension, the member's patients shall be promptly assigned to another member by the Department Chair or by the Medical Staff President considering, where feasible, the wishes of the patient in the choice of a substitute member.
- B. **Medical executive committee Action:** As soon as practicable after such summary suspension has been imposed, a meeting of the Medical Executive committee shall be convened to investigate, review and consider the action. The suspended member may attend and make a statement concerning the issues under investigation on such terms and conditions as the Medical Executive Committee may impose. In no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of the "Fair Hearing Plan". The Medical Executive Committee may modify, continue or terminate the summary suspension, but in any event it shall promptly furnish the member, the Hospital Administrator and the Board of Commissioners with notice of its decision.
- C. **Procedural Rights:** Unless the Medical Executive Committee terminated the summary suspension within fourteen (14) days of its effective date, the member shall be entitled to his rights as set forth in the "Fair Hearing Plan".

SECTION 3. AUTOMATIC SUSPENSION

- A. A temporary suspension of a practitioner's clinical privileges shall be imposed automatically for the following situations without further review or right to hearing/due process under the Medical Staff Fair Hearing Plan:
1. Failure to pay medical staff dues, fees or other assessments as determined elsewhere in these documents.
 2. Revocation, suspension or lapse of a practitioner's license, as of the date such action becomes effective and throughout its term.
 3. Failure to renew or to meet the minimum level of malpractice insurance set by the Board.

4. Upon conviction of violation of the Federal or State fraud and abuse laws or upon exclusion from participation in any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.
- B. Action by a State or the DEA (BNDD) revoking or suspending a practitioner's narcotics registration will result in adjusting the practitioner's privileges, as of the date such action becomes effective and throughout its term. Lapse of a practitioner's DEA certificate or prescribing authority will result in adjusting the practitioner's privileges, as of the expiration date and until renewed.
 - C. Reinstatement of a practitioner's Medical Staff membership and/or privileges will be accorded after the following, as appropriate:
 1. Payment of the delinquent medical staff dues, fees or other assessments, in the appropriate amount.
 2. Presentation by the practitioner to the Hospital of a copy of the current, valid document (medical license, DEA, prescribing authority, etc.) as evidence of authorization. Verification of the document by the Medical Staff Services department will be conducted.
 3. Presentation by the practitioner to the Hospital of a copy of the current, valid malpractice/liability insurance certificate in the appropriate amount set by the Board as evidence. Verification of the document by the Medical Staff Services department will be conducted.
 - D. As soon as practicable after action is taken or warranted as described in Section 3 A.-B., the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following procedures generally set forth commencing at Section 1. Corrective Action.

ARTICLE II. MEDICAL STAFF FAIR HEARING PLAN

SECTION 1. DEFINITIONS

The following definitions, as well as those stated at the beginning of these Bylaws, apply to provisions of this Fair Hearing Plan.

- A. **Appellate Review Body**: means the group designated under this Plan to hear a request for appellate review properly filed and pursued by a petitioner.
- B. **Days**: means regular calendar days unless otherwise specified, i.e., including Saturday, Sunday and official Trios Health holidays. If the day on which a notice, request or report under this Plan must be received or sent falls on a Saturday, Sunday or official Trios Health holiday, the deadline shall be set to be the next regular working day thereafter.
- C. **Hearing Panel**: means a committee appointed under this Plan to hear a request for an evidentiary hearing properly filed and pursued by a petitioner.

- D. **Parties:** means the practitioner, hereafter known as the petitioner, who requested the hearing or appellate review and the body or bodies upon whose unfavorable action a hearing or appellate review request is predicated.

SECTION 2. INITIATION OF HEARING

- A. **Events Giving Rise to Hearing Rights.** Events giving rise to hearing rights are defined in Article I, Section 9.D. of the Medical Staff Bylaws.
- B. **Notice of Unfavorable Action.** The President of the Medical Staff or the Hospital Administrator, as appropriate, within seven (7) days of receiving written notice of an unfavorable action as defined under Article I, Section 9.D. of the Bylaws, shall give the petitioner a Special Notice of any action or recommendation as to which a hearing may be requested. Such notice of action or recommendation shall:
1. Inform the petitioner that he/she has a right to request a hearing;
 2. Concisely state the reasons for the action or recommended action. (In the event a hearing is requested a more detailed Notice of Reasons or Charges may be provided subsequently);
 3. State time limit within which a hearing may be requested, which shall be thirty (30) days following receipt of the Special Notice of action or recommendation; and
 4. Summarize the petitioner's rights in the hearing.
- C. **Request for Hearing.** The petitioner shall have thirty (30) days after receiving the Special Notice of action or recommendation to file a written request for a hearing. The request must be delivered to the Hospital Administrator by Special Notice. In the event the petitioner does not request a hearing within the time and in the manner described, the petitioner shall be deemed to have accepted the action or recommendation involved, and to have waived any right to challenge it. If the Board of Commissioners accepts such action or recommendation following such waiver, the action or recommendation shall be deemed final. If the Board of Commissioners does not accept such action or recommendation following such waiver, the Board of Commissioners shall explain its rejection to the Medical Executive Committee, which shall address the matter. If the Medical Executive Committee does not alter its initial action or recommendation, the Board of Commissioners may take action on its own subject to affording the petitioner with a fair procedure for challenging any measure which is different from that recommended by the Medical Executive Committee and which would entitle the petitioner to a hearing under the Medical Staff Bylaws.

SECTION 3. HEARING PREREQUISITES

A. Notice of Time and Place for Hearing

1. Except as noted in 2.1.b, upon receiving a timely and proper request for a hearing, the Medical Staff President shall send the petitioner, by Special Notice, a notice of hearing including the time, place and date thereof. The hearing date shall be not less than thirty (30) days or more than forty-five (45) days from the date of the notice of hearing, unless a shorter period is agreed to by the parties.
2. When a petitioner who is under summary suspension requests a hearing, the hearing shall commence as soon as the hearing may reasonably be scheduled, which may be less than thirty (30) days if agreed to by the parties, but not later than forty-five (45) days from the date of receipt of the request for a hearing. In such instances, the notice of hearing shall be provided within a reasonable time prior to the date of commencement of the hearing.
3. The parties and hearing panel shall cooperate with each other in scheduling additional hearing sessions, as necessary, to complete the process as soon as practicable.

B. Notice of Charges. A notice of reasons or charges may be sent along with or separate from the notice of hearing, further specifying, as appropriate, the acts or omissions with which the petitioner is charged. The notice of charges shall provide:

1. A list of the charts, if any, which are to be discussed at the hearing.
2. either the notice of hearing or notice of reasons or charges shall include a list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are expected to give testimony or evidence in support of the Medical Executive Committee (or the Board of Commissioners if its action or recommended action prompted the hearing) at the hearing.

C. Hearing Panel. When a hearing is requested, the Medical Staff President and Hospital Administrator shall appoint a hearing panel which shall be composed of not less than three (3) members of the Active Medical Staff selected from qualified nominees submitted by the President of the Medical Staff, who shall gain no direct financial benefit from the outcome, and who have not acted as accusers, investigators, fact finders, initial decision makers, or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action (a "Conflict of Interest"). Knowledge of the matters involved shall not preclude a member of the Active Medical Staff from serving as a member of the hearing panel. In the event that it is not feasible to appoint a hearing panel from the Medical Staff, the Hospital Administrator may appoint physicians who are not members of the Medical Staff. The President of the Medical Staff shall appoint a chairperson of the panel.

In lieu of appointing a hearing panel chosen in the manner set forth above, the Hospital Administrator, the President of the Medical Staff and the petitioner have the discretion should they all agree to enter into an agreement with the petitioner to hold the hearing before an arbitrators mutually acceptable to both parties. Failure or refusal to exercise this discretion shall not constitute a breach of the Medical Staff President and Hospital Administrator's responsibility to arrange for a fair Medical Staff hearing. The hearing and appeals procedures as set forth in this Fair Hearing Plan shall apply as in the event of a Hearing Panel. Thereafter, the arbitrator shall operate in accordance with the rules applicable to the Hearing Panel.

- D. **Failure to Appear or to Proceed.** Unless excused by the hearing panel, the personal presence of the petitioner is required throughout the hearing. The presence of the petitioner's legal counsel or other representative does not constitute the personal presence of the petitioner. A petitioner who fails, without good cause, to be present throughout the hearing unless excused or who fails to proceed at the hearing in accordance with the Fair Hearing Plan shall be deemed to have waived his/her rights in the same manner and with the same consequence as provided in Section 1.3 of this Plan. The issue of good cause shall be determined by the hearing panel.
- E. **Postponements and Extensions.** Once a request for a hearing is initiated, postponements and extensions of time beyond the times prescribed in these Bylaws may be requested by anyone and shall be permitted by the hearing panel, or its chairperson acting on its behalf, upon agreement by the parties or upon a showing of good cause.

SECTION 4. PRE-HEARING PROCEDURE

- A. **The Hearing Officer.** The Hospital Administrator shall appoint a hearing officer to preside at the hearing. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing. The hearing officer shall gain no direct financial benefit from the outcome of the hearing and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer may determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as is reasonable under the circumstances. If requested by the hearing panel, the hearing officer may participate in the deliberations of the hearing panel and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

B. Impartiality. The person who requested the hearing shall be entitled to a reasonable opportunity to question and challenge the impartiality of the hearing panel members and the hearing officer. Challenges to the impartiality of any hearing panel member or the hearing officer shall be ruled on by the hearing officer. The hearing officer shall establish the procedure by which this right may be exercised, which may include requirements that impartiality questions be presented to the hearing officer. The hearing officer shall rule on any challenges in accordance with applicable legal principles defining standards of impartiality for hearing officer of and hearing officers in proceedings of this type.

