TOPPENISH COMMUNITY HOSPITAL
MEDICAL STAFF BYLAWS

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MEDICAL STAFF BYLAWS

OF

TOPPENISH COMMUNITY HOSPITAL

PREAMBLE

WHEREAS, Toppenish Community Hospital, hereinafter referred to as "Hospital", is operated by Yakima HMA LLC hereinafter referred to as "Corporation", a private corporation organized under the laws of the state of Washington and is lawfully doing business in Washington, and is not an agency or instrumentality of any state, county or federal government; and

WHEREAS, no practitioner is entitled to Medical Staff membership and privileges at this Hospital solely by reason of education or licensure, or membership on the Medical Staff of another hospital; and

WHEREAS, the purpose of this Hospital is to serve as a general short-term, acute care hospital, providing patient care and education; and

WHEREAS, the Hospital must ensure that such services are delivered efficiently and with concern for keeping medical costs within reasonable bounds and meeting the evolving regulatory requirements applicable to functions within the Hospital; and

WHEREAS, the Medical Staff must cooperate with and is subject to the ultimate authority and direction of the Board of Trustees; and

WHEREAS, the cooperative efforts of the Medical Staff, management and the Board of Trustees are necessary to fulfill these goals.

NOW, THEREFORE, the practitioners practicing in Toppenish Community Hospital hereby organize themselves into a Medical Staff conforming to these bylaws.

DEFINITIONS

1. "Active Staff" members shall be those physicians (D.O.'s and M.D.'s) licensed in the state of Washington that have the privilege of admitting patients, holding office and voting.

2. "Allied Health Professional" or "AHP" means a credentialed individual, other than a practitioner, who is qualified to render direct or indirect medical or surgical care under the supervision of a practitioner who has been afforded privileges to provide such care in the Hospital. For purposes of these Medical Staff Bylaws, "AHP" shall be deemed to refer only to advance practice professionals who are credentialed as AHPs pursuant to the Medical Staff credentialing process. Such AHPs shall include, without limitation, physician assistants, certified nurse practitioners, certified nurse midwives, and certified registered nurse anesthetists and other such professionals. For purposes of these Bylaws, "Allied Health Professional" shall not be deemed to include those non-credentialed individuals ("Clinical Assistants" pursuant to the Hospital policy) whose appointment and competencies are handled outside the Medical Staff process. The authority of an AHP to provide specified patient care services is established by the Medical Staff based on the professional's qualifications.

3. "Board" means the Board of Trustees of the Toppenish Community Hospital.

4. "Board Certification" shall mean certification in a member board of the American Board of Medical Specialties, the American Board of Osteopathic Specialists, or other applicable specialty boards.

5. "Chief Executive Officer" or "CEO" means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

6. "Chief of Staff" means the member of the Active Medical Staff who is duly elected in accordance with these bylaws to serve as chief officer of the Medical Staff of this Hospital or his/her designee.

7. "Clinical Privileges" means the Board's recognition of practitioners' or AHPs' competence and qualifications to render specific diagnostic, therapeutic, medical, dental, podiatric, chiropractic or surgical services.

8. "Corporation" means Yakima HMA LLC.

9. "Data Bank" means the National Practitioner Data Bank, (or any state designee thereof), established pursuant to the Health Care Quality Improvement Act of 1986, for the purposes of reporting of adverse actions and Medical Staff malpractice information.

10. "Designee" means one selected by the CEO, Chief of Staff or other officer to act on his/her behalf with regard to a particular responsibility or activity as permitted by these bylaws.

11. "Ex-Officio" means service as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

12. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician's or dentist's clinical privileges are adversely affected by a determination based on the physician's or dentist's professional conduct or competence.

13. "Hospital" means Toppenish Community Hospital.

14. “Licensed Independent Practitioner” means any individual permitted by law and by the Medical Staff and Board to provide care and services without direction or supervision, within the scope of the individual’s license and consistent with individually granted clinical privileges.

15. “Medical Executive Committee" or “MEC” means the Executive Committee of the Medical Staff.

16. "Medical Staff" means the formal organization of practitioners who have been granted privileges by the Board to attend patients in the Hospital.

17. "Medical Staff Bylaws" means the Bylaws of the Medical Staff and the accompanying Rules & Regulations, Fair Hearing Plan and such other policies as may be adopted by the Medical Staff subject to the approval of the Board.

18. "Medical Staff Year" means January 1 through December 31.

19. "Member" means a practitioner who has been granted Medical Staff membership and clinical privileges pursuant to these bylaws.

20. “Oral and Maxillofacial Surgeon” means an individual who has successfully completed a post-graduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Department of Education. As determined by the Medical Staff, the individual must be currently competent to perform a complete history and physical examination in order to assess the medical, surgical and anesthetic risks of the proposed operative and other procedure(s).

21. “Peer Review Policy” means the policy and procedure adopted by the Medical Staff with the approval of the Board to provide evidence of objective monitoring of quality concerns for clinical management and evaluation of outcomes, provide oversight of the professional performance of all practitioners with delineated clinical privileges, evaluate the competence of practitioner performance, establish guidelines and triggers for referring cases identified or suspected as variations from quality indicators, and facilitate delivery of quality services that meet professionally recognized standards.

22. "Physician" means an individual with a D.O. or M.D. degree who is properly licensed to practice medicine in Washington.

23. "Practitioner" means a physician, dentist or podiatrist who has been granted clinical privileges at the Hospital.

24. "Prerogative" means a participatory right granted by the Medical Staff and exercised subject to the conditions imposed in these bylaws and in other hospital and Medical Staff policies.

25. "Special Notice" means a written notice sent by mail with a return receipt requested or delivered by hand with a written acknowledgment of receipt.

26. “Telemedicine” means the use of electronic communication or other communication technologies to provide or support clinical care at a location remote from Hospital.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of Toppenish Community Hospital.

ARTICLE II
PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

2.1(a) To be the organization through which the benefits of membership on the Medical Staff (mutual education, consultation and professional support) may be obtained and the obligations of staff membership may be fulfilled;

2.1(b) To foster cooperation with administration and the Board while allowing staff members to function with relative freedom in the care and treatment of their patients;

2.1(c) To provide a mechanism to ensure that all patients admitted to or treated in any of the facilities or services of the Hospital shall receive a uniform level of appropriate quality care, treatment and services commensurate with community resources during the length of stay with the organization, by accounting for and reporting regularly to the Board on patient care evaluation, including monitoring and other performance improvement activities in accordance with the Hospital's performance improvement program;

2.1(d) To serve as a primary means for accountability to the Board to ensure high quality professional performance of all practitioners and AHPs authorized to practice in the Hospital through delineation of clinical privileges, on-going review and evaluation of each practitioner's performance in the Hospital, and supervision, review, evaluation and delineation of duties and prerogative of AHPs;

2.1(e) To work with the Board and management to develop a strategy to maintain medical costs within reasonable bounds and meet evolving regulatory requirements;

2.1(f) To provide an appropriate educational setting that will promote continuous advancement in professional knowledge and skill;

2.1(g) To promulgate, maintain and enforce bylaws and rules and regulations for the proper functioning of the Medical Staff;

2.1(h) To provide a means by which issues concerning the Medical Staff and the Hospital may be discussed with the Board or the CEO;

2.1(i) To participate in educational activities and scientific research with approved colleges of medicine and dentistry as may be justified by the facilities, personnel, funds or other equipment that are or can be made available;

2.1(j) To assist the Board in identifying changing community health needs and preferences and implement programs to meet those needs and preferences; and

2.1(k) To accomplish its goals through appropriate committees.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

2.2(a) Ensuring that practitioners and AHPs cooperate with each other in caring for patients in the Hospital;

2.2(b) Accounting for the quality, appropriateness and cost effectiveness of patient care rendered by all practitioners and AHPs authorized to practice in the Hospital, by taking action to:

(1) Assist the Board and CEO and their designees in data compilation, medical record administration, review and evaluation of cost effectiveness and other such functions necessary to meet accreditation and licensure standards, as well as federal and state law requirements;

(2) Define and implement credentialing procedures, including a mechanism for appointment and reappointment and the delineation of clinical privileges and assurance that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted;

(3) Provide a continuing medical education program addressing issues of performance improvement and including the types of care offered by the Hospital; and require documentation of individual participation in such programs by all individuals with clinical privileges;

(4) Implement a utilization review program, based on the requirements of the Hospital's Utilization Review Plan;

(5) Develop an organizational structure that provides continuous monitoring of patient care practices and appropriate supervision of AHPs;

(6) Initiate and pursue corrective action with respect to practitioners and AHPs, when warranted;

(7) Develop, administer and enforce these bylaws, the rules and regulations of the staff and other hospital policies related to medical care;

(8) Review and evaluate the quality of patient care through a valid and reliable patient care monitoring procedure, including identification and resolution of important problems in patient care and treatment;

(9) Ensure that the functions delineated in Section 12.3(b) of these Bylaws are performed by appropriate standing or ad hoc committee of the Medical Staff; and

(10) Implement a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Practitioner Health Policy.

2.2(c) Assisting the Board in maintaining the accreditation status of the Hospital;

2.2(d) Participating and cooperating in implementation of the policies of federal and state regulatory agencies, including the requirements of the Data Bank; and

2.2(e) Maintaining confidentiality with respect to the records and affairs of the Hospital, except as disclosure is authorized by the Board or required by law.

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

Patient information will be collected, stored and maintained so that privacy and confidentiality are preserved. The Hospital and each member of the Medical Staff will be part of an Organized Health Care Arrangement ("OHCA"), which is defined as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. The OHCA allows the Hospital and the Medical Staff members to share information for purposes of treatment, payment and health care operations. Under the OHCA, at the time of admission, a patient will receive the Hospital's Notice of Privacy Practices, which will include information about the Organized Health Care Arrangement between the Hospital and the Medical Staff.

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

Medical Staff membership is a privilege extended by the Hospital, and is not a right of any person. Membership on the Medical Staff or the exercise of temporary privileges shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws. Membership on the Medical Staff shall confer on the practitioner only such clinical privileges and prerogatives as have been granted by the Board in accordance with these bylaws. No person shall admit patients to, or provide services to patients in the Hospital, unless he/she is a member of the Medical Staff with appropriate privileges, or has been granted temporary, one-case, locum tenens or proctoring privileges as provided herein.

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those practitioners legally licensed in Washington (The only exception to the licensure requirement will be those physicians who are licensed in another state and are commissioned officers with the US Public Health Service or Civil Service), who:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence, professional clinical judgment and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions, to work cooperatively with others and to be willing to participate in the discharge of staff responsibilities;

(3) Comply and have complied with federal, state and local requirements, if any, for their medical practice, are not and have not been subject to any liability claims, challenges to licensure, or loss of Medical Staff membership or privileges which will adversely affect their services to the Hospital;

(4) Have professional liability insurance that meets the requirements of Section 14.2;

(5) Are graduates of an approved college holding appropriate degrees;

(6) Have successfully completed an approved internship program or the equivalent where applicable;

(7) Maintain a good reputation in his/her professional community; have the ability to work successfully with other professionals and have the physical and mental health to adequately practice his/her profession;

(8) Have skills and training to fulfill a patient care need existing within the Hospital, and be able to adequately provide those services with the facilities and support services available at the Hospital; and

(9) Practice in such a manner as not to interfere with orderly and efficient rendering of services by the Hospital or by other practitioners within the hospital.

3.2(b) Effects of Other Affiliations

No person shall be automatically entitled to membership on the Medical Staff or to exercise the particular clinical privileges merely because he/she is licensed to practice in this or any other state, or because he/she is a member of any professional organization, or because he/she is certified by any clinical board, or because he/she had, or presently has, staff membership at this Hospital or at another health care facility or in another practice setting.

3.2(c) Non-Discrimination

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of race, color, sex, national origin or disability (except as such may impair the practitioner's ability to provide quality patient care or fulfill his/her duties under these bylaws), or on the basis of any other criteria unrelated to the delivery of quality patient care in the Hospital, to professional ability and judgment, or to community need.

3.2(d) Ethics

The burden shall be on the applicant to establish that he/she is professionally competent and worthy in character, professional ethics and conduct. Acceptance of membership on the Medical Staff shall constitute the member's certification that he/she has in the past, and agrees that he/she will in the future, abide by the lawful principles of Medical Ethics of the American Osteopathic Association, or the American Medical Association, or other applicable codes of ethics.

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

3.3(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

3.3(b) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies (including Practitioner Health and Disruptive Practitioner policies), and Rules & Regulations of the Medical Staff;

3.3(d) Discharge the staff, committee and hospital functions for which he/she is responsible by staff category assignment, appointment, election or otherwise;

3.3(e) Cooperate with other members of the Medical Staff, management, the Board of Trustees and employees of the Hospital;

3.3(f) Adequately prepare and complete in a timely fashion the medical and other required records for all patients he/she admits or, in any way provides care to, in the Hospital;

3.3(g) Be encouraged to be a member in good standing of respective professional societies and to participate in educational programs as contemplated by these bylaws;

3.3(h) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the hospital drug testing program;

3.3(i) Abide by the ethical principles of his/her profession and specialty;

3.3(j) Refuse to engage in improper inducements for patient referral;

3.3(k) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community;

3.3(l) Notify the CEO and Chief of Staff within seven (7) days if:

(1) His/Her professional licensure in any state is suspended or revoked, or of any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) Any criminal charges, other than minor traffic violations are brought/initiated against him/her; and any guilty pleas or convictions entered;

(5) He/She has been excluded, debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility from such programs or is under investigation by any such program;

(6) He/She is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; and/or

(7) There has been voluntary or involuntary limitation, reduction or loss of clinical privileges on any Medical Staff (including relinquishment of such Medical Staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body).

Failure to provide any such notice, as required above (except as to professional negligence actions that have not resulted in judgment or settlement), shall result in immediate loss of Medical Staff membership and clinical privileges, without right of fair hearing procedures.

3.3(m) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

3.3(n) Admission History

Each patient admitted for inpatient care shall have complete admission history and physical examination recorded by a qualified physician (or other licensed independent practitioner who has been credentialed and granted privileges to perform a history and physical examination) within twenty-four (24) hours of admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia. A written admission note shall be entered at the time of admission, documenting the diagnosis and reason for admission. Oral/maxillofacial surgeons may be granted privileges to perform part or all of the history and physical examination, including assessment of the medical, surgical and anesthetic risks of the proposed operation or other procedure. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. Should the physician fail to ensure that the patient's history and physical is dictated in time to be transcribed and on the chart within twenty-four (24) hours after admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia, the record shall be considered delinquent and the Chief of Staff or his/her designee or the CEO or his designee may take appropriate steps to enforce compliance. If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, 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.

