

BYLAWS OF

THE UNIFIED MEDICAL STAFF OF

PROVIDENCE HOLY FAMILY HOSPITAL

AND

PROVIDENCE SACRED HEART MEDICAL CENTER

AND

PROVIDENCE ST. LUKE’S REHABILITATION MEDICAL CENTER

TABLE OF CONTENTS

PREAMBLE	1
ARTICLE I DEFINITIONS	2
ARTICLE II PURPOSE.....	3
ARTICLE III MEDICAL STAFF MEMBERSHIP	4
Section 1 Nature of Membership	
Section 2 Obligations of Membership	
Section 3 Categories of Membership	
ARTICLE IV APPOINTMENT AND REAPPOINTMENT (See also Appendix B)	5
ARTICLE V CLINICAL PRIVILEGES (see also Appendix C).....	6
Section 1 Delineation of Privileges	
Section 2 Emergency Privileges	
Section 3 Privileges Relating to Employed or Contract Practitioners	
Section 4 Annual review of contracted services’ performance	
ARTICLE VI CORRECTIVE ACTION, SUMMARY SUSPENSION, FAIR HEARING	7
(See also Appendix A)	
ARTICLE VII OFFICERS	9
Section 1 Officers of the Medical Staff	
Section 2 Qualifications of Officers	
Section 3 Election of Officers	
Section 4 Term of Office	
Section 5 Vacancies and Tenure in Office	
Section 6 Removal of Elected Officers	
Section 7 Duties of Officers	
ARTICLE VIII CLINICAL DEPARTMENTS	9
Section 1 Organization of Departments	
Section 2 Removal of Department Chair	

Section 3	Department sections and subcommittees	
ARTICLE IX	COMMITTEES	12
Section 1	Medical Executive Committee (see also Appendix H)	
Section 2	Standing Committees of the Medical Staff (See also Appendix H)	
Section 3	Medical Leadership Council	
Section 4	Professional Practice Evaluation Committee	
Section 5	Special Committees of the Medical Staff	
Section 6	External Committees	
Section 7	Removal of Committee Chairs	
ARTICLE X	MEETINGS	13
Section 1	Medical Staff Meetings	
Section 2	Notice	
Section 3	Quorum	
Section 4	Minutes	
Section 5	Communication	
ARTICLE XI	CONFIDENTIALITY, IMMUNITY, AND LIABILITY.....	14
Section 1	Privilege and Confidentiality	
Section 2	Immunity	
Section 3	Authorization and Releases	
Section 4	Access to Records	
ARTICLE XII	POLICIES AND PROCEDURES	16
ARTICLE XIII	AMENDMENTS TO BYLAWS AND APPENDICES.....	17
Section 1	Amendments and Repeal	
Section 2	Board Approval	
Section 3	Urgent Amendments	
ARTICLE XIV	COMMUNICATION AND MANAGEMENT OF CONFLICT	18
Appendix A	Fair Hearing Plan.....	19
Appendix B	Credentialing Procedures.....	33
Appendix C	Privileging Procedures.....	46
Appendix D	Voluntary Changes in Membership.....	52
Appendix E	Time Periods.....	53
Appendix F	Categories of Medical Staff Membership.....	54
Appendix G	Departments of the Medical Staff.....	57
Appendix H	Committees of the Medical Staff.....	58
Appendix I	General and Department Patient Care Rules.....	64

**BYLAWS OF
THE MEDICAL STAFF OF
PROVIDENCE HOLY FAMILY HOSPITAL (PHFH)
AND
PROVIDENCE SACRED HEART MEDICAL CENTER (PSHMC)
AND
PROVIDENCE ST LUKE’S REHABILITATION MEDICAL CENTER (PSLRMC)**

PREAMBLE

Providence Holy Family Hospital and Providence Sacred Heart Medical Center and Providence St Luke’s Rehabilitation Medical Center are Roman Catholic health care facilities owned and operated by Providence Health & Services-Washington (PH&S-WA), part of the larger Providence Health & Services (PH&S) system which operates health care facilities and services throughout the western United States. PH&S-Washington operates five hospitals in northeastern Washington State under governance of the Providence Inland Northwest Washington (INWA) Community Ministry Board - Providence Holy Family Hospital (Spokane), Providence Sacred Heart Medical Center (Spokane), Providence St. Joseph’s Hospital (Chewelah), Providence St. Luke’s Rehabilitation Medical Center (Spokane), and Providence Mt. Carmel Hospital (Colville).

The medical staffs of Providence Holy Family Hospital, Providence Sacred Heart Medical Center, and Providence St Luke’s became a unified medical staff on August 1, 2022; they are a single, self-governing organization responsible to the INWA Community Ministry Board for the medical practice of its members.

ARTICLE I DEFINITIONS

Section 1. “Chief Operating Officer” (COO) means the hospital administrative leader appointed by the Board to act on its behalf in the overall management of each Hospital. All references to the COO in these Bylaws also include anyone duly designated by the hospital administrative leader to act in his/her stead.

Section 2. “Board” means the Community Ministry Board of Providence Health Care (INWA).

Section 3. “Department” means a department of the medical staff as established by the MEC.

Section 4. “Medical Executive Committee” or “MEC” means the executive committee of the medical staff.

Section 5. “Hospital” means Providence Sacred Heart Medical Center or Providence Holy Family Hospital or Providence St Luke’s Rehabilitation Medical Center.

Section 6. “Member” means a member of the unified Medical Staff appointed to and maintaining membership in a category of the medical staff, in accordance with these bylaws.

Section 7. “Bylaws” incorporate the Appendices by reference.

Section 8. The “Policies” means the policies and procedures of the medical staff.

Section 9. “Chief Medical Officer” (CMO) is the individual appointed by INWA as the administrative/medical liaison to the medical staff.

Section 10. “Division Chief” is an individual appointed by the Chief Medical Officer and Chief Operating Officer to assist the CMO in administrative and clinical leadership across certain specialties or departments.

Section 11. The unified ‘Medical Staff’ of Providence Holy Family Hospital, Providence Sacred Heart Medical Center, and Providence St Luke’s Rehabilitation Medical Center means the medical physicians, osteopathic physicians, licensed oral and maxillofacial surgeons, dentists, podiatrists, nurse-midwives, and clinical psychologists, who receive privileges to practice at these hospitals. Nurse practitioners, physician assistants and clinical pharmacists. [Allied Health Professional—Category 1 (APP1)] are credentialed through the medical staff but are not members. Additionally, some health care providers [designated as Allied Health Practitioner—Category 2 (APP2)] are brought to the hospital by a physician to assist in his treatment of patients; these individuals are credentialed but covered by a ‘Scope of Practice’ rather than privileges. These individuals are not considered members of the medical staff but are governed through the medical staff.

Section 12. “Designee” may refer to another administrative staff or Board member requested to fulfill the administrative need. For medical staff members, designee may include Advanced Practice Providers unless a physician designee is specifically stated. Residents may be

designees in certain instances as outlined by the Graduate Medical Education Committee (GMEC) Resident Scope of Practice document.

ARTICLE II PURPOSE

Section 1. Health professionals are granted privileges specific to each Hospital and are hereby organized into a medical staff to assist the Board in executing the following functions as delegated by the Board to the medical staff.

- 1.1 To ensure all patients treated in Providence Holy Family Hospital, Providence Sacred Heart Medical Center, and Providence St Luke's Rehabilitation Medical Center are provided with quality health care in a safe environment.
- 1.2 To evaluate and recommend to the Board applicants for medical staff membership and clinical privileges.
- 1.3 To evaluate and monitor the behavior and clinical practice of medical and allied health professional staff members to promote and maintain safe, quality health care.
- 1.4 To provide leadership, education and support which fosters practitioner health and well-being through an organized program that is preventative and therapeutic in nature and not punitive.
- 1.5 To adhere to the Ethical and Religious Directives for Catholic Health Care Services and the mission and values of Providence Holy Family Hospital, Providence Sacred Heart Medical Center, Providence St Luke's Rehabilitation Medical Center.
- 1.6 To initiate and maintain self-government in accordance with these Bylaws and the rules, regulations, and policies adopted pursuant to these Bylaws, while remaining accountable to the Board.
- 1.7 To provide a structure through which issues concerning the medical staff may be communicated with the Chief Operating Officer and the Board.

ARTICLE III MEDICAL STAFF MEMBERSHIP

Section 1. Nature of Membership

Membership on the unified medical staff is a privilege that may be granted to those health professionals upon request to the Medical Staff and Board. Qualifications, responsibilities and prerogatives for membership are set forth in the Medical Staff Bylaws, Appendices, and Policies. All individuals credentialed under the Medical Staff Bylaws shall meet the qualifications, standards, requirements and responsibilities set forth in these documents.

Section 2. Obligations of Membership

- 2.1 Credentialed staff agree to follow the Providence Code of Conduct.
- 2.2 Credentialed staff must notify the medical staff office of any change in his/her health which has or has the potential to affect his/her performing the privileges which s/he is requesting or for which s/he is currently privileged.
- 2.3 Credentialed staff agree to comply with requirements of state and national regulatory bodies. This includes, but is not limited to, the following:

2.3.1 History and physical

The admission history and physical (H&P) examination shall be completed by a member of the Medical or Allied Health Professional Staff with privileges to do so. A medical history and examination that was completed within 30 days prior to inpatient/observation patient admission may be accepted but must have an update performed by the attending physician or his designee within 24 hours after admission but prior to surgery, procedure requiring anesthesia services, or other high-risk treatment. The update may be noted as a history and physical update, or an interval note. For patients admitted prior to the date of surgery, a progress note dated the same day of surgery, but entered prior to the surgery/procedure will suffice as an H & P update. The anesthesiologist update may also suffice as the H&P update.

A history and physical exam performed within the prior 30 days, and which meets the following required elements may be accepted from a referring licensed independent practitioner within Washington State, provided it receives the required review and update from a member of the Medical or Allied Health Professional Staff with privileges to do so. The update shall include the re-examination of the patient to include any changes in the patient's health status since the time of the initial history and physical. The update must include evaluation of the heart and lungs.

The history and physical examination must include the chief complaint, details of the present illness, relevant history (appropriate to the patient's age) including drugs and allergies, and an assessment of body systems. A report of the relevant physical examination shall be provided, including a statement of the conclusions or impressions drawn from this examination and a course of action planned for the admission.

The Medical Staff History and Physical Policy provides further clarification regarding H&P requirements.

- 2.4 Credentialed staff agree that all information relative to their credentialing, privileging, and peer review (including all focused professional practice review and ongoing professional practice review) may be shared among the INWA hospitals and with other Providence or Providence-affiliated hospitals if a credentials sharing agreement is in place. (Appendices B-E, which are common to the INWA hospitals, outline the requirements for membership, clinical privileges, reappointment, and voluntary changes in membership.)
- 2.5 Credentialed staff agree to comply with the PH&S Integrity and Compliance program, including disclosure of actual or potential conflicts of interest.
- 2.6 Credentialed staff agree to protect confidentiality of patient care and peer review information in accordance with PH&S, hospital, and medical staff policies.

