

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 qualified to render direct or indirect medical, dental or surgical care under the supervision of an Active Member of the Staff who has been accorded privileges to provide such care in 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. BYLAWS means the Bylaws 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) d/b/a Virginia Mason Memorial (VMM), 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.
- M. MEMBER means any Physician, Dentist, or Podiatrist appointed and maintaining membership in any category of the Staff, in accordance with these Bylaws.
- 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:
 - 1. Article X (Confidentiality, Immunity and Releases);
 - 2. Fair Hearing Plan and Corrective Action Policy.

PREAMBLE

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 d/b/a Virginia Mason Memorial 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 Bylaws.

ARTICLE I - NAME

The name of this organization shall be the Yakima Valley Memorial Hospital d/b/a Virginia Mason Memorial 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. Ongoing 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 Bylaws, 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 Bylaws as necessary to adequately fulfill the foregoing responsibilities.
8. A current History and Physical shall be recorded and on the chart within twenty four (24) hours of admission or registration and prior to any surgical procedure or procedure requiring anesthesia services, by a qualified physician (or other licensed practitioner who has been credentialed and granted privileges to perform a history and physical examination). If the history and physical is completed by a practitioner who is not a physician, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

An H&P is considered current if it is less than thirty (30) days old and an update is performed within twenty four (24) hours of admission or registration, and prior to sedation or anesthesia services and any other procedures that are identified in the Universal Protocol Policy. An update to the H&P summarizes any changes that have occurred or should note that there are no changes since the original H&P. The update can be recorded in the progress note.

If the original H&P is greater than thirty (30) days old, a complete new H&P shall be recorded within twenty four (24) hours of admission or registration.

The Medical Staff may include additional, more specific, requirements for history and physical examinations in the rules and regulations.

- 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 Bylaws 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.

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.
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 Staff and the AHP category.
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 Bylaws.

4. 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 or the CEO, CMO, COO or division chief. 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 one or more of the officers of the MEC and the CEO, CMO or COO 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. a. Continuous Patient Care: Each 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 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 Active Staff to attend the patient.
- b. On-Call Obligations: Each 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) Each physician will be required to take four (4) 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.

- (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 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 Active Staff members.

- d. Medical Back-up On Call: This call group shall consist of 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 MEC
- e. Specialty Call: 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, Family Medicine, Gastroenterology, Hematology/Oncology, Hospitalists, Nephrology, Neurology, Neurosurgery, Ophthalmology, Orthopedics, Pain Medicine, Pediatric Hospitalists, 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 MEC based on Medical Staff membership.
- f. On-Call Residence: Each member of the Active Staff must reside or maintain an on-call residence 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.
- e. Provide change of address and phone numbers as well as call group members as changes occur.
 - f. Agrees to abide by the terms of the Bylaws and related manuals and other policies of the Staff and those of the Hospital 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.

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, Courtesy, Consulting or Resident Staff if they are involved in patient care in the hospital.

Determination for reappointment to particular Staff categories may in part depend upon the number of patient care contacts. For physicians who hold privileges to admit or perform surgery/procedures, involvement in greater number of patient contacts than outlined on the privilege form shall result in automatic transfer to the appropriate category unless the physician can demonstrate to the MEC that his/her practice patterns have changed and that they will comply with activity limitations for this category. 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.
- Working a shift as an Emergency Department Physician, pathology, anesthesiology or radiology physician.

No Practitioner 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]

Qualifications:

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.

Responsibilities:

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.

They shall be required to attend meetings in accordance with these Bylaws, and to pay annual membership dues and /or assessments when due.

Prerogatives:

Active Staff members shall be eligible to vote, hold office and serve as chairpersons of Staff committees.

2. **Courtesy Staff**

Qualifications: Courtesy staff members shall:

The Courtesy Staff shall consist of Physicians, Dentists, and Podiatrists who only occasionally admit patients: (Less than 20 patients in a two [2] year time period).

Responsibilities:

- a. Are responsible for the transaction of all the business of the Medical Staff and for the quality and appropriateness of medical care in the hospital.
- b. Courtesy Staff Members will participate in quality management activities.
- c. Courtesy Staff Members shall pay annual membership dues and special assessments when due.

Prerogatives:

- a. May attend and vote at department meetings and sit on medical staff committees.

3. Consulting Staff

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.

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 Bylaws of the medical staff.

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.
- b. Consulting Staff may not admit patients but may write or give verbal orders within the scope of their privileges.
- 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]

4. Locum Tenens Staff

Locum Tenens Practitioners must satisfy the qualifications and conditions for appointment to the Medical Staff and have completed the Medical Staff initial appointment or reappointment process, as appropriate. Locum Tenens Staff may not be eligible in any other category of the Medical Staff but fulfill a need in departments within the Medical Staff. Requests for Clinical Privileges shall be processed in the same manner as specified for other practitioners. They may attend Hospital educational programs and may exercise their approved Clinical Privileges for up to 120 consecutive days. On case-by-case basis the practitioner will be moved to locum tenens status for a period not to exceed two years. The Locum Tenens staff are not eligible to vote, hold office, or serve on Medical Staff Committees and may be dismissed from the Locum Tenens Staff at the discretion of the MEC. Neither the granting, denial, nor termination of Locum Tenens Staff status shall entitle the individual concerned to any of the procedural rights or review unless the action is reportable to the National Practitioner Data Bank.

5. Telemedicine Staff

The Telemedicine Staff shall include those practitioners who, from a remote site, will provide specialty/subspecialty consultative care in a timely fashion for VMM patients. Telemedicine staff will demonstrate a willingness to be active participants in performance improvement, professional review, and quality measures.

Prerogatives

- Not eligible to hold Medical Staff Office or to vote at meetings of the Medical Staff.
- Shall not be required to serve on the Medical Staff and Hospital committees and/or multidisciplinary teams.
- Exempt from the Immunization Policy
- *Contingent on/related to a contractual relationship with the Hospital.*

B. Non-Patient Care Categories

Practitioners who are qualified for Staff membership shall belong to the Affiliative, Ambulatory, or Emeritus 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 shall not be eligible to vote or to hold office in the staff organization.

If a Member of the Affiliative, Ambulatory, or Emeritus category desires to become a Member of a patient care category, he/she must join an appropriate staff category and obtain privileges.

1. Affiliative

Shall consist of Physicians, Dentists, and Podiatrists who maintain a clinical practice in the hospital service area and wish to follow their patients when they are admitted to the hospital.

Prerogatives:

Members can order outpatient diagnostic tests and services; visit their established patients in the hospital; review their established patient's medical records; discuss ongoing management with the attending physician; and attend medical staff, committee or department/clinical service meetings, continuing medical education functions and social events.

Members cannot be eligible for clinical privileges and cannot manage patient care in the hospital. Members cannot vote on medical staff issues or hold office. Members shall be assessed annual dues as set by the MEC.

2. Ambulatory

Ambulatory Status shall consist of Practitioners who desire to practice in one or more of VMM/Memorial Physician (MP)'s clinics, but do not wish to, or do not qualify for the exercise of clinical privileges on an inpatient basis at the hospital. Ambulatory Status providers may provide procedures, care, and treatment on an outpatient basis for patients. Providers of the Ambulatory Status may not admit inpatients but may initiate an admission by referring a patient to a physician with admitting privileges. Ambulatory Status providers may visit their hospitalized patients and review their patient's medical records, but may not write orders for inpatients or exercise any inpatient clinical privileges.