C. Pre-hearing Disclosure

1. At least ten (10) days prior to the commencement of the hearing, each party shall deliver to the other party and to the hearing officer and hearing panel: (1) a list of the names, addresses, and phone numbers of all the witnesses the party will call at the hearing, together with a brief summary of the expected testimony of each such witness, and (2) a legible copy of all documents, briefs, motions or other written material upon which the party intends to rely in any manner at the hearing. Each party shall have the duty to promptly supplement the witness list or documents to be relied on whenever such change becomes known to such party. Failure to timely disclose the identity of a witness or produce copies of all documents expected to be relied upon may constitute good cause for a continuance. The hearing panel or hearing officer may permit a witness who has not been listed in accordance with this Section to testify if it finds that the failure to list such witness was justified, that such failure did not prejudice the other party, or that the testimony of such witness will materially assist the hearing panel in making its report and recommendation.
2. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer and Chairperson of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may if practicable be made in advance of the Hearing. Objections to any pre-hearing decisions may be made at the Hearing.
3. The Petitioner shall have the right to inspect and copy at the Petitioner's expense any documentary information relevant to the charges which the Medical Executive Committee (or the Board of Commissioners if its action or recommended action prompted a hearing) has in its possession or under its control, as soon as practicable after the receipt of the Petitioner's request for a Hearing. Any identification of an individual patient shall be expunged in such records.
4. The Medical Executive Committee (or the Board of Commissioners if its action or recommended action prompted a hearing) shall have the right to inspect and copy at its expense any documentary information relevant to the charges which the Petitioner has in his possession or control as soon as practicable after requesting the information. Any identification of an individual patient shall be expunged in such records.

5. The failure by either party to provide access to the documentary information described in Sections 3.3 © and (d) at least ten (10) days before the Hearing may constitute good cause for continuance sought by the affected party.
6. The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable Practitioners, other than the Petitioner, or attorney work product. The Hearing Officer or chairperson of the hearing panel shall consider and rule upon any request for access to information, and may impose any safeguards that justice, common sense and the protection of the peer review or Quality Improvement process requires. When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer or chair of the hearing panel may, among other factors, consider the following:
 - (a) Whether the information sought may be introduced to support or defend the charges;
 - (b) Whether the information supports or negates the proposed adverse action;
 - (c) The burden imposed on the party in possession of the information sought if access is granted; and
 - (d) Any previous requests for access to information submitted or resisted by the parties to the same proceeding.
7. A Petitioner shall have no rights to discovery except as specifically provided in this Section 3.3.

D. Procedural Disputes. It shall be the duty of the petitioner who requested the hearing and the Medical Executive Committee/Board of Commissioners (or the Board of Commissioners if its action or recommended action prompted the hearing) or its designee to exercise reasonable diligence in notifying the chairperson of the hearing panel and the hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

E. Representation. The hearings provided for in these Bylaws are for the purpose of resolving, on an intra-professional basis, matters bearing on profession conduct, professional competency, or character. The petitioner shall have the right to have his/her attorney help in the preparation for the hearing and also be present at the hearing. The party bringing the complaint may also use legal counsel but the attorneys for either may not take an active role in the proceedings unless the Chairperson of the Hearing Panel allows the attorneys to participate. The petitioner may be accompanied and assisted at the hearing by a member of the Medical Staff in good standing or by a member of his/her professional society.

- F. **Record of the Hearing.** A record of the hearing shall be kept. The hearing officer shall determine, in his or her discretion, whether the record will be recorded by a court reporter or a tape recording of the proceedings. The cost of the court reporter shall be borne by Trios Health but the cost of the transcript, if any shall be borne by the party requesting it. The hearing panel may, but shall not be required to, order that oral evidence be taken under oath.

SECTION 5. HEARING PROCEDURE

- A. **Rights of the Parties.** Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony; introduce exhibits or other documents determined by the hearing officer to be relevant; cross-examine any witness who shall have testified orally on any matter relevant to the issues; impeach any witness; and rebut any evidence, as long as these rights are exercised in an efficient and expeditious manner. The petitioner who requested the hearing may be called by the Medical Executive Committee (or the Board of Commissioners if its action or recommended action prompted the hearing) and examined as if under cross-examination.
- B. **Miscellaneous Rules.** The hearing need not be conducted strictly according to rules of law relating to the examination of witness or presentation of evidence. In the discretion of the hearing officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Each party shall be entitled, prior to or during the hearing; to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the hearing record. Written memoranda, if any, must be presented to the presiding hearing officer and a copy must be provided to the other party. The hearing panel may ask questions of the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate. Exhibits admitted into evidence before the hearing panel shall be identified as the hearing officer may direct.
- C. **Attendance.** Attendance will be limited to members of the hearing panel and representatives per section 3.5. Variance from this attendance rule will be at the discretion of the hearing panel.
- D. **Burdens of Presenting Evidence and Proof.** In all cases, the Medical Executive Committee (or the Board of Commissioners if its action or recommended action prompted the hearing) shall have the initial duty to present evidence in support of its action or recommendation. Thereafter, the petitioner shall have the burden of coming forward with evidence and proving by clear and convincing evidence that the unfavorable action or recommended action lacks any substantial factual basis or is otherwise arbitrary, unreasonable or capricious.
- E. **Recesses and Adjournment.** The hearing panel may recess and reconvene the hearing, for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, without Special Notice and with such written or oral notice, as it deems appropriate. Upon conclusion of the presentation of oral and written evidence, the hearing shall be adjourned. The hearing panel shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties.

F. Decision of the Hearing Panel.

1. Within thirty (30) days after adjournment of the hearing, the hearing panel shall render a decision, which shall be accompanied by a written report. The hearing panel's decision and report shall be delivered to the parties, the Hospital Administrator and the Board of Commissioners.
2. If the petitioner is currently under suspension, however, the decision and report shall be rendered within fifteen (15) days of adjournment of the hearing. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion reached. Both the petitioner and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the hearing panel shall be subject to such right of appeal or review as described in this Fair Hearing Plan, but shall otherwise be affirmed by the Board of Commissioners as the final action if it is supported by substantial evidence, following fair procedures.

SECTION 6. APPEAL

A. Time for Appeal. Within ten (10) days after receipt of the decision of the hearing panel, either the petitioner or the Medical Executive Committee (or the Board of Commissioners if its action or recommended action prompted the hearing) may request an appellate review by the Board of Commissioners. A written request for such review shall be delivered to the Medical Staff President and Hospital Administrator and the other party in the hearing. If a request for appellate review is not received by the President and the Hospital Administrator within the prescribed period, all rights to such review shall be deemed waived. It shall be the obligation of the party requesting appellate review to product the record of the hearing panel hearing panel hearing, at the appellant's expense.

B. 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:

1. substantial noncompliance with the procedures required by the Fair Hearing Plan in the conduct of hearings and decisions, so as to deny due process and a fair hearing and/or
2. Action taken was arbitrary or capricious and the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 5.5.

C. Time, Place and Notice.

1. If an appellate review is to be conducted, the appeal board shall, within fifteen (15) days after receipt of the request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review.

2. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of receipt of the request for appellate review, provided however, that when the appellate review concerns a petitioner who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed thirty (30) days from the date of the receipt of the request for appellate review.
 3. The time for appellate review may be extended by the appeal board for good cause, including, but not necessarily limited to, a reasonable time for the production of the record. If the record is not produced within a reasonable period through the fault of the appellant, appellate rights shall be deemed waived.
- D. **Appeal Board.** The Board of Commissioners shall appoint an appeal board, which shall be composed of not less than three (3) members of the Board of Commissioners. The chair of the appeal board shall be appointed by the Board of Commissioners. The chair shall determine the order of procedure during the review, make all required rulings, and maintain decorum. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal.
- E. **Appeal Procedure.** The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the hearing panel, provided that the appeal board may, in its sole discretion, accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the hearing panel in the exercise of reasonable diligence and subject to the same rights of cross examination or confrontation provided at the hearing panel for the taking of further evidence and/or clarification, supplementation or reconsideration of its decision. Each party shall have the right to present a written statement in support of its position on appeal and to appear personally for the purpose of presenting oral argument and responding to questions in accordance with the procedure established by the Board of Commissioners. The schedule for presentation of written statements and any additional evidence shall be set by the chair of the appeal board.
- F. **Representation.** If the right to representation by an attorney was afforded to and exercised by the petitioner before the hearing panel, each party shall have the right to be represented by an attorney before the appeal board. If the petitioner was not represented by an attorney before the hearing panel but requests permission to be represented by an attorney at appellate review, the chair of the appeal board may in his/her discretion grant the petitioner's request if the chair determines that the participation of attorneys will assist in the fair and efficient resolution of the appeal. If the petitioner is represented by an attorney at the appellate review, the Medical Executive Committee/Board of Commissioners shall also have the right to be represented by an attorney. The petitioner may be accompanied and assisted by a member of the Medical Staff in good standing or by a member of his/her local professional society.