- 2.7 Credentialed staff must be in the active practice of medicine or medical administration with an office practice and street address in the immediate geographic area. Credentialed staff are always responsible to provide a current office/business address, phone, secure clinical fax, and e-mail. (Providers credentialed solely for telemedicine, surgical assist, or consultation may not be required to have a local address.)
- 2.8 Credentialed staff are assessed annual dues in an amount fixed by the MEC. Members of the Honorary Staff are exempt from paying dues. Dues are payable to the Medical Staff Treasury and are delinquent if not paid within three months of the initial dues notice. Nonpayment shall result in automatic resignation of membership and privileges.

Section 3. Categories of Membership

Categories of Staff are specified in Appendix F. The MEC, considering recommendations of the Department and Credentials Committee, assigns staff category distinct to each hospital according to the level of activity and patient care needs of the hospital. The MEC's reassignment of staff category or nonrenewal due to lack of activity is not reportable to any regulatory agency.

All categories of credentialed physicians who utilize the services of hospitalists to cover their hospitalized patients may be required to, on a rotating basis, provide immediate post-hospitalization or immediate post-emergency care to discharged patients who do not have a primary care practitioner.

ARTICLE IV APPOINTMENT AND REAPPOINTMENT

Requirements for appointment and reappointment are specified in Appendix B, which is incorporated into these Bylaws. These are consistent among the five INWA hospitals and facilitate sharing of information. Medical Staff members and Advanced Practice Providers are subject to ongoing professional practice review and must be reappointed at a maximum of two-year intervals.

ARTICLE V CLINICAL PRIVILEGES

Requirements for clinical privileges, including temporary privileges for urgent patient care needs, are specified in Appendix C, which is appended to these bylaws.

Section 1. Delineation of Privileges

Practitioners providing care within the Hospital/s shall be entitled to exercise only those clinical privileges specifically granted by the Board for the specific hospital. Privileges or scopes of services exercised within the hospital/s are approved by the governing board through their established mechanism after receiving recommendation from the MEC. Each hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital will be considered in all privileging documents.

Section 2. Emergency Privileges

In the case of emergency, any Member or any person who has clinical privileges, to the degree permitted by the person's license and regardless of Department affiliation, specialty staff status or clinical privileges, shall be permitted and expected to do everything possible to save the life of a patient or to save the patient from serious harm, using every facility of the Hospital necessary, including the call for any consultation necessary or desirable.

When an emergency no longer exists, such provider must request the privileges necessary to continue to treat the patient. In the event such privileges are denied, or he/she does not desire to request privileges, the patient shall be assigned to an appropriate member of the Staff.

See also Appendix C, Section 2.A.2. Regarding granting temporary privileges for a patient care need which no currently credentialed provider may fulfill.

Section 3. Privileges Relating to Employed or Contract Practitioners

3.1 A practitioner employed by Providence or providing services pursuant to a contract with the Hospital, in a solely administrative capacity with no clinical duties must be credentialed as Medico-Administrative Staff.

3.2 A practitioner employed by Providence or providing services pursuant to a contract with the Hospital, either full-time or part-time, whose duties include clinical responsibilities or the supervision of the clinical practice of professional staff members, must be a member of the Medical Staff. A practitioner who provides patient care services pursuant to a contract or to employment must meet established membership qualifications, must be evaluated for appointment, reappointment, and clinical privileges in the same manner, and must fulfill all of the obligations of the practitioner's category in the same manner as any other applicant or Member.

3.3 Exclusive Contracts. A member may be employed by Providence or may have a contract with either or both hospitals to provide services on an exclusive basis or may be a member of or employed by or contract with an entity or individual that has a contract with either or both hospitals to provide services on an exclusive basis. The member (or the entity in which the member belongs or is employed) and the hospital/s shall negotiate the terms of any such exclusive arrangement. The terms of any such exclusive arrangement may include, among other provisions, the effect, if any, that termination or expiration of the exclusive arrangement shall have on the exercise of clinical privileges of the Member. The terms of any such agreement shall take precedence over the terms of these bylaws and shall not be deemed to conflict with these bylaws.

Section 4. Annual review of contracted services' performance

The MEC will annually review the safety and effectiveness of patient care services provided to the hospital by contract.

ARTICLE VI CORRECTIVE ACTION, SUMMARY SUSPENSION and FAIR HEARING

Appendix A, the Fair Hearing Plan, is consistent among the five INWA hospitals. It is appended to these bylaws and covers the following components:

- Initial Review
- Investigations
- Summary Suspension of Clinical Privileges
- Action by Third Parties
- Hearing Procedure
- Appeal
- Board Action

ARTICLE VII OFFICERS

Section 1. Officers of the Unified Medical Staff

The elected officers of the Unified Medical Staff are the president and the president-elect.

Section 2. Qualifications of Officers

Each officer must be a Doctor of Medicine or osteopathy in good standing in active staff status on the unified medical staff at the time of nomination and election and must remain a member in good standing during his or her term of office. Failure to maintain such status shall immediately create a vacancy in the office involved. Each must have been a member of the professional staff for at least five consecutive years at the time of nomination. Officers may not simultaneously hold leadership positions on a competitor's Board or Medical Staff. Officers shall be Board Certified or demonstrate comparable competence.

Section 3. Election of Officers

3.1 Members of the Active Staff at either hospital are eligible to vote for President-Elect. Ballots will be provided by e-mail to voting members, and a simple majority of those returning ballots will constitute a quorum. The president-elect shall, upon the completion of his or her term of office in that position, immediately succeed to the office of president.

3.2 The Nominating Committee is outlined in Appendix H.

Section 4. Term of Office

Each officer shall serve a two-year term according to the hospital's established medical staff year, which is determined by the MEC. Each officer shall serve until the end of his or her term and until a successor is elected unless s/he shall sooner resign or be removed from office. In case of removal or resignation, the term shall continue, and the successor shall serve for the remainder of the term.

Section 5. Vacancies and Tenure in Office

In the event of a vacancy, the president-elect shall fill any unexpired term of the president.

A vacancy in the office of president-elect shall be filled by a special election conducted as reasonably soon as possible after the vacancy occurs following the general mechanisms outlined Article VII, Section 3.

The president may not serve more than one successive full term in office, excluding any partial term served to fill a vacancy created by a former president.

Section 6. Removal of Elected Officers

Removal of an elected Medical Staff officer may be initiated by a petition signed by 20% or more of the Active Staff or by request of the Board. The removal must be adopted by a majority vote of Members of the Active Category present at a special meeting with a special quorum as defined in Article X, chaired by an officer not subject to the recall petition. Removal may be based only upon failure to perform the duties of the position held as described in these bylaws. Loss of privileges automatically disqualifies a staff member from holding office (from PMCH)

Section 7. Duties of Officers

7.1 President

The president shall work collegially with the Chief Medical Officer (CMO) regarding matters relating to the medical staff. As the principal elected official of the medical staff, the president shall:

7.1.1 Aid in coordinating the activities and concerns of the Hospital and Hospital Administration, nursing and other patient care services with those of the professional staff.

7.1.2 Communicate and represent the opinions, policies, concerns, needs and grievances of the professional staff to the Board, the CMO, the COO, and other officials of the professional staff.

7.1.3 Enforce Medical Staff bylaws, policies, and procedures, implement sanctions where these are indicated, and promote the professional staff's compliance with procedural safeguards in all instances, including when corrective action has been requested against a member.

7.1.4 Call, preside at, and, together with the CMO prepare the agenda of special meetings of the general Medical Staff.

7.1.5 Together with the CMO, prepare the agenda for the MEC, serve as its chair, and participate as an ex officio member without vote on all other staff committees.

7.1.6 Appoint Department and committee chairpersons with the concurrence of the COO.

7.1.7 Receive and communicate the policies of the Board, as transmitted by the CMO and COO, to the professional staff and report to the CMO, COO, and Board on the performance of the professional staff's responsibility to provide medical care and maintain the quality of medical care.

7.2 President-elect

The president-elect shall be responsible for periodic review of the bylaws, and policies and procedures. S/he shall be a member of the MEC. In the absence, temporary or permanent, of the president, s/he shall assume all the duties and have the authority of the president. S/he shall chair the bylaws committee and finance committees of the MEC, including oversight of the collection of annual staff dues.

ARTICLE VIII CLINICAL DEPARTMENTS

Section 1. Organization of Clinical Departments

Departments are specified in Appendix G. Departments may meet jointly with other INWA hospitals if approved by the Medical Executive Committee

1.1. Assignment to Departments

The MEC will, after consideration of the recommendations of the chairperson of the clinical departments as transmitted through the Credentials Committee, recommend department assignments for all members in accordance with their qualifications. Medical Staff members may be granted privileges in more than one department, and they may have a primary and secondary department assignment. All Medical Staff members are subject to the credentialing criteria, policies, and rules of the department(s) in which they have privileges.

1.2. Functions of Departments

1.2.1. Oversee the quality of clinical care provided within the department.

1.2.2. Meet at least annually, but more frequently as needed, as determined by the Department representatives and/or the MEC.

1.3. Department Chairs

1.3.1. The chair of each department must be a member of the Active Staff, be board certified in his or her specialty or have established comparable competence through training and experience and have been a member in good standing of the department for at least three consecutive years.

1.3.2. Appointment of department chairs is made jointly by the Medical Staff President and the Chief Operating Officer.

- 1.3.3. Department Chairs have the following roles and responsibilities:
- a. Oversee the professional performance of credentialed staff members within the department, including reviewing their clinical competence and providing recommendations to the Credentials Committee regarding initial appointments initial focused reviews, reappointments, participating in focused reviews, and ongoing professional practice evaluations.
 - b. Oversee development of criteria for granting clinical privileges and scopes of practice in the department.
 - c. Participate in the administrative activities of the department when needed, such as
 - Recommending off-site sources for services not provided by the Hospital
 - Development and implementation of policies and procedures to guide and support safe patient care, including those to minimize medication errors
 - Recommendations regarding staffing, space, equipment, and other resources, including recommendations for needed off-site sources for patient care
 - Orientation and education of staff
 - New services and programs to be added
 - Promote processes relating to patient satisfaction, and assist in responses to complaints regarding credentialed staff members, as needed
 - Together with the MEC, support practitioners in following the Code of Conduct.
 - Communicate significant updates to members of the department.
 - d. Together with the Hospital leadership, oversee the quality of clinical care provided in the department, including complaints, safety issues, and patient satisfaction
 - e. Regularly attend MEC meetings and report to the MEC as needed
 - f. Chair the meetings of the department, and communicate issues as needed to members of the department
 - g. Integrate the department into the primary functions of the hospital
 - h. Coordinate and integrate interdepartmental and intradepartmental services

Section 2. Removal of Department Chair

Removal of a Department Chair from office may be initiated upon the recommendation of the MEC, or by petition of ten percent of the Active Staff Department Members. Such recommendations will be taken under advisement by the COO and MEC President. If the COO and MEC do not recommend removal, then a vote from the Active Staff members of the Department will be taken according to Article X.