Prerogatives

- Only Practitioners who are employed by VMM/MP or who are a party to a contractual arrangement with VMM/MP are eligible to request Ambulatory Status and privilege(s) in outpatient clinics, regardless of education, training, and experience.
- Shall be appointed to the Ambulatory Division.

- Actively participate in the performance improvement activities required of the staff and discharge such other Staff functions as may from time to time be required.
- Satisfy the requirements for attendance at meetings of the Staff and Committees of which the provider belongs.
- Cannot hold office.
- Pay dues as established by the MEC.

3. **Emeritus.**

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. Fifteen (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.

Prerogatives:

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, have access to the EMR, or pay dues.

ARTICLE VI – DEPARTMENTS/DIVISIONS

- 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.

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 RCW 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.
 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 accomplishments of the functions generally assigned to such components in these Bylaws 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.

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 Bylaws to the satisfaction of the Members of the applicable Department, of the MEC, and of the Board.
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. Roles and Responsibilities:

- a. Clinically related activities of the department.
- b. Administratively related activities of the department. 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.
- c. Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges. Be responsible for further evaluation of case referrals from the Quality Management Department, including documentation of care, action taken, and recommendations made.
- d. Recommending to the medical staff the criteria for clinical privileges that are relevant to the care provided in the department.
- e. Recommending clinical privileges for each member of the department. In fulfillment of this responsibility, the chairperson will be responsible for the initial review of all physician applications for appointment or reappointment to the medical staff and clinical privileges for physicians and allied health practitioners assigned or to be assigned to his/her department. The Department Chairman shall serve as the agent of the Credentials Committee in performing this review and shall prepare a written report of his/her review findings and recommendations for the Credentials Committee.
- f. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.
- g. Integration of the department or service into the primary functions of the organization, implementing within the department actions taken by the MEC and by the Board.
- h. Coordination and integration of interdepartmental and intradepartmental services.
- i. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- j. Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.
- k. Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.
- l. Continuous assessment and improvement of the quality of care, treatment, and services.
- m. Maintenance of quality control programs, as appropriate. Be accountable to the effective conduct of the quality improvement activities including review, evaluation, and monitoring functions delegated to the department.

- n. Orientation and continuing education of all persons in the department.
- o. Recommending space and other resources needed by the department. 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
- p. 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
- q. Appoint such committees as are necessary to conduct the functions of the department and designate a chairperson
- r. Each chairperson shall be accountable to the Division Chief, MEC, Staff President, and Board in fulfilling the aforementioned duties.

G. Divisions

1. Organization

In order to promote effective Medical Staff management and in order to enhance the quality of medical care the Medical Staff shall be organized into four Divisions: Medicine, Surgery, Women and Children's Services, and Ambulatory Medicine; and each Division into clinical Departments with each Member assigned to the Division in which he/she has the majority of clinical privileges. The member may participate in more than one division based on clinical activity, and may vote on issues relating to each division with Credentials Committee approval.

- a. The Medicine Division is organized to include inpatient medical services. Disciplines in this Division may include: Family Medicine, Emergency Medicine, Radiology, and Internal Medicine with associated medical subspecialties, and Cardiopulmonary.
- b. The Surgery Division is organized to include primarily surgical services. Disciplines in this Division may include all Surgical Specialties, Anesthesia, and Professional Services including Pathology.
- c. The Women and Children's Services Division is organized to include OB/GYN and Pediatric inpatient services. Disciplines/Sections in this division may include Obstetrics, Gynecology, Pediatrics, Family Medicine, and associated medical subspecialties.
- d. The Ambulatory Medicine Division is organized to include outpatient medical services. Disciplines in this division may include; Family Medicine, Internal Medicine, Medical Specialties Pediatrics, Outpatient psychiatry, and associated medical subspecialties.

The Medical Executive Committee may periodically review this structure and recommend to the Board the modification of the above organization, including the creation, elimination, or combining of Divisions and/or Department for greater organizational efficiency and improved patient care. Any Division and/or Department created must satisfy the functions of Divisions and/or Department.

2. **Assignments**

After consideration of the recommendations for membership and privileges by the affected Divisions, the Credentials Committee shall make recommendations to the Board for medical staff membership and recommendations for Privileges for each applicant prior to appointment and reappointment. Each Member will be assigned to the Division in which he/she has been granted privileges and in which the member demonstrates clinical activity.

3. **The Following criteria shall apply in making Division and/or Department designations:**

- a. The area of practice represents a general, distinct field of medical practice at the hospital.
- b. The level of clinical activity at the Hospital is substantial enough to warrant imposing the functions assigned to Clinical Divisions and Department.
- c. An individual practitioner, based on clinical privileges, may be part of one or more Divisions or Department.

4. **Division Chiefs:**

a. Selection and Appointment Process:

In order to apply for the position of Division Chief a Candidate shall be an active staff member or become a member of the active Medical Staff upon appointment to the position of Division Chief. Applications will be reviewed by the Selection Committee and interviews arranged when appropriate. After following the process outlined in the Selection Policy, the final candidate selected by the Selection Committee will be presented to the Division for ratification. Ratification of the final candidate shall be by a majority of Division members casting a ballot.

b. Duties of Division Chiefs:

1. Report to the President of the staff on medical staff issues such as credentialing, quality improvement and other clinical concerns within the division or section.
2. Report to the Chief Medical Officer (CMO) for hospital operation or administrative concerns.
3. Be a member of the Medical Executive Committee and other committees as appropriate.
4. Be responsible for quality performance, peer review, credentialing, and strategic planning and communication in their division.
5. Be responsible for implementation of Medical Staff Bylaws and policies within the division.
6. Other duties as defined by the hospital job description.

c. Performance evaluation of the Division Chief:

1. Annual review of the performance of the Division Chief will be carried out by the President of the Medical Staff and the Chief Medical Officer.
2. Annual review will be based upon performance measured against annual goals and objectives for the Division Chief as established in conjunction with the President of the Medical Staff and the Chief Medical Officer.
3. Annual review shall include a 360 evaluation including representative stakeholders to include no less than two department chairmen within the Division as determined by the President of the Medical Staff and Chief Medical Officer in conjunction with the Division Chief being evaluated.

d. **Removal of Division Chiefs:**

Division Chiefs may be subject to removal from their position. This may be based upon failure to perform the duties of the position held and failure to fulfill the duties as noted in the Medical Staff Bylaws, policies or job description. Removal from office may be based on an unsatisfactory or incomplete annual review and is subject to approval of the Medical Executive Committee and Chief Medical Officer in consultation with the Senior Executive Team.

Consideration for removal can be initiated by a petition of ½ of the members of the Division presented to the President of the Medical staff and Chief Medical Officer or a recommendation by the Chief Medical Officer in consultation with the Senior Executive Team.

5. **Division Roles and Responsibilities:**

a. Clinically related activities of the Division

Each Division shall provide a forum for its members to contribute their professional views and insights to the formulation of Section, Medical Staff and Hospital policy and plans. In addition, the division will provide a multi-specialty forum for matters of clinical concern and for resolving clinical issues arising out of the interface between its members' activities and the activities of other patient care services.

b. Administratively related activities of the Division unless provided by the hospital.

c. Surveillance of the professional performance of all individuals in the Division who have delineated clinical privileges.

Each Division shall review quality improvement data and findings pertinent to the division and make recommendations to take action as appropriate; conduct reviews and special studies of processes and outcomes of care, perform specified monitoring and evaluation and report findings of studies and other activities by serving on medical staff quality review committees.

d. Recommend to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the Division.