- G. Deliberation and Recommendation.** After the appellate hearing, the appeal board may conduct deliberations outside the presence of the appellant and respondent and their representatives within 10 days following the appellate hearing. The appeal board shall present to the Board of Commissioners its written recommendations as to whether the Board of Commissioners should affirm, modify or reverse the hearing panel decision.
- H. Powers.** The appeal board has all the powers granted to the hearing panel, and any additional powers that are reasonably appropriate to or necessary for the discharge of its responsibilities.
- I. Final Decision.**
1. Within thirty (30) days after receipt of the appeal board's written recommendations, the Board of Commissioners shall render a final decision.
 2. Should the Board of Commissioners determine that the hearing panel decision is not supported by substantial evidence, the Board of Commissioners may modify or reverse the decision of the hearing panel or remand the matter to the hearing panel for reconsideration or further proceedings, stating the purpose for the referral. If the Board of Commissioners determines that a fair procedure has not been afforded, it may remand that matter to the hearing panel for further proceedings or take such other measures, as it deems appropriate to provide a fair procedure before a decision is made. If the matter is remanded to the hearing panel for further review and recommendation, the hearing panel shall promptly conduct its review and make its recommendations to the Board of Commissioners. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Commissioners and the chair of the hearing panel.
 3. The final decision of the Board of Commissioners shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the president of the Medical Staff, the petitioner involved, and the Hospital Administrator.
- J. Right to One Hearing.** No petitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter, which shall have been the subject of an adverse action or recommendation.

SECTION 7. EXCEPTIONS TO HEARING RIGHTS

A. Closed Staff or Exclusive Use Departments and Medico-Administrative Officers

1. Closed Staff or Exclusive Use Departments. The fair hearing rights of Medical Staff Fair Hearing Plan do not apply to a Practitioner whose application for Medical Staff membership and privileges was denied or whose Medical Staff membership and privileges are terminated on the basis that the privileges sought or held are granted only pursuant to a closed staff or exclusive use policy. Such Practitioners shall have the right, however, to request that the Board review the denial or termination and the Board shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the Practitioner may personally appear before and/or submit a statement in support of his position to the Board.
2. Employees and Medico-Administrative Officer. The fair hearing rights of the Medical Staff Fair Hearing Plan do not apply to those persons serving the Hospital as an employee thereof or in a medico-administrative capacity. Removal from office or termination of employment of such persons shall instead be governed by the terms of their individual contracts and agreements with the Hospital. However, the hearing rights of the Medical Staff Fair Hearing Plan shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the Practitioner's contract or terms of employment, are also removed or suspended, unless the contract or terms of employment provide otherwise.

B. Automatic Suspension or Limitation of Practice Privileges

No Hearing is required when a Member's license or legal credential to practice has been automatically revoked or suspended pursuant to the Credentialing Policy & Procedure Manual or when otherwise specified in the bylaws or accompanying manuals.

C. Department/Service Formation or Elimination

Upon approval of the Board, a Medical Staff Department/service may be formed or eliminated following a determination by the Medical Staff of appropriateness of such elimination or formation. The Board's decision shall uphold the Medical Staff's determination unless the Board makes specific written findings that the Medical Staff's determination is arbitrary, capricious, and abuse of discretion, or otherwise not in accordance with the laws.

1. The Medical Staff shall determine the formation or elimination of a Department/service to be appropriate based upon consideration of its effects on quality of care in the Hospital and/or community. A determination of the appropriateness of formation or elimination of a Department/service must be based upon the preponderance of the evidence, viewing the record as a whole, presented by any and all interested parties, following notice and opportunity for comment.

2. Practitioners whose privileges may be adversely affected by a determination of appropriateness of Department/service formation or elimination may request a Hearing pursuant to Part II. Such a Hearing will be governed by the provisions of Part II of this Manual, except that
 - (a).the Hearing shall be limited to the following issues:
 - (1) Whether the determination of appropriateness is supported by the preponderance of the evidence;
 - (2) Whether the medical staff followed its meeting requirements for notice and comment on the issue of appropriateness as set forth in the Bylaws.
 - (b) All requests for such a hearing will be consolidated.
- (3) Should an affected Member request a hearing under this subsection, the Medical Staff's recommendation regarding the Department/service elimination or formation will be deferred, pending the outcome of the Hearing.
- (4) Except as specified in the Section, the termination of privileges pursuant to formation or elimination of a Department/service determined to be appropriate by the Medical Staff shall not be subject to the procedural rights otherwise set forth in the Medical Staff Fair Hearing Plan.

SECTION 8. GENERAL PROVISION

- A. Time Periods.** Exceptions to any of the time frames provided in this Fair Hearing Plan may be made by mutual agreement of the parties.
- B. Release.** By requesting a hearing or appellate review under this Plan, a petitioner agrees to be bound by the confidentiality, immunity and release provisions contained in Article VII of the Bylaws.
- C. Confidential Nature of Proceedings.** All meetings, proceedings, and deliberations of the Board, the Medical Staff or their staff or agents concerning the granting, denial, revocation, restriction, or other considerations of the status of the clinical or staff privileges of a practitioner (as that term is defined in the Medical Staff Bylaws) pursuant to Medical Staff Bylaws, Manuals, and Policies and Procedures of the Hospital shall be confidential and conducted in Executive session provided, however, that any final action of the Board regarding the same shall be decided in public session.

MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE 1. MEDICAL STAFF RULES & REGULATIONS

SECTION 1. ADMISSION AND DISCHARGE OF PATIENTS

- A. The attending practitioner shall be a member of the Medical Staff and shall be responsible for the medical care and treatment of his/her patients in the hospital, for the prompt completion and accuracy of the medical record, and for necessary special instructions.
- B. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or reason for admission has been recorded. In the case of an emergency, such statement shall be recorded as soon as possible.
- C. A patient to be admitted on an emergency basis that does not have a practitioner or has a practitioner without Trios Health privileges, will have a Medical Staff member assigned to the case on a rotation basis. Each service shall provide a schedule for such assignments.
- D. Each member of the Medical Staff must assure timely, adequate professional care for his patients in the hospital by being available or having available through his office an eligible alternate practitioner with whom prior arrangements have been made, and who has appropriate clinical privileges at the hospital. A practitioner who will be out of town for over 24 hours should, on the order sheet of the chart of each of his patients, indicate in writing the name of the practitioner who will be assuming responsibility for the care of the patient during his absence.
- E. The admitting/attending practitioner shall be held responsible for giving such information as is available to him to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatsoever.
- F. Patients shall be discharged only by an order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending practitioner. The patient will sign a release, if obtainable, that his/her departure is AMA freeing the hospital, its employees and physicians from liability.
- G. It shall be the responsibility of the attending practitioner to discharge his patients in a timely manner. Discharge planning evaluation should be initiated at the time of admission.
- H. All patients scheduled for elective surgery as a hospital admission, either inpatient or outpatient must have the lab work completed by 1800. A History and Physical must be in the chart prior to surgery; if using the hospital's dictation system, it must be dictated no later than 2300 the day prior to surgery. An update note must be added just prior to surgery (see Section 2-A).

They may be admitted under one of the following categories:

1. Admissions the day before surgery – this would include patients requiring extensive pre-operative work-up, such as respiratory therapy treatments or monitored observation. The patient shall be admitted the day prior to surgery. The chart documentation must accurately reflect the severity of illness or need for early admission.
 2. Admission the day of surgery – surgery admissions may come in the day of surgery provided all laboratory tests have been completed. The patient should come to the Hospital no later than two and one-half (2 ½) hours prior to the surgery time so that adequate preparations can be made.
- I. Outpatient procedures will be performed in the surgery suite or in any designated special procedure room and must be scheduled with the appropriate department specifically as an outpatient procedure. Those outpatient procedures scheduled with the surgery department will be included on the daily operative schedule. This category includes patients in which a general or local anesthesia will be used, but in which the surgeon feels a separate hospital admission or prolonged period of observation is not necessary.
1. Patients Requiring Anesthesia Services: The pre-op lab work must be completed by 1800 hours the day prior to the procedure. A History and Physical must be in the chart prior to the procedure; if using the hospital's dictation system, it must be dictated no later than 2300 the day prior to the procedure. An update note must be added just prior to the procedure (see Section 2-A). These patients will be admitted to and discharged from the Ambulatory Surgery Area. In the event that the patient should have a complication or require prolonged observation, they would be converted to an inpatient or medical observation status, as per a written order by the attending practitioner. In all cases, the patient must be instructed that they cannot drive themselves home, and they must make arrangements for this in advance. They should be advised that if any complications occur in which their safety is concerned, they would be admitted to the hospital. IN all cases in which a general anesthetic is administered, the patient must take nothing by mouth for 8 hours prior to surgery. Outpatients should be instructed to be in the hospital 2 hours in advance of their scheduled surgery.
 2. Patient's Not Requiring Anesthesia Services (local): A brief History and Physical and Operative Report are needed, but lab work is left to the physicians' discretion. These patients will be admitted to and discharged directly from the Ambulatory Surgery Area.
- J. In the event of the death of a hospital patient, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. An entry shall be made and signed by a member of the Medical Staff in the medical record of the deceased within 24 hours after the time of death.

- K. All medical staff members are encouraged to secure autopsies when of meaningful value. An autopsy may be performed only with a written consent, signed in accordance with Washington State law. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours, and the complete protocol shall be made a part of the record within ninety (90) days.
- L. All admission testing shall be ordered at the discretion of the admitting practitioner. To comply with the hospital Corporate Compliance Plan, the testing must be accompanied by a written or verbal order, and an appropriate diagnosis supporting medical necessity.

SECTION 2. MEDICAL RECORDS

- A. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current for each patient. This record shall include identification data; complaint; personal history; allergic history; family history; history of present illness; physical examination; special reports, such as consultations, clinical laboratory and radiology services, and other provisional diagnoses; medical or surgical treatment operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge summary or discharge note.

The History and Physical examination must be completed at the time of admission and no later than 24 hours after admission for each patient. If the examination was done prior to admission, but within 30 days prior to admission, an updated medical record entry documenting an examination for any changes in the patient's condition at the time of admission must be placed on the patient's medical record within 24 hours after admission.

