

## **Medical Staff Bylaws**

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## DEFINITIONS:

- A. **ALLIED HEALTH PROFESSIONAL or AHP** means a person other than a licensed Physician, Dentist, or Podiatrist who is not employed by the Hospital, who exercises independent judgment within the areas of his/her professional competence and who is qualified to render direct or indirect medical, dental or surgical care under the supervision of an Active or Provisional Active Member of the Staff who has been accorded privileges to provide such care in the Hospital. Such AHPs shall include, but not be limited to clinical psychologists, advanced registered nurse practitioners, physician assistants, or physician extenders who provide services that are not otherwise provided by the Hospital, or who are approved by the Hospital.
- B. **YVMH BOARD or Board of Trustees** means the governing body of Yakima Valley Memorial Hospital.
- C. **BUSINESS DAYS** means Monday through Friday, excluding holidays.
- D. **BY-LAWS** means the By-Laws of the Staff of Yakima Valley Memorial Hospital.
- E. **YVMH CHIEF EXECUTIVE OFFICER (CEO)** means the person appointed by the Board to act on its behalf in the over-all administrative management of the Hospital.
- F. **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, podiatric, or surgical services.
- G. **DENTIST** means a fully licensed D.D.S. or D.M.D. as defined by Washington State Law, RCW 18.32.020.
- H. **HOSPITAL** means Yakima Valley Memorial Hospital (YVMH), 2811 Tieton Drive, Yakima Washington 98902.
- I. **LICENSE** means the license, certificate, or other legal credential authorizing a Practitioner to practice in the State of Washington.
- J. **MEDICAL EXECUTIVE COMMITTEE (MEC)** means the executive committee of the Staff.
- K. **MEDICAL STAFF or STAFF** means the formal organization of all licensed allopathic Physicians, osteopathic Physicians, Podiatrists and Dentists who are privileged to attend patients in the Hospital.
- L. **STAFF YEAR** shall mean January 1 - December 31. revised: 11/16/93
- M. **MEMBER** means any Physician, Dentist, or Podiatrist appointed and maintaining membership in any category of the Staff, in accordance with these By-Laws.
- N. **PHYSICIAN** means a person with an M.D. or a D.O. degree who is fully licensed to practice medicine in the State of Washington.
- O. **PODIATRIST** means a Podiatric Physician and Surgeon of the foot licensed to treat ailments of the foot, except: (a) amputation of the foot; (b) the administration of a spinal anesthetic or any anesthetic, which renders the patient unconscious, or the administration and prescription of drugs including narcotics, other than required to perform the services authorized for the treatment of the feet; and (c) treatment of systemic conditions. (As defined by Washington State Law, 18.22 RCW).
- P. **PRACTITIONER** means an appropriately licensed Physician with an unlimited license, or an appropriately licensed Dentist or Podiatrist, or appropriately licensed Allied Health Professional. When used in the "Fair Hearing Plan", the definition shall apply only to the individuals covered by the Plan.
- Q. **SPECIAL NOTICE** means written notification sent by certified mail, return receipt requested.
- R. **SPECIAL DEFINITIONS** are also located in the following areas:
  - A. Article X (Confidentiality, Immunity and Releases);
  - B. Fair Hearing Plan and Corrective Action Policy.

## **PREAMBLE**

(YVMH) WHEREAS, Yakima Valley Memorial Hospital Association is a nonprofit corporation organized under the laws of the State of Washington, and which operates Yakima Valley Memorial Hospital in Yakima, Washington.

WHEREAS it is recognized that one of the primary objectives of the Staff is to strive for quality patient care in the Hospital, and that the Staff must work with and is subject to the ultimate authority of the Board, and that the cooperative efforts of the Staff, Administration and Board are necessary to fulfill the Hospital's primary objective of providing quality care to its patients,

THEREFORE, the Physicians, Dentists, and Podiatrists practicing in the Hospital hereby organize themselves into a Staff in conformity with these By-Laws.

## **ARTICLE I - NAME**

The name of this organization shall be the Yakima Valley Memorial Hospital Medical Staff Medical Staff.

## **ARTICLE II – DURATION**

The duration of the Staff shall be perpetual.

## ARTICLE III – PURPOSES & RESPONSIBILITIES

### A. **Purposes:** The purposes of the Staff are:

1. To be the formal organizational structure through which (1) the benefits of membership on the Staff may be obtained by individual Practitioners and (2) the obligations of Staff membership may be fulfilled.
2. To serve as the primary means for the accountability to the Board for the appropriateness of the professional performance and ethical conduct of its members and the Allied Health Professionals and to strive toward the continual upgrading of the quality and efficiency of patient care delivered in the Hospital consistent with the state of the healing arts and the resources locally available.
3. To provide a means through which the Staff may participate in the Hospital's policy-making and planning processes.
4. To provide quality health care to all patients admitted to or treated in any of the facilities, departments or services of the Hospital.

### B. **Responsibilities:** The responsibilities of the Staff, to be carried out by its officers, departments, and committees on behalf of the hospital, acting at times and under certain circumstances as 'Professional Review Bodies,' as that term is used in the Health Care Quality Improvement Act of 1986, are generally to:

1. Implement and conduct the following specific activities to supervise the quality and efficiency of patient care provided by all Practitioners authorized to practice in the Hospital through the following measures:
  - a. Review and evaluation of the quality of patient care through a valid and reliable Quality Management Program.
  - b. On going monitoring of selected patient care practices through defined mechanisms and Staff organizational components.
  - c. Credentials evaluation, including mechanisms for appointment and reappointment and the matching of clinical privileges to be performed with the verified credentials and current demonstrated performance of the applicant, Member, or AHP.
  - d. Continuing education programs, fashioned at least in part on the needs demonstrated through the quality review, evaluation and monitoring programs.
  - e. Utilization review to allocate inpatient medical and health services based upon patient specific determinations of individual medical needs.
2. Recommend to the Board programs for the establishment, maintenance, continuing improvement and enforcement of professional standards in the delivery of health care within the Hospital.
3. Account to the Board for the quality and efficiency of patient care through regular reports and recommendations concerning the implementation, operation and results of the quality review, evaluation and monitoring activities.
4. Initiate and pursue corrective action with respect to Practitioners, when warranted.
5. Develop, administer, recommend amendments to, and seek compliance with these By-Laws, the rules and regulations of the Staff and other Hospital policies.
6. Assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.
7. Exercise the authority granted by these By-Laws as necessary to adequately fulfill the foregoing responsibilities.

**C. Capacity:** Members of the Staff who serve in leadership capacities representing the individual members of the Staff do so on behalf of the hospital.

## ARTICLE IV - MEMBERSHIP

### A. Nature of Membership.

Membership on the Staff of Yakima Valley Memorial Hospital is a privilege, which shall be extended only to licensed, professionally competent allopathic Physicians, osteopathic Physicians, Podiatrists, and Dentists who continuously meet the qualifications, standards, and requirements set forth in these By-Laws and the rules and regulations of the Staff. Licensure is not required of U.S. Public Health Service Officers who are exempted from licensure under Washington State law. [rev 3/2005]

### B. Qualifications for Membership.

1. Only doctors of Medicine, Osteopathy, Dentistry and Podiatry licensed to practice in their respective fields in the State of Washington who can document their background, experience, training and judgment, individual character and ability to work with others shall be qualified for membership. Each Member shall have such mental capabilities and shall adhere to the ethics of his/her profession with the sufficient adequacy as to assure the Staff and the Board that any patient treated by him/her in the Hospital will be given high quality medical care, and shall otherwise be qualified for membership on the Staff. No Physician, Podiatrist or Dentist shall be entitled to membership on the Staff or particular clinical privileges in the Hospital merely by virtue of licensure to practice medicine, osteopathy, podiatry or dentistry in this or in any other state, or of privileges at another hospital.
2. Acceptance of membership on the Staff shall constitute the Member's agreement to strictly abide by the Principles of Medical Ethics of the American Medical Association, the ethics of the American Podiatric Medical Association, the Principles of Medical Ethics of the American Osteopathic Association or by the Code of Ethics of the American Dental Association, whichever is applicable, and by the ethical standards of other appropriate professional organizations. Each member of the Staff pledges not to receive from or pay to another Physician, Podiatrist or Dentist, or to any other person, either directly or indirectly, any part of a fee received for professional services. This pledge is not intended to prohibit reasonable arrangement for compensation of a hospital-based Physician. [rev 3/2005]
3. No applicant shall be denied Staff membership or clinical privileges based on age, sex, race, religion creed, color, or national origin, or based on any other criterion lacking professional justification.
4. In accordance with the policy of the Board, each Member of the Staff who admits or treats patients in the Hospital shall have professional liability insurance coverage and provide written evidence of such coverage to the CEO. The minimum limits of such insurance shall be determined from time to time by the Board.

### C. Conditions and Duration of Appointment.

1. Initial appointments and reappointments to the Staff shall be made by the Board. The Board shall act on appointments, reappointments, denial of appointments, or revocation of appointments only after there has been a recommendation from the Staff as provided in the Credentialing Policy and Procedure Manual; PROVIDED that in the event of unwarranted delay on the part of the Staff, the Board may act without such recommendation on the basis of documented evidence of the applicant's or Member's professional or ethical qualifications obtained from reliable sources other than the Staff.
2. Initial appointments in the Patient Care Categories are to the Provisional Staff and the AHP category and shall be provisional for one year from the date of appointment.
3. Appointment to the Staff shall confer to the appointee only such clinical privileges as have been granted by the Board in accordance with these By-Laws.
4. Reappointment to the Staff shall be required of an initial appointee by the end of his/her first full

Staff year. Otherwise, each Staff Member must be considered for reappointment to the Staff at least every two (2) years.

5. As a condition of initial and continued appointment to the Staff, Practitioners agree:
- a. To be free of or have under adequate control any physical or mental health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to satisfy the following qualifications:
    - (1) Appropriate training, current experience, clinical results and utilization practice patterns, documenting a continuing ability to provide patient care services at an acceptable level of quality and efficiency given the current state of the healing arts in Washington and consistent with available resources.
    - (2) Ability to work cooperatively with others in the hospital environment, specifically to include refraining from conduct that over time constitutes a pattern of disruption such as to adversely affect the quality or efficiency of patient care services in the Hospital(s).
  - b. To be free from abuse of any type of substance or chemical that affects cognitive, motor or communication ability in a manner that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to satisfy the qualifications of (a) 1. and (a) 2.

In demonstrating satisfaction of the foregoing qualifications, a practitioner may, when a reasonable cause to believe such a problem exists or knowledge of a problem exists, be required to provide such information or to obtain such examinations or tests as may reasonably be requested by an officer of the MEC and the CEO or his/her designee. In addition, a practitioner may be required to submit to random on-the-spot testing on the basis of physical manifestations on the job, or when reasonable cause to believe such a problem exists, or as follow-up of concurrent monitoring of participation in a treatment program.

The results of any such psychiatric or physical examination, or chemical/substance abuse testing shall be confidential and shall initially be considered in closed session by a Committee which shall consist of the officers of the MEC and the CEO or his/her designee as a representative of the Hospital Board. It shall be left to the discretion of this Committee to discuss with the MEC and the Hospital Board those results of the afore-mentioned examinations and/or testing which are deemed necessary to maintain quality patient care.