Each Division shall integrate and cooperate with the Credentials Committee to establish, implement and monitor its members' adherence to clinical standards, policies, procedures and practices relevant to various clinical disciplines under its jurisdiction; develop consistency in patient care standards, policies and procedures within the Division and across any of its constituent Departments, develop and recommend, in consultation with various specialists and subspecialists, criteria for use in making credentialing and privileging recommendations for initial appointments, reappointments and other credentialing matters.

e. Recommend clinical privileges for each member of the Division.

f. Assessing and recommending to the relevant hospital authority off-site sources for needed patient care treatment and services not provided by the division or organization.

g. Integration of the Department or Service into the primary functions of the organization.

- h. Assure coordination and collaboration between Departments within the Division and between Divisions.
- i. Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.
- j. Recommendation for a sufficient number of qualified and competent persons to provide care, treatment and services.
- k. Determination of the qualifications and competence of division or service personnel who are not licensed independent practitioners and who provide patient care treatment and services.
- l. Continuous assessment and improvement of the quality of care, treatment and services.
- m. Maintenance of quality control programs as appropriate.
- n. Orientation and continued education of all persons in the Division.
- o. Recommending space and other resources needed by the Division.

(October 2016)

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
 - d. Past-President
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 Bylaws. 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 Bylaws, 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 Bylaws 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 Bylaws.
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.

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 Bylaws, 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 (voting member)
 - g. Serve as ex-officio member without vote on the Board of Trustees (YVMH).
 - 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.
 - j. Serve as chairperson of the QA Executive Committee.
2. **Vice-President:** The Vice-President shall be responsible for the Bylaws review and revision function. He/she shall be a voting 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.
3. **Secretary/Treasurer:** The Secretary/Treasurer shall be a voting 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:
 - 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 delegatee shall not be deemed a member of any Staff committees and has no vote.

4. **Past-President:** The Past-President shall serve in an advisory capacity to the medical Staff Officers. In accordance with this role, the Past-President shall:
- Attend Medical Staff Officer Meetings as an advisor.
 - Serve on the MEC with a vote
 - Serve on the Medical Staff Quality Assurance Committees as an ex-officio without vote.
 - At the discretion of the Medical Staff President, participate in corrective action proceedings as an advisor to the President.
 - Act as a delegate of the President, or other Medical Staff Officer, at the discretion of the President.
 - Serve as a voting member of the Credentials Committee as outlined in the Medical Staff Bylaws.

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 Bylaws. 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 Bylaws 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 Medical Executive Committee shall consist of Medical Staff Officers, Division Chiefs (or designated temporary alternates), and the chairperson of the Credentials Committee. Ex officio members include the CMO, Quality Medical Director, CEO his/her representatives, CMIO, invited members of the board. As necessary other practitioners may be invited when needs arise. These invitees shall not vote. (October 2016.)
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 Bylaws and the rules and regulations of the Staff. The authority of the MEC is outlined in this section B.2 and additional functions may be delegated or removed through an amendment of this Section B.2.
 - 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.
 - l. Approve all Performance Improvement Plans (FPPE/OPPE) initiated through non-confidential corrective action proceedings or Quality Assurance Committees to ensure fairness and prevent conflicts of interest. This does not include confidential corrective action plans initiated by the Medical Staff Officers in accordance with Medical Staff Bylaws and the Code of Conduct Policy.
3. **Meetings:** The MEC shall meet for at least six (6) meetings per year and maintain a permanent record of its proceedings and actions.
 4. **Selection/Election and Removal of MEC Members:**
Members of the MEC shall be selected/elected/removed in accordance with the provisions governing removal from their respective Medical Staff leadership roles. Officers of the Medical Staff who are ex officio members of the MEC shall be removed in accordance with the procedures described in Section F.3.

C. Staff Functions

Provision shall be made in these Bylaws, 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 Bylaws, 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.
2. All Staff departments and committees, as listed in these Bylaws 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.
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:
 - 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 Courtesy 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 Courtesy 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.
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.

G. **Cancer Committee**

1. **Policy and Procedure Manual:** The Cancer Committee functions in accordance with the current Commission on Cancer Standards. The Cancer Committee also has accountability for cancer program activities.
2. **Composition:** As directed by the Criteria of the Commission on Cancer of the American College of Surgeons.
Voting: As directed by the Criteria of the Commission on Cancer of the American College of Surgeons.
- 3 **Duties**
 - a. To establish and maintain a Comprehensive Community Cancer Program (CCCP) according to guidelines of the Commission on Cancer of the American College of Surgeons.
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.

H. **Cardiac, Pulmonary & Critical Care Quality Assurance/Performance Improvement Committee**

1. **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 MEC
 - 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:
 - a. One Physician to serve as chairperson for a three (3) 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 three interested Physicians shall be appointed by the Staff President to serve three (3) year renewable terms.
 - c. The representative of the medical staff Pediatric Department.
 - d. Five health care professionals (for example social worker, respiratory therapists) from the Hospital, appointed by the Hospital administration to serve three (3) year renewable terms.
 - 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.
 - 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.
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.
 - 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.

J. Credentials Committee

The Credentials Committee shall serve as a regularly constituted committee of the Hospital under RCW4.24.250 with the responsibility for the prospective evaluation of physician competency and qualifications to render particular services for initial applications for medical staff appointment and privileges and the retrospective review of such competency and qualifications for reappointment applications. The Credentials Committee shall report its initial appointment and its reappointment review findings to the Medical Executive Committee.

Hospital staff engaged in the creation, collection, and/or maintenance of information to be used by the Department Chair and/or Credentials Committee for the review of and recommendation on

initial appointment applications and reappointment applications are acting as staff, agents and/or investigators of the Credentials Committee. Hospital staff's initiation of the creation, collection and/or maintenance of information to be used by the Department Chair and/or the Credentials Committee for these purposes shall constitute the initiation of peer review under RCW 4.24.250 for these applicants for appointment or reappointment.

1. **Composition:** The Credentials Committee shall consist of: a) 3 past Presidents for the Medical Staff and 3 physician members appointed (1 each year to serve a 3 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. All voting members must attend a Credentials CME course within 12 months of appointment to the Credentials Committee (unless completed within the previous 3 years) and at least every 3 years while serving.. Ex-officio members: Medical Staff President; Chief Medical Officer, Administrator/CEO or designee, and representatives from Medical Staff Services. Vacancies in the Committee will be filled by appointment of the Medical Staff President.
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.

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.
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.
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.

L. Emergency Department Quality Assurance/Performance Improvement Committee

1. Composition:

- a. The Chairperson shall be appointed to a two-year terms 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 terms by the chairperson of his/her Medical Staff Department. Each Member listed below shall have a vote. Any Member who cannot attend a meeting shall be responsible to see that an alternate department member attends.
- c. Four representatives from the Department of Emergency Medicine, one hospitalist, one member from the departments of CPCC, Surgery, Pediatrics and Radiology. When needed for discussion purposes other departments may be called.
- d. Ex officio members without a vote shall include the Medical/QA Director, QA/PI Coordinator, Risk Manager and other health care professionals at the 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 MEC.
- 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.
 - f. Acknowledge referrals made to the QA Committee, by written letter, to the Department Chair within two weeks after review by the QA Committee
3. **Meetings:** The EDQA/PIC shall meet at least quarterly.

M. Medical Quality Assurance/Performance Improvement Committee (MQA/PIC)

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 MEC
- 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.
- 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.

N. Perinatal Quality Assurance/Performance Improvement Committee (PQA/PIC)

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. 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 MEC.
- 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.