- i. A short stay History and Physical may be used in place of a dictated History and Physical for Same Day Surgery patients who remain an outpatient. See (vi.) for all patient types.
- ii. If the patient is readmitted within 30 days of discharge for the same or related condition, a copy of the previous History and Physical may be placed on the chart. In addition, an interval admission note documenting an examination for any changes in the patient's condition at the time of admission must be placed on the patient's medical record within 24 hours after admission or prior to surgery. The interval note updates any components of the patient's current medical status that may have changed since the history and physical was performed or any areas where more current data is needed showing medical necessity for procedure or care.

A pre-surgery History and Physical obtained through the physician's office no more than 30 days prior to admission will be accepted and may be placed on the patient's medical record. In addition, an admission note documenting an examination for any changes in the patient's condition at the time of admission must be placed on the patient's medical record within 24 hours after admission or prior to surgery.

- iii. A pre-surgery History and Physical obtained through the Physician's office will be accepted, provided that it was performed within 30 days of admission and the Interval note or H&P Update sticker as stated in "ii" above is dictated or written for any History and Physical greater than 24 hours old.
- iv. Patients scheduled for non-emergency surgery will have a History and Physical on the record prior to surgery. For emergent surgeries/procedures, the Short Stay History and Physical may be used. For life-threatening surgeries/procedures, the physician may do the complete History & Physical post-procedure.
- v. The History and Physical must contain the following:
 - a. History
 - 1. Identifying data: Name, age, sex
 - 2. Chief complaint
 - 3. History of Present Illness
 - 4. Medications
 - 5. Allergies
 - 6. Habits: tobacco, alcohol, other as appropriate
 - 7. Past medical and surgical history, as appropriate
 - 8. Relevant past social and family history, as appropriate
 - b. Physical
 - 1. Heart
 - 2. Lungs
 - 3. Area of body as appropriate to the chief complaint
 - c. Laboratory and other results, as appropriate
 - d. Other relevant elements: advance directives, informed consent
 - e. Diagnosis
 - f. Plan

- vi. The following procedures require the following:

Outpatient Record Documentation Requirements
Those with asterisk are required by practitioner

Purpose: As required by the Joint Commission and Medicare, a medical record must be maintained for every individual assessed or treated. The medical record must contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care.

One Time Outpatient – Ancillary (i.e., Lab, Xray, Non-stress tests) - Primarily Diagnostic	One Time Outpatient - Invasive without Conscious Sedation and/or Therapeutic (i.e., Myelogram, Discogram, blood patch, PICC line, Amniocentesis, Blood transfusion, spinal tap)
Facesheet *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. <u>Diagnosis will be included on order.</u> *Results General Consent to Treat (if service provided by Trios Health)	Facesheet *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. <u>Diagnosis will be included on order.</u> *Signed Procedure Note (or Radiology Report) to include, as applicable: findings; procedure(s); specimen(s) removed; pre- and post-procedure diagnosis; name of practitioner, assistant, anesthesia provider *Progress Note and/or other Documentation deemed appropriate based on the patient's condition (all care givers) Discharge Instructions to include medications, follow-up, dietary and activity restrictions, use of any equipment as appropriate (Nsg) *Informed Consent for Invasive Procedure, if applicable General Consent to Treat

One Time Outpatient – Invasive with Conscious Sedation (i.e., Bone marrow biopsy, diagnostic catheterizations, GI procedures)	Series Outpatient/Continuing Ambulatory Care (i.e., IV therapy, BCG's)
Facesheet *History and Physical (elements included are based on the patient's needs and the setting within which the care is to be given) *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. <u>Diagnosis will be included on order.</u> *Signed Procedure Note (or Radiology Report), to include, as applicable: Findings; procedure(s); specimen(s) removed; pre- and post-procedure diagnosis; name of physician, assistant, anesthesia provider Completed Conscious Sedation Record *Progress Note and/or other documentation deemed appropriate based on the patient's condition (all care givers) Test Results, if applicable Outpatient Nursing Assessment Discharge Instructions to include medications, follow-up, dietary and activity restrictions, use of any equipment, as appropriate (Nsg) *Informed Consent for Invasive Procedure, if applicable General Consent to Treat	Facesheet *Initial History and Physical or SOAP Note from Physician's Office (elements included are based on the patient's needs and the setting within which the care is to be given) *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. <u>Diagnosis will be included on order.</u> Progress Note for each patient visit Outpatient Nursing Assessment (first visit) Test Results, if applicable Discharge Instructions to include medication, follow-up dietary and activity restrictions, use of any equipment, as appropriate General Consent to Treat (updated annually) <u>If applicable, any/all of the following:</u> *Informed Consent for Invasive Procedure(s) Completed Conscious Sedation or Anesthesia Record *Signed Procedure Note(s) to include, as applicable: findings; procedure(s); specimen(s) removed; pre- and post-procedure diagnosis; name of practitioner, assistant, anesthesia provider

One Time Outpatient – Non-Invasive with Conscious Sedation (i.e., Pediatric MRI)
Facesheet *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. <u>Diagnosis will be included on order.</u> *Signed Order(s) by Physician for RN administration of medications Completed Conscious Sedation or Anesthesia Record General Consent to treat Results

Same Day Surgery	Observation
Facesheet *History and Physical (elements included are based on the patient's needs and the setting within which the care is to be given) *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. Test Results, if applicable Completed Conscious Sedation or Anesthesia Record *Signed Post-Procedure Handwritten Note by physician, to include: findings; procedure(s); specimen(s) removed; pre- and post-operative diagnosis *Dictated Operative Record, to include findings, procedure(s), pre- and post-operative diagnoses, any specimen(s) removed, name of physician, assistant and anesthesia provider Recovery Room Record, to include criteria met for release from PACU or Conscious Sedation Record Outpatient Nursing Assessment Discharge Instructions to include medications, follow-up, dietary and activity restrictions, use of any equipment etc. *Informed Consent for Procedure General Consent to Treat	Facesheet *History and Physical (elements included are based on the patient's needs and the setting within which the care is to be given) *Signed Order(s) by Physician confirming that the listed services are medically necessary for diagnosis and treatment of patient. *Progress Note and/or other Documentation deemed appropriate based on the patient's condition (all care givers) Test Results, if applicable Outpatient Nursing Assessment with Discharge Planning and Learning Needs (Nsg) Discharge Instructions to include medications, follow-up, dietary and activity restrictions, use of any equipment, as appropriate General Consent to Treat

Note:

Minimal documentation for a History and Physical for outpatient surgery patients is the Trios Health Short Form. A History and Physical from a referring physician is acceptable if it is dated within 30 days of a procedure and is updated at the time of admission or no later than 24 hours after admission and prior to surgery.

All documentation accumulated, for any patient whose procedure was canceled (any reason) or the patient left (any reason) before the procedure, will be kept in the patient's medical record. "VOID" is the only exception to this.

Dentists/Podiatrist:

Dentists and Podiatrists will conduct an H&P as a member of the medical staff.

Allied Health Professionals: (Certified Nurse Midwives, CRNA)

CNM's and CRNA's will conduct a H&P as defined in the above paragraph and as individually approved by the appropriate medical staff medical staff division.

Allied Health Professional: (ARNP, PA-C)

ARNP's and PA-C's may dictate the H&P as individually approved by the appropriate medical staff division with co-signature of their sponsoring physician within the first 24 hours of admission.

A practitioner's lack of adherence to this rule shall be forwarded to the appropriate department/committee for review and action through the quality management activities of the medical staff.

- B. Physicians are required to maintain medical records on all medical patients. The physician is responsible for a history and physical. On all elective surgery cases, if using the hospital's dictation system, the History and Physical must be dictated no later than 2300 the day prior to surgery. An update note must be added just prior to surgery (see Section 2-A). If the dictated H&P has not been transcribed, a handwritten H&P will be required for surgery to begin.

Adequate daily progress notes on all patients are required.

He is also responsible for the proper wording on the operative consent forms. Written, signed, informed surgical consent form shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy, when exceptions to this rule will be allowed as provided in our bylaws.

- C. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care. These shall be documented in the patient's medical record at least daily. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders, the patient's response to and changes in treatment and revision of the diagnosis should be documented, as well as results of tests.

When a short stay or handwritten History and Physical was used on an Outpatient/Same Day Surgery case and the patient subsequently requires admission as an inpatient, a progress note adequately documenting an updated physical examination and reason for the admission will be documented.

- D. Procedure reports are dictated or written in the medical record immediately after surgery and describe the procedure performed, the findings, the technical procedures used, the specimen removed, the pre- and postoperative diagnosis, and the name of the primary surgeon and any assistants. All procedure reports shall be authenticated by the responsible practitioner.

Since the dictated procedure report cannot be placed in the medical record immediately after the procedure due to the transcription and filing processes, a post-procedure progress note is to be entered by the practitioner in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the care of the patient. The note shall include:

- Name of the licensed practitioner that performed the procedure and assistant(s)
- Procedure performed
- Significant findings
- Estimated blood loss
- Specimens removed
- Postprocedure diagnosis

A dictated report is not required for routine dressing changes, cast changes or suture of minor lacerations. However, a brief written description is to be entered on the patient's record in the progress notes.

A practitioner's lack of adherence to this rule shall be forwarded to the appropriate department/committee for review and action through the quality management activities of the medical staff.

- E. Consultation reports shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to the operation.
- F. The current obstetrical record shall include a prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record, transferred to the hospital before admission, provided it is updated at the time of admission and no later than 24 hours after admission and prior to surgery.

A history and current physical examination is to be recorded prior to any major obstetrical operation (see Section 2-B). The usual prenatal form does not satisfy this requirement.