6. [Section 6 added 1/1997; rev. 6/00; rev. September 2011)

- a. Continuous Patient Care: Each ~~Provisional Active~~ and Active Staff Member shall provide for the continuous care of his/her own and assigned patients [see definition in paragraph 6.c. below] in the hospital, either by him/herself or by other appropriate Provisional Active or Active Staff members by prior mutually acceptable arrangements. In case of failure to provide for continuous care, the Chairperson or his/her designee of the Department concerned, and, if unavailable, then the Vice-President of the Medical Staff or his/her designee should be contacted. The President of the Medical Staff or Chairperson of the Department concerned, or their designee shall have the authority to call any Member of the Provisional Active or Active Staff to attend the patient.
- b. On-Call Obligations: Each ~~Provisional Active~~ and Active Staff Member shall, as a condition of appointment and reappointment, agree to participate in either Medical back-up on-call or Specialty call for the care of unassigned or assigned patients (see definition in paragraph 6.c.) for whom coverage is not immediately available admitted to the Emergency Departments or as in-patients. Members of the Medical Staff older than 62 years of age will not be required to take call but do have the option of remaining on the call roster. In the event of unusual situations when the on-call physician in that specialty is occupied with a concurrent emergency, then the requesting physician, after talking to the on-call physician, may need to call the Chairperson of the Department or his/her designee or the on-call physician to arrange for coverage and, if the Department Chair is unavailable, then the on-call physician may contact the President of the Medical Staff or designee. All members of the Medical Staff shall be expected to provide urgent and emergent care in the Hospital as required upon direction of the following individuals or their designee: the Chairperson of the Department concerned. If the Chairperson is not available, then this duty falls to the President of the Medical Staff or his/her designee.

On Call Responsibilities include:

(1) On-call physicians shall be available to respond in a timely manner. It is generally expected that physicians will respond within 30 minutes of initiation of the paging protocol, assuming the paging system in the community is operational. If the paging system is not operational, then an attempt to contact the on-call physician should be made through the office phone, hospital, cellular phone and/or home phone.

(2) A standardized nomenclature and appropriate response time for each type of call (e.g. stat, urgent, routine, consult, FYI) shall be determined by the Medical Executive Committee [*standardized nomenclature approved 10/17/00*] and disseminated to the Members of the Medical Staff and to all Hospital ward and Emergency Department personnel.

- Stat – Patient's life or limb is in jeopardy and patient needs to be seen immediately
- Urgent – Patient needs to be seen within the hour for a condition that may deteriorate to threaten life or limb
- Routine – Patient needs to be seen based on communication between the ER physician and consultant

(3) On-call response shall be determined by the physician making the request, not the on-call physician's evaluation of the need to respond. If the on-call physician disagrees with the requesting physician on the need to respond, the on-call physician shall still respond.

If, after evaluation of the patient, the on-call physician still believes that the call for physical presence was unnecessary, he/she may write a letter of concern to his/her department chairperson and to the department chairperson of the requesting physician. An answer from the department chairperson shall be transmitted back to the on-call physician within two months. If the answer does not satisfy the complainant, he/she may next contact the

chairperson of the two involved departments and the Vice-President of the Medical Staff to discuss the issue. If there is still no resolution, then it will be forwarded to the MEC.

(4) It is recognized that concurrent emergency response to another patient (medical or surgical) may delay or prohibit the physical response of the on-call physician. The on-call physician shall help arrange by verbal response an alternative plan of care, diversion or transfer of the patient.

(5) Neither financial ability of the patient nor the means of payment shall be considered by the on-call physician in the decision to respond, treat, or transfer the patient.

~~(6) In an under-represented specialty, or specialized on-call service, a physician may have reduced on-call responsibilities as determined by the MEC. The definition of an under-represented specialty is any specialty or sub-specialty with a total number of two or less physicians. While it is understood that a physician in an under-represented specialty may have increased on-call responsibilities, no physician shall be required to have more than ten call days per month. Where this policy results in uncovered time segments in the on-call schedule, all patients presenting during the uncovered segments and requiring the services of that specialty will be transferred or diverted as needed to another appropriate facility consistent with the hospital's patient transfer policy. It is the responsibility of each under-represented specialty to have a call schedule in place and any physician who is not scheduled may voluntarily respond to an emergency if he/she is available. Physicians in an under-represented specialty will help arrange, by verbal response, an alternative plan of care, diversion or transfer of the patient, if the need arises.~~

Each physician will be required to take four days of call each month, unless the number of physicians in the specialty is such that full Emergency Department coverage can be achieved with less. When this policy results in uncovered time segments in the on-call schedule, all patients presenting during the uncovered segments and requiring the services of that specialty will be transferred or diverted as need to another appropriate facility consistent with the hospital's patient transfer policy. (Added September 2011)

(7) In the event a staff physician requests consultation of the on-call physician, the requesting physician should directly communicate with the consultant to transfer pertinent clinical information.

c. Definitions:

**Assigned Patients** are individuals with a private physician or healthcare coverage, which has empanelled, contracted, or participating appropriate Provisional Active or Active Staff members.

**Unassigned Patients** are those individuals that do not have a private physician or healthcare plan or have healthcare coverage that does not have empanelled, contracted, or participating appropriate Provisional Active or Active Staff members.

d. Medical Back-up On Call: This call group shall consist of ~~Provisional Active~~ or Active Staff members of the Family Medicine and Internal Medicine Departments available to serve as admitting physicians for unassigned patients. Certain members of the Family Medicine and Internal Medicine Departments may be excused from the Medical Back-up call group in order to serve in Specialty call groups by agreement of the Chairpersons of the Family Medicine and Internal Medicine Departments with concurrence of the M.E.C.

e. Specialty Call: ~~Provisional Active~~ or Active Staff members of the following specialty/sub-specialty departments will participate in appropriate on-call care for unassigned patients in the ED and in-patient units. On-call lists for the following departments will be maintained: Anesthesia, Cardiology, ~~CV/Thoracic Surgery~~, Dentistry, Family Medicine Gastroenterology, Hematology/Oncology, ~~Hand~~, Hospitalists Nephrology, Neurology, Neurosurgery, ~~Nuclear Medicine~~, Ophthalmology, ~~Oral/Maxillofacial Surgery~~, Orthopedics, Pain Medicine, Pediatric Hospitalists, ~~Pediatrics~~, Otolaryngology, Ob/Gyn, Pediatrics,

Neonatology, Physical Medicine/Rehabilitation, Plastic Surgery, Psychiatry, Pulmonary Medicine, Radiation Oncology, Radiology/Nuclear Medicine, Surgery [General], Urology and vascular surgery. Other specialty call groups may be added or deleted by the M.E.C. based on Medical Staff membership.

- f. On-Call Residence: Each member of the Provisional Active or Active Staff must reside or maintain an on-call residence ~~within 15 miles of the Hospital or a shorter distance as required by the departments, Medical Staff By-Laws or government regulations~~ which allows them to physically be present within 30 minutes of an emergency request.
- g. Conformance with State and Federal Regulations: It is the express intent of the Medical Staff to be in compliance with applicable state and federal laws, rules, and regulations, including but not limited to, emergency care defined by the COBRA EMTALA provisions, and designated trauma center requirements. Furthermore, Medical Staff privileges shall be contingent on compliance with applicable state and federal regulations.

In the event of a conflict between state and federal laws, rules and regulations regarding emergency treatment and the call coverage requirement, the Hospital and the Medical Staff member shall work together to come up with a mutually acceptable on call schedule for the Medical Staff member that is in compliance with state and federal laws.

7. A Member accepts the commitment to:

- a. Permit evaluation of his/her performance by peer review;
- b. Participate in the process of evaluation;
- c. Participate in the continuing education process identified by the evaluation.
- d. Provide evidence of renewed licensure, DEA registration (if applicable), and professional liability insurance coverage prior to the expiration date of the same. In addition, the applicant agrees to immediately notify the CEO at any time there is a change made or proposed to the above. *(revised: 06/15/93)*
- e. Provide change of address and phone numbers as well as call group members as changes occur. *[added 3/2005]*
- f. Agrees to abide by the terms of the Bylaws and related manuals and other policies of the Staff and those of the Hospital(s) if granted appointment and/or clinical privileges and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or privileges are granted. *[added 1/2009]*

## ARTICLE V

### CATEGORIES OF THE STAFF

#### A. Patient Care Categories

Physicians, Dentists and Podiatrists who are qualified for Staff Membership shall belong to the Active, Provisional, Courtesy, Consulting or Resident Staff if they are involved in patient care in the hospital. All practitioners in these categories will be appointed on a provisional basis for the first year, during which time they are required to satisfy the proctoring requirements of their department.

Determination for reappointment to particular Staff categories may in part depend upon the number of patient care contacts as determined by the M.E.C. If Practitioners in these categories have more than the maximum or less than the minimum required during any calendar year, the Practitioner's file will be reviewed by the Credentials Committee and recommendations made to the Governing Bodies. His/her staff status will be determined at the discretion of the Board. The definition of patient contacts shall include the following:

- Admission of patient to the hospital as attending Practitioner
- Operating on another Practitioner's patient.
- Assisting on a procedure.
- Consultation on another Practitioner's patient.
- Giving anesthesia to another Practitioner's patient.
- Performance or interpretation of a procedure involving direct contact of the patient of another Practitioner
- Working a shift as an Emergency Department Physician.
- Attending another Practitioner's patient or patients one or more times during a hospitalization (i.e. making rounds).

No Physician can accumulate more than one contact per patient per admission. The Practitioner shall have the responsibility of verifying the number of patient contacts in the above categories.

#### 1. **Active Staff.** (rev.06/99)

The Active Staff shall consist of Physicians, Dentists, and Podiatrists who are in active practice and who regularly care for patients in the Hospital. He/she shall be able to provide continuous care to patients, as outlined in Article IV, C.6., and shall have been a member of the Provisional Staff for at least one (1) year. The Active Staff shall be responsible for the transaction of all the business of the Staff and for the proper quality of all medical care and treatment in the Hospital. Active Staff members shall be eligible to vote, hold office and serve as chairpersons of Staff committees. They shall be required to attend meetings in accordance with these By-laws, and to pay annual membership dues and/or assessments when due.

#### 2. **Provisional Staff.** revised: 06/15/93

The Provisional Staff shall consist of Physicians, Dentists and Podiatrists newly appointed who seek membership on the Active or Courtesy Staff. He/she shall be assigned membership in at least one department, but may request clinical privileges or specified services within any Department. He/she shall be subject to the rules and regulations of that Department and the authority of that Department Chairperson. He/she shall agree to participate in the proctoring mechanisms as outlined by his/her department. The Department Chairperson, following review of the appointee's privilege requests, shall determine if the Physician, Dentist or Podiatrist should be required to fulfill the obligations of Active Staff membership, including but not limited to: use of co-admitter back-up staffing, meeting attendance and voting privileges, and payment of dues and/or annual assessments. Provisional Members with a call residence greater than 15 miles from the hospital must have an Active Staff Member who agrees to the admission of each patient admitted by the Provisional Staff Member, and who is responsible for the care of the patient when the Provisional Member is unavailable.

All Provisional Members shall participate in quality management activities as requested by their Department Chairperson or the MEC.

Following completion of the Provisional period, a written request must be made for a change in staff status to the Active or Courtesy Staff. No Member shall serve on the Provisional Staff for more than two (2) consecutive years.

### 3. **Courtesy Staff.**

The Courtesy Staff shall consist of Physicians, Dentists, and Podiatrists who only occasionally admit patients: [rev. 09/02]

#### **Qualifications: Courtesy staff members shall:**

- a. only occasionally be involved in patient care in the Hospital (current level 4-20 patient care contacts\* in a two (2) year period); and  
(\*contacts=admission, consultations, surgery or rounding on patients. On any specific hospitalization these will count as one patient contact per patient) [changed 1/2007]
- b. have Active Staff privileges at another hospital fully participating in back-up staffing (to include emergency room call) and QA activities there. (see "B" under "Responsibilities" for exceptions.)