At minimum, the medical history and physical examination must contain an age specific assessment of the patient including (a) the chief complaint, which is a statement that establishes medical necessity in concise manner based upon the patient's own words; (b) a history of the present illness outlining the location, quality, severity, duration, timing, context and modifying factors of the complaints; (c) medications, including both prescribed and over-the-counter remedies; (d) allergies and intolerances, including a description of the effects caused by each agent; (e) past medical and surgical history; (f) health maintenance/immunization history; (g) family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges; (h) comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system; (i) diagnostic data that is either available or pending at the time of admission; (j) clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and (k) the plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

A history and physical performed within thirty (30) days prior to hospital admission may be used, as long as the medical record contains durable, legible practitioner documentation indicating the H&P was reviewed and the patient was examined, and noting any changes in the patient's condition not consistent or otherwise reflected in the H&P. If there have been any changes in the patient's condition that are not consistent with or noted in the history and physical, those must be documented within twenty-four (24) hours of admission and prior to any surgical procedure or invasive diagnostic procedure requiring anesthesia.

Each department or service will determine for its members which outpatient procedures require a history and physical examination as a prerequisite and, if required, the scope of such history and physical. Notwithstanding the foregoing, a history and physical examination shall be required for all invasive operative procedures performed in the outpatient setting. Where required, a history and physical must be completed and documented in accordance with the timeframes described above.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

All initial appointments to the Medical Staff shall be for a period not to exceed two (2) years. In no case shall the Board take action on an application, refuse to renew an appointment, or cancel an appointment, except as provided for herein. Appointment to the Medical Staff shall confer to the appointee only such privileges as may hereinafter be provided.

3.4(b) Declaration of Moratorium

The Board may from time to time declare moratoriums in the granting of Medical Staff privileges when the Board, in its discretion, deems such a moratorium to be in the best interest of this Hospital and in the best interest of the health and patient care capable of being provided by the Hospital and its staff. The aforementioned moratoriums may apply to individual medical specialty groups, or any combination thereof. Prior to declaring a moratorium, the Board will seek the input of the Medical Staff regarding the needs of the hospital and the patient community.

3.4(c) Reappointments

Reappointment to the Medical Staff shall be for a period not to exceed two (2) years.

3.4(d) Modification in Staff Category & Clinical Privileges

The MEC may recommend to the Board that a change in staff category of a current staff member or the granting of additional privileges to a current staff member to be made in accordance with the procedures for initial appointment as outlined herein.

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

A staff member may obtain a voluntary leave of absence from the Medical Staff by submitting a written request to the MEC stating the reason for the leave and the time period of the leave, which may not exceed one (1) year. If the leave is granted, all rights and privileges of Medical Staff membership shall be suspended from the beginning of the leave period until reinstatement. If the staff member's period of appointment ends while the member is on leave, he/she must reapply for Medical Staff membership and clinical privileges. Any such application must be submitted and shall be processed in the manner specified in these Bylaws for applications for initial appointment.

3.5(b) Termination of Leave

(1) At least sixty (60) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the CEO or his/her designee for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or

appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

(2) If a member requests leave of absence for the purpose of obtaining further medical training, reinstatement will ordinarily become automatic upon request for same, but only after the MEC has satisfied itself as to the continuing competency of the returning staff member.

Any new privileges requested will be acted upon and monitored in similar fashion as if the member were a new applicant.

(3) Reinstatement will ordinarily be automatic if a leave of absence is for an armed services commitment. However, if such a leave of absence occurs with no medical activity for twelve (12) or more months, the MEC may require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

(4) If a member requests leave of absence for reasons other than further medical training or an armed services commitment, the MEC may, prior to reinstatement, require proof of competency by further education, such as a refresher course, or appropriate monitoring for a period of time, or both, to insure continuing competence.

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall include Active, Active Refer and Follow (see 7.7(a) regarding Refer and Follow), Courtesy, Courtesy Refer and Follow, Consulting, Consulting Refer and Follow and Honorary categories. Qualifications, prerogatives and responsibilities are outlined below. Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

(1) Meet the basic qualifications set forth in these bylaws;

(2) Have an office and/or residence located within forty (40) minutes of the Hospital in order to be continuously available for provision of care to his/her patients, as determined by the Board, unless requesting membership without privileges or “refer and follow” privileges only; and

(3) Regularly admit to, or are otherwise regularly involved in the care of at least ten (10) patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; interpretation of any inpatient or outpatient diagnostic procedure or test; or admission or referral of a patient for inpatient care by a Hospitalist or other practitioner. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) To admit patients without limitation, unless seeking membership without privileges or “refer and follow” privileges only, or, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;

(2) To exercise only such delineated clinical privileges as are granted to him/her pursuant to Article VII;

(3) To vote on all matters presented at general and special meetings of the Medical Staff;

(4) To vote and hold office in the staff organization and on committees to which he/she is appointed; and

(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

(1) Meet the basic responsibilities set forth in Section 3.3;

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in intensive care/critical care status per departmental policy, after admission or sooner if warranted by the patient's condition;

(3) Actively participate:

(i) in the performance improvement program and other patient care evaluation and monitoring activities required of the staff and possess the requisite skill and training for the oversight of care, treatment and services in the Hospital;

(ii) in supervision of other appointees where appropriate;

(iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations and as recommended by the MEC and, approved by the Board, unless he/she holds membership without delineated privileges or "refer and follow" privileges only, including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;

(iv) in promoting effective utilization of resources consistent with delivery of quality patient care; and

(v) in discharging such other staff functions as may be required from time-to-time.

(4) Serve on at least one (1) Medical Staff committee, if appointed by the Chief of Staff; and

(5) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of committees of which he/she is a member.

4.3 COURTESY STAFF

4.3(a) Qualifications

The Courtesy Staff shall consist of practitioners, who:

(1) Meet the basic qualifications set forth in these bylaws;

(2) Have an office and/or residence located within forty (40) minutes of the Hospital in order to provide continuous care for a hospitalized patient or arrange to have continuous coverage of these patients by another member of the staff with privileges appropriate to the treatment provided unless requesting membership without delineated privileges or "refer and follow" privileges only;

(3) Do not admit or regularly participate in the care of more than nine (9) patients in a calendar year (the limitation on patient contacts shall not apply to contracted emergency department physicians who reside outside the community); and

(4) Are members of the Active Staff of another hospital where he/she actively participates in the performance improvement program.

4.3(b) Prerogatives

The prerogatives of a Courtesy Staff member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a) unless requesting membership without delineated privileges or "refer and follow" privileges only;

(2) Exercise such clinical privileges as are granted to him/her pursuant to Article VII;

(3) Attend meetings of the staff and any staff or hospital education programs; and

(4) Serve on any of the standing committees as a voting member on matters of policies and procedure, including vote as a member of the MEC or at a general Medical Staff meeting.

4.3(c) Responsibilities

Each member of the Courtesy Staff shall:

(1) Discharge the basic responsibilities specified in Section 3.3;

(2) Retain responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for who he/she is providing service; and

(3) Satisfy the requirements set forth in these bylaws for attendance at meetings of the Medical Staff and of the committees of which he/she is a member.

4.4 CONSULTING STAFF

4.4(a) Qualifications

Consulting Staff shall consist of a special category of physicians each of whom is, because of board certification, training and experience, recognized by the medical community as an authority within his/her specialty.

4.4(b) Prerogatives

(1) Prerogatives of a Consulting Staff member shall be to:

  (i) consult on patients within his/her specialty to the extent he/she holds delineated clinical privileges to do so; and

  (ii) attend all meetings of the staff that he/she may wish to attend as a non-voting visitor.

(2) Consulting Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

(3) Consulting Staff members with appropriate delineated clinical privileges may provide an unlimited number of consultation reports/recommendations (without managing the direct patient care) during a calendar year. Except where otherwise provided, Consulting Staff members shall not admit patients to the Hospital, transfer patients from the Hospital, or act as the physician of primary care or responsibility for any patient within the Hospital.

4.4(c) Responsibilities

Each member of the Consulting Staff shall assume responsibility for consultation, treatment and appropriate documentation thereof with regard to his/her patients.

4.5 HONORARY STAFF

4.5(a) Qualifications

The Honorary and Retired Staff shall consist of physicians who are not active in the Hospital and who are honored by emeritus positions. These may be:

(1) Physicians who have retired from active hospital services, but continue to demonstrate a genuine concern for the Hospital; or

(2) Physicians of outstanding reputation in a particular specialty, whether or not a resident in the community.

Honorary Staff members shall not be required to meet the qualifications set forth in Section 3.2(a) of these bylaws.

4.5(b) Prerogatives

The prerogatives of an Honorary Staff member shall be:

(1) Attending by invitation any such meetings that he/she may wish to attend as a non-voting visitor.

(2) Honorary Staff members shall not in any circumstances admit patients to the Hospital or be the physician of primary care or responsibility for any patient within the Hospital. Honorary Staff members shall not hold office nor be eligible to vote in the Medical Staff organization.

ARTICLE V
ALLIED HEALTH PROFESSIONALS (AHP)

5.1 CATEGORIES

This article shall pertain only to Advanced Practice Allied Health Professionals ("AHPs"), that is, those who are credentialed pursuant to the Medical Staff process as outlined in the definition of "Allied Health Professional" herein. Clinical Assistants who are not Advanced Practice Allied Health Professionals and who are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital. Allied Health Professionals may be employed by physicians on the staff; but whether or not so employed, must be under the direct supervision and direction of an Active staff physician, who maintains clinical privileges to perform procedures in the same specialty area as the AHP (with the exception of CRNAs, who may be supervised by an anesthesiologist or other physician deemed competent to supervise the administration of anesthesia as defined in the Medical Staff Rules and Regulations).

5.2 QUALIFICATIONS

Only AHPs holding a license, certificate or other official credential as provided under state law, shall be eligible to provide specified services in the Hospital as delineated by the MEC and approved by the Board.

5.2(a) AHPs must:

(1) Document their professional experience, background, education, training, demonstrated ability, current competence and physical and mental health status with sufficient adequacy to demonstrate to the Medical Staff and the Board that any patient treated by them will receive quality care and that they are qualified to provide needed services within the Hospital;

(2) Establish, on the basis of documented references, that they adhere strictly to the ethics of their respective profession, work cooperatively with others and are willing to participate in the discharge of AHP Staff responsibilities;

(3) Have professional liability insurance in the amount required by these bylaws;

(4) Provide a needed service within the Hospital; and

(5) Unless permitted by law and by the Hospital to practice independently, provide written documentation that a Medical Staff appointee has assumed responsibility for the acts and omissions of the AHP and responsibility for directing and supervising the AHP.

5.3 PREROGATIVES

Upon establishing experience, training and current competence, AHPs, as identified in Section 5.1, shall have the following prerogatives:

5.3(a) To exercise judgment within the AHP's area of competence, providing that a physician member of the Medical Staff has the ultimate responsibility for patient care;

5.3(b) To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision or direction of a member of the Medical Staff; and

5.3(c) To participate as appropriate in patient care evaluation and other quality assessment and monitoring activities required of the staff, and to discharge such other staff functions as may be required from time-to-time.

5.4 CONDITIONS OF APPOINTMENT

5.4(a) AHPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of practitioners. The Board in consultation with the MEC shall determine the scope of the activities which each AHP may undertake. Such determinations shall be furnished in writing to the AHP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

5.4(b) Appointment of AHPs must be approved by the Board and may be terminated by the Board or the CEO. Adverse actions or recommendations affecting AHP privileges shall be covered by the provisions of the Fair Hearing Plan.

5.4(c) AHP privileges shall automatically terminate upon revocation of the privileges of the AHP's supervising physician member, unless another qualified physician indicates his/her willingness to supervise the AHP and complies with all requirements hereunder for undertaking such supervision. In the event that an AHP's supervising physician member's privileges are significantly reduced or restricted, the AHP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan. In the case of CRNAs who are supervised by the operating surgeon, the CRNA's privileges shall be unaffected by the termination of a given surgeon's privileges so long as other surgeons remain willing to supervise the CRNA for purposes of their cases.

5.4(d) If the supervising practitioner employs or directly contracts with the AHP for services, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, cause of actions, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP, negligence of such AHP, the failure such AHP to satisfy the standards of proper care of patients, or any action by such AHP beyond the scope of his/her license or clinical privileges. If the supervising practitioner does not employ or directly contract with the AHP, the practitioner shall indemnify the Hospital and hold the Hospital harmless from and against all actions, causes of action, claims, damages, costs and expenses, including reasonable attorney fees, resulting from, caused by or arising from improper or inadequate supervision of the AHP by the practitioner in question.

5.5 RESPONSIBILITIES

Each AHP shall:

5.5(a) Provide his/her patients with continuous care at the generally recognized professional level of quality;

5.5(b) Abide by the Medical Staff Bylaws and other lawful standards, policies and Rules & Regulations of the Medical Staff, and personnel policies of the Hospital, if applicable;

5.5(c) Discharge any committee functions for which he/she is responsible;

5.5(d) Cooperate with members of the Medical Staff and AHPs, administration, the Board of Trustees and employees of the Hospital;

5.5(e) Adequately prepare and complete in a timely fashion the medical and other required records for which he/she is responsible;

5.5(f) Participate in performance improvement activities and in continuing professional education;

5.5(g) Abide by the ethical principles of his/her profession and specialty;

5.5(h) Notify the CEO and the Chief of Staff within seven (7) days if:

(1) His/Her professional license or certification in any state is suspended or revoked, or if any investigation, sanction or notice of intent to sanction or to revoke, suspend or modify his/her license or certification;

(2) His/Her professional liability insurance is modified or terminated;

(3) He/She is named as a defendant, or is subject to a final judgment or settlement, in any court proceeding alleging that he/she committed professional negligence or fraud;

(4) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her; and any guilty pleas or convictions entered;

(5) He/she has been excluded, debarred, suspended, or otherwise declared ineligible from any federal or state health care or procurement program, including Medicare and Medicaid, has been convicted of a crime that meets the criteria for mandatory exclusion, debarment, suspension or ineligibility, or is under investigation by any such program;

(5) He/she is currently either voluntarily or involuntarily participating in any rehabilitation or impairment program, or has ceased participation in such a program without successful completion; and/or

(6) There has been a voluntary or involuntary limitation, reduction or loss of clinical privileges on any Medical Staff (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of sanction or notice of intent to sanction from any peer review or professional review body).