Admissions for conditions of pregnancy without delivery require an update of the prenatal record at the time of admission and no later than 24 hours after admission pertinent to the situation.

- G. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated within 48 hours. Any notes written after discharge of the patient shall be dated with the date of completion.
1. Written orders received via facsimile with the signature of the ordering Licensed Independent Practitioner will be accepted as the original signature
- H. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. A copy of the *Dictionary of Medical Acronyms & Abbreviations, Jabolski*;

will be readily available as stated in the Trios Health policy *Acronym and Abbreviation List*.

- I. Final diagnoses shall be recorded in full, without the use of symbols or abbreviations, and signed by the responsible practitioner by the time of chart completion. This may be recorded in the final progress note, the discharge/transfer/death summary or on the face sheet.
- J. A discharge summary (clinical resume) shall be dictated or written on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries and normal newborn infants. In all instances, the content of the discharge summary shall be sufficient to justify the diagnoses and warrant the treatment and end result (reason for admission, significant x-ray and lab findings, course in the hospital, treatment rendered, discharge instructions, plan for follow-up, primary and secondary diagnoses, and procedures performed).

A summary is required on all patients, regardless of length of stay, who expire or are transferred to another acute health care facility and must include all of the above elements. The cause of death or reason for transfer should be stated in the record. All summaries shall be authenticated by the responsible practitioner.

- K. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with court order, subpoena, or statute. All records are the property of the hospital and shall not otherwise be taken away without permission of the Hospital Administrator. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.
- L. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is under the care of the same practitioner or of another.
- M. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be subject to approval by the Hospital Administrator and the Executive Committee of the Medical Staff before records can be studied. Former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
- N. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Quality Management Committee.
- O. The attending practitioner shall complete the medical record at the time of the patient's discharge, to include progress notes, final diagnoses and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the medical record will be available in the Medical Record Department. If the discharge summary cannot be dictated at the time of discharge, a final progress note must be written in the medical record including a final diagnosis if it is not recorded on the face sheet.

- P. Medical records of discharged patients are to be completed within 30 days of discharge. Records remaining incomplete after 30 days are deemed delinquent and the practitioners shall be subject to a medical record suspension.

This guideline is intended to assure timely completion of patient records; not to penalize practitioners. The implementation of this procedure follows the recommendation stated in *The Office of Inspector General's Compliance Guidance for Hospitals*; February 1998. "Policies and procedures should: provide for proper and timely documentation of all physician and other professional services prior to billing to ensure that only accurate and properly documented services are billed;"

At fourteen (14) day intervals, the HIM Department will notify the practitioner in writing of incomplete medical records. If records remain incomplete at the conclusion of 30 days, a letter will be sent to the practitioner from the Chief Executive Officer indicating that the all clinical privileges are suspended as well as any forwarding of medical record chart copies to the physician office until the delinquent charts are completed.

The Admission Supervisor, the Department Chair, the President of the Medical Staff, and the Administrator will be notified of the practitioner's medical record suspension by the Medical Staff Services Department.

The Department Chair will call the practitioner to discuss the current medical record suspension and how to resolve from it occurring in the future.

Reinstatement shall be automatic upon completion of the delinquent medical records. The HIM Department shall be responsible for analyzing medical records for the purpose of administering this rule and notifying the Medical Staff Services Department.

The HIM Department will notify a practitioner of past suspensions for medical record delinquencies. Medical records are delinquent after 30 days; after 30 days of continued delinquent records, a \$100 fine will be imposed. If after an additional 30 days records are still delinquent, a \$250 fine will be imposed. If after an additional 30 days records are still delinquent, a \$500 fine will be imposed, as well as a voluntary resignation from medical staff. (Revised 2/2002)

- Q. Standing orders shall be implemented only after institutional acceptance by the appropriate Department. Such standing orders shall be dated and subject to Department review and revision where applicable. The standing orders shall be placed on the medical record of the patient so that the orders can be authenticated. Any changes to particular orders shall be done by drawing one line through the order to be changed, writing the new order, date, time and signature of the appropriate physician.

SECTION 3 GENERAL CONDUCT OF CARE

- A. Practitioners shall be responsible for obtaining the patient's informed consent prior to treatment and/or performance of a procedure. The patient shall be informed of the nature and risks of the procedure and of the possible alternatives. The patient shall sign the consent form affirming that the practitioner has personally informed the patient prior to the consent. Space shall be provided on the form for the practitioner to document and sign what was explained to the patient and that the patient understood and agreed to the proposed treatment.
- B. All orders for treatment shall be in writing. Verbal orders, when the practitioner is present, shall only be given in emergency situations.
All verbal and telephone orders:
 - 1. Shall be signed by the appropriately authorized person to who dictated with the name of the practitioner per his or her own name.
 - 2. Must be dated and authenticated as defined by these Medical Staff Rules & Regulations, see Section B.18, first paragraph.
 - 3. Can be accepted and transcribed by registered nurse.
 - 4. Particular to the area of expertise can be accepted and transcribed by designated ancillary certified professionals, i.e. Dietitian, Respiratory therapist, Radiology technologist, Special Procedures/Cardiovascular technologist, Physical therapist, Pharmacist, Laboratory technologist/technician or designated scheduling registration staff
 - 5. **EXCEPTIONS** to the time limit for authentication of verbal or telephone orders may be made in other Hospital and/or medical staff policies and procedures.
(Revised 11/18/99)
- C. The practitioner's orders must be written clearly, legibly and completely. Orders, which are illegible or improperly written, will not be carried out until rewritten by the practitioner or understood by the nurse.
- D. All previous orders are canceled when a patient goes to surgery, except for incentive spirometry initiated pre-op and is to be continues post-op.
- E. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopedia National Formulary or American Hospital Formulary Service.
- F. A method for control of drugs brought into the hospital by the patient shall be established through the pharmacy and therapeutics policy.
- G. Drugs should not be discontinued without notifying the attending practitioner. If the order expires in the night, it should be called to the attention of the practitioner the following morning.

- H. The attending practitioner shall list on the physician's order sheet, progress notes or discharge instruction sheet, and all discharge medications. The list shall include medication strength and directions for use. If the patient is to receive no discharge medication, the practitioner is to so indicate on the order sheet.
- I. In order to implement the "NO-CODE POLICY" it is required that the attending physician create the prognosis committee by personally requesting consultations. Any physician who does not have knowledge of the patient's terminal illness must examine the patient and write or dictate a consultation with prognosis. A physician who already knows the terminal patient's illness need only write a progress note, which briefly delineates his knowledge of the case, and give his prognosis. Staff are encouraged to use physicians who already have knowledge of the terminal patient's illness, rather than obtain new consultations. Be aware that many terminally ill patients have seen an ER physician, surgeon, oncologist or clinical radiologist.

SECTION 4. CONSULTATIONS

- A. Consultations with another qualified member or privileged practitioner should be obtained for cases when, in the judgment of the attending practitioner, the patient requires care beyond the specialty scope of such attending practitioner, the diagnosis is obscure, or there is doubt as to the best therapeutic measures to be utilized.
- B. Any qualified practitioner with clinical privileges in the hospital may be called for consultation within his area of expertise.
- C. The attending physician is responsible for obtaining the consultation. The specific reason for the consultation should be included with the written or verbal order for the consultation, as well as the timeframe for obtaining the consultation. Direct practitioner to practitioner communication is preferred when requesting a consultation from a colleague in order to enhance efficiency, quality and safety of patient care.
- D. A satisfactory consultation includes examination of the patient as well as the health record. When operative procedures are involved, the consultation should be recorded prior to the operation (except in an emergency). The consultant will make and authenticate a record of his findings and recommendations in every case.
- E. **NON URGENT CONSULTATIONS:** The attending physician should attempt to call the consultant for the consultation. If the consultation is non-urgent, the unit secretary/nurse may place the call as long as the reason for the consultation is written-up with the consultant with further details and/or clarification. If the secretary has no clear reason documented for the consultation requested, the secretary or nurse will notify the attending physician at which time it will become the attending's responsibility to notify the consultant.

Non-urgent consults requested between 10pm and 6am should be called between 7am and 9am. Consultations shall be completed in a timely manner, but not more than 24 hours from the time that the consultation is requested or when otherwise stated by the consultant and agreeable with the referring physician.

- F. **URGENT CONSULTATIONS:** The attending physician must place the call to the consultant on all urgent consultations. All consults with an Intensivist are considered urgent consults. In the event the attending is not able to reach the consultant, he/she may leave the pertinent information for the unit secretary to call in the consultation. The attending must leave a number (beeper, phone, answering service, etc.) where he/she can be easily reached by the consultant. If the secretary is unable to reach the consultant after two attempts in one hour, then the secretary will contact the attending. All urgent consultations shall be performed within **one hour** of the request.
- G. **Required Consultations:** Except in an emergency, consultation with another qualified practitioner is required in cases in which, according to the judgment of the attending practitioner:
1. The attending physician should obtain a consultation when the problem is of a serious nature or condition is outside his/her scope of expertise or if the clinical needs of the patient exceed the limits of the attending physician's privileges.
 2. When requested by the patient or his family; or
 3. It is the responsibility of the provider to determine if a patient has an acute psychiatric, emotional, alcohol/chemical abuse condition-requiring consultation, and in such cases arrange for appropriate consultation.
- H. If a nurse has any reason to doubt or question the care provided to the patient, or believes that appropriate consultation is needed and has not been obtained, he/she may call this to the attention of her supervisor, who may in turn, after discussion with the attending practitioner, refer the matter to the Hospital Supervisor (per Clarification of Orders Chain of Command Policy, KGH000150). If warranted, the Hospital Supervisor may bring the matter to the attention of the Chief of Service wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chief of Service may himself request a consultation.