O. **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 formulary 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.

P. Practitioner Wellness Committee

- 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 (3) 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.

Q. 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.
- 3. **Meetings:** The Committee shall meet at least quarterly and shall report its findings to the MEC for action.

R. 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.

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.

S. Surgical Quality Assurance 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: Anesthesia; Head & Neck; Surgery; Radiology; Family Medicine and Pediatrics. The Pediatric Department representative will attend as needed.

- (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 MEC
- 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.

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

T. Trauma (Interdisciplinary) Committee- For Yakima Valley Memorial Hospital 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 the Trauma Committee Policy.
- 2. **Voting:** Voting members of the Trauma Committee are as delegated in the Trauma Committee 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 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.

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

U. Trauma Quality Assurance Committee: For Yakima Valley Memorial Hospital Trauma Services

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 MEC
- 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, MEC 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.

V. Utilization Review Committee: (Added January 2016)

In accordance with 456.105-456 a Utilization Review Committee has been established as a committee of the hospital/medical staff specifically, as a subcommittee of the Medical Executive Committee (MEC). The MEC has the responsibility and authority to take action relative to findings from the utilization review activities, and evaluates the effectiveness of the UM program and approves the written plan. Please see the UR Committee Plan for more details.

1. Composition:

Shall be composed of two or more physicians, (voting members) and may be assisted by other Professional personnel (non-voting members) representing Administration, Health Information Management, Business Services, Decision Support, Care Coordination, Department of Compliance, Performance Improvement, Medical Staff Services and Pharmacy. It will exclude physicians and other professional personnel who may have a conflict of interest, noting physicians and other health professionals may not review/vote on cases under their own care. In addition physicians with a personal financial interest in the hospital may not serve on this committee.

2. Responsibilities:

- Integrate and coordinate the UR activities
- Investigate the appropriateness of resource conservation/allocation regardless of pay source
- Approve utilization review criteria and receive report of utilization management activities.
- Prioritize identified problems, facilitating corrective actions and monitor for corrective action to assure problem resolution

- Provide education reviews and learning processes to Medical Staff
 - Respond to directive from the Professional Review Organization for Washington State
 - Assist with appeals for admission and length of stay denials from outside agencies
 - Ongoing review of regulatory requirements with appropriate review and revision of the written UR policy
 - Monitor the UR Committee's analytic reports for trends in observation vs. inpatient status, length of stay, re-hospitalization, denied days and compare to internal, and if available external benchmarks.
 - Review the case mix index, morbidity and mortality rates
 - Monitor no bills, HINN and ABN activity
 - Identification of specific cases for peer review
 - Identification of specific providers for peer review or intervention by the CMO
 - Collaborative review of selected cases
 - In collaboration with the Pharmacy and Therapeutics Committee evaluation/mitigation of high-cost pharmaceuticals impacting LOS or re-hospitalization
 - Review progress of the Clinical Documentation Improvement Program
 - Review the quarterly PEPPER report
 - Track and trend all cases with condition code 44 or W@ with reporting to URC
 - Monitor and review all 1 day stays for medical necessity and appropriate status.
3. **Meetings:** will meet at least monthly.

W. **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.
- b. Regular meetings may be held at the request of the Medical Staff Officers, the Medical Executive Committee, or the Hospital Board.

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.

4. **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.

5. Quorum

- a. General Staff Meetings. Thirty-three (33%) of the Active Staff shall constitute a quorum except as noted in 6.a. below. For the purposes of quorum requirements, a member of the 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 6(a) "Manner of Action."

6. 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.
- b. It will be the option of the Medical Staff President, the Medical Executive Committee, or a group of not less than 30 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 6.a.
- c. For the purpose of meeting regulatory requirements (TJC, 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.

7. **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.

8. Attendance Requirements

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

B. Committee and Department Meetings

- 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.
- 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.
- 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 (I) 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:** 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 Bylaws. 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 Bylaws, 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.

In cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulations, the Medical Executive Committee may provisionally adopt and the Governing body may provisionally approve an urgent amendment without prior notification of the medical staff. In such instances the medical staff will be immediately notified by the Medical Executive Committee. The medical staff has the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the committee, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

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 Bylaws, 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 shall adopt such Policies as may be necessary to carry out the functions of the Staff. These policies shall be appended to these Bylaws.

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 Bylaws 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 Bylaws 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 Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

H. Transmittal of Reports

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

ARTICLE XII - ADOPTION AND AMENDMENT OF BYLAWS

- A. **Staff Responsibility:** The Staff shall have the initial responsibility to formulate, adopt and recommend to the Board Staff Bylaws 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 Bylaws may be adopted, amended, or repealed by the following combined action:
1. **Staff:** A majority of those Active members voting in accordance with Article IX.6 shall be the action of the Medical Staff, provided at least fourteen (14) days written notice, accompanied by the proposed Bylaws 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 Bylaws. In such event, Staff recommendations and views shall be taken into account by the Board during its deliberations.

I. **CONFLICT RESOLUTION:**

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.

ARTICLE XIII - ALLIED HEALTH PROFESSIONALS

- A. Allied Health privileges shall be available to health care professionals, other than physicians, who hold a license or other legal credential as required by state law to provide certain professional services, (“AHP”). The “privileges” given to AHP’s may differ substantially in scope from privileges granted other Medical Staff members. Said privileges shall be subject to the conditions set forth in these Bylaws and any Policy or Procedure adopted by the Medical Staff as a whole or by the applicable Department. Categories of AHP’s approved to apply for privileges include the categories of: Advanced Registered Nurse Practitioners (ARNP – to include Certified Nurse Midwives, Certified Registered Nurse Anesthetists, and Neonatal Nurse Practitioners), and Physician Assistants (PA), Psychologists, and Registered Nurse First Assistants (RNFA). For more information regarding Allied Health Professional status and privileges, please refer to the AHP policy.

ARTICLE XIV - PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

- A. Processing the Application
1. **Applicant’s Burden** - The Applicant shall have the burden of producing accurate and complete information for a proper evaluation of his/her experience, background, training and demonstrated ability, and physical and mental health status, and of resolving any doubts about these or any of his/her qualifications.
 2. **Verification of Completeness of Application**
 - a. When an application has been returned by the Applicant and is deemed complete, a notification acknowledging receipt of the application will be sent to the Applicant.
 - b. If an Application has been returned and is deemed incomplete, the Applicant will be contacted identifying the missing items.
 3. **Verification of Information**
 1. When the application is received by MSS and is deemed to be complete, the applicable Department Chairperson shall be informed. Representatives of MSS, working with the Credentials Committee Chairperson, organize and coordinate the collection and verification of information.
 2. **Verification Pending**
 - a. If after thirty (30) days, items are still pending, the Applicant will be notified of the need for assistance in gathering missing information.
 - b. If after another fifteen (15) days, the pending items have not been received, MSS will (after consultation with a member of the Credentials Committee or Medical Director, as necessary), request assistant from the applicant describing the information pending and shall indicate the deadline by which the information is to be returned. The date may be modified to the extent necessary and reasonable. Failure of the Applicant to provider the requested information by the date required will result in termination of the application process. This is not reportable to the NPDB and the applicant shall not be entitled to the procedural rights provided in the Fair Hearing Plan.

3. When collection and verification is complete, MSS shall transmit the application and all supporting materials to the Chairperson of each Department in which the Applicant seeks membership and/or privileges. The Applicant shall be so notified.