Failure to provide any such notice, as required above (except as to professional negligence actions that have not resulted in judgment or settlement), shall result in immediate loss of Allied Health membership and clinical privileges, without grievance or appeal right of fair hearing procedures.

5.5(i) Comply with all state and federal requirements for maintaining confidentiality of patient identifying medical information, including the Health Insurance Portability and Accountability Act of 1996, as amended, and its associated regulations, and execute a health information confidentiality agreement with the Hospital.

5.5(j) Consistent with generally recognized quality standards, deliver patient care in an efficient and financially prudent manner, and adhere to local medical review policies with regard to utilization;

5.5(k) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Allied Health membership and exercise the privileges requested prior to initial exercise of privileges, and participate in the hospital drug testing program;

5.5(l) Refuse to engage in improper inducements for patient referral; and

5.5(m) Refrain from engaging in business practices which are predatory or harmful to the Hospital or the community.

ARTICLE VI
PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

The Medical Staff through its designated committees shall investigate and consider each application for appointment or reappointment to the staff and each request for modification of staff membership status and shall adopt and transmit recommendations thereon to the Board which shall be the final authority on granting, extending, terminating or reducing Medical Staff privileges. The Board shall be responsible for the final decision as to Medical Staff appointments. A separate, confidential record shall be maintained for each individual requesting Medical Staff membership or clinical privileges.

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration (for all practitioners except pathologists), a signed Medicare penalty statement and a certificate of insurance must be submitted with the application. Applicants shall supply the Hospital with all information requested on the application.

The application form shall include, at a minimum, the following:

1. ***Acknowledgment and Agreement:*** A statement that the Applicant has been given a copy of the Bylaws, and that his/her application, and all matters relating to the processing and consideration thereof shall be subject to the Bylaws, Rules and Regulations and Policies of the Hospital, whether or not he/she is granted membership and/or clinical privileges; he/she understands the appointment mechanism as described in the Credentialing Policy.
2. ***Qualifications***: Detailed information concerning the Applicant's professional licenses and qualifications, including qualifications specified in the Bylaws for the particular Staff category to which the Applicant requests appointment. Practitioners must be able to present current documentation of the following:
   a. Requisite professional education, training and background.
   b. Demonstrated ability and judgment.
   c. Relevant experience by clinical results.
   d. Current competence to practice his/her profession and perform all requested privileges.
   e. Freedom from significant physical, emotional or behavioral impairment, which prevents him/her from meeting the other qualifications for membership and/or privileges.
   f. Acceptable professional claims history.
   g. Adherence to the lawful ethics of his/her profession.
   h. The ability to work cooperatively with others in the Hospital setting and with professional peers in a consistently cordial and productive time manner.
   i. That he/she does not use drugs or alcohol or any other similar substance to an extent that would be likely to prevent or alter his/her ability to practice his/her profession and perform the requested clinical privileges in a competent manner.
   j. A willingness to participate and properly discharge other Medical Staff responsibilities.
   k. An ability to sufficiently provide continuous quality care to his/her patients to reasonably assure the Staff and Board that any patient treated by him/her in the Hospital will receive care of a quality that is consistent with the standards of the Board and Medical Staff.

3. ***Requests:*** Requests identifying the Staff category, department and clinical privileges to which the Applicant wishes to be considered.

4. ***References:*** The names of at least three (3) persons who have recently worked with the Applicant and directly observed his/her professional performance over a reasonable period of time and who can and will provide reliable information regarding the Applicant's current clinical ability and ethical character and ability to work well with others. At least one of the references shall be from a "peer" of the Applicant who has had similar education and training.

5. ***Professional Sanctions:*** Information as to whether any of the following have ever or are in the process of being denied, revoked, suspended, reduced, not renewed, or voluntarily or involuntarily relinquished:
   a. Staff membership status or clinical privileges at any other hospital or health care institution.
   b. Membership in local, state or national professional organization.
   c. Any licensure or registration.
   d. Drug Enforcement Administration (DEA) number.

   If any such actions ever occurred or are pending, the particulars thereof shall be included.

6. ***Professional Liability Insurance***: A statement that the Applicant carries at least the minimum amount of professional liability insurance coverage required by the Board and shall provide information about his/her malpractice claims, suits, arbitration's and settlements during the five (5) years preceding the date upon which the Applicant's complete application is received, and that the Applicant will disclose any such information that becomes known after the application has been received and through the date when the application is approved or denied. An Applicant consents to the release of information by his/her present and past malpractice insurers.

7. ***Administrative Remedies:*** A statement whereby the Practitioner agrees that, when an adverse ruling is made with respect to Staff membership, Staff status, and/or clinical privileges, he/she will exhaust the administrative remedies afforded by the *Fair Hearing Plan* before resorting to legal action.

The applicant has a continuing duty to keep all of the above information updated and current. Failure to update anything on the above list within seven (7) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights. Failure to update within seven (7) days during any period of appointment or reappointment shall result in immediate loss of medical staff membership and clinical privileges, without right of fair hearing procedures.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

An applicant wishing to be considered for appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her written request for an application form to the CEO or his/her designee.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

(1) Signifies his/her willingness to appear for interviews and acknowledges that he/she shall have the burden of producing adequate information for a proper evaluation of his/her qualifications for staff membership and clinical privileges;

(2) Authorizes Hospital representatives to consult with others who have been associated with him/her and/or who may have information bearing on his/her current competence and qualifications;

(3) Consents to the inspection by Hospital representatives of all records and documents that may be material to an evaluation of his/her licensure, specific training, experience, current competence, health status and ability to carry out the clinical privileges he/she requests as well as of his/her professional ethical qualifications for staff membership;

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application;

(5) Acknowledges that provision of false or misleading information, or omission of information, whether intentional or not, shall be grounds for immediate rejection of his/her application without fair hearing rights;

(6) Acknowledges that, if he/she is determined to have made a misstatement, misrepresentation or omission in connection with an application and such misstatement, misrepresentation, or omission is discovered after appointment and/or the granting of clinical privileges, he/she shall be deemed to have immediately relinquished his/her appointment and clinical privileges, without fair hearing rights;

(7) Pledges to provide continuous care for his/her patients treated in the Hospital; and

(8) Agrees to be bound by the statements described in Section 6.3(c).

6.3(c) <u>Statement of Release & Immunity from Liability</u>

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

I hereby apply for Medical Staff appointment as requested in this application and, whether or not my application is accepted, I acknowledge, consent and agree as follows:

As an applicant for appointment, I have the burden for producing adequate information for proper evaluation of my qualifications. I also agree to update the Hospital with current information regarding all questions contained in this application as such information becomes available and any additional information as may be requested by the Hospital or its authorized representatives. Failure to produce any such information will prevent my application for appointment from being evaluated and acted upon. I hereby signify my willingness to appear for the interview, if requested, in regard to my application.

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges without fair hearing rights. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I shall be deemed to have immediately relinquished my appointment and clinical privileges without fair hearing rights.

If granted appointment, I accept the following conditions:

(1) I extend immunity to, and release from any and all liability, the Hospital, its authorized representatives and any third parties, as defined in subsection (3) below, for any acts, communications, recommendations or disclosures performed without intentional fraud or malice involving me; performed, made, requested or received by this Hospital and its authorized representatives to, from or by any third party, including otherwise privileged or confidential information, relating, but not limited to, the following:

    (i) applications for appointment or clinical privileges, including temporary privileges;

    (ii) periodic reappraisals;

    (iii) proceedings for suspension or reduction of clinical privileges or for denial or revocation of appointment, or any other disciplinary action;

    (iv) summary suspension;

    (v) hearings and appellate reviews;

    (vi) medical care evaluations;

    (vii) utilization reviews;

    (viii) any other Hospital, Medical Staff, service or committee activities;

    (ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and
    (x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

(2) I specifically authorize the Hospital and its authorized representatives to consult with any third party who may have information, including otherwise privileged or confidential information, bearing on my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics, behavior or other matter bearing on my satisfaction of the criteria for continued appointment to the Medical Staff, as well as to inspect or obtain any all communications, reports, records, statements, documents, recommendations and/or disclosure of said third parties relating to such questions. I also specifically authorize said third parties to release said information to the Hospital and its authorized representatives upon request.

(3) The term "Hospital" and "its authorized representatives" means the Hospital Corporation, the Hospital to which I am applying and any of the following individuals who have any responsibility for obtaining or evaluating my credentials, or acting upon my application or conduct in the Hospital: the members of the Board and their appointed representatives, the CEO or his/her designees, other Hospital employees, consultants to the Hospital, the Hospital's attorney and his/her partners, associates or designees, and all appointees to the Medical Staff. The term "third parties" means all individuals, including appointees to the Medical Staff, and appointees to the Medical Staffs of other Hospitals or other physicians or health practitioners, nurses or other government agencies, organizations, associations, partnerships and corporations, whether Hospitals, health care facilities or not, from whom information has been requested by the Hospital or its authorized representatives or who have requested such information from the Hospital and its authorized representatives.

I acknowledge that: (1) Medical Staff appointments at this Hospital are not a right; (2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations; (3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final; (4) I have the responsibility to keep this application current by informing the Hospital through the CEO, of any change in the areas of inquiry contained herein; and (5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence and cooperation, my general support of the acceptable performance of all responsibilities related thereto, as well as other factors that are relevant to the effective and efficient operation of the Hospital. Appointment and continued clinical privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

I understand that before this application will be processed that: (1) I will be provided a copy of the Medical Staff Bylaws and such Hospital policies and directives as are applicable to appointees to the Medical Staff, including these Bylaws and Rules & Regulations of the Medical Staff presently in force; and (2) I must sign a statement acknowledging receipt and an opportunity to read the copies and agreement to abide by all such bylaws, policies, directives and rules and regulations as are in force, and as they may thereafter be amended, during the time I am appointed to the Medical Staff or exercise clinical privileges at the Hospital.

If appointed or granted clinical privileges, I specifically agree to: (1) refrain from fee-splitting or other inducements relating to patient referral; (2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised; (3) refrain from deceiving patients as to the identity of any practitioner or AHP providing treatment or services; (4) seek consultation whenever necessary; (5) abide by generally recognized ethical principles applicable to my profession; (6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and (7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) <u>Submission of Application &Verification of Information</u>

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the CEO or his/her designee. The application shall be returned to the applicant and shall not be processed further if one (1) or more of the following applies:

(1) <u>Not Licensed</u>. The applicant is not licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or

(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the applicant has had his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or had an application rejected as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty; or

(3) Exclusive Contract or Moratorium. The applicant practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital or a moratorium has been imposed by the Board upon acceptance of applications within the applicants' specialty; or

(4) Inadequate Insurance. The applicant does not meet the liability insurance coverage requirements of these bylaws; or

(5) Ineligible for Medicare Provider Status. The applicant has been excluded, suspended or debarred, or otherwise declared ineligible from any state or federal health care program or procurement program, or is currently the subject of a pending investigation by any such program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible; or

(6) No DEA number. The applicant's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists); or

(7) Continuous Care Requirement. For applicants who will be seeking advancement to Active or Courtesy Staff, failure to maintain an office or residence within forty (40) minutes of the Hospital; or

(8) Application Incomplete. The applicant has failed to provide any information required by these bylaws or requested on the application, has provided false or misleading information on the application, or has failed to execute an acknowledgment, agreement or release required by these bylaws or included in the application; and

(9) Electronic Health Record Education/Training: The applicant has failed to complete education in accordance with a facility approved curriculum related to electronic clinical information systems, or fails to appropriately utilize the Electronic Health Record as outlined in more detail in the Electronic Health Record Policy of this Hospital.

The refusal to further process an application form for any of the above reasons shall not entitle the applicant to any further procedural rights under these bylaws.

In the event that none of the above apply to the application, the CEO or his/her designee shall promptly seek to collect or verify the references, licensure and other evidence submitted. The CEO or his/her designee shall promptly notify the applicant, via special notice, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within two (2) weeks of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of

current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Chairperson of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) Description of Initial Clinical Privileges

Medical Staff appointments or reappointments shall not confer any clinical privileges or rights to practice in the hospital. Each practitioner who is appointed to the Medical Staff of the hospital shall be entitled to exercise only those clinical privileges specifically granted by the Board. The clinical privileges recommended to the Board shall be based upon the applicant's education, training, experience, past performance, demonstrated competence and judgment, references and other relevant information. The applicant shall have the burden of establishing his/her qualifications for, and competence to exercise the clinical privileges he/she requests.

6.3(f) Credentials Committee Action

Within thirty (30) days of receiving the completed application, the members of the Credentials Committee shall review the application, the supporting documentation, and such other information available as may be relevant to consideration of the applicant’s qualifications for the staff category and clinical privileges requested. The Credentials Committee shall transmit to the MEC on the prescribed form a written report and recommendation as to staff appointment and, if appointment is recommended, clinical privileges to be granted and any special conditions to be attached to the appointment. The Credentials Committee also may recommend that the MEC defer action on the application. The reason for each recommendation shall be stated and supported by references to the completed application and all other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

6.3(g) Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee recommendation, but no later than thirty (30) days, the MEC shall consider the recommendation and other relevant information available to it. Where there is doubt about an applicant’s ability to perform the privileges requested, the MEC may request an additional evaluation. The MEC shall make specific findings as to the applicant’s satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o). The MEC shall then forward to the Board a written report on the prescribed form concerning staff recommendations and, if appointment is recommended, staff category and clinical privileges to be granted and any special conditions to be attached to the appointment. The MEC also may defer action on the application. The reasons for each recommendation shall be stated and supported by reference to the completed application and other information considered by the committee. Documentation shall be transmitted with the report. Any minority views shall also be reduced to writing, supported by reasons, references and documents, and transmitted with the majority report.

6.3(h) Effect of Medical Executive Committee Action

(1) Deferral: Action by the MEC to defer the application for further consideration must be followed up within ninety (90) days with a recommendation for appointment with specified clinical privileges or for rejection of the application. An MEC decision to defer an application shall include specific reference to the reasons therefore and shall describe any additional information needed. If additional information is required from the applicant, he/she shall be so notified, and he/she shall then bear the burden of providing same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the CEO or his/her designee shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the application form and its accompanying information and the report and recommendation of the Credentials Committee.