SECTION 5. GENERAL RULES REGARDING SURGICAL CARE

- A. Except in severe emergencies, the preoperative diagnosis required laboratory tests and H&P must be recorded in the patient's medical record prior to any surgical procedure, as per the Process for Admission for Surgery protocol.
- B. All significant tissues removed at the operation shall be sent to the hospital pathologist, who shall make such examination, as he may consider necessary to arrive at a tissue diagnosis.
- Non-tissue specimens shall be sent to the pathologist at the discretion of the attending physician. His authenticated report shall be made a part of the patient's permanent medical record.
- C. Induction of Anesthesia: The surgeon or assistant surgeon must be in the hospital at the onset of anesthesia.

- D. Change of Schedule: In the event of cancellation or postponement of a case, the operating room supervisor, the attending practitioner and the anesthesia department will be notified depending upon who cancels the operation. Any practitioner following that operation will then be notified of the cancellation and the new estimated time of his case. Practitioners who are on suspension will be unable to schedule surgery cases until their medical records have been completed.
- E. "Bumping" Scheduled Cases: In the event of an emergency, the emergency surgeon needs to contact the scheduled surgeon regarding "bumping" the scheduled case.
- F. Departmental Meetings: Active and Provisional/Active medical staff members shall not be allowed to schedule elective surgery cases during the general medical staff meeting.
- G. In all surgical procedures, the use of a surgical assistant will be at the discretion of the attending surgeon. Duly licensed and/or qualified nurses, certified surgical technicians, medical students, and physicians assistants may assist in surgical procedures as first assistant, following completion of the credentials or hospital Human Resource process.
- H. The need for immediate surgical pathology consultation should be scheduled in advance if at all possible. The surgeon (in consultation with the pathologist) shall deem which specimens require immediate examination.
- I. All general surgeons who are not Board Certified (or Board Eligible) on-call for trauma in the Emergency Department must maintain education in ACLS (Advanced Cardiac Life Support) and Advanced Trauma Life Support (ATLS).

SECTION 6. GENERAL RULES REGARDING OBSTETRICAL CARE

- A. Laboratory work that should be completed for obstetrical patients includes type and Rh, serology, CBC and urinalysis.
- B. Threatened abortion and miscarriages greater than 20 weeks gestation are to be admitted directly to the obstetrical area unless the attending physician wants the patient to be examined in the emergency department, or specified admission to another area.

SECTION 7. GENERAL RULES REGARDING NURSERY PATIENT CARE

- A. The results of the prenatal VDRL (or serology) test required by Washington State law, type and Rh of the mother must be recorded on the infant's chart.
- B. It is recommended that all infants discharged within 24 hours after birth are seen by the attending physician within 3 days (recommendation of the American Academy of Pediatrics). Also, the early discharge checklist shall be utilized if infant is to be discharged before 24 hours of age.
- C. All infants will be examined by the attending physician within the first 24 hours of life. Ill infants will be given more immediate attention.

SECTION 8. GENERAL RULES REGARDING PEDIATRIC PATIENT CARE

- A. Unless admitted directly from the physician's office, the pediatric patient should be seen by the attending physician within 12 hours, or as soon as possible if unstable; or by 0900 hours the following day if stable.
- B. Preoperative laboratory work for pediatric patients may be performed up to, but no longer than 7 days before admission.
- C. All children under age 5 with fracture and suspected child abuse will have further evaluation of the skeletal system. All children with suspicion of child abuse and symptoms such as bony tenderness or limited range of motion will have a skeletal bone survey.
- D. Visiting hours shall be according to the Pediatric Department visiting policy.

SECTION 9. GENERAL RULES REGARDING ICU/CCU

- A. Admission and medical care of the intensive care patient will be under the discretion of physicians who have been approved by the Board with appropriate privileges/credentials for admitting patients to the intensive care unit.
- B. Physicians who do not have intensive care unit admission privileges will obtain consultation/admitting services for the admission and co-management of the intensive care patient.
- C. Admission Process
 - 1. Direct transport to Intensive Care
 - a. A physician with intensive care unit admission privileges will be granted direct ICU admission for his/her out-of-the hospital patient.
 - b. The admitting physician will assure notification of the Admissions Nurse/Patient Care Coordinator.
 - c. The admitting process will be completed after the patient has arrived in intensive care unit.
 - 2. Admission from the Emergency Department
 - a. A brief history by the ED physician will dictate the necessity for intensive care admission.
 - b. The admitting process will be completed after patient has arrived in the intensive care unit
 - 3. Minimum Information Required for Patient Admission to the Intensive Care Unit

- a. Name of patient
 - b. Age of patient
 - c. Diagnosis
 - d. Name of admitting/attending physician (If the admitting physician will not be assuming primary care responsibility for the patient, the attending physician responsible for the patient's care will be identified upon acceptance of admission to the intensive care unit).
- D. Management of the intensive care patient will be in accordance with the intensive care unit policies and procedures.
 - E. All patients admitted to the intensive care unit will be seen/evaluated by the attending/consulting physician or (designee) within two (2) hours prior to or following admission. Daily physician progress notes are required for all intensive care unit patients.
 - F. Upon admission to the intensive care unit from other hospital services, all previous patient care orders will be canceled and new orders written.
 - G. Upon discharge from the intensive care unit to other hospital services, all current patient care orders will be reviewed by the physician and new orders will be written.
 - H. When appropriateness of care and scope of practice issues arise involving the intensive care patient, the Medical Director of ICU/CCU will be consulted for problem resolution.

SECTION 10: GENERAL RULES REGARDING EMERGENCY SERVICES

Any individual who presents to the Hospital Emergency Department, and who request, or have a request made on his or her behalf for an examination or treatment of a medical condition or any individual who presents on hospital property for examination or treatment of what may be an emergency medical condition or whose appearance or behavior would lead a person to believe the individual needs emergency treatment, will receive a medical screening exam. A member of the Trios Health Medical Staff will perform the medical screening exam in the Emergency Department. In the case of a pregnant woman in labor who presents to the Hospital, a trained labor and delivery registered nurse may perform the exam. The Hospital property is defined as the entire main Hospital campus including the parking lots, sidewalks and driveways, as well as any other facility or organization that is located off the main campus, but is adjacent to it or within 250 yards of the main building. Medical screening exams are not required in the physician clinics, walk-in clinics, or private physician offices.

- A. **DEFINITION: "Unassigned Patient"** – A patient is unassigned when either of the following occurs:
 - 1. When the patient comes through the door of Trios Health and has no provider or a provider with no admitting privileges at Trios Health.

2. If there is a provider with admitting privileges at Trios Health who refuses to come in, the patient becomes unassigned and the refusing provider is written up; with the complaint going to the Department Chair and the Quality Management Committee.
- B. All emergency room physicians shall be ACLS (Advanced Cardiac Life Support) and ATLS (Advanced Trauma Life Support) and PALS (Pediatric Advanced Life Support) educated.
- All emergency room physicians shall maintain PALS or APLS certification, or maintain seven (7) hours of pediatric education every three years.
- All emergency room physicians who are not board certified shall maintain ACLS and ATLS certification.
- C. If, in the judgment of the emergency room physician, another physician's help is required because the emergency room is overwhelmingly busy, the on-call emergency room physician will be called in.
- D. **CALL:** Members of the Medical Staff shall accept responsibility for emergency service care in accordance with emergency service policies and procedures. Active medical staff members, as well as associate medical staff members intending to become active staff, will accept "on-call" assignments as assigned by the department in which their scope of practice lies. When a physician on the Active Medical Staff plans to be unavailable for hospital call, he shall notify the emergency room of the period of his absence, and name the physician of the same specialty/privileges who has agreed to take his calls.
- E. **TRAUMA CALL OBLIGATION:**
1. When a physician is on-call for Trios Health Emergency Department, that physician is to respond to emergency calls, particularly emergencies involving major trauma. This is to be done within the Trauma Policy time limits.
 2. If the on-call surgeon is involved in treatment of a patient elsewhere and will be unavailable for a prolonged period of time, the trauma back-up surgeon should be called to care for the patient.
 3. The above are meant to serve as guidelines and apply to all specialists taking emergency call.
- F. **CALL:** Any person who presents to the Emergency Room and is determined to require admission must be admitted to Trios Health if we supply the service the patient needs, and the patient has no practitioner and/or the patient's practitioners does not have privileges at Trios Health.
- G. **CALL:** All physicians, including those without admitting privileges at Trios Health, shall be notified of their patient's need for admission and shall be given the opportunity to be involved in the disposition of their patient's care. Failure of the on-call physician to attend to unassigned patients or patients whose physicians have no admitting privileges at Trios Health shall be reported to the appropriate Department Chair and the Quality Management Committee. Failure of a physician with admitting privileges at Trios Health to respond to his/her patient who requires admission through the emergency room shall

be reported to the appropriate Department Chair and the Quality Management Committee.