Section 3. Departments, sections, and subcommittees

- 3.1 A current list of Departments, subcommittees, and sections of the Medical Staff will be maintained in the Medical Staff Office.
- 3.2 The MEC may recognize additional groups wishing to organize into an official section. Sections may be specific to one hospital or cross both hospitals. Sections may perform any of the following activities:
 1. Continuing education
 2. Grand rounds
 3. Discuss and recommend policies
 4. Discuss and recommend equipment needs
 5. Recommend development of criteria for clinical privileges when requested by the department chair
 6. Discuss and make recommendation on a specific issue at the special request of a department chairperson or the MEC
- 3.3 Reporting - Organized sections will regularly report at their respective Department meetings.
- 3.4 Special section meetings may be scheduled for a specified purpose. Such special meetings must be preceded by at least seven (7) days prior notification to the members of the section.
- 3.5 Sections are responsible to select their chairs by vote or rotation.

ARTICLE IX - COMMITTEES

Committees may meet jointly across one or more INWA hospitals if approved by the MEC. The committees of the unified Medical Staff, including the Medical Executive Committee, are outlined in Appendix H, and are fully incorporated into these bylaws.

Removal of an appointed Committee Chair may be initiated by a petition signed by 20% or more of the Active Staff. The removal must be adopted by a majority vote of Members of the Active Category present at a special meeting (or by communication with request for vote) as defined in Article X, chaired by a MEC officer not subject to the recall petition.

ARTICLE X MEETINGS

Section 1. Medical Staff Meetings

1.1 General Staff Meetings

General Medical Staff meetings may be scheduled as determined to be necessary by the MEC to conduct business or to provide information to the professional staff. The order of business at a regular general staff meeting shall be determined by the president. Except as otherwise provided, the action of a majority of the Active Members present and voting at a general staff meeting shall be the action of the group.

1.2 Special Meetings

Special meetings of the Active Staff may be called by written request of the Board, COO, President of the Medical Staff, MEC, or by a written request signed by at least 20% of the members of the Active Staff. All written requests from the Active Staff membership for special meetings must be submitted to the Medical Staff President and state the purpose of the requested meeting. The special meeting must be held within twenty-one (21) days after receipt of the written request. No business shall be conducted at any special meeting except that stated in the meeting notice. Except as otherwise provided, the action of a majority of the Active Members present and voting at a special staff meeting shall be the action of the group.

Section 2. Notice

Notice of the time, place and agenda must be given for all general and special meetings of the Active Staff. Notice will be by e-mail, and unless of an urgent nature must be given at least seven (7) days before the meeting.

Notices for regularly scheduled committees and meetings may be provided in the method most convenient to members of the specific committee.

Section 3. Quorum

3.1. Special meetings: Except as otherwise provided, the action of a majority of the Active Members present and voting at a special staff meeting shall be the action of the group. (Voting on issues may also be conducted by e-mail with the majority of responses received within a specified time frame being the action of the group. Unless the issue is of an urgent nature, the normal time for a special vote will be 15 days.)

3.2 Non-physician and ex-officio members shall not be counted in determining the presence of a quorum. The chair or their physician designee may vote.

- 3.3 MEC: 50% of the voting members shall constitute a quorum.
- 3.4 Credentials Committee: 50% of the voting members shall constitute a quorum.
- 3.5 Department, and committee, meetings: 20% of the appointed members, but not fewer than two (2) appointed members, will constitute a quorum at any meeting. Those present and counted in the quorum will include the Department, Committee Chair or their physician designee. (A department meeting may include all providers represented by the Department.)
- 3.6 Subcommittee, Section or Specialty meetings may also be authorized by departments, as needed. For these meetings those present will comprise the quorum.
- 3.7 Voting by electronic means is utilized for timely input regarding issues important to the medical staff. Professional staff must maintain an e-mail address on file with Medical Staff Services in order to be kept informed and given opportunity to participate in decisions made by electronic vote. If opportunity for electronic vote is given to the general medical staff, departments, or committees, a simple majority of responses received within the specified time frame shall constitute a quorum.

Section 4. Minutes

Minutes of general staff, special, MEC, Department, committees specified in these bylaws shall be prepared and shall include a record of attendance and the vote taken on each matter. A file, either paper or electronic, of the minutes of each meeting shall be maintained, with a master list of documents maintained by Medical Staff Services, unless otherwise provided by the organization. These minutes shall be maintained according to the PH&S Retention Policy.

Section 5. Communication

Notice of meetings, votes, and important actions of staff, department, and other committees are provided by e-mail.

ARTICLE XI PRIVILEGE, CONFIDENTIALITY, RELEASE OF INFORMATION and IMMUNITY FROM LIABILITY, and ACCESS TO RECORDS

As a condition of appointment and reappointment to the Medical Staff, each member agrees to the following:

Section 1. Privilege and Confidentiality

By law, any and all information, minutes, documents, proceedings, reports, or records which are collected or prepared by any regularly constituted committee of the Medical Staff or Board, whose duty is to evaluate the competency or qualifications of a Medical Staff member or applicant for Medical Staff membership or clinical privileges, or to

evaluate patient care, are privileged and shall be kept confidential to the fullest extent permitted by law. This privilege extends to information supplied by members of the Medical Staff, the MEC, the Board, and to third parties who supply information for the purposes set forth above. For the purposes of this Article, the term 'third parties' means both individuals and organized representatives of the Board or the Medical Staff, including that of any other institution or facility.

In order to protect this privilege, all communication, information, documents, proceedings, records, reports, recommendations and disclosures prepared or collected by a regularly constituted committee or board of the Medical Staff or Board whose duty is to evaluate the competency or qualifications of a Medical Staff or Allied Health Professional staff member, including applicants for membership, or to review and evaluate patient care, shall be kept strictly confidential, and shall not be used for any other purpose except as may be required by law or by these Bylaws.

Section 2. Immunity

To the fullest extent permitted by law, any member of the Medical Staff, the MEC, Board or third party who, in good faith, files charges, presents evidence, provides information or participates in a regularly constituted committee of the Medical Staff or Board, whose duty is to evaluate the competency or qualifications of Medical Staff and Allied Health Professional staff members, including applicants for membership or clinical privileges, or to review and evaluate the quality of patient care, shall be immune from civil liability arising out of such activities.

Medical Staff Officers, Department Chairs, section and all department and committee members, as well as all those participating in peer review and Morbidity and Mortality (M&M) functions are covered by the Hospital's professional liability insurance when acting in good faith within the scope of their responsibilities under these Bylaws.

Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution's activities related, but not limited to:

- A. Applications for appointment and clinical privileges.
- B. The reappointment process.
- C. Corrective action, including summary suspension.
- D. Hearings and appellate reviews.
- E. Medical care evaluations and other peer and case review activities.
- F. Utilization reviews; and
- G. Other hospital, departmental, service, or committee activities related to quality of patient care and professional conduct.

Section 3. Authorizations and Releases

By submitting an application for appointment or reappointment to the professional staff, the practitioner agrees to be bound by the bylaws, manuals, and the governing policies and procedures of the professional staff and of the hospital.

By submitting an application for appointment or reappointment to the Medical or Allied Health Professional Staff or by applying for or exercising clinical privileges, a practitioner authorizes representatives of the Medical Staff and/or Hospital to solicit, provide, and act upon information and documents bearing upon the practitioner's education, training, experience, competence, ethical standards, ability to work with others, and health status; and agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff and/or Hospital in accordance with the provisions of this Article. Consistent with the Health Insurance Portability and Accountability Act (HIPAA), any personal health information (PHI) obtained by the Hospital as part of the credentialing process is maintained as confidential and subject to the Hospital's privacy policy.

Each practitioner shall, upon request of the Medical Staff and/or Hospital, execute general and specific releases as required in these Bylaws as may be applicable under relevant Washington State Law. Execution of such releases is not a prerequisite to the effectiveness of these Bylaws. Failure to execute such releases in an application for reappointment or clinical privileges shall be deemed as a voluntary resignation of staff membership. Such releases are considered valid for 180 days.

The authorizations and releases set forth herein are for the protection of the Hospital's practitioners, other appropriate Hospital personnel, and third parties.

All applicants for appointment and reappointment consent to complete and continuous release of information for any purposes set forth in these Bylaws among the Providence Health Care organizations.

Section 4. Access to Records

Practitioners' credentials files maintained by the Medical Staff Office contain privileged and confidential information. Access to these files shall only be for the purpose of conducting the activities set forth in Section 2 above, and is restricted to the following individuals:

- A. Hospital COO or his designee.
- B. Chair of the Board or his designee.
- C. President of the Medical Staff or his designee.
- D. Chief Medical Officer/Director.
- E. Chief Medical Executive.
- F. Chair of the department to which the practitioner is assigned or his designee, if a departmentalized hospital.
- G. Members of the Credentials Committee if a separate function from the MEC.
- H. Personnel in the Medical Staff Office.

A practitioner may have access to, and the right to obtain a copy of, any of the documents in his or her credentials file which s/he has submitted pertaining to his application, reappointment, or clinical privileges, or correspondence pertaining to him which was addressed to or copied to him. A practitioner shall not have access to any other documents in his credentials file unless otherwise required by law or provided in accordance with hearing and appellate review procedures set forth in the Fair Hearing Plan.

Minutes of Departments, and Committees outlined in these bylaws will be maintained by the Medical Staff Office or in specified secure locations. Access to minutes of Medical Executive Committee, Credentials Committee, and all peer review committees is restricted to members of the respective committees, personnel of the Medical Staff Office, and individuals authorized by the Medical Staff President or Chief Operating Officer. Copies of these minutes, except for copies distributed at committee meetings, cannot be removed from the Medical Staff Office unless expressly authorized by the President of the Medical Staff, Chief Medical Officer, if applicable, Hospital COO or their designee. Minutes and records of all quality and peer review activities may only be transmitted by secure means and may not be released outside the organization.

ARTICLE XII POLICIES AND PROCEDURES

Regulatory requirements are included within the body of the Bylaws and Appendices. The MEC has the responsibility to further clarify these Bylaws and Appendices with policies which provide further detail and process.

Each hospital's unique circumstances and any significant differences in patient populations and services offered in each hospital will be considered in all policies approved by the Medical Executive Committee.