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the CEO or his/her designee shall immediately inform the applicant by special notice which shall specify the reason or reasons for denial and the applicant then shall be entitled to the procedural rights as provided in the Fair Hearing Plan or for AHPs the procedure outlined in 5.4(b). The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan or for the AHPs, the procedure outlined in 5.4(b).

6.3(i) Board Action

(1) Decision; Deadline. The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete. The Board of Trustees may accept, reject or modify the MEC recommendation.

The Board may appoint a committee consisting of at least two (2) Board members to review the recommendations received from the MEC. If the committee returns a positive decision concerning the application, the full Board shall ratify that decision at its next regular meeting. If the committee returns a negative decision concerning the application, the application shall be returned to the MEC for further recommendation prior to final action by the Board.

The expedited process may not be used in the following circumstances:

(i) The applicant submits an incomplete application;
(ii) The MEC makes a recommendation that is adverse or with limitation;
(iii) There is a current challenge or a previously successful challenge to licensure or registration;
(iv) The applicant has received an involuntary termination of Medical Staff membership at another organization;
(v) The applicant has received an involuntary limitation, reduction, denial, or loss of clinical privileges; or
(vi) There has been a final judgment adverse to the applicant in a professional liability action.

Any of the above circumstances will require review and consideration by the full Board.

In either case, and in situations in which no committee has been appointed t*he** Secretary of the Board shall reduce the ***full Board's decision to writing and shall set forth therein the reasons for the decision. ***The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o).*** The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Trustees shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

(2) 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 granted. 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.

(3) Adverse Action. In the event that the MEC's recommendation was favorable to the applicant, but the Board of Trustees' action is adverse, the applicant shall be entitled to the procedural rights specified in the Fair Hearing Plan or for AHPs, the procedure outlined in 5.4(b). The CEO or his/her designee shall immediately deliver to the applicant by special notice, a letter enclosing the Board of Trustees' written decision and containing a summary of the applicant's rights as specified in the Fair Hearing Plan, or for AHPs the procedure outlined in 5.4(b).

Under no circumstances shall any applicant be entitled to more than one (1) evidentiary hearing under the Fair Hearing Plan based upon an adverse action.

6.3(j) Interview

An interview may be scheduled with the applicant during any of the steps set out in Section 6.3(f) - 6.3(j). Failure to appear for a requested interview without good cause may be grounds for denial of the application.

6.3(k) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five (5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, the application materials.

6.3(l) Time Periods for Processing

Applications for staff appointments shall be considered in a timely and good faith manner by all individuals and groups required by these bylaws to act thereon and, except for good cause, shall be processed within the time periods specified in this section. The CEO or his/her designee shall transmit a completed application to the Credentials Committee upon completing his/her verification tasks, but in any event within ninety (90) days after receiving the completed application, unless the applicant has failed to provide requested information needed to complete the verification process.

6.3(m) Denial for Hospital's Inability to Accommodate Applicant

A decision by the Board to deny staff membership, staff category assignment or particular clinical privileges based on any of the following criteria shall not be deemed to be adverse and shall not entitle the applicant to the procedural rights provided in the Fair Hearing Plan:

(1) On the basis of the hospital's present inability to provide adequate facilities or supportive services for the applicant and his/her patients as supported by documented evidence; or

(2) On the basis of inconsistency with the hospital's current services plan, including duly approved privileging criteria and mix of patient services to be provided; or

(3) On the basis of professional contracts the hospital has entered into for the rendition of services within various specialties.

However, upon written request of the applicant, the application shall be kept in a pending status for the next succeeding two (2) years. If during this period, the hospital finds it possible to accept applications for staff positions for which the applicant is eligible, and the hospital has no obligation to applicants with prior pending status, the CEO or his/her designee shall promptly so inform the applicant of the opportunity by special notice.

Within thirty (30) days of receipt of such notice, the applicant shall provide, in writing on the prescribed form, such supplemental information as is required to update all elements of his/her original application. Thereafter, the procedure provided in Section 6.2 for initial appointment shall apply.

6.3(n) Appointment Considerations

Each recommendation concerning the appointment of a staff member and/or for clinical privileges to be granted shall be based upon an evidence-based assessment of the applicant's experience, ability, and current competence by the Credentials Committee, MEC and Board, including assessment of the applicant's proficiency in areas such as the following:

(1) **Patient Care** with the expectation that applicants provide patient care that is compassionate, appropriate and effective;

(2) **Medical/Clinical Knowledge** of established and evolving biomedical clinical and social sciences, and the application of the same to patient care and educating others;

(3) **Practice-Based Learning and Improvement** through demonstrated use and reliance on scientific evidence, adherence to practice guidelines, and evolving use of science, evidence and experience to improve patient care practices;

(4) **Interpersonal and Communication Skills** that enable establishment and maintenance of professional working relationships with patients, patients' families, members of the Medical Staff, Hospital Administration and employees, and others;

(5) **Professional** behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude to patients, the medical profession and society; and

(6) **Systems-Based Practice** reflecting an understanding of the context and systems in which health care is provided.

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

At least ninety (90) days prior to the expiration date of an applicant's present staff appointment, the CEO or his/her designee shall provide the applicant a reapplication form for use in considering reappointment. The staff member who desires reappointment shall, at least sixty (60) days prior to such expiration date, complete the reapplication form by providing updated information with regard to his/her practice during the previous appointment period, and shall forward his/her reapplication form to the CEO or his/her designee. Failure to return a completed application form shall result in automatic termination of membership at the expiration of the member's current term.

6.4(b) Content of Reapplication Form

The Reapplication Form shall include, at a minimum, updated information regarding the following:

(1) Education: Continuing training, education, and experience during the preceding appointment period that qualifies the staff member for the privileges sought on reappointment;

(2) License: Current licensure;

(3) Health Status: Current physical and mental health status only to the extent necessary to determine the applicant's ability to perform the functions of staff membership or to exercise the privileges requested;

(4) Program Participation: Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion.

(5) Previous Affiliations: The name and address of any other health care organization or practice setting where the staff member provided clinical services during the preceding appointment period;

(6) Professional Recognition: Memberships, awards or other recognitions conferred or granted by any professional health care societies, institutions or organizations during the preceding appointment period;

(7) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following during the preceding appointment period:

(i) membership/fellowship in local, state or national professional organizations; or

(ii) specialty board certification; or

(iii) license to practice any profession in any jurisdiction; or

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except for pathologists) (including any sanction or notice of intent to sanction or to revoke, suspend or modify his/her DEA number/controlled substance license; or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges (including relinquishment of such medical staff membership or clinical privileges after an investigation of competence, professional conduct, or patient care activities has commenced or to avoid such investigation; or receipt of a sanction or notice of intent to sanction from any peer review or professional review body); or

(vi) the applicant's management of patients which may have been given rise to investigation by the state board; or

(vii) participation in any private, federal or state health care or procurement program, including Medicare or Medicaid including conviction of a crime that meets the criteria for mandatory exclusion from such program regardless of whether such exclusion has yet become effective.

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete.

(8) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending or pursued to final judgment;

(9) Criminal Charges: Any current criminal charges pending against the applicant, including any federal and/or state criminal convictions related to the delivery of health care, and any convictions or pleas during the preceding appointment period. This includes any arrests related to the use, misuse or abuse of drugs or alcohol including DUIs and DWIs;

(10) Fraud and Civil Judgments related to Medical Practice: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period; and any civil judgments or settlements related to the delivery of health care;

(11) Managed Care Affiliations: The names of all HMO's, PPO's and other managed care organizations in which the applicant has participated in the past three (3) years during the preceding appointment period;

(12) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws, together with a letter from the

insurer stating that the Hospital will be notified should the applicant's coverage change at any time;

(13) Current Competency: Quality Assurance findings regarding patters of care relating to professional performance, judgment and clinical or technical skills.

(14) Notification of Release & Immunity Provisions: The acknowledgments and statement of release set forth in Sections 6.3(b) and (c);

(15) Information on Ethics/Qualifications: Such other specific information about the staff member's professional ethics and qualifications that may bear on his/her ability to provide patient care in the hospital;

(16) References: At the request of the Credentials Committee, the MEC, or the Board, when based on the opinion of the same, there is insufficient data concerning the applicant's exercise of privileges in this Hospital during the preceding term of appointment to base a reasonable evaluation, the names of at least three (3) practitioners who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training and experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others; and

(17) Continuing Education and Training: Evidence of satisfactory completion of continuing education requirements and other MEC directed education or safety training as required by this Hospital, which should be related to the physician's specialty and to the provision of quality patient care in the Hospital.

The applicant has a continuing duty to keep all of the above information updated and current. Failure to update anything on the above list within seven (7) days of any change or action while the application is pending shall result in a refusal to process the application, without Fair Hearing Rights. Failure to update within seven (7) days during any period of appointment or reappointment shall result in immediate loss of medical staff membership and clinical privileges, without right of fair hearing procedures.

6.4(c) Verification of Information

The CEO or his/her designee shall, in timely fashion, verify the additional information made available on each Reapplication Form and collect any other materials or information deemed pertinent, including information regarding the staff member's professional activities, performance and conduct in the hospital and the query of the Data Bank. Peer recommendations will be collected and considered in the reappointment process. When collection and verification are accomplished, the CEO or his/her designee shall transmit the Reapplication Form and supporting materials to the Chairman of the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.4(d) Action on Application

The application for reappointment shall thereafter be processed as set forth as described in Section 6.3(f) - 6.3(m) for initial appointment; except that an individual whose application for reappointment is denied shall not be permitted to reapply for a period of five (5) years or until the defect constituting the basis for the adverse action is corrected, whichever is later. Any

reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

6.4(e) Basis for Recommendations

Each recommendation concerning the reappointment of a staff member and the clinical privileges to be granted upon reappointment shall be based upon an evaluation of the considerations described in Section 6.3(o) as they impact upon determinations regarding the member's professional performance, ability and clinical judgment in the treatment of patients, his/her discharge of staff obligations, including participation in continuing medical education, his/her compliance with the Medical Staff Bylaws, Rules & Regulations, his/her cooperation with other practitioners and AHPs and with patients, results of the hospital monitoring and evaluation process, including practitioner and AHP-specific information compared to aggregate information from Performance Improvement activities which consider criteria directly related to quality of care, and other matters bearing on his/her ability and willingness to contribute to quality patient care in the hospital.

6.5 REQUEST FOR MODIFICATION OF APPOINTMENT

A staff member may, either in connection with reappointment or at any other time, request modification of his/her staff category or clinical privileges, by submitting the request in writing to the CEO. Such request shall be processed in substantially the same manner as provided in Section 6.4 for reappointment. No staff member may seek modification of privileges or staff category previously denied on initial appointment or reappointment unless supported by documentation of additional training and experience.

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

A practitioner or AHP who is providing contract services to the hospital must meet the same qualifications for membership; must be processed for appointment, reappointment, and clinical privilege delineation in the same manner; must abide by the Medical Staff Bylaws and Rules & Regulations and must fulfill all of the obligations for his/her membership category as any other applicant or staff member.

6.6(b) Requirements for Service

In approving any such practitioners or AHP for Medical Staff membership, the Medical Staff must require that the services provided meet Joint Commission requirements, are subject to appropriate quality controls, and are evaluated as part of the overall hospital quality assessment and improvement program.

6.6(c) Termination

Unless otherwise provided in the contract for services, expiration or termination of any exclusive contract for services pursuant to this Section 6.6, shall automatically result in concurrent termination of Medical Staff membership and clinical privileges. The Fair Hearing does not apply in this case.

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Every practitioner or AHP providing direct clinical services at this Hospital shall, in connection with such practice and except as provided in Section 7.5, be entitled to exercise only those clinical privileges or services specifically granted to him/her by the Board. Said privileges must be within the scope of the license authorizing the practitioner or AHP to practice in this state and consistent with any restrictions thereon. The Board shall approve the list of specific privileges and limitations for each category of practitioner and AHP, and each practitioner or AHP shall bear the burden of establishing his/her qualifications to exercise each individual privilege granted.

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant. The request for specific privileges must be supported by documentation demonstrating the practitioner or AHP's qualifications to exercise the privileges requested. In addition to meeting the general requirements of these Bylaws for medical staff membership, each practitioner and AHP must provide documentation establishing that he/she meets the requirements for training, education and current competence set forth in any specific credentialing criteria applicable to the privileges requested. A request by a staff member for a modification of privileges must be supported by documentation supportive of the request, including at least one (1) peer reference.

7.2(b) Basis for Privileges Determination

Granting of clinical privileges shall be based upon community and hospital need, available facilities, equipment and number of qualified support personnel and resources as well as on the practitioner's education, training, current competence, including documented experience treatment areas or procedures; the results of treatment; and the conclusions drawn from performance improvement activities, when available. For practitioners or AHPs who have not actively practiced in the hospital within the prior appointment period, information regarding current competence shall be obtained in the manner outlined in Section 6.4(b) (13) herein. In addition, those practitioners or AHPs seeking new, additional or renewed clinical privileges (except those seeking emergency privileges) must meet all criteria for Medical Staff membership as described in Article VI of these Bylaws, including a query of the National Practitioner Data Bank. When privilege delineation is based primarily on experience, the individual's credentials record should reflect the specific experience and successful results that form the basis for granting of privileges, including information pertinent to judgment, professional performance and clinical or technical skills. Clinical privileges granted or modified on pertinent information concerning clinical performance obtained from other health care institutions or practice settings shall be added to and maintained in the Medical Staff file established for a staff member or AHP.

7.2(c) Procedure

All requests for clinical privileges shall be evaluated and granted, modified or denied pursuant to the procedures outlined in Article VI and shall be granted for a period not to exceed two (2) years. The Data Bank shall be queried each time new privileges are requested.

7.2(d) Limitations on Privileges

The delineation of an individual's clinical privileges shall include the limitations, if any, on an individual's prerogatives to admit and treat patients or direct the course of treatment for the conditions for which the patients were admitted.

7.2(e) Initial and Additional Grants of Privileges

All initial appointments and grants of new or additional privileges to existing members of the Medical Staff shall be subject to a period of focused professional practice evaluation for a period of no more than six (6) months. The evaluation period may be renewed for additional periods up to the conclusion of the member's period of initial appointment or initial grant of new or additional privileges. Results of the focused professional practice evaluation conducted during the period of appointment shall be incorporated into the practitioner or AHP's evaluation for reappointment.