- H. **CALL:** If in the judgment of the emergency physician a patient needs to be admitted to the hospital, the ER physician will call either the patient's physician or the physician on-call if the patient is unassigned. ER physicians do not have admitting privileges. The admitting physician will then either arrange for the patient's admission by telephone, or come to the emergency room as promptly as possible to evaluate the patient's condition himself before deciding whether or not to admit the patient. The responsibility for the patient's care will then be transferred to the physician who is admitting the patient. If the physician disagrees with the judgment of the ER physician to admit the patient to the hospital, that physician must come to the Emergency Room and evaluate the patient before the patient can be released or transferred. It is the obligation of the on-call physician to accept care of the patient without regard as to the patient's method of payment or his ability to pay for medical service. All patients admitted to the hospital through the emergency room will be seen by the attending physician within a reasonable amount of time.
- I. Patients are to receive stabilizing treatment of emergency conditions within the available resources of the Hospital. It is the physician's right and duty to make reasonable medical judgments as to whether an individual is "stabilized" under the law. Where there is doubt as to whether a patient is considered "stabilized" for purposes of EMTALA, the transferring physician should comply with the transfer requirements of EMTALA and certify that the benefits of transfer outweigh the risks, and obtain the consent of the receiving hospital.
- I. To facilitate trauma patient transfers to Trios Health, the Emergency Department physician will be responsible for determining which patients can be satisfactorily cared for at Trios Health, and maintaining compliance with COBRA guidelines in all cases. In addition, an emphasis will be placed on facilitating such transfers in order to expedite them and assist the referring physician (through telephone consultation) in proper stabilization of the patient for transport. When applicable, the Emergency Department physician is to ensure that ACLS and ATLS standards are complied with by the referring facility, and that the patient is stabilized to the best of the referring physician's and hospital's capability.

SECTION 11. GENERAL RULES REGARDING ANESTHESIA SERVICES

- A. Anesthesia services are directed by the Medical Director of Anesthesia who is a member of the medical staff with overall administrative responsibility for anesthesia services. The Surgery Department oversees this function.
- B. The Medical Director of Anesthesia services will develop and review regulations for anesthetic safety and departmental policy.
- C. All anesthesiologists and CRNA's on-call for trauma in the Emergency Department maintain education in ACLS (Advanced Cardiac Life Support), PALS (Pediatric Advanced Life Support), and NRP (Neonatal Resuscitation Program).

Types of Anesthesia Services Requiring Anesthesia Personnel:

General Anesthesia: a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilator support is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. General anesthesia is used for those procedures when loss of consciousness is required for the safe and effective delivery of surgical services.

Regional anesthesia: the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks, is used when loss of consciousness is not desired but sufficient analgesia and loss of voluntary and involuntary movement is required. Given the potential for the conversion and extension of regional to general anesthesia in certain procedures, it is necessary that the administration of regional and general anesthesia be delivered by a practitioner of anesthesia as defined below.

Monitored anesthesia care (MAC): anesthesia care that includes the monitoring of the patient by a practitioner who is qualified to administer anesthesia as defined below. Indications for MAC depend on the nature of the procedure, the patient's clinical condition, and/or the potential need to convert to a general or regional anesthetic. Deep sedation/analgesia is included in MAC>

Deep sedation/analgesia: a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilator function may be impaired. Patients may require assistance in maintaining patent airway, and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained. Because of the potential for the inadvertent progression to general anesthesia in certain procedures, it is necessary that the administration of deep sedation/analgesia be delivered or supervised by a practitioner as defined below.

Types of Sedation NOT REQUIRING Anesthesia Personnel:

Moderate sedation/analgesia ("Conscious sedation"): a drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained. CMS, consistent with ASA guidelines, does not define moderate or conscious sedation as anesthesia.

Minimal sedation: a drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilator and cardiovascular functions are unaffected. This is also not anesthesia.

Topical or local anesthesia: the application or injection of a drug or combination of drugs to stop or prevent a painful sensation to circumscribed area of the body where a painful procedure is to be performed. There are general no systemic effects of these medications, which also are not anesthesia, despite the name.

Organization and Staffing

1. Anesthesia services must only be provided by a member of the medical staff, in good standing with appropriate clinical privileges, who is either:
 - a. A Physician (M.D. or D.O.) who has completed an approved residency in the field of anesthesia and is licensed by the State of Washington or
 - b. A CRNA (Certified Registered Nurse Anesthetist) who is licensed by the State of Washington.
2. A sufficient number of qualified staff must be present to evaluate the patient, help with the procedure, provide the sedation and/or anesthesia, and monitor and recover the patient. The number of qualified staff deemed sufficient shall be determined by the person administering anesthesia.

Pre-Operative Procedures

1. The following must occur before the operative and other procedures requiring the administration of anesthesia services by anesthesia personnel occurs:
 - a. The anticipated needs of the patient are assessed to plan for the appropriate level of post-procedure care
 - b. Pre-procedural evaluation must be performed for each patient receiving anesthesia services
 - c. The pre-procedural evaluation must be performed for each patient receiving anesthesia services
 - d. The pre-procedural evaluation must be performed within 48 hours of the start of the procedure requiring anesthesia services
 - e. A “time out” is conducted immediately before starting the procedure, as described in the Universal Protocol
 - f. The pre-procedural evaluation is to be documented and is to include any relevant co-morbid conditions, document the results of an auscultatory examination of the heart and lungs, and assess the patient’s general health. This documentation is also required to include any medications the patient is taking on a regular basis, allergies to medications, an evaluation of the patient’s airway, any relevant laboratory or diagnostic results (e.g. x-rays, EKGs, echocardiograms, etc.), patient’s physical status (i.e. height and weight) and any adverse reaction to anesthesia by the patient or the patient’s blood relatives.

Intra-Operative Procedures

1. All patients receiving anesthesia services must be monitored during the procedure. Appropriate methods shall be used to continuously monitor oxygenation (SpO21%), ventilation (EtCO2) [where feasible], and circulation (EKG, HR and BP) either invasive or non-invasive). Additional monitoring shall be at the discretion of the person providing the anesthesia services.
2. All events taking place during the induction and maintenance of, and the emergence from anesthesia services, must be documented on a separate anesthesia record, including:
 - a. The dosage and duration of all anesthetic agents
 - b. Other drugs, intravenous fluids, blood or blood products

- c. The technique used
 - d. Unusual events during the anesthesia period
 - e. The status of the patient at the conclusion of anesthesia
3. Accounting of controlled medication usage will be performed with proper documentation of drug waste disposition as mandated per State and Federal regulations. Drug waste disposition may be documented either in the drug dispensing machine from which the controlled substances were obtained (i.e. Omni cell or Pixies) or the anesthesia record of the patient with the initials or signature of the person wasting the controlled substance(s) and one other member of the hospital staff who is either an RN or MD/DO.

Post-Anesthesia Evaluations

1. Patients shall be monitored immediately after the administration of anesthesia services until such time that the patient is considered stable by a person qualified to administer anesthesia services, as defined above, or by an RN who is qualified to make such a determinations (e.g. PACU RN or ICU RN).
2. A post –anesthesia evaluation must be completed and documented upon admission to and discharge for the post-anesthesia within 48 hours after the end of surgery.
3. Post-anesthesia evaluation and follow-up will be conducted upon admission to and discharge from the post-anesthesia recovery unit (PACU) to evaluate the patient for proper anesthesia recovery. A post-anesthesia evaluation note will be documented in the patient's medical record by an individual qualified to administer anesthesia prior to discharge from the PACU.
4. The post-procedure evaluation note will include the patient's:
 - a. Physiological and mental status and pain level
 - b. Vital signs
 - c. Level of consciousness
 - d. Fluids administered during the procedure
 - e. Blood loss during the procedure
 - f. Blood products administered during the procedure
 - g. Any unusual events or post-operative complications
5. The post-anesthesia evaluation for discharge from the PACU shall include an evaluation of the patient who is recovered from anesthesia and ready for discharge from the PACU. The evaluation shall include evaluation of the patient's:
 - a. Respiratory function
 - b. Cardiovascular stability
 - c. Mental alertness
 - d. Pain control
 - e. Control of nausea and/or vomiting
 - f. Any complications of either the procedure or recovery
6. Patients shall be discharged from the recovery area and the Hospital by a qualified licensed independent practitioner or according to rigorously applied criteria approved by the clinical leaders. Post-operative documentation shall record the patient's

- discharge from the PACU and record the name of the individual responsible for discharge.
7. Patients who have received sedation or anesthesia in an outpatient setting shall be discharged to the company of a responsible, designated adult.
 8. When surgical or anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.
 9. General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical anesthetic procedures are considered lifesaving.

**MEDICAL STAFF JOB DESCRIPTIONS
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ARTICLE I. MEDICAL STAFF JOB DESCRIPTIONS

SECTION 1. PRESIDENT OF THE MEDICAL STAFF

The president of the medical staff reports directly to the Medical Executive Committee and the Board of Commissioners. He/She must also report to the CEO, as necessary.

A. Position Purpose

The president of the medical staff provides leadership and guidance to the medical staff and promotes effective communication among the medical staff, Medical Executive Committee, administration, and the Board of Commissioners.

The individual serves as the president of the medical staff of the organization and chairman of the Medical Executive Committee is responsible for:

1. Ensuring bylaw implementation
2. Securing and maintaining JCAHO accreditation;
3. Providing information to the Board of Commissioners concerning the care and treatment of patients; and
4. Facilitating positive relationships among administration, the medical staff and other organizational support services.

B. Accountability and Functions

As required by his or her office, the president of the medical staff must:

1. Coordinate the activities and concerns of administration, nursing services, and other patient care services with those of the medical staff;
2. Communication and represent the opinions, policies, concerns, need, and grievances of the medical staff to the Board of Commissioners, president of the organization, and other appropriate officials;
3. Enforce medical staff Bylaws, Rules and Regulations, Corrective Action and Fair Hearing Process, Organizational Rules.
4. Ensure the medical staff's compliance with procedural safeguards in all instances in which corrective action has been recommended in regard to the practitioner;
5. Call, preside at, and develop the agenda for all general medical staff meetings;
6. Serve as chair of the Medical Executive Committee, as an ex officio member of any Joint Conference with the Board of Commissioners, and as an ex officio member of all other medical staff committees; and

C. Position Requirements

This individual must:

1. Be an active physician member of the medical staff, having held that status for at least 4 years.
2. Be board certified or board admissible
3. Have prior experience as a department chair, credentials committee member/board member; Medical Executive Committee member, or in a similar medical staff leadership position; and
4. Have received out of hospital education and training in medical administrative activities and medical staff leadership.