#### **Responsibilities:**

- a. Courtesy Staff members must arrange coverage at all times by an Active Staff member or another courtesy Staff Member in the same department when the Courtesy Staff Member is not available. The available physician must have similar training and privileges for the specialty care to be provided. [changed 01/2007]
- b. Courtesy Staff members must either be on another hospital's Active Staff or participate in back-up staffing (to include emergency room call) for YVMH as determined by the Department Chairperson and the MEC. [See Article IV.C.(6).] The specific criteria for back-up exemptions are:
  - (1) The physician is on an outside Active hospital Staff fully participating in QA activities and back-up staffing.
  - (2) The physician is engaged in a specialty field, which does not warrant call coverage as determined by the MEC.
  - (3) Upon physician written request, as approved by the MEC who shall request and consider the Department Chairperson's recommendation.
- c. Courtesy Staff Members will participate in quality management activities.
- d. Courtesy Staff Members shall pay annual membership dues and special assessments when due.

#### **Prerogatives:**

- a. Courtesy Staff members shall not be eligible to vote or hold office.

### 4. **Consulting Staff** [added 7/99]

Consulting Medical Staff status is established for those medical practitioners of recognized ability, who are not members from another category of the Medical Staff, such as Active or Courtesy, who may be called in for consultation or assistance by any member of the Medical Staff. [rev 4/02]

#### **Qualifications**

- a. Shall be appointed to a specific Department.
- b. Shall be in good standing on the active staff of another hospital OR
- c. Engaged in clinical practice in a specialty not required to maintain specialty call coverage by these By-laws of the medical staff. [rev 4/02]

#### **Responsibilities:**

- a. Consulting Staff may only attend patients who are under the active care of an Active

Medical Staff Member who has admitting privileges for the duration of the specific consultation for which they were called. (0-20 patient contacts every two years.) [rev 12/2004]

- b. Consulting Staff may not admit patients but may write or give verbal orders within the scope of their privileges. [rev 12/2004]
- c. Consulting Staff will participate in quality management activities, as requested by their Department Chairperson or the MEC.
- d. Consulting Staff Members shall pay annual membership dues and special assessments when due.

**Prerogatives:**

- a. Consulting Staff Members shall not be eligible to vote at the Department or staff level, however, can attend appropriate department and Staff meetings including social functions. [rev 04/02]

**5. Resident Staff.** revised: 06/15/93

The Resident Staff shall consist of those Physicians practicing in the Hospital in a training status. They shall have no vote, pay no dues, and they may not hold office. A Resident Staff Member may admit and treat patients, and write orders only when clearly acting under the supervision of a Physician who is on the Active Staff or a Provisional Active Member who has completed the proctoring requirements set forth by his/her Department. Licensure requirement should be determined by their particular residency program and in compliance with the State of Washington. Resident Staff membership shall be terminated upon completion of the training program, or at any time by the Board upon recommendation of the MEC.

**B. Non-Patient Care Categories**

Physicians, Dentists, and Podiatrists who are qualified for Staff membership shall belong to the Educational, Emeritus, Inactive, or Administrative Staff if they are not involved in patient care in the Hospital. They are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital. They may attend any Staff or Hospital educational meeting but shall attend staff, departmental, or committee meetings only with the Chairperson's permission. They shall not be eligible to vote or to hold office in the staff organization. [rev 04/02]

If a Member of the Educational, Emeritus, or Administrative non-patient care category desires to become a Member of a patient care category, he/she must join the Provisional Staff and have all requests for privileges recommended and approved by the Credentials Committee and the Board. (revised 1/95)

**1. Educational.** [rev 04/02]

Shall consist of Physicians, Dentists, and Podiatrists in this community or surrounding area who ordinarily refer patients to members of the Staff, but who only desire to participate in hospital and Staff educational programs. Educational Staff members may use the library facilities of the hospital. Educational Staff may attend medical staff meetings only with the permission of the Chair. Educational Staff generally do not attend medical staff social functions. Educational staff members shall be assessed annual dues as set by the MEC.

Any member of the Active Staff in good standing may, upon retirement from Active Staff, apply for educational staff status. Educational members need not maintain professional licensure or malpractice insurance.

**2. Emeritus.** [rev 04/02]

Shall consist of Physicians, Dentists, and Podiatrists who have retired from active practice and who have provided extensive and meritorious services to the Medical Staff, Hospital(s), or Community over an extended period of time. Appointment to the Emeritus Staff shall be on the basis of three (3) of the following criteria:

1. 15 or more years in good standing on the Active Staff.
2. Served as a Department Chairman.
3. Served as a Medical Staff Officer.
4. Exemplary record of community service.
5. Recommendation by the Medical Executive Committee.

Emeritus members are not eligible for clinical privileges but shall abide by all confidentiality rules of the medical staff.

Emeritus members need not maintain professional licensure or malpractice insurance.

Emeritus members may attend medical staff meetings, CME activities, and medical staff social events.

Emeritus members may participate as members of committees of the Medical Staff not otherwise limited to Active Staff members provided the Emeritus member has been requested to do so by a Department or Committee Chairman and authorized to do so by the Medical Staff President.

Emeritus members shall not hold office, vote in Medical Staff elections, or pay dues.

**3. Inactive.** (rev. 6/99)

Shall consist of members of the Staff who, because of prolonged illness, military service, sabbatical leave or other conditions of reasonable validity request they be transferred to inactive status by submitting a written request for a Leave of Absence in accordance with the Leave of Absence Policy. No member may be in this category for more than two (2) years.

**4. Administrative.** (added: 02/03/92)

Shall consist of Physicians, Dentists, or Podiatrists who may serve in an administrative position such as Medical Director or Quality Assurance Director and who are not involved in direct patient care in the hospital.

## ARTICLE VI

### STAFF CLINICAL DEPARTMENT

- A. Organization of Departments.** Each department shall be organized as a separate part of the Staff and shall have a chairperson who is selected, and has the authority, duties, and responsibilities as specified in Article VI.F.
- B. Designation.** The current clinical departments are listed in the Staff Organizational Manual. The specialties assigned to these Departments are listed in the specific Rules for that Department and the Staff Organizational Manual. (revised 1/95; rev 3/2005).

When deemed appropriate and consistent with the provisions of Section E of this Article VI, the MEC, with the approval of the Board, by their joint action, may create new departments or eliminate, subdivide, further subdivide, or combine departments.

- C. Assignments to Departments.** Each Member of the Staff and each AHP shall be assigned, through the credentialing process, membership in at least one department, but may be granted membership and/or clinical privileges or specified services in one or more of the other departments. The exercise of clinical privileges or the performance of specified services within any department shall be subject to the rules and regulations of that Department and the authority of the Department Chairperson.
- D. Functions of the Department.** The primary responsibility delegated to each Department is to implement and conduct specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care provided in the department. To carry out this responsibility each Department shall:
1. Follow the Hospital-wide Quality Plan for the purpose of analyzing, reviewing and evaluating the quality of care within the Department, by participating in the appointed Quality Committees to investigate retrospectively any specific incidents or any Physician's performance in the Hospital. (The proceedings, reports, and written records of the Committee are protected from discovery by R.C.W. 4.25.250.). Each Department shall review all clinical work performed by the Members of that Department. Each Medical Staff Department is responsible for follow through and recommending action to be taken regarding members of their Department following review of care by either their Department or other Departments of the Staff. (revised 08/03/92; 1/95); [rev 3/2005]
  2. Establish guidelines for the granting of clinical privileges and the performance of specified services within the department and submit the recommendations required in accordance with the Credentialing Policies and Procedures regarding the specific privileges each member or applicant may exercise and the specific services each AHP may provide.
  3. Conduct or participate in, and make recommendations regarding the need for, continuing education programs pertinent to changes in the state-of-the-art and to findings of review, evaluation, and monitoring activities.
  4. Monitor, on a continuing and concurrent basis, adherence to:
    - a. Staff and hospital policies and procedures;
    - b. Requirements for alternate coverage and for consultations;
    - c. Sound principles of clinical practice to assure provision of quality and appropriate patient care by all individuals with clinical privileges.
  5. Coordinate the patient care provided by the department's members with nursing and ancillary patient care services and with administrative support services.
  6. Submit written reports to the MEC on a regularly scheduled basis concerning:
    - a. Findings of the department's review, evaluation and monitoring activities, actions taken thereon, and the results of such action;

- b. Recommendations for maintaining and improving the quality of care provided in the department and the Hospital; and
  - c. Such other matters as may be requested from time to time by the MEC.
7. Meet at least once each quarter during each Staff year for the purpose of receiving, reviewing, and considering Quality Management activities and the results of the department's other review, evaluation and monitoring activities and of performing or receiving reports on other department and Staff functions. (revised: 06/15/93)
  8. Establish such committees or other mechanisms as are necessary and desirable to properly perform the functions assigned to it.

**E. Modification in Clinical Organization Unit.** In creating, eliminating, subdividing, or combining departments, sections, or any other clinical organization units that may exist or be contemplated, the following guidelines shall be followed:

1. **Creation of Subdivision:** A sufficient number of Practitioners are available for appointment to and will be appointed to and/or actively participate in the new organizational component to enable accomplishment of the functions generally assigned to such components in these By-Laws and Rules and Regulations, and the patient or service activity to be associated with the new component is substantial enough to warrant imposition of the responsibility to accomplish those functions.
2. **Eliminations:** The number of Practitioners available is no longer adequate and will not be so in the foreseeable future to accomplish assigned functions where the patient or service activity associated with the component to be dissolved is no longer substantial enough to warrant imposition of the responsibility to accomplish those assigned functions.
3. **Combination:** The union of the two or more organizational components will result in more effective and efficient accomplishment of assigned functions and the patient or service activity to be associated with the combination is substantial enough, without being unwieldy, to warrant imposition of the responsibility to accomplish those assigned functions.

In all instances of modification, the Hospital's written plan of development as currently being implemented and any constraints or mandates imposed by external planning authorities shall also be considered.

**F. Department Chairperson.** Each Chairperson shall be 1) a Member of the Active Staff, 2) shall have demonstrated an ability in at least one of the clinical areas covered by the department, 3) shall be willing and able to faithfully discharge the functions of his/her office; and 4) shall be certified by an appropriate specialty board, or affirmatively have established, through the privilege delineation process, that he/she is possessed of comparable competence. (revised 1/95); [rev 3/2005]

1. **Selection and Appointment.** Each Chairperson shall be appointed by the members of their Department, in a manner determined by the department, for a minimum of a one-year term. A Chairperson may be reappointed for as many years as agreeable to the Department members so long as he/she is carrying out the duties and responsibilities provided in these By-Laws to the satisfaction of the Members of the applicable Department, of the MEC, and of the Board. [revised 9/01]
2. **Removal.** Removal of a Chairperson during his/her term of office may be initiated by a vote of two-thirds of all Active Staff Members of the Department, but no such removal shall be effective unless and until it has been ratified by the MEC and the Board.
3. **Duties.** Each Chairperson shall:
  - a. Be accountable to the MEC and the Staff President for all professional and administrative activities within the department, and particularly for the quality of patient care rendered by members of the department and for effective conduct of the Quality Management activities including review, evaluation and monitoring functions delegated to the department

and for proctoring of Staff members.