7.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges from dentists and oral surgeons shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists and oral surgeons shall be under the overall supervision of the Chief of Surgery, however, other dentists and/or oral surgeons shall participate in the review of the practitioner through the performance improvement process. All dental patients shall receive the same basic medical appraisal as patients admitted for other surgical services. A physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

7.4(a) Temporary Privileges- Important Patient Care Need – Pending Application

Temporary privileges may be granted when there is an important patient care, treatment, or service need that mandates an immediate authorization to practice, for a limited period of time, to a new applicant with a fully completed, fully verified application that raises no concerns following review and recommendation by the Chief of Staff and pending MEC review and Board approval. "New applicant" includes an individual applying for clinical privileges at the hospital for the first time and an individual holding clinical privileges who is requesting one of more additional privileges.

In these cases only, the CEO or his/her designee, upon recommendation of the Chief of Staff, may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query and upon verification that there are no current or prior successful challenges to licensure, or registration, that the practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days of service.

The letter approving temporary privileges shall identify the specific privileges granted. Except as provided above, temporary privileges may not be granted pending processing of applications for appointment or reappointment.

7.4(b) Temporary Privileges- Important Patient Care Need – No Pending Application

Temporary privileges may be granted by the CEO upon recommendation of the Chief of Staff when there is an important patient care, treatment or service need that mandates an immediate authorization to practice for a limited period of time, when no application for medical staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately.

Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than sixty (60) consecutive days), but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service as locum tenens within a calendar year. All practitioners providing coverage for other practitioners must ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care need, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and telephone confirmation of privileges at the practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

Members of the Medical Staff seeking to facilitate coverage for their practice via a substitute practitioner shall, where possible, advise the Hospital at least thirty (30) days in advance of the identity of the practitioner and the dates during which the locum tenens services will be utilized in order to allow adequate time for appropriate verification to be completed. Failure to do so without good cause shall be grounds for corrective action.

7.4(c) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30) days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed the period of proctorship, or a maximum of one hundred twenty (120) days. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the practitioner's primary hospital. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases only, the CEO or his/her designee, upon recommendation of the President of the Medical Staff, Chairperson of the Credentials Committee, may grant such privileges upon receipt of the required information.

7.4 (d) Conditions

Temporary and proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant's qualifications, ability and judgment to exercise the privileges granted. Special requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such applicant be admitted upon dual admission with a member of the Active Staff. Before temporary privileges are granted, the applicant must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

7.4(e) Termination

On the discovery of any information or the occurrence of any event of a professionally questionable nature concerning a practitioner's qualifications or ability to exercise any or all of the privileges granted, the CEO may, after consultation with the Chief of Staff terminate such practitioner's temporary privileges. Where the life or well-being of a patient is endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article VIII, Section 8.2(a). In the event of any such termination, the practitioner's patients then in the hospital shall be assigned to another practitioner by the Chief of Staff. The wishes of the patient shall be considered, if feasible, in choosing a substitute practitioner.

7.4(f) Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by these bylaws because of his/her inability to obtain temporary or proctoring privileges or because of any termination or suspension of such privileges.

7.4(g) Term

No term of temporary or proctoring privileges shall exceed a total of one hundred and twenty (120) days.

7.5 EMERGENCY & DISASTER PRIVILEGES

For the purpose of this section, an "emergency" is defined as a condition in which serious or permanent harm to a specific patient is imminent, or in which the life of a specific patient is in immediate danger, delay in administering treatment immediately would add to that danger and no appropriately credentialed individual can be available in the time required to respond. A "disaster" for purposes of this section is defined as a community-wide disaster or mass injury situation in which the number of existing, available medical staff members is not adequate to provide all clinical services required by the citizens served by this facility. In the case of an emergency, or disaster as defined herein, any practitioner, or licensed independent practitioner, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall, as approved by the CEO or his/her designee or the Chief of Staff, be permitted to do, and be assisted by hospital personnel in doing everything reasonable and necessary to save the life of a patient or to prevent imminent harm to the patient.

Disaster privileges may be granted by the CEO or Chief of Staff when, and for so long as, the Hospital's emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner, shall be required to present a valid photo ID issued by a state, federal or

regulatory agency, and at least one of the following: a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team (DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications. The CEO and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

As soon as possible after disaster privileges are granted, but not later than seventy-two (72) hours thereafter, the practitioner shall undergo the same verification process outlined in Section 7.4(a) for temporary privileges when required to address an emergency patient care need. In extraordinary circumstances in which primary source verification of licensure, certification or registration cannot be completed within seventy-two (72) hours it shall be done as soon as possible, and the Hospital shall document in the emergency/disaster volunteer's credentialing file why primary source verification cannot be performed in the required time frame, the efforts of the practitioner to continue to provide adequate care, treatment and services, and all attempts to rectify the situation and obtain primary source verification as soon as possible. In all cases, whether or not primary source verification could be obtained within seventy-two (72) hours following the grant of disaster privileges, the Chief of Staff, or his or her designee, shall review the decision to grant the practitioner disaster privileges, and shall, based on information obtained regarding the professional practice of the practitioner, make a decision concerning the continuation of the practitioner's disaster privileges.

In addition, each practitioner granted disaster privileges shall be issued a Hospital ID (or if not practicable by time or other circumstances to issue official Hospital ID, then another form of identification) that clearly indicates the identity of the practitioner, and the scope of the practitioner's disaster responsibilities and/or privileges. A member of the medical staff shall be assigned to each disaster volunteer practitioner for purposes of overseeing the professional performance of the volunteer practitioner through such mechanisms as direct observation of care, concurrent or retrospective clinical record review, mentoring, or as otherwise provided in the grant of privileges.

7.6 TELEMEDICINE

7.6(a) Scope of Privileges

The Medical Staff shall make recommendations to the Board of Trustees regarding which clinical services are appropriately delivered through the medium of telemedicine, and the scope of such services. Clinical services offered through this means shall be provided consistent with commonly accepted quality standards.

7.6(b) Telemedicine Physicians

Any physician who prescribes, renders a diagnosis, or otherwise provides clinical treatment to a patient at the Hospital through a telemedicine procedure (the "telemedicine physician"), must be credentialed and privileged through the Medical Staff pursuant to the credentialing and privileging procedures described in these Medical Staff Bylaws. An exception is outlined below for those circumstances in which the practitioner's distant-site entity or distant-site hospital is Joint Commission accredited and the Hospital places in the practitioner's credentialing file a copy of written documentation confirming such accreditation.

In circumstances in which the distant-site entity or hospital is Joint Commission accredited, the Medical Staff and Board may rely on the telemedicine physician's credentialing information from the distant-site entity or distant-hospital to credential and privilege the telemedicine physician ONLY if the Hospital has ensured through a written agreement with the distant-site entity or distant-site hospital that all of the following provisions are met:

(1) The distant-site entity or distant-site hospital meets the requirements of 42 CFR § 482.12(a)(1)-(7), with regard to the distant-site entity's or distant-site hospital's physicians and practitioners providing telemedicine services;

(2) The distant-site entity, if not a distant-site hospital, is a contractor of services to the Hospital and as such, in accordance with 42 CFR § 482.12(e), furnishes the contracted services in a manner that permits the Hospital to comply with all applicable federal regulations for the contracted services;

(3) The distant-site organization is either a Medicare-participating hospital or a distant-site telemedicine entity with medical staff credentialing and privileging processes and standards that at least meet the standards set forth in the CMS Hospital Conditions of Participation;

(4) The telemedicine physician is privileged at the distant-site entity or distant-site hospital providing the telemedicine services, and the distant-site entity or distant-site hospital provides the Hospital with a current list of the telemedicine physician's privileges at the distant-site entity or distant-site hospital;

(5) The telemedicine physician holds a license issued or recognized by the state in which the Hospital is located; and

(6) The Hospital has evidence, or will collect evidence, of an internal review of the telemedicine physician's performance of telemedicine privileges at the Hospital and shall send the distant-site entity or distant-site hospital such performance information (including, at a minimum, all adverse events that result from telemedicine services provided by the telemedicine physician and all complaints the Hospital has received about the telemedicine physician) for use in the periodic appraisal of the telemedicine physician by the distant-site entity or distant-site hospital.

For the purposes of this Section 7.6, the term "distant-site entity" shall mean an entity that: (1) provides telemedicine services; (2) is not a Medicare-participating hospital; and (3) provides contracted services in a manner that enables a hospital using its services to meet all applicable CMS Hospital Conditions of Participation, particularly those related to the credentialing and privileging of physicians providing telemedicine services. For the purposes of this Section 7.6, the term "distant-site hospital" shall mean a Medicare-participating hospital that provides telemedicine services.

If the telemedicine physician's site is also accredited by Joint Commission, and the telemedicine physician is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telemedicine physician's credentialing information from that site may be relied upon to credential the telemedicine physician in the Hospital. However, this Hospital will remain responsible for primary source verification of licensure, professional liability insurance, Medicare/Medicaid eligibility and for the query of the Data Bank.

7.7 MEMBERSHIP WITHOUT DELINEATED CLINICAL PRIVILEGES

7.7(a) Membership with "Refer & Follow" Privileges Only

Practitioners who meet the basic qualifications set forth in Section 3.2(a) of these Medical Staff Bylaws and do not provide patient care in this Hospital may apply for Medical Staff membership without delineated clinical privileges. Practitioners who do not wish to actively treat patients within the Hospital may seek "refer and follow" privileges only. These will permit the practitioner to refer patients to the Hospital for outpatient testing and refer patients to Medical Staff members or Hospitalists for procedures or treatment within the facility. If the admitting/attending physician agrees, a practitioner with "refer and follow" privileges may visit his/her patients in the Hospital, review patient medical records and receive information concerning the patient's medical condition and treatment. However, under no circumstances shall a practitioner with "refer and follow" privileges participate in any treatment or procedure, make any entries in the medical record, or admit a patient to the Hospital. Practitioners who apply for "refer and follow" privileges only may apply for Active, Courtesy or Consulting category.

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive, undermine a culture of safety or interfere with hospital operations, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, department chair, the CEO, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed in the event of corrective action against a physician or dentist with clinical privileges, and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

All requests for corrective action under this Section 8.1 shall be submitted in writing to the MEC, and supported by reference to the specific activities or conduct which constitutes the grounds for the request. The Chief of Staff shall promptly notify the CEO or his/her designee in writing of all requests for corrective action received by the committee and shall continue to keep the CEO or his/her designee fully informed of all action taken in conjunction therewith.

8.1(c) Investigation by the Medical Executive Committee

The MEC shall begin to investigate the matter within forty-five (45) days or at its next regular meeting whichever is sooner, or shall appoint an ad hoc committee to investigate it. When the investigation involves an issue of physician impairment, the MEC shall assign the matter to an ad hoc committee of three (3) members who shall operate apart from this corrective action process, pursuant to the provisions of the Hospital's Practitioner Health Policy. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.1(d) Medical Executive Committee Action

Within sixty (60) days following receipt of the report, the MEC shall take action upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action;

(2) Recusing itself from the matter and referring same to the Board without recommendation, together with a statement of its reasons for recusing itself from the matter, which reasons may include but are not limited to a conflict of interest due to direct economic competition or economic interdependence with the affected physician;

(3) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(4) Recommending terms of probation or required consultation;

(5) Recommending reduction, suspension or revocation of clinical privileges;

(6) Recommending reduction of staff category or limitation of any staff prerogatives; or

(7) Recommending suspension or revocation of staff membership.

8.1(e) Procedural Rights

Any action by the MEC pursuant to Section 8.1(d)(4), (5) (6) or (7) (where such action materially restricts a practitioner's exercise of privileges) or any combination of such actions, shall entitle the physician or dentist to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The Board may be informed of the recommendation, but shall take no action until the member has either waived his/her right to a hearing or completed the hearing.

8.1(f) Other Action

If the MEC's recommended action is as provided in Section 8.1(d)(1), (2), (3) or (d)(4) (where such action does not materially restrict a practitioner's exercise of privileges), such recommendation, together with all supporting documentation, shall be transmitted to the Board. The Fair Hearing Plan shall not apply to such actions.

8.1(g) Board Action

When routine corrective action is initiated by the Board pursuant to Section 1.2(2) or (3) of the Fair Hearing Plan, the functions assigned to the MEC under this Section 8.1 shall be performed by the Board, and shall entitle the practitioner to the procedural rights as specified in the Fair Hearing Plan.

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

Notwithstanding the provisions of Section 8.1 above, whenever a practitioner willfully disregards these bylaws or other hospital policies, or his/her conduct may require that immediate action be taken to protect the life, well-being, health or safety of any patient, employee or other person, then the Chief of Staff, the CEO, or a member of the MEC shall have the authority to summarily suspend the Medical Staff membership status or all or any portion of the clinical privileges immediately upon imposition. Subsequently, the CEO or his/her designee shall, on behalf of the imposer of such suspension, promptly give special notice of the suspension to the practitioner.

Immediately upon the imposition of summary suspension, the Chief of Staff shall designate a physician with appropriate clinical privileges to provide continued medical care for the suspended practitioner's patients still in the hospital. The wishes of the patient shall be considered, if feasible, in the selection of the assigned physician.

It shall be the duty of all Medical Staff members to cooperate with the Chief of Staff and the CEO in enforcing all suspensions and in caring for the suspended practitioner's patients.

8.2(b) Medical Executive Committee Action

Within seventy-two (72) hours after such summary suspension, a meeting of the MEC shall be convened to review and consider the action taken. The MEC may recommend modification, ratification, continuation with further investigation or termination of the summary suspension.

8.2(c) **Procedural Rights**

If the summary suspension is terminated or modified such that the practitioner's privileges are not materially restricted, the matter shall be closed and no further action shall be required.

If the summary suspension is continued for purposes of further investigation the MEC shall reconvene within fourteen (14) days of the original imposition of the summary suspension and shall modify, ratify or terminate the summary suspension.

Upon ratification of the summary suspension or modification which materially restricts the practitioner's clinical privileges, the practitioner shall be entitled to the procedural rights provided in Article IX and the Fair Hearing Plan. The terms of the summary suspension as sustained or as modified by the MEC shall remain in effect pending a final decision by the Board.