4. **Department Chairperson:**

Department Chairperson's Report - The Department Chairperson shall review the application. He/ She will schedule the interview with the Applicant, in person or by telephone, within seven (7) days and have the interview completed within fifteen (15) days. If the interview is not scheduled within seven (7) days, the Credentials Committee will be asked to facilitate the interview. In reviewing and submitting the report to the Credentials Committee, the Department Chair is acting as an agent or investigator for the Credential's Committee. *Interviews do not need to be performed on an AHP practicing under a scope of service. Furthermore, if an AHP applicant's credentials file is deemed by the Department Chairperson to be free of any discrepancies, an interview is not necessary.*

A. **Favorable Findings:** Department Chairpersons must document their findings pertaining to adequacy of education, training and experience for all privileges requested. References to any criteria for privileges review must be documented. Specific reference to the credentials file should be made in support of all findings.

B. **Deferral of Report:** If a Department Chairperson requires further information, he/she may defer transmitting his/her report, for as many as thirty (30) days, except where more time is necessary and good cause exists for additional deferral, the applicable Department Chairperson must notify through MSS, the Applicant, the Chairperson of the Credentials Committee, and the Medical Staff President in writing of the deferral and the grounds. If the Applicant is to provide the additional information or a specific release/authorization to allow hospital representatives to obtain information, the notice to him/her must so state, must be a Special Notice, and must include a request for the specific data/explanation or release/authorization required and the specific date for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application. In the event a Chairperson is unable to formulate a report for any reason, he/she must so inform the Credentials Committee.

C. **Unfavorable Findings:** Department Chairpersons must document the rationale for all unfavorable findings.

5. **Credentials Committee Action** - The Credential Committee composition, function and duties are outlined in the Medical Staff Bylaws Article VIII J. The Credentials Committee meetings occur at least 10 times per year.

During the next Credentials Committee meeting, after receipt of the Department Chairperson's Report, the Committee will review the content of the Applicant's file and will conduct, unless previously done by the appropriate Department Chairperson, a personal and/or telephone

interview with the Applicant. The Credentials Committee will then make a recommendation regarding Staff Membership and/or Privilege delineation to the Medical Executive Committee for transmittal to the Governing Board. The recommendation shall be made within thirty (30) days after the applicant has been notified that the application is complete.

- A. **Favorable Recommendation:** When the Credentials Committee's recommendation is favorable to the Applicant in all respects, the file shall promptly forward with the recommendation, as well as at least one copy of all supporting documentation, to the Medical Executive Committee. "All Documentation" means the application forms and accompanying information, the reports and recommendation of the Department Chairperson, Credentials Committee, and all dissenting views.
- B. **Deferral Recommendation:** Action by the Credentials Committee to defer the application for further consideration must be followed within forty-five (45) days by subsequent recommendations as to approval or denial of, or any special limitations to, Medical Staff appointment, category of Medical Staff and prerogatives, department affiliations, and scope of clinical privileges. The Credentials Chair or Medical Staff Services shall promptly send the Applicant written notice of an action to defer.
- C. **Adverse Recommendation:** If the Credentials Committee determines that the applicant be denied, or that the scope of clinical privileges be less than those applied for, the reasons and supporting documents shall be forwarded to the Medical Executive Committee.

6. **Medical Executive Committee**

MEC Review and Recommendation at the next scheduled meeting, after receipt of the Credentials Committee's Report and recommendation, the MEC shall vote:

- A. **Favorable Recommendation:** When the MEC's recommendation is favorable to the Applicant in all respects, the MEC shall promptly forward with the recommendation to the Governing Board.
- B. **Deferral Recommendation:** Action by the MEC to defer the application for further consideration must be followed within forty-five (45) days by subsequent recommendations as to approval or denial of, or any special limitations to, Medical Staff appointment, category of Medical Staff and prerogatives, department affiliations, and scope of clinical privileges. The Credentials Chair or Medical Staff Services shall promptly send the Applicant written notice of an action to defer.
- C. **Adverse Recommendation:** If the MEC determines that the applicant be denied, or that the scope of clinical privileges be less than those applied for, the Fair Hearing Plan shall be initiated.

If an MEC meeting is cancelled, action on credential items should not be deferred. Voting members of the MEC will be requested to review credential items in the Medical Staff

Office and provide a written vote. A simply majority will be sufficient to forward items to the Governing Board.

7. **Governing Board Action** - The Governing Board may adopt or reject, in whole or in part, a favorable or unfavorable recommendation from the MEC.

- A. **Based on a Favorable Action:** In the event that the Board of Trustees' decision is favorable to the applicant, such decision shall constitute final action on the application. The CEO or his/her designee shall promptly inform the applicant that his/her application has been approved. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.
- B. **Deferral of Action:** The Governing Board may refer the recommendation back to the MEC for further consideration, stating the reasons for the referral back and setting a time limit within which a subsequent recommendation must be made.

As part of any of its actions outlined in this Credentialing Policy and Procedure Manual, the Governing Board may, at its discretion, conduct an interview with the Applicant, or designate one or more individuals to do so on its behalf. If, as part of its deliberations, the Governing Board determines that it requires further information, it may defer action but for generally not more than thirty (30) days, except for good cause, and it shall notify the Applicant and the President of the Staff in writing of the deferral and the grounds for the deferral.

If the applicant is to provide additional information or a specific release/authorization to allow Hospital representative to obtain information, the notice to the Applicant must so state, must be a Special Notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for a response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application and does not entitle the procedural rights provided in the Fair Hearing Plan.

- C. **Adverse Action:** In the event of an Adverse Board action on an Applicants credential file, a Special Notice will be mailed by a representative of the Governing Board to the Applicant, the Applicant shall then be entitled to the procedural rights provided in the Fair Hearing Plan.
- D. **Adverse Board Action defined:** Adverse action by the Board means action to deny appointment or reappointment, or to deny or restrict clinical privileges.

E. **After Procedural Rights:** In the case of adverse MEC recommendation and a request for a Hearing, the Board will take final action on the matter as provided in the Fair Hearing Plan.

8. **Basis for Recommendation and Action:** The report of each individual or group, including the Board, required to act on an application must state the reasons for each recommendation or action taken, with specific reference to the completed application and all other documentation considered

9. **Notice of Final Decision:**

A. Notice of the Governing Board's final decision shall be given through the CEO to the MEC, the Credentials Committee and to the Chairperson of each Department concerned. The Applicant shall receive written notice of appointment or Special Notice of any adverse final decision within ten (10) calendar days of the Governing Board decision.

B. A decision and notice of appointment includes:

1. The Staff category to which the Applicant is appointed.
2. The Department to which he/she is assigned.
3. The clinical privileges he/she may exercise.
4. Any special conditions attached to the appointment.
5. Notice of onboarding/orientation process.

10. **Application after Adverse Appointment Decision**

Except as otherwise provided in the Bylaws or as determined by the Credentials Committee, in light of exceptional circumstances, an Applicant or Member who has received a final unfavorable decision regarding, or who has voluntarily resigned to avoid an adverse action, or accepted a condition, limitation or restriction on, or withdrawn an application for appointment, Medical Staff category, Department assignment, or clinical privileges, is not eligible to reapply to the Medical Staff or for the applicable category, Department assignment, or privileges for a period of twenty four (24) months from the date of the notice of the final unfavorable decision or the effective date of the resignation or application withdrawal. Any such reapplication shall be processed in accordance with the procedures set forth in this Policy. The Applicant or Member must submit such additional information as the Medical Staff and/or Governing Board may require in demonstration that the basis of the earlier unfavorable action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed. No Applicant or Member shall submit or have in process at any given time more than one application for initial appointment, reappointment, Medical Staff category, a particular Department assignment or the same clinical privileges.