Notice of such policies is provided to the active staff within 30 days of approval. Objections regarding changes to policies will be returned to the MEC for reconsideration; if more than 10% of the active staff object to the policy or change to a policy, if not a current regulatory requirement, the policy or change in policy will be sent to the active staff for vote.

ARTICLE XIII AMENDMENTS TO BYLAWS AND, APPENDICES

Section 1. Amendments to, restatements, or repeal of these bylaws shall be accomplished through a cooperative process involving both the Medical Staff and the Board.

Amendments to these bylaws may be initiated by the Bylaws Committee, a member of the Medical Executive Committee, the Governing Body, or by 10% of the voting members.

If the voting members of the medical staff propose to adopt a rule, regulation, or policy, or an amendment thereto, they should first communicate the proposal to the MEC. If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it communicates this to the voting members of the medical staff. This does not prohibit a medical staff member from making a proposal directly to the Board.

Amendment/s may be proposed at any regular, special, or virtual meeting of the Medical Executive Committee, but may not be voted upon until a subsequent regular or special meetings of the Medical Executive Committee at least two weeks after the amendment has been proposed. If approved by a majority vote of the Executive Committee, proposed amendment/s shall be provided to the Active staff within two weeks of the date of the Medical Executive Committee approval. The proposed change/s may be communicated at a special meeting or to the provided e-mail of Active Staff members who may submit ballots in the manner designated by

the MEC, whether in person, by first class mail, by facsimile, or by other electronic or non-electronic means. These amendments shall be deemed approved by the Active Staff upon the receipt of a simple majority vote of the ballots returned by the specified date on the ballot, which will be at least 30 days from the date the ballot is sent.

Section 2. Board Approval. Any amendments enacted by the MEC or by the organized medical staff shall be effective only when approved by the Governing Board. Neither the Medical Staff nor the Governing Board can unilaterally amend the Medical Staff Bylaws. The Medical Staff Bylaws and Appendices may not conflict with governing body bylaws.

Section 3. Urgent amendments to comply with law or regulation. The Medical Executive Committee may, by majority vote, make changes to the bylaws specifically required by state law, Joint Commission, or Centers for Medicare/Medicaid. Substantive changes to the bylaws will be communicated to the medical and APP staffs either by direct mailing, fax, e-mail, or in the physician newsletter within two weeks. If there is no conflict between the organized medical staff and the Medical Executive Committee, the provisional amendment stands. If there is conflict over the provisional amendment, the process for resolving conflict between the organized medical staff and the Medical Executive Committee is implemented. If necessary, a revised amendment is then submitted to the governing body for action.

Changes to the Bylaws and Appendices which are not substantive in nature, such as re-numbering or correction of typographical errors, shall not require a vote of the membership.

Section 4. Unified and integrated medical staff structure.

- A. Medical staff members of each separate hospital within INWA have voted by majority of their active staff members to accept a unified and integrated medical staff structure. This structure shall represent each member hospital's unique circumstances and any significant differences in patient populations and services offered at each hospital. A unified and integrated medical staff must establish and implement policies and procedures to ensure that the needs and concerns expressed by members of the medical staff at each of INWA's separately certified hospitals, regardless of practice or location, are given due consideration, and that the unified and integrated medical staff has mechanisms in place to ensure that issues localized to particular hospitals are duly considered and addressed.
- B. A majority vote of active staff members privileged at a specific INWA hospital may vote to opt out of the unified and integrated medical staff structure as provided below.
 1. Initiation of the voting process requires submission to the medical staff office of a written petition signed by at least 10% of the active staff members of the hospital requesting an opt-out vote. A copy of the petition shall be provided by the medical staff office to the unified MEC and the Board at least 20 days prior to submission to the active staff members of that hospital for the opt out vote. Any comments of the unified MEC or the Board on the proposed opt-out vote shall be included with the written ballot.
 2. Voting shall be by regular mail or electronic transmission sent to all voting members of the active staff of the hospital that has petitioned for the opt-out vote. A decision to opt out of the unified medical staff requires an affirmative vote of at least 51% of the ballots returned within 30 days of mailing.
 3. If the result is an affirmative vote to opt out, the opt out shall be effective 60 days after the vote to allow sufficient transition time.

4. If there is an affirmative opt-out vote by one of the separately licensed hospitals, the unified medical staff bylaws shall be automatically superseded by the medical staff bylaws for the separately licensed hospitals that were in existence on the day each of the medical staff voted to become a unified medical staff.
5. The results of a vote on a petition to opt out of the unified medical staff pursuant to this section are final for a period of two (2) years. Unless otherwise approved by the board, vote to opt out may not be held sooner than two (2) years from the date such hospitals' active staff opted into the unified medical staff or two (2) years after a previous vote under this section.
6. Medical staff members will be informed at initial appointment and at reappointment of the option to initiate an opt-out vote.

ARTICLE XIV COMMUNICATION AND MANAGEMENT OF CONFLICT

Methods for the medical staff to provide input to the governing body regarding Medical Staff Bylaws and Appendices and Policies are provided in these documents.

If conflict exists between any of the entities (credentialed staff, MEC, departments, senior leadership team, committees, or Board), the Leadership Group Conflict Management guidelines provided by Providence Health & Services, and as approved by the MEC, shall guide resolution.

Appendices A-C are consistent among the five Providence Health Care hospitals—Holy Family Hospital, Mount Carmel Hospital, Sacred Heart Medical, St. Joseph’s Hospital, and St. Luke’s Rehabilitation Medical Center, although some process variances will exist between departmentalized and non-departmentalized hospitals.

- **Fair Hearing Plan**
- **Credentialing**
- **Privileging**
- **Voluntary Changes in Status**
- **Time Periods**

Appendix A. FAIR HEARING PLAN

For the Medical Staffs of
Providence Holy Family Hospital,
Providence Sacred Heart Medical Center & Children’s Hospital,
Providence Mount Carmel Hospital
Providence St. Joseph’s Hospital of Chewelah
and Providence St. Luke’s Rehabilitation Medical Center

This fair hearing plan (the “plan”) has been adopted and approved by the Community Ministry Board of Providence Health Care (the “board”) and each of the medical staffs of the five hospitals listed above. References to the medical staff include the allied health professional staff of the hospital, and references to members of the medical staff include Advanced Practice Providers on the medical staff.

Article I. INITIAL REVIEW

1.01 **Collegial Intervention.** When a concern is raised regarding (a) the clinical competence or clinical practice of a member of the medical staff, or (b) compliance by a member of the medical staff with applicable ethical standards, the bylaws, rules or regulations of the medical staff, or policies of the hospital or the medical staff, medical staff and hospital leaders are encouraged to use collegial intervention. The goal of collegial intervention is

cooperation by the medical staff member to resolve the matter. Collegial intervention is encouraged but is not required. Its use is within the discretion of medical staff and hospital leaders. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education. Collegial intervention is part of the hospital's performance improvement and professional and peer review activities. Medical staff and hospital leaders shall determine whether to include documentation of collegial intervention in the medical staff member's credentials file. If documentation of collegial intervention is included in the individual's file, the individual will be provided an opportunity to review and respond to it in writing. The individual's response shall be maintained in the same file.

1.02 **Referral for Further Review.** Where collegial intervention, if used, has not resolved the matter, or if a determination is made by medical staff and hospital leadership to not use collegial intervention, the matter should be referred to the medical staff president, the chief medical officer, the chair of the department to which the medical staff member is assigned, the hospital COO, or the chair of the board. The person to whom the matter is referred shall make sufficient inquiry to satisfy him or herself that the concerns raised are credible and, if so, shall provide a written report to the president of the medical staff and the chief medical officer. The president of the medical staff in conjunction with the chief medical officer and the hospital COO shall determine whether the matter should be handled in accordance with hospital policies or forwarded to the medical staff executive committee (MEC) for consideration. Action taken pursuant to this Article I is not an investigation.

Article II. INVESTIGATIONS

2.01 **Initiating an Investigation.** When a concern regarding the clinical competence and/or professional conduct of a medical staff member is before the MEC, the MEC shall review the matter and determine whether to conduct an investigation or direct the matter be handled under applicable hospital policy. In making this determination the MEC may discuss the matter with the practitioner whose clinical competence and/or professional conduct is in question. An investigation shall begin only if the MEC votes to conduct an investigation. If the MEC votes to conduct an investigation it shall inform the practitioner being investigated. If the practitioner is a dependent allied health professional staff member, the practitioner's supervising physician shall also be notified of the investigation. Notification may be delayed if in the MEC's judgment

informing the practitioner could compromise the investigation or disrupt the operation of the hospital or medical staff. The president of the medical staff shall keep the hospital COO fully informed of the status of an investigation. In the event board initiates the investigation references to the MEC in Sections 2.02-2.07 shall mean the board.

2.02 Investigating Committee. If the MEC votes to conduct an investigation, it may elect to investigate the matter itself, request one of its standing committees to conduct the investigation (e.g., the credentials committee), or appoint an individual or ad hoc committee to conduct the investigation. The body or individual conducting the investigation is referred to in this plan as the “investigating committee”. The investigating committee shall not include business associates or relatives of the individual being investigated but may include individuals not on the hospital’s medical staff. If the committee is investigating the individual’s clinical competence the committee should have at least one member with credentials similar to the person being investigated or engage an outside consultant with expertise in the individual’s area of practice. The committee may engage an outside reviewer if the individual under review has questioned or may question the objectivity of the investigating committee.

2.03 The Investigation. The investigating committee has the authority to review all documents and interview all individuals it determines may be relevant to its investigation. The investigating committee may require a physical and/or mental examination of the practitioner by health care professionals acceptable to the committee and may require the results of such examination(s) be provided to the committee. The individual being investigated shall be afforded an opportunity to meet with the investigating committee. At the meeting, the individual shall be invited to respond to the concerns that gave rise to the investigation. A summary of the meeting shall be prepared by the committee and provided to the individual. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual being investigated does not have the right to be represented by legal counsel at this meeting.

2.04 Findings and Recommendations. Upon completion of its investigation, the investigating committee shall prepare a report of its findings, conclusions and recommendations. The report along with the written summary of the committee’s meeting with the individual shall be submitted to the MEC. In making its recommendation the investigating

committee shall consider the best interests of patients, the orderly operation of the hospital and fairness to the individual investigated, recognizing that fairness does not require that the individual agree with the committee's recommendation. The committee may consider relevant literature and clinical practice guidelines, opinions and views expressed throughout the investigation, reports from any outside reviewers, and information provided by the individual under review.

2.05 Time Period for Investigations. The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation if an outside reviewer is not used. When an outside reviewer is used the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the report from the outside reviewer. These time periods are guidelines only and do not create any right for the individual being investigated to have the investigation completed within a set period of time. In the event the investigating committee is unable to complete the investigation and issue its report within these time periods, it shall inform the individual of the reasons for the delay and the approximate date on which it expects to complete the investigation.