8.3 ADMINISTRATIVE CORRECTIVE ACTION

8.3(a) Criteria for Initiation

Whenever a practitioner violates Hospital policies, rules or regulations, exhibits behavior that undermines a culture of safety or acts in a manner disruptive to hospital operations, or in such a manner as to endanger the assets of the hospital because of financially imprudent actions not justified by patient care considerations, administrative corrective action may be initiated pursuant to the Hospital Policy Regarding Disruptive Behavior. Such action shall be taken pursuant to this section, in conjunction with the above policy, rather than Section 8.1 or 8.2, only in those instances in which disruptive or inappropriate conduct, rather than clinical competency is in question. Such instances may include, but are not limited to, abusive treatment of hospital employees, refusal to discharge Medical Staff duties unrelated to patient care, violation of policies, rules or regulations, or harassment.

8.3(b) Corrective Action by the MEC and/or Board

If collegial intervention and progressive discipline pursuant to the Policy Regarding Disruptive Behavior is not successful in remediating the issue, the MEC and/or Board may take action as provided herein. If the MEC addresses the issue, the procedure in Section 8.1 shall apply. If the MEC elects to refer the matter directly to the Board, or the Board takes action on its own initiative, the Board may commence an investigation. The CEO shall be responsible for presenting the history of conduct to the Board. The Board shall be fully apprised of the previous meetings and warnings, if any, so that it may pursue whatever action is necessary to terminate the unacceptable conduct. Should the Board determine that further investigation is necessary, the Board Chairperson shall appoint an individual or an ad hoc committee to investigate and report back to the Board at its next regular meeting. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.3(c) Board Action

Within sixty (60) days following receipt of the report, the Board shall take action upon the request. Its action shall be reported in writing and may include, but is not limited to:

(1) Rejecting the request for corrective action;

(2) Issuing a warning or a reprimand to which the practitioner may write a rebuttal, if he/she so desires;

(3) Requiring terms of probation or required consultation;

(4) Reducing, suspending or revoking clinical privileges;

(5) Reducing staff category or limiting prerogatives; or

(6) Suspending or revoking staff membership.

8.3(d) <u>Procedural Rights</u>

Any action by the Board pursuant to Section 8.3(c)(4), (5) or (6), or (c)(3) (where such action materially restricts a practitioner's exercise of privileges) or any combination of such actions, shall entitle the practitioner to the procedural rights as specified in the provisions of Article IX and the Fair Hearing Plan. The action will not become final until the practitioner has either waived his/her right to a hearing or completed the hearing.

8.3(e) <u>Other Action</u>

If the Board's action is as provided in Section 8.3(c) (1) and (2), or (c) (3) (where such action does not materially restrict a practitioner's exercise of privileges), such action shall become the final action of the Board, and the practitioner shall not be entitled to the rights enumerated in the Fair Hearing Plan.

8.4 <u>AUTOMATIC SUSPENSION</u>

8.4(a) <u>License</u>

A staff member or AHP whose license, certificate, or other legal credential authorizing him/her to practice in Washington is revoked, relinquished, suspended, or restricted shall immediately and automatically be suspended from the staff and practicing in the hospital.

8.4(b) <u>Drug Enforcement Administration (DEA) Registration Number</u>

Any practitioner (except a pathologist) or AHP whose DEA registration number/controlled substance certificate or equivalent state credential is revoked, suspended or relinquished shall immediately and automatically be suspended from the staff and practicing in the Hospital until such time as the registration is reinstated.

8.4(c) <u>Medical Records</u>

(1) Automatic suspension of a practitioner or AHP's privileges shall be imposed for failure to complete medical records as required by the Medical Staff Bylaws and Rules & Regulations. The suspension shall continue until such records are completed unless the practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.

(2) <u>Medical Records- Expulsion</u>: Notwithstanding the provision of Section 8.4(c)(1), any staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension under said subsection 8.4(c)(1) shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45th) consecutive day of such automatic suspension.

8.4(d) Malpractice Insurance Coverage

Any practitioner or AHP unable to provide proof of current medical malpractice coverage in the amounts prescribed in these bylaws will be automatically suspended until proof of such coverage is provided to the MEC and CEO.

8.4(e) Failure to Appear/Cooperate

Failure of a practitioner or AHP to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner or AHP's clinical privileges as the MEC may direct. In addition, failure to complete required initial training or training updates regarding electronic health information systems as directed by the MEC and more specifically described in the facility Electronic Health Record Policy shall result in automatic suspension until such training is completed.

8.4(f) Exclusions/Suspension from Medicare

Any practitioner or AHP who is excluded, debarred, suspended, or otherwise declared ineligible from any state or federal government healthcare program or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider has yet been excluded, debarred, suspended or otherwise declared ineligible) will be automatically suspended.

8.4(g) Automatic Suspension - Fair Hearing Plan Not Applicable

No staff member, whose privileges are automatically suspended under this Section 8.4, shall have the right of hearing or appeal as provided under Article IX of these bylaws. The Chief of Staff shall designate a physician to provide continued medical care for any suspended practitioner's patients.

8.4(h) Chief of Staff

It shall be the duty of the Chief of Staff to cooperate with the CEO in enforcing all automatic suspensions and expulsions and in making necessary reports of same. The CEO or his/her designee shall periodically keep the Chief of Staff informed of the names of staff members who have been suspended or expelled under Section 8.4.

8.5 CONFIDENTIALITY

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these bylaws for peer review and corrective action.

8.6 SUMMARY SUPERVISION

Whenever criteria exist for initiating corrective action pursuant to this Article, the practitioner or AHP may be summarily placed under supervision concurrently with the initiation of professional review activities until such time as a final determination is made regarding the practitioner or AHP's privileges. Any of the following shall have the right to impose supervision: Chief of Staff, the CEO, or the Board.

8.7 PROTECTION FROM LIABILITY

All members of the Board, the Medical Staff and hospital personnel assisting in Medical Staff peer review shall have immunity from any civil liability to the fullest extent permitted by state and federal law when participating in any activity described in Section 6.3(c) of these bylaws.

8.8 REAPPLICATION AFTER ADVERSE ACTION

An applicant who has received a final adverse decision pursuant to Section 8.1, 8.2 or 8.3 shall not be considered for appointment to the Medical Staff for a period of five (5) years after notice of such decision is sent or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require.

8.9 FALSE INFORMATION ON APPLICATION

Any practitioner or AHP who, after being granted appointment and/or clinical privileges, is determined to have made a misstatement, misrepresentation, or omission in connection with an application shall be deemed to have immediately relinquished his/her appointment and clinical privileges. No practitioner or AHP who is deemed to have relinquished his/her appointment and clinical privileges pursuant to this Section 8.9 shall be entitled to the procedural rights under these Bylaws and the Fair Hearing Plan, except that the MEC may, upon written request from the practitioner or AHP, permit the practitioner or the AHP to appear before it and present information solely as to the issue of whether the practitioner or AHP made a misstatement, misrepresentation, or omission in connection with his/her application. If such appearance is permitted by the MEC, the MEC shall review the material presented by the practitioner or AHP and render a decision as to whether the finding that he/she made a misstatement, misrepresentation, or omission was reasonable, which MEC decision shall be subject to the approval of the Board.

ARTICLE IX
INTERVIEWS & HEARINGS

9.1 INTERVIEWS

When the MEC or Board is considering initiating an adverse action concerning a practitioner, it may in its discretion give the practitioner an interview. The interview shall not constitute a hearing, shall be preliminary in nature and shall not be conducted according to the procedural rules provided with respect to hearings. The practitioner shall be informed of the general nature of the proposed action and may present information relevant thereto. A summary record of such interview shall be made. No legal or other outside representative shall be permitted to participate for any party.

9.2 HEARINGS

9.2(a) Procedure

Whenever a practitioner requests a hearing based upon or concerning a specific adverse action as defined in Article I of the Fair Hearing Plan, the hearing shall be conducted in accordance with the procedures set forth in the Fair Hearing Plan and the Health Care Quality Improvement Act.

9.2(b) Exceptions

Neither the issuance of a warning, a request to appear before a committee, a letter of admonition, a letter of reprimand, a recommendation for concurrent monitoring, a denial, termination or reduction of temporary privileges, terms of probation, nor any other actions which do not materially restrict the practitioner's exercise of clinical privileges, shall give rise to any right to a hearing.

9.3 ADVERSE ACTION AFFECTING AHPS

Any adverse actions affecting AHPs shall be accomplished in accordance with Section 5.4 of these bylaws.

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

(1) Chief of Staff;
(2) Vice-Chief of Staff;
(3) Immediate Past Chief of Staff.

10.1(b) Qualifications

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 of an officer to maintain such status shall immediately create a vacancy in the office.

10.1(c) Nominations

(1) The Nominating Committee shall consist of the Chief of Staff, the Past-Chief of Staff of the Medical Staff and the CEO. This committee shall offer one (1) or more nominees for each office (with the exception of the office of Immediate Past Chief of Staff) to the Medical Staff thirty (30) days before the annual meeting.

(2) Nominations may also be made from the floor at the time of the annual meeting or by petition filed prior to the annual meeting signed by at least ten percent (10%) of the appointees of the Active Staff, with a signed statement of willingness to serve by the nominee, filed with the Chief of Staff at least thirty (30) days before the annual meeting.

10.1(d) Election

Officers shall be elected at the annual meeting of the staff and when otherwise necessary to fill vacancies. Only members of the Active Staff who are present at the annual meeting shall be eligible to vote. Voting may be open or by secret written ballot, as determined by the members present and voting at the meeting. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of all the valid ballots cast, subject to approval by the Board of Trustees, which approval may be withheld only for good cause.

10.1(e) Removal

Whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff, undermining a culture of safety, or to be disruptive to or interfering with the operations of the Hospital, the officer may be removed by a two-thirds (2/3) majority of the Active Medical Staff. Reasons for removal may include, but shall not be limited to violation of these bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

10.1(f) Term of Elected Officers

Each officer shall serve at least a one (1) year term, commencing on the first day of the Medical 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.

10.1(g) Vacancies in Elected Office

Vacancies in office, other than Chief of Staff, shall be filled by the MEC until such time as an election can be held. If there is a vacancy in the office of Chief of Staff, the Vice-Chief of Staff shall serve out the remaining term.

10.1(h) Duties of Elected Officers

(1) Chief of Staff. The Chief of Staff shall serve as the Chief Medical Officer and principal official of the staff. As such he/she will:

(i) appoint multi-disciplinary Medical Staff committees;

(ii) aid in coordinating the activities of the hospital administration and of nursing and other non-physician patient care services with those of the Medical Staff;

(iii) be responsible to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and professional performance within the hospital and for the effectiveness of patient care evaluations and maintenance functions delegated to the staff; work with the Board in implementation of the Board's quality, performance, efficiency and other standards;

(iv) in concert with the MEC and Credentials Committee, develop and implement methods for credentials review and for delineation of privileges; along with the continuing medical education programs, utilization review, monitoring functions and patient care evaluation studies;

(v) participate in the selection (or appointment) of Medical Staff representatives to Medical Staff and hospital management committees;

(vi) report to the Board and the CEO concerning the opinions, policies, needs and grievances of the Medical Staff;

(vii) be responsible for enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

(viii) call, preside and be responsible for the agenda of all general meetings of the Medical Staff;

(ix) serve as a voting member of the MEC and an ex-officio member of all other staff committees or functions;

(x) assist in coordinating the educational activities of the Medical Staff;

(xi) serve as liaison for the Medical Staff in its external professional and public relations;

(xii) confer with the CEO, CFO, CNO and Service Chief on at least a quarterly basis as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

(xiii) assist the Service Chief as to the types and amounts of data to be collected and compared in determining and informing the Medical Staff of the professional practice of its members.

(2) Vice-Chief of Staff: The Vice-Chief of Staff shall be a member of the MEC. In the absence of the Chief of Staff, he/she shall assume all the duties and have the authority of the Chief of Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board. The Vice-Chief of Staff shall automatically succeed the Chief of Staff when the latter fails to serve for any reason.

In addition, the Vice Chief of Staff shall:

(i) give proper notice of all staff meetings on order of the appropriate authority;

(ii) prepare accurate and complete minutes for MEC and Medical Staff meetings;

(iii) assure that an answer is rendered to all official Medical Staff correspondence;

(iv) be responsible for the preparation of financial statements and report status of Medical Staff funds, if any; and

(v) perform such other duties as ordinarily pertain to his/her office.

(3) The Immediate Past Chief of Staff shall be a member of the MEC and Credentials Committee and perform such additional duties as may be assigned to him/her by the Chief of Staff, the MEC or the Board.

10.1(i) Conflict of Interest of Medical Staff Members

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff members who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally, bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

No Medical Staff member shall use his/her position to obtain or accrue any improper benefit. All Medical Staff members shall at all times avoid even the appearance of influencing the actions of any other staff member or employee of the Hospital or Corporation, except through his/her vote, and the acknowledgment of that vote, for or against opinions or actions to be stated or taken by or for the Medical Staff as a whole or as a member of any committee of the Medical Staff.

Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff member, and/or a member of the community, which in any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

(1) Any leadership position on another Medical Staff or educational institution that creates a fiduciary obligation on behalf of the practitioner, including, but not limited to membership on the governing body, executive committee, or service chairmanship with an entity or facility that competes directly or indirectly with the Hospital;

(2) Direct or indirect financial interest, actual or proposed, in an entity or facility that competes directly or indirectly with the Hospital;

(3) Direct or indirect financial interest, actual or proposed, in an entity that pursuant to agreement provides services or supplies to the Hospital; or

(4) Business practices that may adversely affect the hospital or community.

In addition to the foregoing, a new Medical Staff leader (defined as any member of the Medical Executive Committee, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board of Trustees) shall file the written statement immediately upon being elected or appointed to his/her leadership position. This disclosure requirement is not a punitive process and is only intended to identify those conflicts of interest which may affect patient safety or quality of care. This disclosure requirement is to be construed broadly, and a Medical Staff member should finally determine the need for all possible disclosures of which he/she is uncertain on the side of disclosure, including ownership and control of any health care delivery organization that is related to or competes with the Hospital. This disclosure requirement will not require any action which would be deemed a breach of any state or federal confidentiality law, but in such circumstances minimum allowable disclosures should be made.