B. **Reappointment/ Recredentialing Process**

1. **All Staff categories** shall be reappointed or recredentialed with exception of Resident, Education, or Emeritus.
2. **Notice of Expiration** shall be sent to each qualified reappointment.

3. **Time requirement for Reappointment/ Recredentialing Forms –**

Each Member requesting reappointment shall deliver his/her completed reappointment forms to MSS within fifteen (15) days of the notice of expiration. Extensions may be granted for an additional fifteen (15) days by MSS. Failure, without good cause, to return the forms to MSS shall be deemed a voluntary resignation from the Staff and shall result in automatic termination of Membership/Privileges at the expiration date of the Member's current term of (re) appointment/ (re)credentialing.

No temporary privileges will be extended to practitioners whose reappointment processing has not been completed by the date of the expiration.

4. **Processing of Reappointment/ Recredentialing –**

Members will be notified if the forms are incomplete or information is missing. The Practitioner shall return corrections or the additional information to the MSS within ten (10) business days.

5. **Reappointment Approval Process**

When Collection and verification are complete, the reappointment approval process will follow as outlined in Section 4 through 10 of this Article.

ARTICLE XV - DETERMINATION OF CLINICAL PRIVILEGES

A. DELINEATION OF PRIVILEGES

1. **REQUESTS:**

Each application for appointment or reappointment to the Staff must contain a request for specific clinical privileges desired by the Applicant. Specific requests must also be submitted for a modification of privileges in the interim between appointments.

2. **BASIS FOR PRIVILEGES DETERMINATION:** Requests for clinical privileges will be evaluated based on education, training, experience, demonstrated competence, ability and judgment. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include observed clinical and documented results of the Staff's quality assurance program activities. Privilege determinations will also be based on pertinent information from other sources, especially other institutions and health care settings where a professional exercises clinical privileges. Where appropriate, review of the records of patients treated in other hospitals may also serve as the basis for privilege determination. If the Practitioner's level of clinical activity at Virginia Mason Memorial Hospital is not sufficient to permit the applicable Staff and Board authorities to make an informed judgment as to his/her competence in exercising the clinical privileges requested, the Practitioner shall have the burden of providing evidence of clinical performance at his/her principal institution in such form as may be required by the hospital authorities. The information will be added to and maintained in the Staff file established for the Staff appointee.

3. The procedure by which clinical privileges are processed is found in the above Article XIV Section A: Processing the Application.

4. Temporary Privileges (Pending Application Review Process; Care of a Specific Patient; Locum Tenens) are granted to meet an important patient care need and are granted for a period not to exceed 120 days.

See Delineation of Clinical Privileges Policy for additional details.

Summary: Disaster Privileges

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. See Temporary Privileges in Event of a Disaster Policy for additional details.

ARTICLE XVI - INTERVIEWS, CORRECTIVE ACTION

A. Precautionary (Summary) Suspension

1. Imposition

- A. Precautionary Suspension: Any two of (i) the Medical Staff President, (ii) the Medical Staff Vice-President, (iii) the Immediate Medical Staff Past-President (iv) the Chair of the Credentials Committee, (v) the Chair of a Medical Staff Peer Review Committee, (vi) the Chair of a Department, (vii) The Chief of a Division, (viii) the Chief Executive Officer (ix) the Chief Medical Staff Officer or (ix) the Chairperson of the Board of Trustees, acting together as a professional review committee shall have the authority to suspend all or any portion of the Privileges of a Member whenever failure to take such action may result in an imminent danger to the health and/or safety of any individual or to the orderly operation of the hospital.
- B. Imminent Danger. Among other possible reasons, a danger may be considered “imminent” if it is reasonably believed under the circumstances, that the situation, condition, or circumstance could cause harm to a present or future patient, increase the risk or likelihood of complications to a patient, complicate or delay a patient’s recovery, or cause any similar threat to the patient’s health, safety, or recovery.
- C. Notice. Such precautionary suspension shall become effective immediately upon imposition. Notice of the suspension shall be written and promptly be forwarded to the Chair of the Medical Executive Committee, the Chief Executive Officer, and, by certified mail, return receipt requested, or hand delivery to the Member.
- D. Interim. Such suspension shall be deemed an interim precautionary step in the professional review activity related to the ultimate professional review action that will be taken with respect to the suspended Member, but is not a complete professional review action in and of itself. It shall not imply any final finding of responsibility for the situation that caused the suspension.

2. Action by Medical Executive Committee.

- A. Review. The Medical Executive Committee, within ten (10) days of receipt of notice of the imposition of a precautionary suspension or as soon thereafter as it is able to meet, shall meet and review the matter and shall recommend modification, continuance, or

termination of the terms of the suspension, and shall promptly notify the CEO of its action, with similar notice to the Member by certified mail, return receipt requested or hand delivery.

- B. Terms. If the Medical Executive Committee recommends modification or continuation of the suspension, the terms of the suspension as sustained or as modified by the Medical Executive Committee shall remain in effect unless or until modified by the Medical Executive Committee or the Board.
- C. Reinstatement. If the Medical Executive Committee recommends termination of the suspension, the Member's privileges shall be reinstated. The Board, following notice to it of reinstatement, may continue the suspension on terms directed by it. If the suspension is continued, investigation by the Medical Executive Committee shall proceed in accordance with Section 2.4 of the Fair Hearing and Corrective Action Policy.

3. Continuity of Patient Care.

Immediately on the imposition of a precautionary suspension, the President of the Medical Staff or responsible Department Chair shall have responsibility to provide for alternative medical coverage for the patients of the suspended Member still in the Hospital(s) at the time of the suspension. The wishes of the patient and the Member under suspension shall be considered in the selection of such alternative coverage.

4. Medical Executive Committee Investigation.

- A. Investigation. The Medical Executive Committee shall consider a precautionary suspension as a request for investigation and shall immediately proceed as outlined in Section 1.2 of the Fair Hearing and Corrective Action Policy.
- B. Report. Recognizing the need to resolve such issues as soon as reasonably possible, the Medical Executive Committee shall make every reasonable effort to conclude the investigation promptly and report its findings and recommendations.

5. Timelines and Reporting.

- A. Guidelines. Time and other technical requirements set forth herein shall be considered guidelines only, and failure of the Medical Executive Committee or its designee to adhere to such timelines and technical requirements shall not be grounds for invalidating any action taken.
- B. Data Bank. The National Practitioner Data Bank will be notified if the precautionary suspension is longer than thirty (30) days.
- C. Department of Health: Upon determination that a health care practitioner has committed an action defined as unprofessional conduct under RCW 18.130.180 the hospital shall report the action to the Department of Health as stipulated in their guidelines. [added 2/2007]

B. Administrative (Automatic) Suspension

Administrative removal of privileges will not result in a report filed with the National Practitioner Data Bank. Any administrative removal of greater than 90 days will be considered a voluntary resignation from the Medical Staff and will result in a requirement for reapplication. Practitioners who have their privileges administratively removed must make coverage arrangements for any patients in house and any call responsibilities they may have.