In addition to the above requirements, the president of the medical staff may not, during his or her term of office, be a medical staff leader at any other hospital.

D. Recognition and Benefits

The president of the medical staff receives a stipend and the opportunity to participate in two external continuing education programs.

E. Occupational Hazards

The president of the medical staff should anticipate some degree of stress, significant practice disruption, and some degree of strain on professional relations and personal friendships. This position requires approximately eight to ten hours per week for committee meetings and related work. Due to the possibility of legal entanglements, the institution provides protection to the individual holding this position, in the form of indemnification and pledge to support the actions of the president of the medical staff – provided those actions relate directly to the performance of the functions described in this position description or other documents – such as when he or she advises the Board of Commissioners on specific competence-related issues.

SECTION 2. VICE-PRESIDENT OF THE MEDICAL STAFF

A. Reporting

The vice-president of the medical staff reports directly to the president of the medical staff and the Medical Executive Committee. However, the committee advises the Medical Executive Committee and the chair provides reports to relevant physician leaders. As a result it could become one of the most important advisory committees. He or she also reports to the CEO, when necessary.

B. Position Purpose

The vice-president of the medical staff provides continuity in leadership when the president of the medical staff is absent or otherwise unable to perform his or her assigned functions. The vice-president of the medical staff is expected to stay informed of all medical staff issues at all times.

The individual serves as the vice-president of the medical staff of the organization and chairman of the Quality Management Committee is responsible for:

1. Ensuring bylaw implementation
2. Securing and maintaining JCAHO accreditation;
3. Providing information to Medical Executive Committee, and Joint Conference concerning the care and treatment of patients; and
4. Facilitating positive relationships among administration, the medical staff and other organizational support services.

C. Accountability and Functions

The vice-president of the medical staff assists in performing any functions specified by the president of the medical staff, often for the Medical Executive Committee.

As a Medical Executive Committee member; this individual also serves as liaison between the Quality Management committee and the Medical Executive Committee. Specifically, the vice-president of the medical staff is required to attend chair all Quality Management Committee meetings and represent the findings and recommendations of the Quality Management Committee to the Medical Executive Committee.

D. Position Requirements

This individual must:

1. Be an active physician member of the medical staff, having held that status for at least 4 years;
2. Be board certified or board admissible;

In addition to the above requirements, the vice-president of the medical staff may not, during his or her term of office, hold a physician leadership position at any other organization.

E. Position Recommendations

1. Have received out of hospital education and training on medical administrative activities and physician leadership.

F. Recognition and Benefits

The vice-president of the medical staff receives a stipend and the opportunity to participate in two external continuing education events.

SECTION 3. QUALITY MANAGEMENT CHAIRMAN

A. Reporting

The medical staff quality management committee chair reports directly to the Medical Executive Committee and the Board of Commissioners.

B. Position Purpose

The quality management committee chair organizes, administers, and directs the medical staff's quality improvement and monitoring efforts. The quality management committee chair must ensure that the medical staff's quality improvement activities are in compliance with the hospital's quality improvement policies and activities and applicable laws.

C. Accountability and Functions

The medical staff quality management committee chair must:

1. Understand QI approaches and methods;
2. Provide leadership for measuring, assessing, and improving performance;
3. Chair the quality management committee, usually consisting of three to five physicians and a few non physician members, and direct them in:
 - a. Assuming responsibility for monitoring all medical staff performance and quality
 - b. Indicators and therefore, the quality of care provided by medical staff members;
 - c. Overseeing all peer review of Type 3 events, soliciting outside input as needed; and
 - d. Coordinating aggregation of data for three indicant categories, notifying the appropriate department chair and/or the Medical Executive Committee when Quality Management analysis or corrective action seems necessary;
 - e. Maintaining accurate and complete documentation concerning the entire quality improvement process, including quality monitoring reporting for medical records completion, patient care, utilization review, peer review files, etc.

4. Participate in multi-disciplinary initiatives to improve patient care and hospital functions that support patient care;
5. Work with hospital leaders to select the organization's annual performance improvement goals and discuss these goals with the medical staff; and
6. Provide mechanisms for effective communication between and medical staff, hospital administration and the Board of Commissioners.

D. Position Requirements

The vice-president, who must be an active member of the medical staff, having held that position for at least four years, holds the Quality management committee chair. Participation as a physician leader at any other institution is not permitted during the individual's term of office.

E. Position Recommendations

1. Have received out of hospital education and training on medical administrative activities and physician leadership.

F. Occupational Hazards

The quality management committee should anticipate the challenge of resolving difficult quality management issues, which are likely to require significant time and patience. The quality management committee chair should anticipate some degree of stress, significant practice disruption, and some degree of strain on professional relations and personal friendships. The position carries a slight risk of involvement in Corrective Action/Fair Hearing and peer review litigation. Should the organization be sued, based upon actions taken as a result of the quality management committee's recommendations, the quality management chair is protected by the indemnification provisions of the Board of Commissioners and by the fact that the organization has pledged to stand behind its physician leaders in such circumstances.

SECTION 4. MEDICAL STAFF DEPARTMENT CHAIRS

A. Reporting

Medical Staff department chairs report directly to the president of the medical staff and the Medical Executive Committee. They may also need to make additional reports to the Board of Commissioners and Administration, as necessary. Department chairs also periodically report to board subcommittees and to the entire medical staff.

B. Position Purpose

Each department chair acts as the primary medical administrative officer for his or her department. Department chairs are responsible for all administrative and medical activities occurring within their departments and must account for departmental performance – especially any identified problems.

C. Department Chairs are expected to:

1. Coordinate departmental activities with those of other organizational units.
2. Report to the Board of Commissioners, Administration, and nursing services for issues pertaining to or affecting the department.
3. Assist in the operation of the credentialing program, the budgeting process, and the administration of the department.
4. Develop collaborative relationships with hospital department managers and administrators.
5. Integrate the department service into the primary functions of the organization.
6. Coordinate and integrate the interdepartmental and intradepartmental services.
7. Recommend a sufficient number of qualified and competent persons to provide care, treatment and service.
8. Determine qualification and competence of department or service personnel who are not Licensed Independent Practitioners and who provide patient care, treatment and services.
9. Maintain quality control programs as appropriate.
10. Recommend space and other resources needed by the department or service.

D. Accountability and Functions

Department chairs report to the Medical Executive Committee and the president of the medical staff for all professional and administrative activities within their departments, particularly for the quality of patient care given by department physicians and for the performance of any patient care evaluations and monitoring functions that the quality committee delegates to their departments.

E. Each Department Chair Must:

Submit written reports to the Medical Executive Committee concerning:

1. The findings of the department's patient care evaluation and monitoring activities and any resulting actions.
2. Recommendations for maintaining and improving the quality of care provided in the department and the hospital, and
3. Any other matters that Medical Executive Committee considers appropriate for reports;
4. Develop and implement departmental programs, in cooperation with the president of the medical staff and certain committees, for
5. Evaluation of patient care,
6. Ongoing monitoring of clinical practice,
7. Credentials and privileges review,
8. Medical education, and

9. Utilization review
10. As a member of the Medical Executive Committee, provide input on medical policies of the hospital, and make specific recommendations regarding his or her own department;
11. Continuously review the performance of all practitioners with clinical privileges and specified services in the department, and regularly report the findings of such reviews to the president of the medical staff, the Medical Executive Committee, and the Quality Management Committee;
12. Transmit recommendations concerning clinical privileges, specified services, or Corrective Action/Fair Hearing with respect to practitioners in the department – to the appropriate authorities, as required by the bylaws;
13. Appoint and designate chairs for any committees that are necessary for conducting departmental functions;
14. Enforce hospital and medical staff bylaws, rules and regulations, and policies with the department, and initiate investigations of clinical performance or order consultations when necessary;
15. Implement any actions taken by the Medical Executive Committee and/or the Board of Commissioners within the department;
16. Participate in every phase of administration in the department such as cooperating with nursing services and administration in matters affecting patient care including personnel, supplies, special regulations, standing orders, and techniques;
17. Assist in the preparation of annual reports pertaining to the department, including budgetary planning reports, as required by the Medical Executive committee, the president of the hospital, or the Board of Commissioners;
18. Appoint an assistant department chair, if necessary, with the concurrence of the president of the medical staff; and
19. Perform any other duties as may be requested by the president of the medical staff, the Medical Executive Committee, or the Board of Commissioners.

F. Position Requirements

Each department chair must be an active physician member of the medical staff, having held the position for 4 years. Preference is given to those candidates who also have working knowledge of management techniques and/or have prior successful service within the medical staff structure.

The department chair may not, at any point during his or her term, be an officer or leader in any other medical staff organization.

Medical staff department chairs position will require a significant time commitment and possibly significant family and practice disruptions.

G. Recognition and Benefits

The department chair is entitled to use the services of the medical staff office for departmental support.

H. Occupational Hazards

Department chairs face potential legal involvement in matters pertaining to corporate negligence and antitrust. In response to such risk, the institution provides protection to individuals holding this position, in the form of indemnification and a pledge to support the actions of the department chairs – provided those actions relate directly to the performance of the functions described in this position description or other documents.

The time commitment this position demands is quite significant and may preclude development of personal practice plans. Sometimes, department chairs must participate in controversial or difficult issues that may result in a decreased number of referrals.

Medical staff department chairs position will require a significant time commitment and possibly significant family and practice disruptions.