Between regular disclosure dates, any new relationship of the type described, whether actual or proposed, shall be disclosed in writing to the MEC by the next regularly scheduled MEC meeting. The Vice Chief of Staff will provide each MEC member with a copy of each leader's written disclosure at the next MEC meeting following filing by the leader for review and discussion by the MEC.

Medical Staff leaders shall abstain from voting on any issue in which the Medical Staff leader has an interest other than as a fiduciary of the Medical Staff. Failure to disclose a conflict as required by this Section 10.1(i) or failure to abstain from voting on an issue in which the Medical Staff member has an interest other than as a fiduciary of the Medical Staff may be grounds for corrective action. In the case of Medical Staff leaders, a breach of these provisions is deemed sufficient grounds for removal of a breaching leader from his/her leadership position by the remaining members of the MEC or the Board on majority vote.

ARTICLE XI
CLINICAL SERVICES

11.1 CLINICAL SERVICES

11.1(a) There shall be clinical services of medicine, surgery and such other services as may be established by unanimous vote of the MEC or added by amendment procedures as described in Article XV of these bylaws.

11.2 SERVICE FUNCTIONS

The primary function of each service is to implement specific review and evaluation activities that contribute to the preservation and improvement of the quality and efficiency of patient care. To carry out this overall function, each service shall:

11.2(a) Require that patient care evaluations be performed and that appointees exercising privileges be reviewed on an ongoing basis and upon application for reappointment;

11.2(b) Conduct, participate in, and make recommendations regarding the need for continuing education programs pertinent to changes in current professional practices and standards;

11.2(c) Monitor on an ongoing basis the compliance of its members with these bylaws, and the rules and regulations, policies, procedures and other standards of the Hospital;

11.2(d) Monitor on an ongoing basis the compliance of its members with applicable professional standards;

11.2(e) Coordinate the patient care provided within the service with nursing, administrative, and other non-Medical Staff services;

11.2(f) Foster an atmosphere of professional decorum within the service;

11.2(g) Review all deaths occurring within the service and all unexpected patient care events and report findings to the MEC;

11.2(h) As applicable, establish a system for adequate professional coverage within the service, including an on-call system, which systems shall be fair and non-discriminatory;

11.2(i) Make recommendations to the MEC subject to Board approval of the kinds, types, and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members; and

11.2(j) Submit written reports to the MEC on a regular basis concerning:

(1) Findings of the service's review and evaluation activities, actions taken thereon, and the results thereof;

(2) Recommendations for maintaining and improving the quality of care provided in the service and in the Hospital; and

(3) Such other matters as may be requested from time to time by the MEC.

ARTICLE XII
COMMITTEES & FUNCTIONS

12.1 GENERAL PROVISIONS

12.1(a) The Standing Committees and the functions of the Medical Staff are set forth below. The MEC shall appoint special or ad hoc committees to perform functions that are not within the stated functions of one (1) of the standing committees.

12.1(b) Each committee shall keep a permanent record of its proceedings and actions. All committee actions shall be reported to the MEC.

12.1(c) All information pertaining to activities performed by the Medical Staff and its committees shall be privileged and confidential to the full extent provided by law.

12.1(d) The CEO or his/her designee shall serve as an ex-officio member, without vote, of each standing and special Medical Staff committee.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) Composition

Members of the committee shall include the following:

(1) The Chief of Staff, who shall act as Chairperson;
(2) The Vice Chief of Staff;
(3) The Immediate Past Chief of Staff;
(4) Chiefs of Service; and
(5) The CEO, ex-officio, or his/her designee.

12.2(b) Functions

The committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board and shall be empowered to act for the Medical Staff in the intervals between Medical Staff meetings. All Active Medical Staff members shall be eligible to serve on the MEC. The authority of the MEC is outlined in this Section 12.2(b) and additional functions may be delegated or removed through amendment of this Section 12.2(b). The functions and responsibilities of the MEC shall include at least the following:

(1) Receiving and acting upon committee reports;

(2) Implementing the approved policies of the Medical Staff;

(3) Recommending to the Board all matters relating to appointments and reappointments, the delineation of clinical privileges, staff category and corrective action;

(4) Fulfilling the Medical Staff's accountability to the Board for the quality of the overall medical care rendered to the patients in the Hospital;

(5) Initiating and pursuing corrective action when warranted, in accordance with Medical Staff Bylaws provisions;

(6) Recommending action to the CEO on matters of a medico-administrative nature;

(7) Developing and implementing programs for continuing medical education for the Medical Staff;

(8) Developing and implementing programs to inform the staff about physician health and recognition of illness and impairment in physicians, and addressing prevention of physical, emotional and psychological illness;

(9) Assuring regular reporting of performance improvement and other staff issues to the MEC and to the Board of Trustees and communicating findings, conclusions, recommendations and actions to improve performance to the Board and appropriate staff members;

(10) Evaluating areas of risk in the clinical aspects of patient care and safety and proposing plans and recommendations for reducing these risks;

(11) Assuring an annual evaluation of the effectiveness of the Hospital's performance improvement program is conducted;

(12) Informing the Medical Staff of Joint Commission and other accreditation programs and the accreditation status of the Hospital;

(13) Requesting evaluation of practitioners in instances where there is doubt about an applicant's ability to perform the privileges requested. Initiating an investigation of any incident, course of conduct, or allegation indicating that an applicant to or practitioner on the Medical Staff may not be complying with the bylaws, may be rendering care below the standards established for practitioners to the Medical Staff, or may otherwise not be qualified for continued enjoyment of Medical Staff appointment or clinical privileges without limitation, further training, or other safeguards;

(14) Participating in identifying community health needs and in setting Hospital goals and implementing programs to meet those needs;

(15) Developing and monitoring compliance with these bylaws, the rules and regulations, policies and other Hospital standards; and

(16) Making recommendations to the Board regarding the Medical Staff structure and the mechanisms for review of credentials and delineation of privileges, fair hearing procedures and the mechanism by which Medical Staff membership may be terminated.

12.2(c) Meetings

The MEC shall meet as needed, but at least monthly and maintain a permanent record of its proceedings and actions.

12.2(d) Special Meeting of the Medical Executive Committee

A special meeting of the MEC may be called by the Chief of the Medical Staff, when a majority of the MEC can be convened.

12.2(e) Removal of MEC Members

Members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff leadership provisions. Officers of the Medical Staff who are ex officio members of the MEC shall be removed in accordance with the procedures described in Section 10.1(e).

12.3 MEDICAL STAFF FUNCTIONS

12.3(a) Composition of Committees

The MEC shall designate appropriate Medical Staff committees to perform the functions of the Medical Staff.

12.3(b) Functions

The functions of the staff are to:

(1) Monitor, evaluate and improve care provided in and develop clinical policy for all areas, including special care areas, such as intensive or coronary care unit; patient care support services, such as respiratory therapy, physical medicine and anesthesia; and emergency, surgical, outpatient, home care and ambulatory care services;

(2) Conduct or coordinate appropriate performance improvement reviews, including review of invasive procedures, blood and blood component usage, drug usage, medical record and other appropriate reviews;

(3) Conduct or coordinate utilization review activities;

(4) Assist the Hospital in providing continuing education opportunities responsive to performance improvement activities, new state-of-the-art developments, services provided within the Hospital and other perceived needs and supervise Hospital's professional library services;

(5) Develop and maintain surveillance over drug utilization policies and practices;

(6) Investigate and control nosocomial infections and monitor the Hospital's infection control program;

(7) Plan for response to fire and other disasters, for Hospital growth and development, and for the provision of services required to meet the needs of the community;

(8) Direct staff organizational activities, including staff bylaws, review and revision, staff officer and committee nominations, liaison with the Board and Hospital administration, and review and maintenance of Hospital accreditation;

(9) Provide for appropriate physician involvement in and approval of the multi-disciplinary plan of care, and provide a mechanism to coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other hospital patient care and administrative services;

(10) Provide as part of the Hospital and Medical Staff's obligation to protect patients and others in the organization from harm, the Medical Staff has adopted a Practitioner Health Policy. The purpose of this policy is to provide education about practitioner health, address prevention of physical, psychiatric, or emotional illness, and facilitate confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. The Practitioner Health Policy affords resources separate from the corrective action process to address physician health. The policy provides a confidential mechanism for addressing impairment of Medical Staff members and providing appropriate advice, counseling or referrals;

(11) Provide leadership in activities related to patient safety;

(12) Ensure that the Medical Staff provides leadership for process measurement, assessment and improvement for the following processes which are dependent on the activities of individuals with clinical privileges:

(i) medical assessment and treatment of patients;

(ii) use of medications, use of blood and blood components;

(iii) use of operative and other procedure(s);

(iv) efficiency of clinical practice patterns; and

(v) significant departure from established patterns of clinical practice.

(13) Ensure that the Medical Staff participates in the measurement, assessment and improvement of other patient care processes, including, but not limited to, those related to:

(i) education of patients and families;

(ii) coordination of care, treatment and services with other practitioners and hospital personnel, as relevant to the care of an individual patient;

(iii) accurate, timely and legible completion of patients' medical records including history and physicals;

(iv) patient satisfaction;

(v) sentinel events; and

(vi) patient safety.

(14) Ensure that when the findings of assessment processes are relevant to an individual's performance, the Medical Staff determines their use in peer review or the ongoing evaluation of a practitioner's competence;

(15) Recommend to the Board policies and procedures that define the trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a practitioner's performance and evaluation of a practitioner's performance by peers. The process and procedure for focused professional review shall be substantially in accord with the Hospital's Peer Review Policy. The information relied upon to investigate a practitioner's professional conduct and practice may include (among other items or

information), internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, assistants, nursing or Administrative personnel involved in the care of patients;

(16) Make recommendations to the Board regarding the Medical Staff Bylaws, Rules & Regulations, and review same on a regular basis;

(17) Engage in other functions reasonably requested by the MEC and Board or those which are outlined in the Medical Staff Rules & Regulations, or other policies of the Medical Staff;

(18) Review and evaluate the qualifications, competence and performance of each applicant and make recommendations for membership and delineation of clinical privileges;

(19) Review, on a periodic basis, applications for reappointment including information regarding the competence of staff members; and as a result of such reviews make recommendations for the granting of privileges and reappointments;

(20) Investigate any breach of ethics that is reported to it;

(21) Review AHP appeals of adverse privilege determinations as provided in Section 5.4(b); and

(22) To prepare and recommend a slate of nominees for the officers of the Medical Staff.

12.3(c) Meetings

These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

12.4 CONFLICT RESOLUTION COMMITTEE

The Conflict Resolution Committee shall provide an ongoing process for managing conflict among leadership groups. Said Committee shall consist of two (2) members of the Medical Staff who are selected by the Medical Executive Committee (and may or may not be members of the Board), two (2) non-physician Board members who are selected by the Board Chair and the CEO. The Committee shall meet, as needed, specifically when a conflict arises that, if not managed, could adversely affect patient safety or quality of care. When such a conflict arises, the Committee shall meet with the involved parties as early as possible to resolve the conflict, gather information regarding the conflict, work with the parties to manage and when possible, to resolve the conflict, and to protect the safety and quality of care.

12.5 CREDENTIALS COMMITTEE

The review of medical services provided in the respective hospital with the objective of improving the quality of patient care. The Credentials Committee is a regularly constituted review committee conducting quality assurance and related reviews in accordance with the applicable provisions of Washington law, including, without limitation to, RCW 4.24.250 and RCW 70.41.200 and RCW 70.41.230.

12.5(a) Composition of Credentials Committee

1. Three past Chiefs of Staff;
2. Quality Management Director;

3. CEO or designee, without vote;
4. Representative from Medical Staff Services, as staff without vote.

Vacancies in the committee will be filled from a list of Past Presidents.

12.5(b) Functions

The Credentials Committee coordinates the staff credentials functions by:

1. Receiving and analyzing applications and recommendations for reappointment, conclusions or extensions of the provisional period, clinical privileges, and changes therein, and recommending action thereon;
2. Integrating quality review, professional liability, prevention and utilization management findings, membership and other relevant information into individual credential files;
3. Developing, coordinating, periodically reviewing, and making recommendations as to:
    - **a.** The procedures and forms to be used in connection with each component of the credentialing process.
    - **b.** Standards for the content and organization and overseeing maintenance of the individual credential file.
4. Assist in the development and oversees implementation of the credentialing procedures for AHP's.
5. 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 different Services for new procedures or devices.

12.5(c) Meetings

The Credentials Committee shall meet as often as necessary to discharges it's assigned duties and report to the MEC. The Credentials Committee shall maintain a permanent record of its findings, proceedings and actions.

12.6 QUALITY IMPROVEMENT COMMITTEE

12.6(a) Composition

Membership includes but is not limited to representatives from both clinical and non-clinical areas including the Medical Staff, senior leadership (CEO, CNO, CQO, CFO), Quality Coordinator, Risk Management/Patient Safety Officer and other clinical and non-clinical staff as appropriate on an ad hoc basis. All members may vote.

12.6(b) Functions

Quality Improvement Council is the multidisciplinary body that serves to oversee, coordinate, direct and collaborate on organization quality improvement activities. The Council's primary function is to set guidelines for organization monitoring and evaluation of patient care and safety. Activities include but are not limited to:

1. Develop, evaluate, modify and approve the Quality Improvement Plan
2. Consider the setting, scope and services provided and select meaningful measures addressing the needs of the patients served.
3. Set priorities for ongoing measurement of important processes.
4. Evaluating the need to reprioritize improvement activities in response to unusual or urgent events identified through measurement and/or changes in the environment of care or community.
5. Receive and review reports regarding the effectiveness of organization-wide QAPI activities.
6. Review new service proposals ensuring appropriate quality measures are established.

7. Analyze and identify trends or patterns that might suggest an improvement opportunity.
8. Compare data with external sources when available.
9. Review and act upon Opportunity/Process Improvement Referrals.
10. Support quality improvement teams, acting upon their recommendations.
11. Convening multidisciplinary QI teams for specific improvement efforts, some of which may be triggered by the results of ongoing measurement and/or customer feedback.
12. Communicating relevant activities, as necessary, throughout the organization.
13. Review Customer Service Surveys, QI Teams, Risk Management, Hospital Committees, Resource Management reports and other executive level data/information impacting organization quality and safety.
14. Evaluate the effectiveness of the QAPI activities of the hospital departments and teams.
15. Integrate findings and outcomes of reviews conducted by the Medical Staff that identify systems process issues.
16. Determine the education and training needs of the organization related to Quality Improvement.
17. Evaluate and validate corrective action has resulted in improvement.
18. Reporting to the Medical Staff and Board of Trustees.
19. Maintain a permanent record of council proceedings.