1. State License

- A. Revocation. If a Member's license to practice in the state of Washington, or any other state, is revoked, the Member's Medical Staff appointment and all clinical privileges are immediately and administratively removed as of the date such action becomes effective. Upon reinstatement of the Member's license to practice, he or she must reapply for Medical Staff appointment and clinical privileges.
- B. Restriction. During the period in which a Member's license to practice in Washington, or any other state, is partially limited or restricted in any way, those clinical privileges that he or she has been granted that are within the scope of the limitation or restriction are similarly limited or restricted, automatically, as of the date such action becomes effective and throughout its term. Upon reinstatement of the Member's license to practice without such restrictions or limitations, he or she must reapply for those clinical privileges that were limited or restricted.
- C. Suspension. If a Member's license to practice medicine in Washington, or any other state, is suspended, the Member's Medical Staff appointment and clinical privileges are automatically suspended as of the date such action becomes effective. Upon reinstatement of the Member's license to practice without such limitations or restrictions, he or she must reapply for those clinical privileges that were limited or restricted.
- D. Probation. If a Member is placed on probation by the relevant licensing authority of any state in which the Member is licensed to practice medicine, his or her Medical Staff membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and shall remain so throughout the term of probation. Further, his or her office and/or Department chairmanship shall be automatically terminated. Upon termination of the probation, he or she must reapply for Medical Staff appointment and those clinical privileges that were subject to the probation.

2. Drug Enforcement Administration (DEA) Certificate.

If a Member's right to prescribe controlled substances is revoked, restricted, suspended or placed on probation by a proper licensing authority, his or her privileges to prescribe such substances in the Hospital(s) will be administratively removed or placed on probation automatically. Upon reinstatement of the Member's DEA certificate, he or she must reapply for the privilege to prescribe controlled substances in the Hospital.

3. Medical Records.

- A. Timely Completion. The failure to prepare and/or to complete medical records in a legible and timely fashion, as defined in these Bylaws, may result in limitation or automatic suspension of some or all of the Member's rights and clinical privileges. The Member will be given written notice and sufficient time to complete the medical records as set forth in the Incomplete Record/Suspension Policy before automatic suspension is imposed.
- B. Membership Status Review. After a third suspension within any twelve-month period for failure to complete or prepare records, a Member shall be deemed to have voluntarily resigned from the Medical Staff, absent affirmative action by the Medical Executive Committee or the Board to the contrary.

4. Professional Liability Insurance.

A Member's Medical Staff appointment and clinical privileges are immediately administratively removed for failure to maintain the minimum amount of professional liability insurance required

by the Board. The Member may be reinstated when proof of coverage is provided to the Medical Staff Office with a satisfactory written explanation of the Member's failure to maintain the minimum amount of professional liability insurance as required.

5. Medicare Excluded Provider.

If a Member is excluded from participation in the Medicare, Medicaid or other federal or state health care programs, such Member's medical staff membership and privileges shall be automatically suspended. The Member will be eligible to reapply for medical staff privileges upon the Member's reinstatement with the applicable federal or state health care program.

6. Medical Staff Privileges.

If an adverse action consisting of limitation, restriction, supervision, or termination of medical staff privileges is taken against a Member at any other hospital or health care entity, such Member's medical staff privileges at Hospital shall automatically become subject to the same terms and conditions of such adverse action. Upon reinstatement of medical staff privileges at another hospital, the Member must reapply for those medical staff privileges adversely impacted at Hospital.

7. Peer Review File.

A copy of the automatic suspension shall be placed in the Member's confidential peer review file.

ARTICLE XVII - HEARINGS AND APPELLATE REVIEW

A. Fair Hearing Prerequisites

1. Notice and Time and Place for Hearing. When a proper request for a Fair Hearing is received, the CEO shall schedule the Fair Hearing, and shall send the practitioner Special Notice of the time, place and date of the Fair Hearing. The Fair Hearing date shall not be less than thirty nor more than sixty (60) days after practitioner's receipt of the Special Notice.
2. Statement of Issues and Witnesses. The notice of Fair Hearing must contain a concise statement of the nature of the adverse recommendation or action, and the specific grounds or reasons forming the basis for the adverse action or recommendation. In addition, the notice shall include a proposed list of the witnesses (if any) expected to testify at the Fair Hearing in support of the adverse recommendation or action. This statement and the potential witness list may be amended or added to at any time, including during the Fair Hearing, so long as the additional material is relevant to the appointment or clinical privileges of the practitioner requesting the Fair Hearing, and that the practitioner and the practitioner's counsel have sufficient time to study this additional information and rebut it.
3. Witness List. Each party to the Fair Hearing shall provide a written list of the names of the individuals expected to offer testimony or evidence on their behalf at least ten (10) days prior to the Fair Hearing unless good cause for failure to notify is shown. The witness list shall include a brief summary of the nature of the anticipated testimony.
4. Appointment of Fair Hearing Committee.
 - A. By CEO. The CEO shall appoint a Fair Hearing Committee composed of three individuals, at least two of whom shall be health professionals. The CEO shall also appoint a Presiding Officer.
 - B. Service on Hearing Committee. An individual is not disqualified from serving on a Fair Hearing Committee merely because he or she has heard of the case or has knowledge of the facts involved or what he or she supposes the facts to be. The individual or a member of a body whose adverse recommendation or action initiated the Fair Hearing shall not serve on the Fair Hearing Committee. The Fair Hearing Committee shall not include partners, business associates or relatives of the practitioner and none of the committee members may be in direct economic competition with the practitioner. The members of the Fair Hearing Committee must give fair and impartial consideration of the case.
 - C. Notice. The CEO shall give special notice to the parties of the names of the Fair Hearing Committee members, the name of the Presiding Officer, and the address to which statements, lists, and exhibits may be submitted.

B. Fair Hearing Procedure.

1. Personal Presence. The personal presence of the practitioner is required at the Fair Hearing. A practitioner who fails without good cause to appear and respond to questions at the Fair Hearing shall be deemed to have waived his or her right to a Fair Hearing.
2. Presiding Officer. The Presiding Officer, appointed under Section 4.3, shall
 - A. Maintain decorum and assure that all participants have a reasonable opportunity to present relevant oral and documentary evidence;
 - B. Determine the order of procedure during the Fair Hearing;
 - C. Make all rulings on matters of law, procedure and admissibility of evidence; and
 - D. At his or her discretion, limit the number of witnesses.
3. Representation. The practitioner may be accompanied and represented at the Fair Hearing by an attorney or other person of the practitioner's choice provided he or she notifies all parties of

the identity of the representative at least five (5) days before the Fair Hearing. The Medical Executive Committee may appoint an attorney or other person to represent it, and shall give notice of that person's identity to the other parties.