- b. Develop and implement departmental programs in cooperation with the President of the Staff, and consistent with these By-Laws, for Quality Management activities, ongoing monitoring of practice, credentials review and privileges delineation, medical evaluation, and utilization review.
- c. Be a member of the MEC, give guidance on the overall medical policies of the Hospital, and make specific recommendations and suggestions regarding his/her own department.
- d. Maintain continuing review of the professional performance of all Practitioners with clinical privileges and of all AHPs with specified services in the department and report regularly thereon to the President of the Staff and to the MEC.
- e. Transmit to the appropriate authorities' recommendations concerning appointment and classification, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to Practitioners in the department.
- f. Appoint such committees as are necessary to conduct the functions of the department and designate a chairperson and secretary for each.
- g. Enforce the Hospital and Staff By-Laws, Rules, policies, and regulations within the Department, including initiating corrective action and investigation of clinical performance and ordering consultations to be provided or to be sought when necessary.
- h. Implement within the department actions taken by the MEC and by the Board.
- i. Participate in every phase of administration of the department through cooperation with the nursing service and Hospital administration in matters affecting patient care, including personnel, supplies, special regulations, standing orders, and techniques.
- j. Assist in the preparation of such annual reports, including budgetary planning pertaining to the department as may be required by the MEC, the President of the Staff or the Board.
- k. Perform such other duties commensurate with his/her office as may from time to time be reasonably requested by the President of the Staff, the MEC, the CEO, or the Board.
- l. Be responsible for further evaluation of case referrals from the Quality Management Department, including documentation of care, action taken, and recommendations made.
- m. Be responsible for making appropriate proctoring assignments for Staff Members.
- n. Be a member of the Quality Management Executive Committee.
- o. Assess and recommend to the relevant hospital authority off-site sources [such as reference labs] for needed patient care services not provided by the department or organization. (added 12/1998)
- p. Be responsible for the orientation of all Department members. The Department Chairperson shall also be responsible to facilitate appropriate CME activities for Department members. (added 12/1998)
- q. Be responsible for providing to the Board, by and through its appointed Medical Staff Development Committee, recommendations on the number and specialty-types of Practitioners and AHPs which shall be eligible to apply for privileges in the Hospital(s). (added 12/1998)

## ARTICLE VII OFFICERS

### A. General Officers of the Staff.

1. **Identification.** The general officers of the Staff shall be:
  - a. President
  - b. Vice-President
  - c. Secretary/Treasurer
2. **Other Officials of the Staff.** Other officials of the Staff may include a medical director, department chairpersons, a director of medical education, and such other officials as may be selected pursuant to these By-Laws. To the extent that any such official performs any clinical function, he/she must become and remain a Member of the Staff. In all events, he/she is subject to these By-Laws, the Staff rules and regulations and all other lawful policies of the Hospital.
3. **Qualifications.** General officers must be members of the Active Staff at the time of nomination and election and must remain Members in good standing during their term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. The President and Vice-President must be Practitioners with demonstrated competence in their respective fields of practice and demonstrated qualifications on the basis of training, experience and ability to direct the medico-administrative aspects of hospital and Staff activities.
4. **Nominations.** The Nominating Committee shall consist of the three general officers of the Staff and three active staff Members appointed by the President. The committee shall offer one or more nominees for election to each office. Nominations may also be made from the floor at the annual meeting of the Staff.
5. **Election.** The Secretary/Treasurer shall be elected at the annual meeting of the Staff each year. Only Staff Members accorded the prerogative to vote for general Staff officers under these By-Laws shall be eligible to vote. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast and subject to approval by the Board. If no candidate for the office received a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.
6. **Succession.** The Vice-President shall, upon the completion of his/her term of office in that position, immediately succeed to the office of President. Similarly, the Secretary-Treasurer will serve one term as Secretary- Treasurer, one term as Vice-President, and one term as President.
7. **Term of Elected Office.** Each officer shall serve a one-year term, commencing on the first day of the Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign, or be removed from office.
8. **Removal of Elected Officers.** Except as otherwise provided, removal of a general Staff officer may be initiated by the Board, acting upon its own initiative, or by a two-thirds vote of the Members of the Staff eligible to vote for Staff officers. Removal may be based only upon failure to perform the duties of the position held as described in these By-Laws.
9. **Vacancies in Elected Office.** Vacancies in offices, other than those of President, Vice-President, and Secretary/Treasurer shall be filled by the MEC. If there is a vacancy in the office of President, the Vice-President shall serve out the remaining term as well as his/her subsequent term of office. A vacancy in the office of Vice-President shall be filled by the

Secretary-Treasurer who shall also serve out his/her subsequent term of office. A vacancy in the office of Secretary-Treasurer shall be filled by a special election conducted as reasonably soon after the vacancy occurs as possible following the general mechanism outlined hereinabove. [6/00]

## **B. Duties of General Officers.**

- 1. President:** The President shall serve as Chief of Staff of the Hospital, and shall:
  - a. Coordinate the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the Staff.
  - b. Be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and performance within the Hospital and for the effectiveness of quality management functions delegated to the Staff by means of regular reports and recommendations based on the results of these activities.
  - c. Communicate and represent the opinions, policies, concerns, needs, and grievances of the Staff by means of regular reports and recommendations based on the results of these activities.
  - d. Be responsible for the enforcement of Staff By-Laws, Rules and Regulations, for implementation of sanctions where these are indicated, and for the Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a Practitioner.
  - e. Call, preside at, and be responsible for the agenda of all general meetings of the Staff.
  - f. Serve as chairperson of the MEC, as ex-officio member without vote on all other Staff committees.
  - g. Serve as ex-officio member without vote on the Board of Trustees (YVMH). [rev 3/2005]
  - h. Develop, implement, supervise and evaluate in cooperation with the department chairpersons, methods for quality management activities, ongoing monitoring of practice, credentials review, delineation of privileges and specified services, continuing education and training for Staff members, interns and residents, and utilization review.
  - i. Appoint the membership of those Staff committees concerned with the activities indicated in paragraph (h) above. [rev. 09/01]
  - j. Serve as chairperson of the QA Executive Committee.
- 2. Vice-President:** The Vice-President shall be responsible for the By-Laws review and revision function. He/she shall be a member of the MEC, the QA Executive Committee, the Physician Wellness Committee (ex-officio) and shall serve on the hospital-wide Quality Management Coordinating Committee. In the absence, temporary or permanent, of the President, he/she shall assume all the duties and have the authority of the President. He/she shall perform such additional duties as may be assigned to him or her by the President, the MEC, or the Board. (rev.6/99)
- 3. Secretary/Treasurer:** The Secretary/Treasurer shall be a member of the MEC, the QA Executive Committee, and an ex-officio member without vote on all other Staff committees. The duties of the Secretary/Treasurer shall be to: (revised: 06/15/93)
  - a. Act as coordinator of the credentialing activities.
  - b. Give proper notice of all Staff meetings on order of the appropriate authority.
  - c. Prepare accurate and complete minutes for all meetings.
  - d. Supervise the collection and accounting for any funds that may be collected in the form of

Staff dues, assessments, or application fees.

- e. Perform such other duties as ordinarily pertain to this office. Since the duties of the Secretary/Treasurer are essentially administrative, they may, in whole or in part, be delegated with the approval of the President and Vice-President, except that a delegee shall not be deemed a member of any Staff committees and has no vote.

## ARTICLE VIII

### COMMITTEES AND FUNCTIONS

- A. Designation and Substitution.** There shall be a Medical Executive Committee (MEC) and such other standing and special committees of the Staff responsible to the MEC as may from time to time be necessary and desirable to perform the Staff functions listed in this Article VIII, and otherwise stated or implied in these By-Laws. The MEC may, by resolution and upon approval by the Board, establish a Staff committee to perform one or more of the required Staff functions. Those functions requiring participation of, rather than direct oversight by, the Staff may be discharged by Staff representation on such Hospital committees as are established to perform such functions.

Whenever these By-Laws require that a function be performed by, or that a report or recommendation be submitted to:

1. A named Staff committee but no such committee shall exist, the MEC shall perform such function or receive such report or recommendation or shall assign the functions of such committee to a new or existing committee of the Staff or to the Staff as a whole.
2. The MEC, but if a standing or special committee has been formed to perform the function, the committee so formed, shall act in accordance with the authority so delegated to it.

**B. Medical Executive Committee (MEC).**

1. **Composition.** The MEC shall be a standing committee and shall consist of the following voting members: officers of the Staff and the Chairperson of each clinical department. Ex-officio members who may attend without vote: Cancer Committee Chairperson, Consultative Ethics Committee Chairperson, Infection Control Committee Chairperson, Pharmacy & Therapeutics Committee Chairperson, Physician Wellness Committee Chairperson, Radiation Safety Committee Chairperson and Interdisciplinary Trauma Committee Chairperson; the Medical Director or the Director of Quality Management for the Staff; the CEO his/her representatives, and invited members of the Board. The President of the Staff shall serve as chairperson of the MEC. All members of the MEC, except the elected officers and Department Chairmen, shall be appointed by the Chairperson of the MEC. (revised 10/15/96; rev. 9/01)
2. **Duties.** The duties of the MEC shall be to:
  - a. Represent and act on behalf of the Staff, subject to such limitations as may be imposed by these By-Laws and the rules and regulations of the Staff.
  - b. Receive and act upon reports and recommendations from the departments, committees and officers of the Staff concerning quality management activities and other review, evaluation and monitoring functions, and the discharge of their delegated administrative responsibilities and recommend to the Board specific programs and systems to implement these functions.
  - c. Coordinate the activities of and policies adopted by the Staff, departments, and committees.
  - d. Recommend to the Board as to all matters relating to appointments, reappointments, staff category, department assignments, clinical privileges, and corrective action.
  - e. Account to the Board and to the Staff for overall quality and efficiency of patient care in the Hospital.
  - f. Take reasonable steps to insure professionally ethical conduct and competent clinical performance on the part of Staff Members, including initiating investigations and pursuing corrective action, when warranted.
  - g. Make recommendations on medico-administrative and Hospital management matters.
  - h. Inform the Staff of the accreditation program and the accreditation status of the Hospital.

- i. Participate in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs.
  - j. Provide liaison between the Staff and the CEO and the Board.
  - k. Assure that medical records in the Hospital meet required standards.
3. **Meetings.** The MEC shall meet for at least six (6) meetings per year and maintain a permanent record of its proceedings and actions. revised: 11/16/93; 10/1997

**C. Staff Functions.**

Provision shall be made in these By-Laws, or by resolution of the MEC approved by the Board, either through assignment to the departments, to Staff officers or officials, or to other disciplinary Hospital committees, for the effective performance of the Staff functions specified in this section and described in the following section, of all other Staff functions required by these By-Laws, and of such other Staff functions as the MEC or the Board shall reasonably require, such as to:

- 1. Conduct, coordinate and review quality management activities that include monitoring activities such as surgical case review, blood usage review, antibiotic and drug usage review, and morbidity and mortality review. All retrospective reviews of specific incidences or Physician's performances in the Hospital will be reviewed by the Quality Management Executive Committee. (rev. 1/95)
- 2. All Staff departments and committees, as listed in these By-Laws or as may be added at a future time, shall assist in the function of review and evaluation of quality of patient care.
- 3. Conduct, coordinate and review, or oversee the conduct of utilization review activities.
- 4. Conduct, coordinate and review, credentials investigations and recommendations regarding Staff membership and grants of clinical privileges and specified services.
- 5. Monitor and evaluate care provided in and develop clinical policy for: special care areas, such as critical care units; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, outpatient, home care, and other ambulatory services.
- 6. Provide continuous education opportunities responsive to quality activity findings, new state-of-the-art developments and other perceived needs and supervise the Hospital's professional library services.
- 7. Review the completeness, timeliness, and clinical pertinence of patient medical and related records.
- 8. Develop and maintain surveillance of drug utilization policies and practices.
- 9. Prevent, investigate and control hospital-acquired infections and monitor the Hospital's infection control program.
- 10. Participate in planning for response to fire and other disasters, for hospital growth and development, and for the provisions of services required to meet the needs of the community.
- 11. Supervise and train medical students and graduate trainees.
- 12. Direct Staff organizational activities, including Staff Bylaw review and revision, Staff officer and committee nominations, liaison with the Board and Hospital administration, review and maintenance of Hospital accreditation.