2.06 MEC Action/Recommendations. The MEC may accept, modify, or reject the recommendation of the investigating committee. Specifically, the MEC may:

- 1) Take no action on the recommendation.
- 2) Issue the individual a letter of guidance, warning, or reprimand.
- 3) Impose conditions for the individual's continued appointment to the medical staff.
- 4) Impose a requirement for monitoring or consultation.
- 5) Recommend additional training or education.
- 6) Recommend reduction of clinical privileges.
- 7) Recommend suspension of clinical privileges for a specific period of time.
- 8) Recommend revocation of appointment and/or clinical privileges; Make other recommendations it deems necessary or appropriate; or.
- 9) Require a medical and/or psychiatric evaluation to determine fitness for continued membership.

2.07 Notice of MEC Action/Recommendations: The MEC shall notify the hospital COO of its decision, and the hospital COO will notify the Board. The Medical Staff President shall give prompt written notice to the individual of the MEC's decision. If the MEC's decision does not entitle the individual to request a hearing, it shall take effect immediately. If the MEC's decision entitles the individual to a hearing the notice shall contain:

- 1) A statement of the MEC's decision and the reasons for it.
- 2) If applicable, a list of patient records or incidents relied upon by the MEC in making its decision.
- 3) Notification that the individual has the right to request a hearing within 30 days of receipt of the notice: and
- 4) A copy of this plan.

If the individual is a dependent allied health professional staff member, the individual's supervising physician shall also be provided a copy of the notice.

2.08 Actions Which are Grounds for Hearings. A medical staff member is entitled to a hearing only if the MEC:

- 1) Summarily suspends or upholds a summary suspension that will last for more than 30 days, however, a suspension for failure to complete medical records is not grounds for a hearing.
- 2) Recommends denial of appointment or reappointment to the medical staff.
- 3) Recommends revocation of the individual's medical staff appointment.
- 4) Recommends denial or restriction of requested clinical privileges.
- 5) Recommends reduction or revocation of clinical privileges; or
- 6) Recommends mandatory, concurring consultation, (i.e., the consultant must approve the course of treatment before treatment starts).

2.09 Actions not Grounds for a Hearing. The following are examples of actions that are not grounds for a hearing, however, the individual may provide a written response to any such action to be included in his or her file:

- 1) A letter of guidance, warning, or reprimand.
- 2) A precautionary suspension or disciplinary time-out lasting 30 days or less.

- 3) Automatic relinquishment of privileges for failure to maintain required professional license/s.
- 4) Voluntary resignation of medical staff membership or clinical privileges.
- 5) Denial of a request for a leave of absence, or for an extension of a leave of absence.
- 6) Determination that an application for medical staff membership or clinical privileges is incomplete or contains a misstatement and will not be processed.
- 7) Denial of clinical privileges for failure to meet the hospital's minimum threshold criteria for the privileges.
- 8) Denial of privileges because another physician or group or physicians has an exclusive contract with the hospital for such privileges.
- 9) Assignment or reassignment to staff category or department.
- 10) Conditional appointment for a duration of less than 24 months.
- 11) Requiring a consult before treating a patient, but only if approval by the consultant is not required before treatment.
- 12) Termination of temporary privileges.
- 13) Termination of clinical privileges or medical staff membership for failure to timely complete medical records.
- 14) Requiring additional training or continuing education.
- 15) Denial of request for procedure/s which have not been approved by the Board to be within the hospital's scope of service.
- 16) Termination of medical staff membership and privileges of a dependent allied health professional staff member solely because the individual is no longer employed by a INWA hospital or a member of the active medical staff; or
- 17) Suspension or restriction of clinical privileges for 30 days or less.

2.10 Request for a Hearing. If the decision of the MEC gives rise to a right to a hearing, the individual has 30 days following receipt of the notice to request a hearing. The request must be in writing addressed to the hospital COO. Failure to timely request a hearing constitutes a waiver of the right to a hearing. If a hearing is requested, the Board will be notified.

2.11 Application to Other INWA Hospitals. Action taken by the MEC of one of the five hospitals shall apply equally to the individual's medical staff membership and clinical privileges,

if any, at the other three hospitals. Actions taken pursuant to this plan shall be monitored by medical staff leaders at each INWA hospital where the practitioner has been granted privileges through the hospital's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

Article III. SUMMARY SUSPENSION OF CLINICAL PRIVILEGES

3.01 Authority to Summarily Suspend. Whenever action must be taken to prevent imminent danger to the health or welfare of any individual in the hospital, any member of the MEC, the board, the chief medical officer, or the hospital COO/designee has the authority to summarily suspend all or any portion of the clinical privileges of a medical staff member. The summary suspension is deemed to be the action of the MEC or the board, as the case may be. A summary suspension also applies to each INWA hospital where the practitioner has clinical privileges.

3.02 Report to MEC. Summary suspensions shall be promptly reported to the MEC and shall be reviewed by the MEC within ten days of the suspension. The MEC may modify, continue or terminate the suspension.

3.03 Coverage for Suspended Individual. The chair of the department to which the suspended medical staff member is assigned has the authority to provide alternative coverage for any patient of the suspended practitioner hospitalized in a INWA hospital at the time of suspension. The wishes of the patients shall be considered in the selection of an alternate practitioner.

Article IV. ACTION BY THIRD PARTIES

A medical staff member's clinical privileges are automatically suspended upon:

- 1) **License.** Revocation, expiration, suspension or the placement of conditions or restrictions on the individual's license.
- 2) **Certification.** Revocation, expiration, suspension or the placement of conditions or restrictions on any certification required by the hospital for the granted privilege/s.

- 3) **Controlled Substance Authorization.** Revocation, suspension or the placement of conditions or restrictions on the individual's DEA or state-controlled substance authorization if a DEA or state-controlled substance authorization is a requirement of the privileges granted.
- 4) **Insurance Coverage.** Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the hospital.
- 5) **Medicare and Medicaid Participation.** Termination, exclusion, or preclusion from participation in the Medicare or Medicaid programs.
- 6) **Criminal Conduct.** Conviction, or a plea of guilty or *nolo contendere* pertaining to any gross misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance fraud or abuse; or (iv) violence against another, or to any felony.

Article V. **HEARING PROCEDURE**

5.01 **Appointment of Hearing Panel.** When a hearing has been duly requested in accordance with this plan, the hospital COO and the medical staff president shall appoint a hearing panel composed of not fewer than three members, one of whom shall be designated as chair ("hearing panel" and "hearing panel chair" respectively). The hearing panel will be composed of members of the medical staffs from any of the INWA hospitals where the individual requesting the hearing has or is seeking clinical privileges. The hearing panel shall not include anyone who is in direct economic competition with, or professionally associated with the individual requesting the hearing. The hospital COO may also appoint a hearing officer. The hospital COO shall notify the medical staff member and the MEC of the names and specialty of the hearing panel members and the name of the hearing officer if one is appointed. Objections to any member of the hearing panel or the hearing officer must be made in writing to the hospital COO within ten days of receipt of the notice of the names of the hearing panel members and/or the hearing officer, as defined in 5.03 below. The individual or the MEC may file objections. The hospital COO will determine whether objections are meritorious and if so, will appoint another person to fill the position. Failure to timely object waives the right to object to the member serving on the hearing panel or as the hearing officer.

5.02 Hearing Panel Chair. The hearing panel chair shall serve as the presiding officer and shall have one vote on all matters before the panel. The hearing panel chair shall not act as an advocate for either the MEC or the individual. The hearing panel chair shall:

- 1) Allow the parties a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination.
- 2) Prohibit conduct or evidence that is redundant, excessive, irrelevant, abusive or causes undue delay.
- 3) Maintain decorum throughout the process.
- 4) Rule on all matters of procedure and the admissibility of evidence; and
- 5) Consult with the hearing officer, if one has been appointed, on any of these matters.

5.03 Hearing Officer. The hearing officer serves as advisor to the hearing panel on procedural matters. This person may be an attorney. The hearing officer may not represent clients in direct economic competition with the individual. The hearing officer is not entitled to vote on matters before the hearing panel.

5.04 Scheduling Pre-hearing Conference and Hearing. The chair of the hearing panel shall schedule the hearing, which shall be as soon as practicable, but no sooner than 30 days after the notice of the hearing, unless an earlier date has been agreed to in writing by the individual and the MEC. The hearing panel chair shall also schedule a pre-hearing conference with the MEC representatives and the individual (and their respective legal counsels, if any) to address and resolve procedural issues. The chair shall provide written notice to the individual and the MEC representatives, and their counsels if any, of the date, time and place of the pre-hearing conference and the hearing.

5.05 Documents. The practitioner is entitled to have access to or copies of the following documents, subject to the condition that all documents and information be maintained as confidential and not disclosed or used for any purpose outside of the hearing:

- 1) Patient medical records relied upon by the MEC in making its decision, provided the cost of copying such records shall be the practitioner's expense.

- 2) Reports of internal and external (if any) reviews relied upon by the MEC, and
- 3) Copies of any other documents relied upon by the MEC in making its decision.
- 4) List of witnesses.

The practitioner has no right to discovery beyond the above documents. The practitioner is not entitled documents or information regarding other members of the medical staff.

5.06 Witnesses and Exhibits. At least ten days before the pre-hearing conference the MEC and the practitioner shall each provide the other and the hearing panel with a written list of the names of witnesses expected to offer testimony on their behalf, and copies of all documents they propose to offer at the hearing. The witness lists shall include a brief summary of the anticipated testimony by each witness. Objections to documents or witnesses must be submitted to the chair of the hearing panel in writing in advance of the pre-hearing conference. The hearing panel chair shall not entertain subsequent objections unless the party offering the objection demonstrates good cause. In the discretion of the hearing panel chair, witness and exhibit lists may be amended prior to or during the hearing, provided there is no prejudice to the other party. Neither party may contact the other party's witnesses without the prior approval of the hearing panel chair.

5.07 Pre-Hearing Conference. The hearing panel chair shall require representatives for the practitioner and for the MEC (who may be their legal counsel) to participate in a pre-hearing conference. At the pre-hearing conference the hearing panel chair, in consultation with the hearing officer if one has been appointed, shall address and resolve all procedural questions, including any objections to exhibits or witnesses, and the time to be allotted to each witness's testimony and cross-examination.

5.08 Conduct of Hearing. The hearing shall be conducted in as informal and collegial a manner as practicable. The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which reasonable persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to determine whether the individual is qualified for medical staff membership and clinical privileges.