4. Rights of Parties. During a Fair Hearing, each party may:
 - A. Call and examine witnesses, provided the other parties have been notified of witness names at least ten (10) days prior to the Fair Hearing unless good cause for failure to notify is shown;
 - B. Introduce exhibits, provided the other parties have been furnished copies of the exhibits at least ten (10) days prior to the Fair Hearing unless good cause for failure to furnish is shown;
 - C. Cross-examine any witness on any matter relevant to the issues; and
 - D. Submit or make a written or oral statement at the close of the Fair Hearing.
 - E. Have a record made of Proceedings, a copy of which may be obtained by the practitioner upon payment of any reasonable charges associated with the preparation thereof.
5. Pre-Hearing Conference. The Presiding Officer may require parties to attend a pre-hearing conference to resolve all procedural matters prior to the hearing. Such matters include, but are not limited to:
 - A. Both parties may be required to present all of the documents they plan to submit at the Fair Hearing;
 - B. A list of witnesses to be called will be presented by both parties;
 - C. Time limits can be set for witnesses' testimony and cross-examination;
 - D. Objections to witnesses, documents, or the plan set forth for the conduct of the proceeding will be dealt with at this time;
 - E. Any witnesses or documents not identified and agreed upon at the pre-hearing conference will be excluded from the hearing absent good cause as determined by the Presiding Officer.
6. Practitioner's Testimony. If the practitioner does not testify on his or her own behalf, he or she may be called and examined as if under cross-examination.
7. Procedure and Evidence. The Fair Hearing need not be conducted according to rules of law relating to the examination of witnesses or presentation of evidence. Any relevant matter upon which responsible persons might customarily rely in the conduct of serious affairs may be considered regardless of the admissibility of such evidence in a court of law. The Committee is also entitled to consider all other relevant information that can be considered under the Bylaws in connection with credential matters. Each party shall be entitled, prior to, during, or at the close of the Fair Hearing, to submit memoranda concerning any issue of law or fact, and those memoranda shall become part of the Fair Hearing record. Oral evidence shall be taken only on oath or affirmation.
8. Scope of Review and Burden of Proof. The party whose adverse action or recommendation gave rise to the Fair Hearing shall have the initial duty to present evidence in support of its action or recommendation. Thereafter, the burden shall shift to the practitioner who requested the Fair Hearing to come forward with evidence in response. The practitioner has the burden to establish, by clear and convincing evidence, that the adverse action or recommendation lacks factual basis or that the basis or conclusions drawn therefrom are arbitrary, capricious, or not supported by substantial evidence.
9. Hearing Record. An accurate, permanent record of the Fair Hearing must be kept that is sufficient to permit an informed judgment to be made by any group that may later be called upon to review the record and render a recommendation or decision in the matter. The Fair Hearing Committee may select the method to be used for making the record, such as court reporter, electronic recording unit, detailed transcription, or minutes of the proceedings. The Fair Hearing record shall also contain all exhibits or other documentation considered, written

statements submitted by the parties, and correspondence between the parties or between the Fair Hearing Committee and the parties, if any, during the Fair Hearing process. The record of the Fair Hearing shall be available to all parties at a reasonable price.

10. Postponement. Requests for postponement of a Fair Hearing beyond the time set forth in this Plan may be granted by the Fair Hearing Committee only upon showing of good cause and only if the request is made as soon as is reasonably practical. Granting of the postponement shall be at the sole discretion of the Fair Hearing Committee and shall not exceed fourteen (14) days absent special circumstances.
11. Presence of Hearing Committee Members. A majority of the Fair Hearing Committee must be present throughout the Fair Hearing and deliberations.
12. Recesses and Adjournment. The Fair Hearing Committee may recess and reconvene the Fair Hearing for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. Upon conclusion of the presentation of oral and written evidence and argument, the Fair Hearing shall be closed. The Fair Hearing Committee shall, at a time convenient to itself, conduct its deliberations outside the presence of the parties. Upon conclusion of its deliberations, the Fair Hearing shall be adjourned. Adjournment shall be no later than fourteen (14) days after the Fair Hearing is closed.

C. Fair Hearing Committee Report

1. Within fourteen (14) days after adjournment of the Fair Hearing, the Fair Hearing Committee shall issue a written report and recommendations which will contain findings of fact sufficient in detail to indicate the basis for the Fair Hearing Committee's decision. The report along with the hearing record will be delivered to the CEO and the Chair of the Board, with a copy to the Medical Executive Committee and the practitioner in person, overnight delivery or by certified mail with return receipt requested. In addition, the practitioner shall be notified in writing of the practitioner's right to appeal the Fair Hearing Committee's recommendation as provided in Section D. The decision of the Fair Hearing Committee shall be final, subject to the right of appeal as provided in section D. If such appellate review is not requested within the required time period, both parties shall be deemed to have accepted the Fair Hearing Committee recommendation, and the hearing panel's report and recommendation shall be forwarded to the Board.

D. Appeal of Fair Hearing Committee's decision

1. Right to Appeal. Either party (the Medical Executive Committee or the practitioner) may appeal an adverse recommendation of the Fair Hearing Committee by submitting to the Chair of the Board or the Chair's designee and to the other party a written notice of intention to appeal within three (3) business days of receiving the Fair Hearing Committee report. The appellant must submit a written argument to the Board and the other party no later than ten (10) business days of receiving the Fair Hearing Committee's report, and the other party must submit its written response, if any, within five (5) business days of receiving the appellant's written argument in person, overnight delivery or by certified mail with return receipt requested.. The appeal must be based on the hearing record and must not include evidence not offered to the Fair Hearing Committee.
2. Grounds for Appeal. The grounds for appeal shall be limited to the following:
 - A. Lack of compliance with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing.
 - B. The recommendation of the Fair Hearing Committee is considered arbitrary or capricious.

E. Board Action

1. Whenever an appeal is requested as set forth in the preceding sections, the Chair of the Board shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected parties shall be given notice of the time, place, and date of the appellate review. The chair of the board may extend the time for appellate review for good cause.
2. The Chair of the Board shall appoint a review panel composed of at least three (3) members of the Board to consider the information on which the recommendation was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.
3. The review panel may, but is not required to, accept new oral or written evidence subject to the same procedural constraints in effect for the Fair Hearing Committee. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied.
4. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited 30-minute oral argument. The review panel shall recommend final action to the Board.
5. The board may affirm, modify, or reverse the recommendation of the review panel; or, in its discretion, refer the matter for further review and recommendation; or make its own decision based on the board's ultimate legal responsibility to grant appointment and clinical privileges.
6. No applicant or medical staff member shall be entitled as a matter of right to more than one hearing or appellate review on any single matter that may be the subject of an appeal.

F. Notice of Board Action

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing and shall deliver copies to the practitioner, the Medical Executive Committee and the CEO, in person, overnight delivery or by certified mail with return receipt requested. The Fair Hearing Committee is dismissed upon the Board's final action.

G. Limitation on Hearing

Notwithstanding any other provision of this or any other governing document, a practitioner is entitled as a right to no more than one evidentiary hearing with respect to an adverse recommendation.

H. Timelines and Other Technical Requirements

Time and other technical requirements set forth herein shall be considered guidelines only, and failure of the Medical Executive Committee or the Board to adhere to such timelines and technical requirements shall not be grounds for invalidating any action taken.

See Corrective Action and Fair Hearing Plan for Initiation of Fair Hearing Process

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 [Added Conflict Resolution], 1/12 [Removal of Administrative and Inactive Staff , Added Affiliative], 3/12, 11/12, 1/13 [Added Policy summaries] 1/2016 added UR Committee 4/2016 changed frequency of meeting dates for UR Committee. 10/2016 [Revised MEC Composition]. 12/2017 [Revised Article IV Membership, Conditions and Duration of Appointment- who can request examinations or tests on a provider, and who is included in the Committee to review results of such tests; Article VIII Committees and Functions- MEC Composition- revised to include Quality Medical Director]. 6/2018 [Added H&P requirements; Removed Resident Status; Added Locum Status; Added Telemedicine Status; Revised Affiliative Status; Removed Educational Status; Added Ambulatory Status; Revised Dept Chair Roles/Responsibilities; Added MEC authority delegation/removal language; Added Selection/election removal of MEC members; Added AHP language; Added procedure for appointment/reappointment; Added determination of clinical privileges; Added Precautionary and Administrative Suspension language; Added Fair Hearing process].

Current Approval:

Medical Staff:	6/5/2018
Governing Board:	6/26/2018