**D. Description of Functions.**

- 1. **Quality Management Activities.** The duties involved in conducting, coordinating and reviewing Quality Management activities and monitoring programs are to:

- a. Adopt, subject to the approval of the MEC and the Board, a hospital-wide Quality Management (IOP) Plan for reviewing, evaluating and maintaining the quality and efficiency of patient care within the Hospital, including at least mechanisms for:
  - (1) Establishing objective criteria;
  - (2) Measuring actual practice against the criteria;
  - (3) Analyzing practice variations from criteria by peers;
  - (4) Taking appropriate action to correct identified problems;
  - (5) Following up on action taken; and
  - (6) Reporting the findings and results of quality management activities to the Staff, the CEO and the Board.
- b. Review and act upon, on a regular basis, factors affecting the quality and efficiency of patient care provided in the Hospital, including tissue, mortality, antibiotic and blood usage studies and fulfillment of consultation requirements.
- c. Coordinate the findings and results of department, committee and Staff quality management activities; Hospital utilization review activities; continuing education activities; reviews of medical record completeness, timeliness, and clinical pertinence, and other Staff activities designed to monitor patient care practices.
- d. Submit, at least quarterly, reports to the MEC on the overall quality and efficiency of medical care provided in the Hospital and on the department, committee and quality management activities, utilization review and other quality review, evaluation and monitoring activities. (rev 1/95)

**2. Credentials Function.** The duties involved in conducting, coordinating and reviewing credentials investigations and recommendations are to:

- a. Review and evaluate the qualifications of each applicant for appointment, reappointment, or modification of appointment to the Staff, and for clinical privileges, and in connection therewith to obtain and consider the recommendations of appropriate department Chairpersons.
- b. Review and evaluate the qualifications of each AHP applying to perform specified services, and in connection therewith to obtain and consider the recommendations of appropriate department Chairpersons.
- c. Submit reports, in accordance with the Credentialing Policy and Procedure Manual, on the qualifications of each applicant for Staff membership or particular clinical privileges and of each AHP for specified services. Such reports shall include recommendations with respect to appointment, Staff category, department affiliation, clinical privileges or specified services, and special conditions attached thereto.
- d. Investigate, review and report on matters, including the clinical or ethical conduct of any Practitioner assigned or referred to the Credentials Committee by:
  - (1) The President of the Staff;
  - (2) The MEC; or
  - (3) Those responsible, respectively, for the functions described in Sections C and D of this Article
- e. Submit reports approximately monthly to the MEC on the status of pending applications, including the specific reasons for any inordinate delay in processing an application or request.

**3. Continuing Education Function.** The duties involved in organizing continuing education programs and supervising the Hospital's professional library services are to:

- a. Develop and plan, or participate in programs of continuing education that are designed to

keep the Staff informed of significant new developments and new skills in medicine and that are responsive to quality assurance findings.

- b. Evaluate through the quality management functions, the effectiveness of the educational programs developed and implemented.
- c. Analyze, on a continuing basis, the Hospital's and Staff's need for professional library services.
- d. Act upon continuing education recommendations from the MEC, the departments, or other committees responsible for quality management activities and other quality review evaluation and monitoring functions.
- e. Maintain a record of education activities and submit periodic reports to the MEC concerning these activities, specifically including their relationship to the findings of the quality management program, other quality review, evaluation and monitoring functions.
- f. To sponsor and encourage contributions and support of the library and to act with the Administrator and librarian in the formulation and enforcement of rules governing the use of the library.
- g. To purchase or solicit donations for textbooks, reference books, monographs, journals, visual and auditory aids.
- h. To develop, in consultation with the Secretary/Treasurers of the Staff, a request for educational speaker funds at the beginning of each Staff year.

**4. Bylaws Review and Revisions Function.** The duties involved in maintaining the appropriate Bylaws, rules, regulations and other organizational documents pertaining to the Staff are to:

- a. Conduct a bi-annual review of the bylaws and rules, regulations, procedures and forms promulgated in connection therewith.
- b. Submit recommendations to the MEC and to the Board for changes in these documents.
- c. Receive and consider all matters specified in sub- paragraph (a) above, as may be referred by the Board, the MEC, the departments, the President of the Staff, the CEO, and committees of the Staff.

**5. Nominating Function.** The duties involved in presenting to the Staff qualified candidates for elective positions in the Staff organizations are to:

- a. Consult with members of the Staff and administration concerning the qualifications and acceptability of prospective nominees.
- b. Submit, at the appropriate times as provided in these Bylaws, one or more nominations for:
  - (1) Each elective office of the Staff to be filled;
  - (2) Each of the member-at-large positions, if any, on the MEC;

**6. Medical Records Function.** The functions and duties involved in reviewing the completeness, timeliness, legibility, and clinical pertinence of patient medical records are to: [rev. 9/2003]

- a. Review and evaluate medical records to determine that they:
  - (1) Properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken.
  - (2) Are sufficiently and timely completed, so as to facilitate continuity of care and communications between all those persons providing patient care services in the Hospital.
- b. Review Staff and Hospital policies, rules and regulations relating to medical records, including medical records completion, forms, formats, filing, indexing, storage, destruction and availability and recommend methods of enforcement thereof and changes therein.
- c. Act upon recommendations from the departments, and other committees responsible for

- quality management activities and other quality review, evaluation and monitoring functions.
- d. Provide liaison with Hospital administration and the medical records professionals in the employ of the Hospital on matters relating to medical record practices.
- e. Maintain a record of all actions taken.
- f. Periodically inspect the quality of medical records in response to requests from personnel of the Hospital's Health Information Management.
- g. Review standing orders.

**7. Utilization Review Function.**

- a. Develop a written utilization review plan for the Hospital, which shall be approved by the Staff, the Board, and appropriate agencies of the State of Washington, and which shall be in effect at all times and include provision for at least review of admissions and continued hospital stay, discharge planning, and data collection and reporting.
- b. Conduct utilization review studies in accordance with the Utilization Review Plan.
- c. Report utilization review results to the Board.

**E. Participation on Interdisciplinary Hospital Committees.**

Staff functions and responsibilities relating to liaison with the Board and Hospital administration, Hospital accreditation, disaster planning, facility and services planning, financial management, and quality management committees shall be discharged by the appointment of Staff members to such Hospital committees as are established to perform these functions. Appointment of Staff members to any Hospital committees shall be made and such committees shall operate in accordance with the Hospital's corporate Bylaws and the written policies of the Hospital and of the Staff.

**F. Committees of the Staff.**

- 1. Composition and Appointment.** A staff committee established to perform one or more of the Staff functions required by these Bylaws shall be composed of members of the Active and Provisional Active Staffs, and may include, where appropriate, representation from Hospital administration, nursing service, and such other Hospital departments as are appropriate to the functions to be discharged. Unless otherwise specifically provided, the Staff members shall be appointed by the Staff President, and the administrative Staff members shall be appointed by the CEO. Each committee shall, with the approval of the MEC, select its chairperson and secretary where the same are not provided for in these Bylaws. The Staff President and the CEO, or their respective designees, shall serve as ex-officio members without vote on all committees, unless otherwise expressly provided.
- 2. Voting.** Only Active and Provisional Active members of the medical staff shall be voting members of committees unless otherwise approved by the MEC. Each voting member shall have one vote. Voting by proxy shall not be permitted except that an Active staff member of the same department can be designated by the Department Chairperson to represent the interests of the Department at the MEC meeting, including participation in discussion and voting, in the absence of the Department Chairperson. No member in attendance shall have more than one vote. Either Medical Staff Services or the Medical Staff President must be notified in writing of any requests for an alternate not less than 24 hours prior to the scheduled MEC meeting. The request from the Department Chairperson shall include the reason for the absence. (rev.12/99); [rev 3/2005]
- 3. Term and Prior Removal.** Unless otherwise specifically provided, a Staff committee member (other than one serving ex-officio) shall continue as such until the end of his/her normal period of Staff appointment and until his/her successor is elected or appointed, unless he/she shall sooner resign or be removed from the committee. A staff committee member, other than one serving ex-officio, may be removed by a majority vote of the MEC. An administrative Staff committee member shall serve for a term equivalent to that of a Staff committee member and until his/her

successor is elected or appointed, unless he/she shall sooner resign or be removed from the committee. An administrative Staff committee member may be removed by action of the CEO.

4. **Vacancies.** Unless otherwise specifically provided, vacancies on any Staff committee shall be filled in the same manner in which original appointment to such committee is made.
5. A staff committee established to perform one or more of the Staff functions required by these Bylaws shall meet as often as is necessary to discharge its assigned duties. (rev. 1/95)

**G. Cancer Committee** (revised September 2011)

1. **Policy and Procedure Manual.** Because one of the duties of this committee will be to maintain a cancer program conforming to the Criteria of the Commission on Cancer of the American College of Surgeons, which may change from time to time, the structure and functions of this committee shall be detailed in a separate Policy and Procedure Manual. [rev 3/2005]
2. **Composition.** ~~The committee shall consist of at least one (1) medical staff member from oncology, one (1) from surgery, one (1) from pathology, one (1) from radiology, and medical staff members representing the five major cancer sites. The Cancer Committee chairman can be the cancer liaison physician. The medical staff members shall be appointed by the president of the medical staff. Other members include cancer registry, oncology nurse, social services, quality management, and hospital administrative representative(s).~~

As directed by the Criteria of the Commission on Cancer of the American College of Surgeons.

**Voting:** ~~Each physician shall have one vote.~~ As directed by the Criteria of the Commission on Cancer of the American College of Surgeons.

**3 Duties.**

- a. To establish and maintain a Community Cancer Program (CCP) according to guidelines of the Commission on Cancer of the American College of Surgeons.
- b. ~~Provide leadership and coordination for the activities of the cancer program to improve patient care through educational and consultative cancer conferences, quality management studies, and the collection of accurate and complete cancer data.~~
- c. ~~To maintain a permanent record of the committee's activities, which shall include all reports or recommendations generated by it, minutes of committee meetings, correspondence, and a copy of its Policy and Procedure Manual.~~
- d. ~~To prepare a Policy and Procedure Manual describing the committee's composition and functions, and to submit such charter to the MEC for approval, and by amendment or revision, requiring approval of the MEC.~~
- e. ~~To coordinate as a formal sub-committee the Tumor Board Conference, whose functions, duties, and responsibilities will be as outlined in the Cancer Committee Policy and Procedure Manual.~~
- f. ~~Maintain and improve relationships with external organization and perform period evaluations for quality, outcomes, and patient satisfaction.~~
- g. ~~Develop and evaluate the annual goals and objectives for the clinical and educational activities related to cancer.~~
- h. ~~Ensure that there is an active supportive care system in place for patients, families, and staff.~~
- i. ~~Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.~~
- j. ~~Supervise the cancer registry and ensure accurate and timely abstracting, staging, and follow-up reporting.~~

- k. ~~Approve the annual report and ensure that it meets requirements and that it is distributed in a timely manner.~~

- 4. **Meetings.** The Cancer Committee shall meet at intervals as stated in their Policy and Procedure Manual at the call of its chairperson, and shall submit copies of the minutes of the meetings to the MEC. (rev. 1/95, 11/05)

## **H. Cardiac, Pulmonary & Critical Care Quality Assurance/Performance Improvement Committee.** (Added September 2011)

### **Composition.**

- a. The Chairperson shall be appointed to a one year term by the President of the Medical Staff. He/she shall vote only if necessary to break a tie vote.
- b. Each Member of the department shall sit on this committee. In addition there will be a representative from the Department of Emergency Medicine, and a hospitalist.  
Ex-officio members without a vote shall include the Medical Directors for Quality Assurance and Performance Improvement, hospital QA coordinator and hospital risk manager and Cardiac Service line administrator. When appropriate other representatives from administration, performance improvement or other healthcare professional may be invited as approved by the committee chairman.