5.09 Order of Presentation/Burden of Proof: The MEC shall first present evidence in support of its action or recommendation. Consistent with the burden on the individual to demonstrate that he or she satisfies, on a continuing basis, all criteria for medical staff membership and clinical privileges, thereafter the burden shifts to the individual to present evidence to prove by a preponderance of the evidence, that the action or recommendation by the MEC was arbitrary, capricious, or not supported by credible evidence. The practitioner and the MEC shall have the following rights, subject to reasonable limits determined by the hearing panel chair, (1) to call and examine witnesses; (2) to introduce exhibits; (3) to cross-examine any witness on any matter relevant to the issues; (4) to be represented by legal counsel throughout the hearing process and (5) to submit a written statement to the hearing panel at the close of the hearing. If the medical staff member does not testify in his or her own behalf, he or she may be called and questioned by the MEC or by the panel. The hearing panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence not provided by either the MEC or the practitioner.

5.10 Record of Hearing. A stenographic reporter shall be present to make a record of the hearing. The cost of the reporter shall be borne by the hospital. The cost of transcribing the record shall be born by the party ordering the transcript. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

5.11 Persons Present. Attendance at the hearing shall be restricted to those individuals involved in the proceeding and their legal counsel. The MEC may be represented at the hearing by an individual or individuals chosen by the medical staff president. The hearing panel chair shall determine who else may attend the hearing.

5.12 Failure to Appear. Failure by the individual or his representative, without good cause, to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the board for final action.

5.13 **Postponements and Extensions.** Postponements and extensions of time for the pre-hearing conference or the hearing may be requested by either party or the hearing panel but shall only be permitted by the hearing panel chair on a showing of good cause.

5.14 **Post-Hearing Statement.** Each party shall have the right to submit a written statement, and the hearing panel may request that statements be filed, following the close of the hearing.

5.15 **Concluding Hearing, Deliberations and Recommendations.** The hearing panel chair shall determine when the hearing is concluded. Within fourteen days after the close of the hearing the hearing panel shall deliberate outside the presence of any other person except the hearing officer and shall render a recommendation, accompanied by a report, which shall contain a concise statement of the basis for its recommendation. The hearing panel shall deliver its report to the hospital COO who shall provide it to the practitioner and the MEC.

Article VI. APPEAL

6.01 **Grounds for Appeal.** The recommendation of the hearing panel may be appealed to the board only if: (1) there was a substantial failure to comply with this plan so as to deny a fair hearing; and/or (2) the recommendation of the hearing panel is arbitrary or capricious and not supported by credible evidence.

6.02 **Requesting an Appeal.** Either the individual or the MEC may ask the board to review the recommendation of the hearing panel. The request must be submitted in writing to the hospital COO within ten days of when the hearing panel's recommendation has been provided to both the individual and the MEC. The request must specify the grounds for the review. If an appeal is not so requested the right to appeal is waived and the hearing panel's report and recommendation shall be forwarded to the board for final action.

6.03 **Appellate Panel:** If an appeal is duly requested the chair of the board shall appoint an appellate review panel composed of not less than three persons who may be members of the board or other reputable persons. In the alternative the chair of the board may have the entire board serve as the review panel. Knowledge of the matter involved shall not preclude a person

from serving on the appellate review panel so long as that person is not in direct economic competition with the individual and did not take part in the investigation or a prior hearing on the same matter.

6.04 Appeal Procedure. The review panel shall notify each party of that it has the right to present a written statement in support of its position on appeal, and the schedule for submitting the statements. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. In its sole discretion, the appellate review panel may allow each party and/or their legal counsel to appear before it and give oral argument in support of their position. Oral argument is limited to 30 minutes per side. The appellate review panel may, in its discretion, accept oral or written evidence not presented to the hearing panel only if the party seeking to admit the new evidence can demonstrate that the evidence is relevant to the appeal and could not have been presented to the hearing panel or that the opportunity to admit it at the hearing was improperly denied. After completing its review, the appellate review panel shall recommend final action to the board unless the entire board is sitting as the appellate review panel, in which case the decision of the review panel will be final without further action by the board.

Article VII. BOARD ACTION

7.01 Board Action if No Hearing. If the decision of the MEC does not give rise to a right to a hearing, or if hearing is not requested, the decision of the MEC shall be submitted to the board for final action. If the board modifies the decision of the MEC such that if the MEC had made the same decision the individual would be entitled to a hearing, the individual shall be so notified in writing and afforded an opportunity to request a hearing as set forth above.

7.02 Board Action Following Hearing. If there is no appeal, within 30 days after the time for requesting an appeal has expired the board shall render a final decision. The board may affirm, modify, or reverse the recommendation of the hearing panel or it may refer the matter for further review and recommendation.

7.03 Board Action Following Appeal. In the event the entire board is sitting as the appellate review panel, the decision of the appellate review panel shall be the final decision of the board. Otherwise, within 30 days after receipt of the appellate review panel's recommendation the board shall render a final decision. The board may affirm, modify, or reverse the recommendation of the appellate review panel, or it may refer the matter for further review and recommendation.

7.04 Board's Decision Final. The decision of the board is final and shall be effective on the date it is signed unless another date is so stated in the decision. The board's decision shall be provided to the individual, the MEC and the COO of each of the five hospitals at which the individual holds privileges.

Article VIII. MISCELLANEOUS

8.01 Peer Review Protection. All records of actions taken, and recommendations made pursuant to this plan are confidential and shall be afforded the full protection from release or discovery as permitted by law.

8.02 Notices. All notices given under this plan shall be in writing and sent either via first class mail or hand delivered to the recipient. If sent via first class mail from city in which the hospital is located notices are deemed received three days after deposited with the United States Postal Service, postage prepaid. In all other cases, the period for calculating time under this plan will be from the date of actual receipt by the recipient.

8.03 Data Bank Reporting. Actions taken and decisions made pursuant to this plan will be reported to the National Practitioner Data Bank as required by law.

APPENDIX B. CREDENTIALING PROCEDURES

Section 1. Qualifications for membership

- A. Qualified and Board-approved providers will be members of the 'Unified Medical Staff of PHFH, PSHMC, and PSLRMC, but privileges will be granted specific to the hospital/s where the provider will provide services and is approved by the MEC and Board.
- B. Only individuals licensed to practice medicine, osteopathy, dentistry, or podiatry in the State of Washington and who can document education, training, experience, current competence, ethical standards, ability to work with others, and health status to meet the standards of the Hospital may be considered for admission to the Medical Staff.
- C. Other health care practitioners for whom privileges or scopes of service have been approved by the Board and who can document education, training, experience, competence, ethical standards, ability to work with others, and health status to meet the standards of the Hospital may be considered for credentialed status.
- D. All applicants must sign and agree to follow the Code of Conduct, as adopted by the MEC.
- E. Appointment to the staff and the granting of clinical privileges shall not be denied on the basis of sex, age, race, creed, religion, color or national origin.
- F. Appointment to the staff or the granting of clinical privileges shall not be granted solely by virtue of licensure, membership in a professional organization or appointment to the staff of another healthcare facility.
- G. Applicants for Medical Staff membership from Doctors of Medicine, Doctors of Osteopathy, and Doctors of Podiatric Medicine must have completed a residency approved by one of the following: Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or American Podiatric Medical Association (APMA), or the equivalent. (Physicians on staff at either hospital prior to the unification of the medical staff may hold an exemption to this requirement.)

Residents may be approved to moonlight. They will be credentialed and follow the moonlighting policy. The resident must provide an active WA state license and DEA. When serving in this capacity all of the resident's work will be supervised and they must meet all credentialing requirements as defined in appendix B, with the exception of completion of an ACGME residency. They are not member of the medical staff, but are required to follow medical staff and hospital policy

- H. Physician applicants must, in addition to all other requirements, be board certified or board eligible in the specialty in which they are practicing by a board recognized by the American Board of Medical Specialties, American Osteopathic Association, or Council on Podiatric Medical Education, or an equivalent organization. If at the time of application, the individual is board eligible, rather than board certified, the individual must achieve board certification within six years from highest level of postgraduate training. This requirement applies to Medical Staff membership and not clinical privileges. Specialty clinical privilege requirements may specify a period less than six (6) years to achieve Board Certification. The MEC may make limited exceptions to the Board Certification requirement based on

training, years of experience, and current continuing medical education. (Physicians on staff at either hospital prior to the unification of the medical staff may hold an exemption to the board certification requirement.)

- I. The Board makes the final determination regarding membership and privileges.
- J. Applicants must be in process of establishing an office practice in the immediate geographic area, must show intent to practice at the hospital/s, and provide written evidence of call coverage such that patients will receive continuous care.

Section 2. Responsibilities of Applicants, Staff Members and the Hospital/s

A. Responsibilities of Applicants:

- 1. Applicants for staff membership must furnish the documents specified in this Appendix and authorize the release to the Medical Staff of information relevant to the applicant's education, training, experience, competence, ethical standards, ability to work with others, and health status. By applying for appointment to the staff, each member thereby signifies his agreement that all application documentation, including but not limited to application forms, peer references, competency verifications, performance improvement information, and procedures lists may be shared within INWA organizations and with other Providence or Providence-affiliated hospitals if a credentials sharing agreement is in place. The authorization will release from liability the hospital/s and all individuals and organizations providing information to the hospital/s in good faith and without malice.
- 2. Applicants have the burden of producing information which the Medical Staff deems adequate to properly evaluate the applicant's education, training, experience, competence, ethical standards, ability to work with others, and health status. Applicants must update their applications with current information when it is available. Failure to update is grounds for rejecting an application.
- 3. Applications will be reviewed for completeness and accuracy. An application containing false or misleading information will be voided and not processed. Incomplete applications will be voided and not processed unless the missing information is provided within 180 days of the initial submission of the application. If primary source verification cannot be obtained within 180 days of initial request from the medical staff office, the application will be voided and not processed. Applicants whose applications are voided for incompleteness may not reapply for two years (24 months) from the date the application was voided.
- 4. Applicants may request clinical privileges in addition to membership on the staff. Application for clinical privileges is described in Appendix C.

B. Responsibilities of Staff Membership

- 1. Staff members agree to abide by these Bylaws, the rules, regulations, and policies, adopted pursuant to these Bylaws, as well as the policies and procedures of the hospital/s.

2. Staff members must promptly notify the Medical Staff Office of
 - a. Any substantive changes in their physical or mental health that may affect their ability to perform current or requested clinical privileges
 - b. Malpractice claims paid on their behalf, whether by settlement or judgment, and changes in their professional liability insurance coverage
 - c. Sanctions, suspension (other than medical record suspension), limitations, or restrictions of privileges imposed on them by any other health care institution, regulatory body, or governmental agency and
 - d. Sanctions, suspension (other than medical record suspension), restrictions, limitations, or revocations of any license to practice medicine from any licensing agency.
3. Following initial Board certification, board recertification in the specialty of current practice is required for all staff members unless specifically exempted by the MEC.