12.6(c) Meetings

Council meetings are at minimum, ten (10) per year. Quality Council reports the results of monitoring activities and the improvement action plans as appropriate to the Medical Executive Committee, Administration, and Board on at least a quarterly basis.

12.7 PHARMACY AND THERAPEUTICS/INFECTION CONTROL COMMITTEE

The Pharmacy and Therapeutics/Infection Control Committee shall report to the Chief of Staff for administration, who shall appoint the Chairperson.

12.7(a) Composition

Membership shall consist of each chief of service or their representative, the Director of Pharmacy, Infection Control Director and Director of Nursing Services.

12.7(b) Functions

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:

1. Serve as an advisory group to the hospital Medical Staff and the Pharmacist on matters pertaining to the choice of available drugs;
2. Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
3. Develop and review periodically a formulary or drug list for use in the hospital;
4. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients;
5. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital; and
6. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

The Infection Control Committee shall be responsible for the surveillance of inadvertent hospital infection potentials, the review and analysis of actual infections, the promotion of a preventative and corrective program designed to minimize infection hazards and the supervision of infection control in all phases of the hospital's activities including:

1. Operating rooms, delivery rooms, recovery rooms, special care units;
2. Sterilization procedures by heat, chemicals or otherwise;
3. Isolation procedures;
4. Prevention of cross-infection by anesthesia apparatus or inhalation therapy equipment;
5. Testing of hospital personnel for carrier status;
6. Disposal of infectious material; and
7. Other situations as requested by the Executive Committee.

12.7(c) Meetings

This committee shall meet and send quarterly reports to the Medical Executive Committee regarding its activities.

12.8 SURGERY COMMITTEE

The Pharmacy and Therapeutics/Infection Control Committee shall report to the Chief of Staff for administration, who shall appoint the Chairperson.

Surgical Case Review- Assure the effective monitoring and evaluation of the quality and appropriateness of surgery performed and anesthesia administered. This includes a comprehensive review for justification of all surgeries performed including those procedures in which no tissue has been removed. Specific considerations shall be given to the agreement or disagreement of the preop and the pathological diagnosis.

Blood Review- The committee reviews the analysis of blood and blood components for appropriateness of patient care and identification and evaluation of problems and all reported blood transfusion reactions. Preliminary blood review shall have been accomplished in the various services including Family Practice, Medicine/CICU, OB, Emergency Department and Pediatric/Newborn and their findings are reported to the Surgery Committee for final and complete review of all blood usage and/or problems within the hospital.

Surgery Committee- The Surgery Committee shall consist of members from the specialty areas including: General Surgery, Gynecology, Urology, Orthopedics, Family Practice, Anesthesia and Pathology. The Surgery Committee shall meet at least quarterly and shall document and maintain records of proceedings including problems and recommendations for corrective actions which shall be reported to the Executive Committee by the chief of Surgery who shall act as Chairperson.

12.9 COMMITTEES OF THE STAFF

12.9(a) Composition and Appointment

A staff committee established to perform one or more of the Staff functions required by these bylaws shall be composed of members of the Active and Provisional staff, and may include, where appropriate, representation from Hospital administration, nursing service, medical records service, pharmaceutical service, social 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 Chief of Staff, and the administrative Staff members shall be appointed by the CEO. The Chief of Staff and the CEO, or their respective designees, shall serve as ex-officio members without vote on all committees, unless otherwise expressly provided.

12.9(b) Voting

Only physicians and dentists shall be voting members of committees unless otherwise approved by the individual committees and the MEC.

12.9(c) 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 Medical Staff committee member and until his/her successor is 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.

12.9(d) 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.

12.9(e) Meetings

A staff committee established to perform one or more of the staff functions is required by these bylaws shall meet as often as is necessary to discharge its assigned duties, but no less often than quarterly.

12.10 CONFIDENTIALITY OF COMMITTEE RECORDS

The following committees include, as part of their function, the review and evaluation of the quality of patient care and/or the evaluation of the competency and qualifications of medical staff members:

- Quality Improvement Committee
- Medicine/Radiology Committee
- Surgery/Anesthesia/Gynecology/Tissue Committee
- Obstetrics Committee
- Pediatric/Newborn Committee
- Executive Committee
- Pharmacy and Therapeutics/Infection Control Committee
- Family Practice Committee
- Emergency Committee
- Credentials Committee

In accordance with RCW 2.24.250, each of the committees cited above, plus any other regularly constituted hospital committee not listed, which is involved in the review and evaluation of the quality of patient care, is protected from subpoena and discovery. This protection extends to proceedings, reports and written records of such committees or boards, and to members, staff, employees, and investigators of such committees and boards.

ARTICLE XIII
MEETINGS

13.1 ANNUAL STAFF MEETING

13.1(a) Meeting Time

The annual Medical Staff meeting shall be the last meeting of the year at a date, time and place determined by the MEC.

13.1(b) Order of Business & Agenda

The order of business at an annual meeting shall be determined by the Chief of Staff. The agenda shall include:

(1) Reading and accepting the minutes of the last regular and of all special meetings held since the last regular meeting;

(2) Administrative reports from the CEO or his/her designee, the Chief of Staff and appropriate Service Chiefs;

(3) The election of officers and other officials of the Medical Staff when required by these bylaws;

(4) Recommendations for maintenance and improvement of patient care; and

(5) Other old or new business.

13.2 REGULAR STAFF MEETINGS

13.2(a) Meeting Frequency & Time

The Medical Staff shall meet at least quarterly with the last meeting each year to be designated as the Annual Staff Meeting. The Medical Staff may, by resolution, designate the time for holding regular meetings and no notice other than such resolution shall then be required. If the date, hour or place of a regular staff meeting must be changed for any reason, the notice procedure in Section 13.3 shall be followed.

13.2(b) Order of Business & Agenda

The order of business at a regular meeting shall be determined by the Chief of Staff.

13.2(c) Special Meetings

Special meetings of the Medical Staff or any committee may be called at any time by the Chief of Staff or, for Committees, the Chief of Staff or Committee Chair, and shall be held at the time and place designated in the meeting notice. No business shall be transacted at any special meeting unless stated in the meeting notice.

13.3 NOTICE OF MEETINGS

The MEC may, by resolution, provide the time for holding regular meetings and no notice other than such resolution shall be required. If a special meeting is called or if the date, hour and place of a regular staff meeting has not otherwise been announced, the Vice Chief of Staff shall give written notice stating the place, day and hour of the meeting, delivered either personally or by mail, to each person entitled to be present there at not less than three (3) days nor more than thirty (30) days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

13.4 QUORUM

13.4(a) General Staff Meeting

The presence of 25% of the total membership of the Active and Courtesy staff at any regular or special meeting shall constitute a quorum. Written, signed proxies will not be permitted in any voting at any meeting.

13.4(b) Committee Meetings

The members of a committee who are present, but not less than two (2) members, shall constitute a quorum at any meeting of such committee; except that the MEC and Performance Improvement Committee shall require fifty (50%) percent of members to constitute a quorum.

13.5 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting of the committee, if a unanimous consent in writing setting forth the action to be taken is signed by each member entitled to vote.

13.6 MINUTES

Minutes of all meetings shall be prepared by the Secretary of the meeting or his/her designee and shall include a record of attendance and the vote taken on each matter. A permanent file of the minutes of each meeting shall be maintained.

Complete and detailed minutes must be recorded and maintained.

13.7 ATTENDANCE

13.7(a) Regular Attendance

Active or Provisional Active Members of the Medical Staff are encouraged to attend at least 25% of the regular and special meetings of the Medical Staff as well as the meetings of those committees of which they are members.

13.7(b) Special Appearance: Cooperation with the MEC

Any committee of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee is questioning the practitioner's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the

meeting shall be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the practitioner's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIV
GENERAL PROVISIONS

14.1 STAFF RULES & REGULATIONS AND POLICIES

Subject to approval by the Board, the Medical Staff shall adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Medical Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations shall be considered a part of these bylaws, except that they may be amended or repealed at any regular meeting at which a quorum 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. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

14.1(a) Notice of Proposed Adoption or Amendment

Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Where the MEC proposes to adopt a rule or regulation, or an amendment thereto, it must first communicate the proposal to the Medical Staff. The MEC is not, however, required to communicate adoption of a policy or an amendment thereto prior to adoption. In such circumstances, the MEC must promptly thereafter communicate such action to the Medical Staff.

14.1(b) Provisional Adoption by MEC

In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Medical Staff.

In such cases, the Medical Staff shall be immediately notified by the MEC. The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Medical Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

14.1(c) Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments

When conflict arises between the Medical Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Medical Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict.

Nothing in the foregoing is intended to prevent Medical Staff members from communicating with the Board on a rule, regulation, or policy adopted by the Medical Staff or the MEC or to limit the Board's final authority as to such issues.

14.1(d) Final Authority of the Board

The Board shall have final authority regarding the adoption of any rule, regulation or policy or amendment thereto and (except in the case of a provisional adoption provided for in Section 14.1(b) of this Article) no such rule, regulation or policy or amendment thereto, shall be effective until approved by the Board.

14.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner or Allied Health Professional granted clinical privileges in the hospital shall maintain in force professional liability insurance in an amount not less than the current minimum state statutory requirement for such insurance or any future revisions thereto, or, should the state have no minimum statutory requirement, in an amount not less than $1,000,000.00 per occurrence and $3,000,000.00 in the aggregate. Such insurance shall be with a carrier reasonably acceptable to the hospital, and shall be on an occurrence basis or, if on a claims made basis, the practitioner or AHP shall agree to obtain tail coverage covering his/her practice at the hospital. Each practitioner and AHP shall also inform the MEC and CEO of the details of such coverage annually. He/She shall also be responsible for advising the MEC and the CEO of any change in such professional liability coverage.

14.3 FORMS

Application forms and any other prescribed forms required by these bylaws for use in connection with staff appointments, reappointments, delineation of clinical privileges, corrective action, notices, recommendations, reports and other matters shall be developed by the CEO or his/her designee, subject to adoption by the Board after considering the advice of the MEC. Such forms shall meet all applicable legal requirements, including non-discrimination requirements.

14.4 CONSTRUCTION OF TERMS & HEADINGS

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

14.5 TRANSMITTAL OF REPORTS

Reports and other information which these bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the CEO or his/her designee.

14.6 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

14.6(a) Reports to be Confidential

Information with respect to any practitioner, including applicants, staff members or AHPs, submitted, collected or prepared by any representative of the hospital including its Board or Medical Staff, for purposes related to the achievement of quality care or contribution to clinical research shall, to the fullest extent permitted by the law, be confidential and shall not be disseminated beyond those who need to know nor used in any way except as provided herein. Such confidentiality also shall apply to information of like kind provided by third parties.

14.6(b) Release from Liability

No representative of the hospital, including its Board, CEO, administrative employees, Medical Staff or third party shall be liable to a practitioner or AHP for damages or other relief by reason

of providing information, including otherwise privileged and confidential information, to a representative of the hospital including its Board, CEO or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner or AHP who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the hospital, provided such disclosure or representation is in good faith and without malice.

14.6(c) Action in Good Faith

The representatives of the hospital, including its Board, CEO, administrative employees and Medical Staff shall not be liable to a practitioner or AHP for damages or other relief for any action taken or statement of recommendation made within the scope of such representative's duties, if such representative acts in good faith and without malice after a reasonable effort to ascertain the facts and in a reasonable belief that the action, statement or recommendation is warranted by such facts. Truth shall be a defense in all circumstances.

ARTICLE XV
ADOPTION & AMENDMENT OF BYLAWS

15.1 DEVELOPMENT

The Medical Staff shall have the initial responsibility to formulate, adopt and recommend to the Board the Medical Staff Bylaws and amendments thereto which shall be effective when approved by the Board. The Medical Staff shall exercise its responsibility in a reasonable, timely and responsible manner, reflecting the interest of providing patient care of recognized quality and efficiency and of maintaining a harmony of purpose and effort with the Hospital, the Board, and the community.

15.2 ADOPTION, AMENDMENT & REVIEWS

The bylaws shall be reviewed and revised as needed, but at least every two (2) years. When necessary, the bylaws and rules and regulations will be revised to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Medical Staff organization and functions.

15.2(a) Medical Staff

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of a two-thirds of the Medical Staff members eligible to vote, who are present and voting at a meeting at which a quorum is present, provided at least five (5) days written notice, accompanied by the proposed bylaws and/or alternatives, has been given of the intention to take such action. This action requires the approval of the Board.

15.2(b) Board

The Medical Staff Bylaws may be adopted, amended or repealed by the affirmative vote of two-thirds of the Board after receiving the recommendations of the Medical Staff. If the Medical Staff fails to act within a reasonable time after notice from the Board to such effect, the Board may resort to its own initiative in formulating or amending Medical Staff Bylaws when necessary to provide for protection of patient welfare or when necessary to comply with accreditation standards or applicable law. However, should the Board act upon its own initiative as provided in this paragraph, it shall consult with the Medical Staff at the next regular staff meeting (or at a special called meeting as provided in these Bylaws), and shall advise the staff of the basis for its action in this regard.

15.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

Amendments to these bylaws approved as set forth herein shall be documented by either:

15.3(a) Appending to these bylaws the approved amendment, which shall be dated and signed by the Chief of Staff, the CEO, the Chairperson of the Board of Trustees and approved by corporate legal counsel as to form; or

15.3(b) Restating the bylaws, incorporating the approved amendments and all prior approved amendments which have been appended to these bylaws since their last restatement, which restated bylaws shall be dated and signed by the Chief of Staff, the CEO and the Chairperson of the Board of Trustees approved by corporate legal counsel as to form.

Each member of the Medical Staff shall be given a copy of any amendments to these bylaws in a timely manner.

MEDICAL STAFF BYLAWS
ADOPTED & APPROVED:

MEDICAL STAFF:

By: ____ ____________________
Chief of Staff Date

BOARD OF TRUSTEES:

By: ____ ____________________
Chairperson Date

TOPPENISH COMMUNITY HOSPITAL:

By: ____ ____________________
Chief Executive Officer Date

APPROVED AS TO FORM:

By: ____ ____________________
Legal Counsel for Toppenish Community Hospital Date