### **2. Functions and Duties.**

- a. To monitor performance through data analysis, outcome measurement (risk adjusted, as possible), critical pathway/care track measurement, comparison to internal and external benchmark for outcomes and processes and referrals from other medical staff committees or administration.
- b. To improve performance by assessing problems, processes, and outcomes of care, reaching conclusions and making recommendations to the practitioners or departments involved. Actions necessary to improve performance are the responsibility of the appropriate Medical Staff Department Chairperson and the M.E.C.
- c. To assess and make recommendations regarding the findings of reviews.
- d. To assess and make recommendations regarding the review of referrals from other medical staff departments and committees.
- e. To report significant trends (hospital-wide, departmental-wide and practitioner specific) as well as areas that have shown or may need improvement to the appropriate medical staff departments or committees.

- 3. **Meetings.** The CPCC QA/PIC shall meet no less than three times a year.

- 4. **Education:** Refer case topics to educational forums.

## **I. Consultative Ethics Committee.**

- 1. **Composition.** The Hospital shall have its own Consultative Ethics Committee (CEC). Members will be selected based on their interest in Bioethics and commitment to support of the CEC's functions and programs. The composition of the CEC shall be: (revised 7/2006)
  - a. One Physician to serve as chairperson for a three year renewable term. The chairperson shall chair the CEC and will be appointed on a rotating basis by the Staff President.
  - b. A minimum of ~~two~~ three interested Physicians shall be appointed by the Staff President to serve three year renewable terms. (revised: 08/03/92, 1/2010)
  - c. The representative of the medical staff Pediatric Department. (revised 09/95)

- d. ~~Three nurses and two other~~ Five health care professionals (for example social worker, respiratory therapists) from the Hospital, appointed by the Hospital administration to serve three year renewable terms. (revised: 7/2006, 1/2010)
- e. Additional Members of each CEC may include an ethicist, a chaplain, an administrator, and a Board Member, patient care advocate, attorney with healthcare experience, the patient or family member (revised 1/2010)
- f. Additional members may be added for case discussions involving infants to include a neonatal intensive care nurse and an advocate for the developmentally disabled. (revised: 9/95)

**2. Functions and Duties.**

- a. The CEC is a non-voting Committee, decisions of that are made based on consensus, and quorum shall be based on the entire membership and not just the physician segment. (revised 9/94)
- b. The CEC shall consult on cases at the request, or with the approval, of the attending Physician.
- c. The CEC is a facilitative and advisory body seeking to illuminate all ethical aspects of a case and thus increase the confidence and effectiveness of medical care decision-makers.
- d. The CEC shall keep the medical, nursing staff, and other disciplines informed about current developments in Bioethics as well as provide educational opportunities for the community.
- e. CEC members will serve as a resource for policy-setting bodies of the Staff, administrations, and Board.

- 3. Meetings.** The CEC shall meet periodically, as necessary, and shall maintain a permanent record of its proceedings. (rev. 7/2006)

**J. Credentials Committee**

The Credentials Committee has as one of its responsibilities the review of medical services provided in the hospital with the objective of improving the quality of patient care. This Committee is a regularly constituted review committee conducting quality assurance and related reviews in accordance with the applicable provisions of Washington law, including, without limitation, RCW 4.24.250 and RCW 70.41.200 and .230. (added: 06/15/93)

- 1. Composition.** The Credentials Committee shall consist of: a) three past Presidents for the Medical Staff and three physician members appointed (one each year to serve a three year term) by the Medical Staff President in consultation with the Credentials Committee. It is recommended that all members of the Credentials Committee have experience in Medical Staff leadership roles as a Medical Staff Officer, Past Department Chairperson or Committee Chairperson. b) Medical Staff President (ex-officio without vote); c) Quality Management Director (ex-officio without vote); d) Administrator/CEO for YVMH or designee, without vote; e) Representatives from Medical Staff Services, as staff and without vote. Vacancies in the Committee will be filled by appointment of the Medical Staff President. [revised 06/00]
- 2. Functions and Duties.** The Credentials Committee coordinates the Staff credentials function by:
  - a. Receiving and analyzing applications and recommendations for appointment, conclusion or extension of the provisional period, clinical privileges, and changes therein, and recommending action thereon;
  - b. Integrating quality review, professional liability, prevention and utilization management findings, membership, and other relevant information into individual credentials files;
  - c. Developing, coordinating, periodically reviewing, and making recommendations as to:
    - (1) the procedures and forms to be used in connection with each component of the credentialing process;
    - (2) a standard for the content and organization and for overseeing maintenance of the individual credentials files.

- d. Assists in the development and oversees implementation of the credentialing procedures for AHPs.
  - e. Evaluates the merits of new procedures or devices to be performed or used by Staff Members and reviews and makes recommendations on protocols established by the Departments for new procedures or devices.
3. **Meetings.** The Credentials Committee shall meet for at least ten (10) meetings per year and report to the Medical Executive Committee and the Board. The Credentials Committee shall maintain a permanent record of its findings, proceedings, and actions. [Rev. 06/15/93; 10/99]

## **K. Infection Control Committee.**

1. **Composition.** The Infection Control Committee shall be a committee with multi-disciplinary representation of Members from the Departments listed in the Staff Organizational Manual. The chairperson of the committee shall be appointed by the Staff President. (rev. 1/95)
2. **Functions and Duties.** The functions and duties of the Infection Control Committee, in order to prevent, investigate, and control Hospital-acquired infections are to:
  - a. Maintain a surveillance over the Hospital infection control program.
  - b. Develop a system for reporting, identifying, and analyzing the incidence and cause of all infections.
  - c. Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.
  - d. Develop, evaluate and revise preventive, surveillance and control policies and procedures relating to all phases of the Hospital's activities, including: Operating rooms, delivery rooms, special care units, central service, housekeeping and laundry; sterilization and disinfection procedures by heat, chemicals, or otherwise; isolation procedures; prevention of cross infection by anesthesia apparatus or inhalation therapy equipment; testing of Hospital personnel for carrier status; disposal of infectious material; food sanitation and waste management; and other situations as requested.
  - e. Coordinate action on findings from the Staff's review of the clinical use of antibiotics.
  - f. Act upon recommendations related to infection control received from the Staff President, the MEC, the departments and other Staff and Hospital committees.
  - g. Maintain a record of all activities relating to infection control and submit periodic reports thereon to the MEC and to the Staff President.
  - h. Institute any surveillance, prevention, and control measures or studies when there is reasonably considered to be a danger to any patient or personnel. (added: 02/03/92)
3. **Meetings.** The Infection Control Committee shall meet at least quarterly as called by the chairperson and shall report its findings to the MEC for actions. The Staff shall accordingly conduct monthly infection control activities and shall maintain a record of its proceedings and activities. (revised: 06/94; 1/95)

## **L. Medical Quality Assurance/Performance Improvement Committee.**

1. **Composition.**
  - a. The Chairperson shall be appointed to a two-year term by the President of the Medical Staff. He/she shall vote only if necessary to break a tie vote.
  - b. Each Member shall be appointed to a two-year term by the chairperson of his/her Medical Staff Department. Each Member listed below in 1 and 2 shall have a vote. Any Member who cannot attend a meeting shall be responsible to see that an alternative department Member attends.

- (1) Members appointed in even years include representatives from the following departments: Family Medicine; Internal Medicine; Pediatrics; Psychiatry.
- (2) Members appointed in odd years include representatives from the following department: Emergency; Internal Medicine; Radiology.
- (3) Ex-officio members without a vote shall include the Medical or QA Director; QA/PI Coordinator, Hospital administrative representative, other health care professionals upon request of the chairperson.

## 2. Functions and Duties.

- a. To monitor performance through data analysis, outcome measurement (risk adjusted, as possible), critical pathway/care track measurement, and comparison to internal and external benchmark for outcomes, processes and cost.
- b. To improve performance by assessing problems, processes, and outcomes of care, reaching conclusions and making recommendations to the practitioners or departments involved. Actions necessary to improve performance are the responsibility of the appropriate Medical Staff Department Chairperson and the M.E.C.
- c. To assess and make recommendations regarding the review of the following: Morbidity and Mortality, Surgical and other invasive procedures, Drug usage, Medical records, Blood usage, Infection Control, Pharmacy & Therapeutics, Administrative & risk management referrals, Safety, Utilization review.
- d. To assess and make recommendations regarding the review of the following: Referrals from other sources such as Cancer Committee, PRO-West and other medical Staff departments and/or committees; Hospital-wide and department specific "sentinel event" generic screens; Critical Pathway/Care Track variations and results.
- e. To report at least quarterly all significant trends (hospital-wide, departmental-wide and practitioner specific) as well as areas that have shown or may need improvement to the appropriate medical staff departmental meeting as well as to the Medical Executive Committee. [rev 3/2005]
- f. Acknowledge referrals made to the QA Committee, by written letter, to the Department Chairman within two weeks after review by the QA Committee.

## 3. Meetings. The MQA/PIC shall meet at least quarterly.

## M. Perinatal Quality Assurance/Performance Improvement Committee.

### 1. Composition: [rev 09/2003]

- a. The Chairperson shall be appointed to a two-year term by the President of the Medical Staff. He/she shall vote only if necessary to break a tie vote.
- b. Members - all members listed in 1, 2, and 3 below shall have a vote:
  - (1) Two members of the Family Medicine Department who have privileges for and practice obstetrics;
  - (2) Two members of the Ob/Gyn Department who have privileges for and practice obstetrics;
  - (3) Two members of the Pediatric Department of which one must have privileges for and practice in the NICU.
  - (4) Ex-officio members without a vote shall include: PA's and ARNPs who have privileges to practice obstetrics or neonatology (in the NICU); Medical or QA Director; QA/PI Coordinator; Hospital administrative representative; and other health care professionals upon request of the chairperson.

### 2. Functions and Duties.

- a. To Monitor performance through data analysis, outcome measurement (risk adjusted, as possible), critical pathway/care track measurement, and comparison to internal and external benchmark for outcomes, processes and cost.
  - b. To improve performance by assessing problems, processes, and outcomes of care, reaching conclusions and making recommendations to the practitioners or departments involved. Actions necessary to improve performance are the responsibility of the appropriate Medical Staff Department Chairperson and the M.E.C.
  - c. To assess and make recommendations regarding the review of the following: Morbidity and Mortality, Surgical and other invasive procedures, Drug usage, Medical records, Blood usage, Infection Control, Pharmacy & Therapeutics, Administrative & risk management referrals, Safety, Utilization review. Referrals from other sources such as Cancer Committee, PRO-West and other medical Staff departments and/or committees; Hospital-wide and department specific "sentinel event" generic screens; Critical Pathway/Care Track variations and results.
3. **Meetings.** The PQA/PIC shall meet at least quarterly.

## N. Pharmacy & Therapeutics Committee.

1. **Composition.** The Pharmacy and Therapeutics Committee shall be a committee with multi-disciplinary representation from the departments as listed in the Staff Organizational Manual. Also, included on this committee will be one member from the pharmaceutical service, one member from the nursing service, and one member from the Hospital's administration. The chief pharmacist shall be a member of the committee and shall act as its secretary.
2. **Functions and Duties.** The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of all drug utilization policies and practices within the Hospital in order to assure optimum clinical results and a minimum potential for hazard. The committee shall assist in the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital. It shall also perform the following specific functions:
  - a. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to drugs in the Hospital.
  - b. Advise the Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs.
  - c. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.
  - d. Develop and review periodically a formula or drug list for use in the Hospital.
  - e. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and establish standards concerning the use and control of investigational drugs and research in the use of recognized drugs.
  - f. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.
  - g. Establish a drug utilization or review program.
  - h. Perform such other duties as assigned by the Staff President or the MEC.
  - i. Maintain a record of all activities relating to the pharmacy and therapeutic function and submit periodic reports and recommendations to the MEC concerning drug utilization policies and practices in the Hospital.
3. **Meetings.** The Pharmacy and Therapeutics Committee shall meet usually on a quarterly basis and shall provide written reports to the MEC regarding its activities. (rev. 1/95)

**O. Practitioner Wellness Committee** [added 02/20/96; rev.12/99; 09/2003]

1. **Composition:** The membership of the PWC will include at least five (5) members of the Medical Staff, preferably who are not Department chairs or Medical Staff Officers. One member should be from the Department of Psychiatry. The other members are to be selected for their specific expertise in problems of physician health, chemical and alcohol dependence, experience and willingness to serve. The term on the Committee shall be for a period of three years, to provide continuity and development of expertise. A physician may serve more than one term.  
**Chair:** The Chair of the Practitioner Wellness Committee will be appointed by the President of the Medical Staff.
2. **Functions and Duties.** (See Practitioner Wellness Policy)
3. **Attendance/Minutes:** Records shall be sufficient to document meetings and general activities of this Committee.
4. **Meetings:** The Committee shall meet at least quarterly or as frequently as required to fulfill its charges in accordance with its Policies and Procedures.