C. Responsibilities of the Hospital/s

Within 90 days of receipt of a complete and accurate application, all required supporting documentation, and all primary source verifications, the MEC will make its recommendation to the Board and the Board will make its decision regarding the application for staff membership and/or clinical privileges.

Section 3. Initial Appointment Requirements and Process

- A. All applicants to the staff must meet minimum established membership and credentialing criteria, including sufficient clinical activity to assess current clinical competence, to be considered for appointment. If an application does not meet established criteria, the individual will be notified, with no rights to a hearing or appeal. By applying to the staff, the applicant agrees to adhere to Medical Staff Bylaws, Code of Conduct, and Ethical and Religious Directives for Catholic Healthcare Facilities, in the event medical staff membership is granted.
- B. Only members of the staff shall be entitled to obtain clinical privileges, except as otherwise provided herein. When applicants apply to the staff, the hospital will provide the applicant electronic access the medical staff bylaws, which describe the appointment and privileging process.
- C. Application for appropriate staff membership and clinical privileges shall be made on forms provided by the hospital/s. The application shall include the applicant's professional education and qualifications, special training, all previous staff appointments, all former clinical privileges obtained, history and disposition of any disciplinary actions, and physical and mental conditions adversely affecting the applicant's competence, including, but not limited to, drug and alcohol abuse, and such other information as may be required by the Board. For both membership and privileging considerations, the application shall include information as to whether there have been any challenges to any licensure or registration; voluntary and involuntary relinquishment of any license or registration; voluntary and involuntary termination of medical staff membership; voluntary and involuntary limitation, reduction, or loss of

clinical privileges; all professional liability actions resulting in a final judgment against the applicant and, if so, the findings for each such claim; documentation as to the applicant's health, relevant practitioner-specific data as compared to aggregate data (as available); and morbidity and mortality data (as available). Only a complete application which includes the following documentation obtained by the hospital, will be processed. Any information during the credentialing process that is found to be false shall void the application.

1. Primary source verification of the medical schools attended, verifying the applicant's attendance and graduation.
2. Primary source verification of completion of residency program and fellowship program (if applicable). If a recent graduate, if available, the confirmation should include an evaluation according to the Accreditation Council on Graduate Medical Education (ACGME) Core Competencies.
Letters of current good standing or good standing at the time of resignation from a representative of each hospital with which the applicant is or has been affiliated for a minimum of the past ten years (unless superseded by any other policy such as might be created specific to telemedicine providers)
3. Three (3) peer references, including evaluation of the following core competencies must attest to current competency for the specific requested procedures.
 - a. Patient care
 - b. Medical/clinical knowledge
 - c. Practice-based learning and improvement
 - d. Interpersonal and communication skills
 - e. Professionalism
 - f. Systems-based practice
4. Additional documentation and verification of current competency when deemed necessary for specific privileges requested as specified on specialty privilege lists or by the Credentials Committee or MEC.
5. Primary source evidence of current Washington state license/registrations/s as required for scope of practice.
6. Evidence of a DEA certificate, if applicable.
7. Primary source or other acceptable evidence of other certificates as applicable to privileges requested
9. Specification of clinical privileges being requested. Applicant may be requested to provide a listing of privileges currently or previously held at other entities. Applicant must supply a summary of procedures performed and/or types of patient admissions over the past two years. Data from prior organizations' professional practice reviews will be obtained if available.
10. Statement from the applicant that no health problems exist which could affect his ability to perform the privileges being requested.
11. Written evidence that the applicant carries at least the minimum amount of professional liability insurance, \$1 million per occurrence and \$3 million umbrella/aggregate as required by the Executive Committee and Board of Directors; information on all malpractice claims and a consent to the release of information by present and past malpractice insurance carriers. The board may amend the required amount of coverage; this determination will take effect pending the next bylaw review and approval.
12. Copy of government issued photo ID verified by medical staff office personnel in the presence of the practitioner or by notarization prior to beginning practice.

13. Individually assigned NPI (National Practitioner Identifier) number (unless exempted).
 14. For physician applicants, Federation of State Medical Boards (FSMB) or American Medical Association (AMA) profile to confirm license status in other states.
 15. Photograph suitable for internal provider roster
- C. The National Practitioner Data Bank will be queried by each hospital regarding any information relative to the applicant.
 - D. The Washington State Patrol and other contracted agencies, as applicable, will be queried for criminal history information.
 - E. The Department of Health and Human Services/Office of the Inspector General (OIG/LEIE) and the General Services Administration/Excluded Parties Listing System (GSA/EPLS) will be checked to confirm no exclusions from eligibility for governmental payments exist.
 - F. The applicant has the burden of producing adequate information for a proper evaluation of his or her competence, character, ethics and other qualifications and for resolving any doubts about such qualifications to the satisfaction of the Credentials Committee, MEC, and Board.
 - G. Every application for staff appointment shall be signed by the applicant and shall contain the applicant's specific acknowledgment of receipt of a copy of the current bylaws, appendices, and agreement to abide by the terms of the bylaws, appendices, and policies and procedures.
 - H. If any material information provided by the applicant is found to be false or misleading, the application shall automatically be voided, and will not be processed. The applicant will be notified that the application is void, including the reason, and will not be eligible to reapply for staff membership or to reapply for clinical privileges for a period of at 24 months from the date the applicant is notified that his application is void. If the applicant chooses to reapply at the end of this period, the reapplication will not be considered unless the applicant meets his/her burden of producing adequate information of his integrity. A determination that an application is void because it contains false or misleading information or fails to include material information is not grounds for a hearing or appeal.
 - I. By applying for appointment to the staff, each applicant thereby signifies his or her willingness to appear for interviews in regard to his or her application, authorizes the hospital to consult with members of the medical staffs of other hospitals with which the applicant has been associated, and with other persons who may have reliable information bearing on the applicant's competence, character, ethical qualifications, and ability to perform the privileges requested, and consents to the hospital's inspection of all records and documents which may be material to an evaluation of his or her professional qualifications, competence, and ability to carry out the clinical privileges requested. If concerns are identified regarding a potential physical or mental health issue which may affect the practitioner's ability to perform the privileges requested, the MEC may require a physical or mental health evaluation from a mutually agreed upon internal and/or external health care professional/s.

- J. All completed applications will be forwarded to the chairman of the appropriate clinical department or departments and the Credentials Committee (including ad hoc credentials committees which may be established for specific privileging issues) for recommendations regarding membership and clinical privileges. A report of the clinical department chairman's recommendations, specifically delineating the applicant's recommended clinical privileges, will be forwarded to the Credentials Committee.
- K. The Credentials Committee will review the applicant's qualifications for membership and clinical privileges and will review the recommendation(s) from the clinical department chairman. If the application for membership and clinical privileges is satisfactory, and if the department chairman recommends approval, the Credentials Committee shall forward the application with its recommendations to the MEC. If the Credentials Committee recommendation does not concur with the Department Chair's recommendation, the application may be referred back to the Department Chair for further discussion and action, or the application may be forwarded to the MEC for discussion of the conflicting recommendations at the MEC level. When privileges are requested from more than one clinical department, the Credentials Committee will arbitrate and resolve any conflicting recommendations from the Department Chairs and send its recommendation to the MEC for resolution.
- L. After receipt of the application and the report and recommendation of the appropriate clinical department chairman, and the recommendation of the Credentials Committee, the MEC shall determine whether to recommend that the applicant be appointed to the Staff, that the applicant be rejected for staff membership, that certain requested privileges not be granted, or that the application be deferred for further consideration. All recommendations to appoint must also specifically recommend the clinical privileges to be granted. Such clinical privileges may be qualified by probationary conditions. Only the Medical Staff President, Hospital COO, or their designees, shall be authorized to report to an applicant the status of his or her application and the decision of the MEC.
- M. If the recommendation of the MEC is to defer the application for further consideration, it must be followed up within sixty (60) days of the decision to defer with a subsequent recommendation for appointment, appointment with specified clinical privileges deferred, or for rejection for staff membership. If the recommendation is adverse, and gives rise to fair hearing rights, the Medical Staff President, COO, or their designee shall give written notice to the applicant. The Governing body shall take no action with regards to the recommendation until the applicant has either exhausted or waived their rights.
- N. The Medical Staff President/Hospital COO shall forward the MEC's recommendation, together with all supporting documentation, to the next meeting of the Board and/or Board Subcommittee.
- O. An expedited process of approval by two of three designated Board members may be utilized for initial appointment as outlined in Appendix B, Section 7.I.
- P. If the Board denies membership, privileges, or a portion of the requested privileges to either a new applicant applying for privileges or membership, or to a current staff member applying for additional privileges, the applicant shall be informed of the denial.

Adverse recommendations may be reportable to the appropriate State licensing agency and the National Practitioner Data Bank.

- Q. Within ten working days of action by the Board, the decision shall be provided from the Medical Staff President/Hospital COO to the applicant.
- R. Any applicant who has received a final decision denying staff membership or all or any portion of the privileges requested shall not be eligible to reapply for staff membership or to reapply for the denied privileges, as the case may be, for a period of sixty (60) months from the date of the final decision.
- S. A final decision as referred to in this Article means the effective date of any adverse recommendation as referred to in the Fair Hearing Plan.
- T. Privileges granted to each practitioner are made available to all patient care staff of the hospital. These are updated within one week of Board decision.
- U. By applying to the medical staff of any INWA hospital, the applicant agrees that all application information received from the applicant or gained from any source during the application process may be shared among the INWA hospitals for credentialing and privileging purposes.

Section 4. Procedures For Reapplication

- A. The Board makes the final determination regarding membership and privileges.
- B. Any Staff member who has received a final decision denying initial staff appointment, staff reappointment, curtailing existing privileges, or denying all or a portion of new privileges requested shall not be eligible to reapply for staff reappointment or for the curtailed or denied privileges, as the case may be, for a period of 60 months (five years) from the date of the final decision.
- C. A reapplication for staff membership or privileges shall be accompanied by such additional information as the Executive Committee may require demonstrating that the basis for the original final decision no longer exists; further, a reapplication by an applicant not a member of the Staff shall be processed as an original application.

Section 5. Initial Professional Practice Evaluation (IFPPE)

- A. All initial appointments to the Medical Staff (with the exception of members with no privileges) shall be subject to initial professional practice review (IFPPE) for a minimum period of six (6) months two (2) years. If in the two-year period the appointed practitioner has not exercised the privileges granted, the Credentials Committee and MEC has the discretion to not reappoint the practitioner as lack of documented patient activity at the hospital precludes the MEC from recommending to the Board that the practitioner has the requisite professional competency to retain inpatient privileges. This is an automatic relinquishment due to a failure to exercise the privileges granted and not an adverse action to restrict or revoke professional privileges, therefore, reporting to the

National Practitioner Data Bank under the Health Care Quality Improvement Act of 1986 may not be required in this case. See current Medical Staff Policy which amplifies the IFPPE process.