**P. Quality Management Executive Committee:**

1. **Composition:** This Committee shall have the same officers and members as the MEC.
2. **Functions and Duties:** This Committee shall review findings and recommendations from the Hospital-wide Quality Assurance Coordinating Committee, and the QA Committees of the Staff, departments and committees. The Committee shall accomplish the above as outlined in the Quality Management (IOP) Plan. (rev. 1/95)
3. **Meetings:** The Committee shall meet at least quarterly and shall report its findings to the MEC for action.

**Q. Radiation Safety Committee.**

1. **Composition.** The Radiation Safety Committee will have multi-disciplinary representation, including at least one Physician from each specialty listed in the Radioactive Materials License and other staff Physicians having special interest or expertise in the medical use of radionuclides. Other members of the committee may include hospital representatives from radiology, Nuclear Medicine Radiation Therapy; nursing service, and Hospital administration. [rev 3/2005]
2. **Functions and Duties.** The committee is responsible for:
  - a. Ensuring that all individuals who work with or in the vicinity of radioactive material have sufficient training and expertise to enable them to perform their duties safely and in accordance with state rules and regulations and the conditions of the license.
  - b. Ensuring that all use of radioactive material is conducted in a safe manner and in accordance with state rules and regulations and the conditions of the license.  
The Committee shall:
  - c. Be familiar with all pertinent regulations, the terms of the license, and information submitted in support of the request for the license and its amendments.
  - d. Review the training and experience of all individuals who use radioactive materials (including Physicians, technologists, physicists, and pharmacists) and determine that their qualifications are sufficient to enable them to perform their duties safely and in accordance with regulations and the conditions of the license.
  - e. Establish a program to ensure that all individuals whose duties may require them to work in the vicinity of radioactive material (e.g. nursing, security, and housekeeping personnel) are properly instructed as required by WAC 402-48-030.
  - f. Review and approve all requests for use of radioactive material within the institution.

- g. Prescribe special conditions that will be required during a proposed use of radioactive material such as requirements for bioassays, physical examinations of users, and special monitoring procedures.
- h. Review the entire radiation safety program at least annually to determine that all activities are being conducted safely and in accordance with state rules and regulations and the conditions of the license. The review shall include an examination of all records, reports from the radiation safety officer, results of state inspections, written safety procedures, and the adequacy of the institution's management control system.
- i. Recommend remedial action to correct any deficiencies identified in the radiation safety program.
- j. Maintain written records of all committee meetings, actions, recommendations, and decisions.
- k. Ensure that the radioactive material license is amended, when necessary, prior to any changes in facilities, equipment, policies, procedures, and personnel, as specified in the license.

3. **Meetings.** The Radiation Safety Committee shall meet as often as necessary to conduct its business but not less than once in each calendar quarter.

**R. Surgical Quality Assurance Committee.** [revised: added Trauma 12/2003, deleted Trauma 9/2006]

1. **Composition.**

- a. The Chairperson shall be appointed to a two-year term by the President of the Medical Staff. He/she shall vote only if necessary to break a tie vote.
- b. Each Member shall be appointed to a two-year term by the chairperson of his/her Medical Staff Department. Each Member listed below in 1 and 2 shall have a vote. Any Member who cannot attend a meeting shall be responsible to see that an alternative department Member attends. [revised 12/2003]
  - (1) Members appointed in even years include representatives from the following departments: Anesthesia; Head & Neck; Surgery; Radiology; Family Medicine and Pediatrics. The Pediatric Department representative will attend as needed. [revised 12/2003]
  - (2) Members appointed in odd years include representatives from the following departments: Orthopedics; Pathology; Emergency Department and Ob/Gyn.
  - (3) Ex-officio members without a vote shall include the Medical or QA Director; QA/PI Coordinator, Hospital administrative representative, and other health care professionals upon request of the chairperson.

2. **Functions and Duties.**

- a. To Monitor performance through data analysis, outcome measurement (risk adjusted, as possible), critical pathway/care track measurement, and comparison to internal and external benchmark for outcomes, processes and cost.
- b. To improve performance by assessing problems, processes, and outcomes of care, reaching conclusions and making recommendations to the practitioners or departments involved. Actions necessary to improve performance are the responsibility of the appropriate Medical Staff Department Chairperson and the M.E.C.
- c. To assess and make recommendations regarding the review of referrals from all sources.
- d. To report at least quarterly all significant trends (hospital-wide, departmental-wide and practitioner specific) as well as areas that have shown or may need improvement to the appropriate medical staff departmental meeting as well as to the Medical Executive Committee. [rev 3/2005]

3. **Meetings.** The Surgical Quality Assurance Committee shall meet at least quarterly.

## **S. Trauma (Interdisciplinary) Committee. For Yakima Valley Trauma Services**

**Policy and Procedure Manual.** Because one of the duties of this Committee will be to maintain a trauma program conforming to the Washington State Department of Health regulations which may change from time to time, the structure and functions of this Committee shall be detailed in a separate Policy and Procedure Manual.

**1. Composition** The Interdisciplinary Trauma Committee shall consist of members as outlined in the Trauma Committee Policy.

**2. Voting:** Voting members of the Trauma Committee are as delegated in the Trauma Policy.

**3. Chairperson:** The chairperson will be the Trauma Service Medical Director.

**4. Functions and Duties.** The Interdisciplinary Trauma Committee integrates the resources of YVMH and Yakima Regional in providing trauma care in the Yakima Valley. The role of the committee is to provide an organized approach for the Care to the trauma patient that ultimately optimizes outcomes. Functions and duties of the committee will be as outlined in the Trauma Policies and include to:

- a. review and discussion of trauma patient care issues referred to the committee. The committee provides a forum for discussion of trauma care issues brought to the committee as well as a complete review of all trauma-related deaths. To develop a plan for further action required to improve patient care or remedy trauma service organization issues;
- b. review of policies and procedures related to trauma care and;
- c. recommending standards of trauma patient care;
- d. coordinating trauma services with sub-specialty trauma support groups;
- e. monitoring the quality of trauma care and developing a plan of action when appropriate (Quality Management information is protected under RCW 780.41.200(3)).
- f. recommending trauma education with emphasis on trauma care personnel needs and community needs;
- g. directing information pertinent to optimizing the care of trauma patients to the appropriate trauma care providers.

**6. Meetings.** The committee will meet no less than quarterly and shall report its findings to the MEC.

## **T. Trauma Quality Assurance Committee: For Yakima Valley Trauma Services** (added 08/06)

1. Composition.

- a. The Trauma Director will serve as Chairman. He or she shall vote only if necessary to break a tie vote.
- b. Members shall be appointed as outlined in the Trauma Committee Policies
- c. Ex-officio members as outlined in the Trauma Committee Policies.

2. Functions and Duties as outlined in the Trauma Policies, include:

- a. To monitor performance through data analysis, outcome measurement (risk adjusted, as possible), and comparison to internal and external benchmark for outcomes, processes and cost.
- b. To improve performance by assessing problems, processes and outcomes of care, reaching conclusions and making recommendations to the practitioners, committee or departments involved. Actions necessary to improve performance are the responsibility of the appropriate Medical Staff Department Chairperson and the M.E.C.

- c. To assess and make recommendations regarding indicator review, chart reviews and to review referrals from other sources, committees, department, or administration.
- d. To report quarterly to the Trauma (Interdisciplinary) Committee, M.E.C. and Board all significant trends regarding trauma care (hospital wide, departmental-wide and practitioner specific) as well as areas that have shown or may need improvement to the appropriate medical staff departments.

3. Meetings: The committee shall meet at least quarterly and report to the Medical Executive Committee/Quality Assurance.

**U. Conferences.** Conferences for the purposes of evaluating and auditing the quality of patient care may be established from time to time by the Staff on an Ad Hoc or standing basis. Examples of such conferences include: Cardiac/Surgery Conference, Family Medicine Conference, Intensive Care Conference, Internal Medicine Conference, Internal Medicine Mortality and Morbidity Conference, Neonatal Phone Conference, High Risk Ob Conference, Pediatric Conference, Pediatric/Obstetrical Conference, Surgical Mortality and Morbidity Conference, Tumor Board Conference, and Orthopedic Journal Club.

# ARTICLE IX

## MEETINGS

### A. General Staff Meetings.

#### 1. Regular Meetings.

- a. A mandatory annual meeting shall be held for the purpose of election of Medical Staff Officers and any other business that may come before the Medical Staff. [rev. 12/02]
- b. Regular meetings may be held at the request of the Medical Staff Officers, the Medical Executive Committee, or the Hospital Board. [added 12/02]; [rev 3/2005]

#### 2. Special Meetings.

Special meetings of the staff may be called at any time by the Board, the Staff President, the MEC or not less than thirty (30) members of the active Staff and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting except that stated in the meeting notice.

#### 3. Order of Business and Agenda.

The order of business at a regular meeting shall be determined by the Staff President. The agenda shall include at least:

- a. Reading and acceptance of the minutes of the last regular and of all special meetings held since the last regular meeting.
- b. Administrative reports from the CEO, the Staff President, departments, and committees.
- c. The election of officers and of representatives to Staff and Hospital committees, when required by these Bylaws.
- d. Reports by responsible officers, committees and departments on the overall results of quality management activities and other review, evaluation and monitoring activities of the Staff, and on the fulfillment of the other required Staff functions.
- e. New business.

#### 5. Notice of Meetings.

Printed notice stating the place, day and hour of any general Staff meeting, of any special meeting, or of any regular committee or department meeting not held pursuant to resolution shall be delivered either personally or by mail to each person entitled to be present not less than three days nor more than twenty days before the date of such meeting. If mailed, the notice of the meeting shall be deemed delivered 24 hours after deposited, postage prepaid, in the United States mail addressed to each person entitled to such notice at his/her address as it appears on the records of the Hospital. Personal attendance at a meeting shall constitute a waiver of notice of such meeting. [rev 3/2005]

#### 6. Quorum.

- a. **General Staff Meetings.** Thirty-three (33%) of the Active and Provisional Active Staff shall constitute a quorum except as noted in 7.a. below. For the purposes of quorum requirements, a member of the Active or Provisional Active Staff shall be considered in attendance if the member is present during a meeting or votes on a matter as set forth in paragraph 7(a) "Manner of Action." [rev 12/2002]

#### 7. Manner of Action.

- a. The action of a majority of members present and voting at a meeting and by written ballot delivered to the Medical Staff Services Office at the hospital between 9:00 am and 4:00 pm. on the meeting day and between 7:00 am and 4:00 pm the following day shall be the action of the group. Voters will be required to sign in to confirm their attendance. [rev 12/2002, 12/2003]
- b. It will be the option of the Medical Staff President, the Medical Executive Committee, or a group of not less than 30 Active and/or Provisional Active members, to place issues before the Medical Staff for discussion and debate, with voting to take place by written ballot at a later date. In such circumstances a final discussion period will be held on the morning of a scheduled vote, with voting to occur as outlined in 7.a. [added 12/2002; rev 09/2003,

12/2003]

- c. For the purpose of meeting regulatory requirements (JCAHO, WSDOH, etc.), or for general housekeeping issues such as minor language changes to correct grammar or clarify written documents, the Medical Executive Committee may act to modify Medical Staff Bylaws, Policies and/or Rules and Regulations as needed with a report to be made to the Medical Staff. [added 12/2002]

**8. Minutes.** Minutes of all meetings shall be prepared by the secretary of the meeting and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be signed by the presiding officer or appropriate designee, forwarded to the MEC through a capsule summary, approved by the attendees, and made available to the Staff for approval. A permanent file of the minutes of each meeting shall be maintained.

**9. Attendance Requirements.**

Physicians shall meet the meeting attendance requirements as established by their Department and the MEC.

**B. Committee and Department Meetings.** [rev 12/2002]

- a. **Regular Meetings.** Committees and departments will provide the time for holding regular meetings. The frequency of such meetings shall be as required by these Bylaws. Agenda will be available prior to the meeting. [rev 09/2003]
- b. **Special Meetings:** A special meeting of any committee or department may be called by, or at the request of, the chairperson of the committee or department's current voting members. No business shall be transacted at any special meeting except that stated in the meeting notice.
- c. **Quorum.** Each department will decide on its own quorum requirements. [rev. 08/2006]
- d. **Attendance Requirements:** Physicians shall meet the meeting attendance requirements as established by their Department and Committee Chairperson with approval of the MEC.

## ARTICLE X

### CONFIDENTIALITY, IMMUNITY AND RELEASES

- A. Special Definitions.** For the purposes of this Article, the following definitions shall apply:
1. **INFORMATION** means record of proceedings, minutes, records, reports, memoranda, statements, recommendations, data and other disclosures whether in written or oral form relating to any subject matter specified in Section E (l) of this Article.
  2. **MALICE** means the dissemination of a knowing falsehood or of information with a reckless disregard for whether or not it is true or false.
  3. **PRACTITIONER** means a Staff member or applicant or an AHP.
  4. **REPRESENTATIVE** means the Board and any officer, trustee, member, or committee thereof; the CEO or his designee; the Staff and any member, officer, department or committee thereof; and any individual authorized by any of the foregoing to perform specific information gathering or disseminating functions.
  5. **THIRD PARTIES** means both individuals and organizations providing information to any representative.
- B. Authorizations and Conditions.** By application for, or acceptance of Staff membership, or exercising clinical privileges or providing specified patient care services within the Hospital, a Practitioner:
1. Authorizes Representatives of the Hospital and the Staff to solicit, provide, and act upon information bearing on his/her professional ability and qualifications.
  2. 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.
  3. Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Staff membership and the continuation of such membership or to his/her exercise of clinical privileges or provision of specified patient services at the Hospital.
- C. 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 Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality, or contributing to clinical research shall, to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a Representative nor be used in any way except as provided herein or except as otherwise required 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.
- D. Immunity for Liability.**
1. **For Action Taken.** No Representative of the Hospital or Staff shall be liable to a Practitioner for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a Representative, if such Representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts. Truth shall be an absolute defense in all circumstances.
  2. **For Providing Information.** No Representative of the Hospital or Staff and no Third Party shall be liable to a Practitioner for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a Representative of this Hospital or Staff or to any other health care facility or organization of health professionals concerning a Practitioner or AHP who is or has been an applicant to or Member of the Staff or who did or does exercise clinical privileges or provide specified services in this Hospital, provided that such Representative or Third Party acts in good faith and without malice.

**E. Activities and Information Covered.**

1. **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 health care facilities organization's activities concerning, but not limited to:
  - a. Applications for appointment, clinical privileges or specified services.
  - b. Periodic reappraisals for reappointment, clinical privileges or specified services.
  - c. Corrective action.
  - d. Hearings and appellate reviews.
  - e. Quality management activities.
  - f. Utilization reviews.
  - g. Other hospital, department, committee, or staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct.
2. **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, emotional stability, professional ethics, or any other matter that might directly or indirectly affect patient care.

**F. 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 this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

**G. 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, and in the event of conflict, the applicable law shall be controlling.

**H. Joint Commission Surveys.** Surveys by the Joint Commission are part of the medical staff/hospital quality management process. Survey results shall be reviewed by the administrator and other appropriate authorities as part of their responsibilities to manage the quality management process and recommend action to improve quality of care.

# ARTICLE XI

## GENERAL PROVISIONS

**A. Staff Rules and Regulations.**

Subject to approval by the Board, the Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found in these By-Laws. These shall relate to the proper conduct of Staff organizational activities as well as embody the level of practice that is to be required of each Practitioner or AHP in the Hospital. Such rules and regulations shall be a part of these By-Laws, except that they may be amended or repealed at any regular meeting at which a quorum is present and without previous notice, or at any special meeting on notice, by a majority vote of those present and eligible to vote. Such changes shall become effective when approved by the Board.

**B. Departmental Rules and Regulations.**

Subject to the approval of the MEC, each department shall formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with these By-Laws, the general rules and regulations of the Staff, or other policies of the Hospital.

**C. Policies.**

Subject to the approval of the Board, the MEC and/or Credentials Committee shall adopt such Policies as may be necessary to carry out the functions of the Staff. These policies shall be appended to these By-Laws.

**D. Professional Liability Insurance.**

Each Practitioner or AHP granted clinical privileges or specified services in the Hospital shall maintain in force professional liability insurance in not less than the minimum amounts if any, as from time to time may be determined by resolution of the Board.

**E. Staff Dues.**

Subject to the approval of the Board, the MEC shall have the power to set the amount of annual dues for each category of Staff membership and the amount of the processing fee for initial applications and to determine the manner of expenditure of funds received.

**F. Forms.**

Application forms and any other prescribed forms required by these By-Laws and Policies of the Staff for use in connection with Staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports, and other matters shall be subject to adoption by the Board after considering the advice of the MEC and/or Credentials Committee.

**G. Construction of Terms and Headings.**

Words used in these By-Laws shall be read as the masculine or feminine gender and as the singular or plural, as the context requires. The captions or headings in these By-Laws are for convenience only and are not intended to limit or define the scope or effect of any provision of these By-Laws.

**H. Transmittal of Reports.**

Reports and other information that these By-Laws require the Staff to transmit to the Board, shall be deemed so transmitted when delivered, unless otherwise specified, to the CEO.

## ARTICLE XII

### I. ADOPTION AND AMENDMENT OF BYLAWS

- A. Staff Responsibility.** The Staff shall have the initial responsibility to formulate, adopt and recommend to the Board Staff By-Laws and amendments thereto which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency and of maintaining a harmony of purpose and effort with the Board and with the Community.
- B. Methodology.** Staff By-Laws may be adopted, amended, or repealed by the following combined action:
- 1. Staff.** A majority of those Active and Provisional Active members voting in accordance with Article IX.7 shall be the action of the Medical Staff, provided at least fourteen (14) days written notice, accompanied by the proposed By-Laws and/or alterations, has been given; and
  - 2. Board.** The affirmative vote of a majority of the Board. Provided, however, that in the event that the Staff shall fail to exercise its responsibility and authority as required by Section A of this Article, and after notice from the Board to such effect including a reasonable period of time, not exceeding ninety (90) days, for response, the Board may resort to its own initiative in formulating or amending Staff By-Laws. In such event, Staff recommendations and views shall be taken into account by the Board during its deliberations. [rev. 12/2002]

### II. Conflict Resolution (Added September 2011)

Each staff member in the active category may challenge any rule, regulation, policy, bylaw or procedure established by the MEC through the following process:

1. The staff member submits to the president of the medical staff his or her challenge to the document in writing, including any recommended changes to it.
2. At the MEC meeting that follows such notification, the MEC shall discuss the challenge and determine if it will change the document.
3. If changes are adopted, they will be communicated to the medical staff. At such time, each medical staff member in the active category may submit written notification of any further challenge(s) to the document to the president of the medical staff.
4. In response to a written challenge, the MEC may, but is not required to appoint a task force to review the challenge and recommend potential changes to address concerns raised by the challenge.
5. If a task force is appointed, the MEC will take final action on the rule, regulation, policy or bylaw based on the recommendations of the task force.
6. Once the MEC has taken final action in response to the challenge, with or without recommendations from a task force, any medical staff member may submit a petition signed by 10% of the members of the active category requesting review and possible changes to the document. (Note: The 10% must include from at least three different departments.) After receiving a petition, the MEC will follow the adoption procedure outlined in Article XII. Section I.

If the medical staff votes to recommend directly to the board an amendment to the bylaws, rules, regulations, or policies that is different from what the MEC has recommended, the following conflict resolution process shall be followed:

1. The MEC shall have the option of appointing a task force to review the differing recommendations of the MEC and the medical staff and recommend language to the bylaws, rules, and regulations or policies that is agreeable to both the medical staff and the MEC.
2. Regardless of whether the MEC adopts modified language, the medical staff shall have

the opportunity to recommend alternative language directly to the board. If the board receives differing recommendations for bylaws, rules, regulations or policies from the MEC and the medical staff, the board shall have the option of appointing a task force to study the basis of the differing recommendations and to recommend appropriate board action.

3. Regardless of whether the board appoints such a task force, the board shall have final authority to resolve the differences between the medical staff and the MEC. At any point in the process of addressing a disagreement between the medical staff and MEC regarding the bylaws, rules, regulations, or policies the medical staff MEC or governing board shall each the right to recommend using an outside facilitator to assist in addressing the disagreement. The final decision regarding whether to use an outside resource and the process that will be followed in so doing is the responsibility of the board. (Added Sept. 2011)

## ARTICLE XIII

### ALLIED HEALTH PROFESSIONALS

- A. For information regarding Allied Health Professional (A.H.P.) status and privileges, please refer to the **A.H.P. policy**.

## ARTICLE XIV

### PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

- A. For information regarding appointment and reappointment policies and procedures, please refer to: a) "**Appointment Policies and Procedures for YVMH**"; b) "**Reappointment Policy & Procedures for Processing an Application for Reappointment to the Medical Staff of YVMH**".

## ARTICLE XV

### DETERMINATION OF CLINICAL PRIVILEGES

- A. For information regarding clinical privileges, please refer to: a) policy "**Delineation of Clinical Privileges**"; b) "**Policy for Medical Staff Membership and Clinical Privileges for Podiatrists**"; c) policy "**Processing Requests for Temporary Privileges/Locum Tenens Requests**"; d) "**Allied Health Professional Policy**", section "**Procedure for Specification of Services**" e) **Temporary Privileges in the Event of a Disaster Policy**.

Temporary Privileges in the Event of a Disaster: (Please see Policy) During a disaster in which the emergency management plan has been activated and YVMH is unable to handle immediate patient need, the CEO or his/her designee, or Medical Staff President or his/her designee may grant temporary privileges. The Emergency Medical Director or designee will orient and provide oversight for practitioners granted temporary disaster privileges.

## ARTICLE XVI

### INTERVIEWS, CORRECTIVE ACTION

- A. For information regarding Interviews and Corrective Action, please refer to the **Fair Hearing Plan and Corrective Action Policy** of the Staff.

## ARTICLE XVII

### HEARINGS AND APPELLATE REVIEW

- A. For information regarding Hearings and Appellate Review, please refer to the **Fair Hearing Plan and Corrective Action Policy**.

#### ADOPTED:

YVMH Hospital Board of Trustees: 11/25/1991

#### REVISED:

April 14, 1993; May 15, 1995; October 15, 1996; October 21, 1998; July 20, 1999 (Consulting Staff); 12/99; 06/00; 12/02; 09/03; 03/05; 12/05 (Removal of Yakima Regional Medical & Cardiac Center), 05/07; 03/08 (Removal of Medical Records/UR, Education [change to function] and Endovascular QA Committees), 01/10, 9/11

Signature page on file in Medical Staff Services