- B. Newly appointed staff members shall be assigned to one or more clinical departments which will be responsible to oversee the initial performance monitoring process. The performance monitoring criteria will be shared with the applicant. Information during this process may be gained from chart reviews, monitoring of clinical practice patterns, simulation, proctoring/precepting, external peer review, and discussion with other individuals involved in the care of mutual patients. This initial focused evaluation will follow the six competency areas as outlined in Initial Appointment Requirements and Process B.1, which includes a review of quality and safety of patient care by the Department Chair.
- C. As a general rule, additional privilege requests are not granted during the IFPPE period.
- D. With the exception of remotely located providers, medical staff orientation, electronic health record training and high reliability training must be completed within six months of initial appointment unless exempted by policy or the MEC. (Extensions may not exceed twelve months on staff unless extended by Credentials Committee.)
- E. The Department Chair will communicate with the practitioner during IFPPE review if there are areas for improvement. The Chair has the authority to:
 - 1. Approve the satisfactory completion of the IFPPE.
 - 2. Continue the IFPPE process to further assess quality and activity.
 - 3. Continue the IFPPE for certain privileges to further assess quality and activity
 - 4. Notify provider if any initially requested privileges are not granted due to criteria not being met during the IFPPE.
 - 5. Initiate collegial intervention or corrective action.
 - 6. If low volume activity (or no volume but an identified need for call purposes), request a minimum of one peer reference relative to the privileges held. (Activity/good standing at another INWA hospital or other hospitals may be considered by the Department Chair if there is an identified need for the provider's services.)
 - 7. Assign to another category of staff appropriate to the level of activity, or the needs of the hospital.
- F. If any initially requested privileges are not recommended for approval following the IFPPE, the Department Chair will refer the issue to the Credentials Committee, which will review and endorse or reverse the recommendation of the Department Chair and forward their recommendation to the MEC. Quality concerns are reviewed by PPEC.
- G. The MEC will review the recommendations and communicate its recommendation to the staff member with an explanation of the decision.
- H. If the MEC recommends denial of advancement from IFPPE for any reason other than a failure to exercise the privilege within the facility during the review period, the staff member shall have the rights accorded by these bylaws to a member of the Medical Staff who has failed to be reappointed.

Section 6. Ongoing Professional Practice Evaluation (OPPE)

- A. All practitioners with clinical privileges are subject to ongoing professional practice evaluation to allow the hospital to identify trends which may impact quality of care and patient safety. The type of data to be collected is determined by individual departments and approved by the PPEC.
- B. Ongoing evaluation may include the following:
 - 1. Compliance with established quality and safety standards of the hospital
 - 2. Patterns of patient and staff complaints
 - 3. Medical record delinquencies
 - 4. Resource utilization, such as blood, pharmaceuticals, tests and procedures
 - 5. Length of stay patterns
 - 6. Morbidity and mortality data
 - 7. Observation by another health care professional
 - 8. Other relevant criteria as determined by the department or the organized medical staff
- C. Ongoing practice evaluation data is reviewed by the Department Chair and may be shared with the practitioner. Aggregate data may be reviewed at the Department level and be integrated into performance improvement activities for the department.
- D. Concerns identified during the ongoing evaluation process may result in a performance improvement plan (PIP), focused practice review or the investigative process as outlined in the Fair Hearing Plan.
- E. During OPPE practitioners may be moved to an appropriate category of staff depending upon their activity within the hospital. Such reclassifications are also made based upon the needs of the hospital.

Section 7. Reappointment Requirements and Process

- A. Medical Staff appointments are for up to two years. The reappointment process is initiated by Medical Staff Services sending a reappointment form to the practitioner at least 90 days prior to the expiration of his current appointment. The reappointment form must be completed and returned along with all requested information to Medical Staff Services within 30 days after receipt by the practitioner. Failure to timely return the completed reappointment form and requested information may be considered a resignation from the staff.
- B. Physicians must obtain and maintain board certification as outlined in Appendix B, Section 1.H. unless an exemption is recommended by the MEC and approved by the Board. (Physicians on staff at either of the hospitals at the time of unification of medical staff may hold a prior approved exemption.)

- C. Reappointment applications shall include the following:
1. Evidence of current licensure/registration in the state of Washington as required for scope of practice.
 2. Evidence of continuing training, current competence, education and recent experience that qualifies a staff member for the privileges sought on reappointment.
 3. Current reference from a minimum of one peer who has direct, personal and current knowledge and attests to the practitioner's current competence for the privileges requested. Peer is defined as MD/DO to MD/DO, dentist to dentist, ARNP to ARNP, PA to PA. In certain instances, however, a provider from another type of licensure will have the most knowledge regarding the provider's current competency, and these references will be considered by the Department Chair.
 4. Information regarding all physical and mental conditions adversely affecting competence including, but not limited to, drug and alcohol abuse, and the individual provider's declaration of health status. The staff member agrees, upon request of the Executive Committee or Board, to submit to a physical and/or psychiatric examination by a physician agreeable to both the MEC and the staff member to verify physical and mental fitness.
 5. The name and address of all other health care organizations or practice setting wherein the staff member provided clinical services during the preceding period.
 6. Sanctions of any kind imposed or pending by any other health care institution, professional health care organization, regulatory body or licensing authority.
 7. Evidence of malpractice insurance coverage (including cancellations, non-renewals and limits), and description of any pending malpractice actions.
 8. Such other specifics about the staff member's professional ethics, qualifications and ability requested by the Staff that may bear on the member's ability to provide safe, high quality patient care in the hospital.
 9. An acknowledgment of access to current bylaws/appendices of the Staff and an agreement that the staff member agrees to abide by the terms thereof; in addition, agreement that in the event of dispute with the Staff or with the hospital that the member will exhaust all means available to him or her of resolving the dispute prior to resorting to litigation.
 10. By applying for reappointment to the staff, each member thereby signifies his willingness to appear for interviews in regard to his reapplication, authorizes the hospital to consult with members of the medical staffs of other hospitals with which the member has been associated and with other qualified persons who may have reliable information bearing on the member's current health status, competence, character and ethical qualifications, and consents to the hospital's inspection of all records and documents which may be material to an evaluation of his or her professional qualifications and competence to carry out the clinical privileges s/he requests.
 11. By applying for reappointment to the staff, each member thereby signifies his agreement that all reappointment, peer review, and performance improvement information may be shared within the INWA hospitals.
- D. Medical Staff Office personnel are responsible for reviewing the reappointment form for completeness and collecting information concerning the applicant's volume of activity during the previous twenty-four (24) months, results from ongoing professional practice

evaluations, the applicant's participation in the functions of the medical staff, the completion of the applicant's medical records, and recommendations from peer.

- E. The Department Chair or his designee will provide initial review of the reappointment application and the supporting documentation, and provide recommendation to the Credentials Committee according to the following competencies:
 - 1. Patient care
 - 2. Medical/clinical knowledge
 - 3. Practice-based learning and improvement
 - 4. Interpersonal and communications skills
 - 5. Professionalism
 - 6. System-based practice
- F. The Credentials Committee reviews the file and recommendations of the Department Chair/designee. A recommendation of appropriate staff category is part of the reappointment process. Reassignment of staff category or nonrenewal of privileges due to no activity is not reportable to any regulatory agency.
 - 1. If no or low inpatient activity at a Providence Health Care hospital over the prior two years, a physician may be reappointed to a more appropriate staff category (associate, community-based, or medico-administrative).
 - 2. If a provider has no activity for the past two years, and does not regularly refer patients to the hospital, s/he may not be reappointed to the medical staff, at the discretion of the Department Chair and MEC. Non-reappointment due to no activity is not reportable and does not give rights to a fair hearing.
 - 3. Physicians with no documented inpatient activity, but who are part of a special call group requiring privileges may retain Associate Staff privileges if current competency for the requested privileges may be verified by other knowledgeable sources.
 - 4. APPs with no documented inpatient activity will not be reappointed unless their physician sponsor provides written documentation that there are plans for the APP to begin assisting in inpatient care within the next six months.
- G. The Credentials Committee shall present its findings and recommendations to the Executive Committee, which considers the recommendations of the Credentials Committee in its recommendation to the Board.
- H. At the Board meeting, prior to the completion of the member's biennial appointment, the Executive Committee shall present a written recommendation concerning the reappointment or non-reappointment and the modification, continuation or curtailment of clinical privileges for the ensuing year. When non-reappointment or curtailment of privileges is recommended or additional requested privileges are not approved for any reason other than required criteria are not met, the reasons therefor shall be stated.
- I. The Board holds the decision to reappoint, modify the reappointment request, or deny reappointment. If the Board denies reappointment or denies any of the requested privileges, the provider shall be so informed, including notification of the rights provided in the hearing and appellate review procedures contained in the Fair Hearing Plan.

- J. An expedited process of approval by two of three designated Board members may be utilized for both initial appointment and reappointment. This process may be utilized for an application which demonstrates all of the following:
1. Application and supporting documentation are complete
 2. No current or previously successful challenge to licensure or registration
 3. No involuntary termination of medical staff membership at another organization
 4. No involuntary limitation, reduction, denial or loss of clinical privileges
 5. No unusual patterns or excessive numbers of professional liability actions resulting in judgment against the applicant
 6. No issues (other than traffic infractions) identified through criminal background checks
 7. See '*Board Credentials Committee*' policy which amplifies the process if there are any issues which require special consideration at the Board level.
 8. Applicant has been recommended by Credentials Committee and the MEC and is awaiting review at the next Board meeting
- K. The Department Chair or the MEC may at any time recommend a performance improvement plan (PIP) or focused professional practice evaluation if questions arise regarding the individual's practice within the facility. The PIP or focused review is separate from the ad hoc committee or investigation process as outlined in the Fair Hearing Plan. See Medical Staff Policy which distinguishes between initial focused professional practice evaluation, performance improvement plans, and focused professional practice evaluations.
- L. Providing false or misleading information is a basis for not renewing membership and/or clinical privileges.
- M. Failure to return reappointment forms will be considered a resignation from staff.

APPENDIX C. PRIVILEGING PROCEDURES

Section 1. Privileges

- A. The types of privileges performed at each hospital are recommended through the Medical Executive Committee for approval by the Board. These 'privileges' or 'scope of service' documents include the qualifications to apply for the specific procedure or category of procedures. Prior to approving a new procedure to be performed within the Hospital, the resources necessary to support the requested privilege are determined to be currently available, or available within a specified time frame. This includes equipment as well as the training of personnel. See also the policy 'Privileging for New Procedures'.
- B. A physician may request to opt out of performing specific procedures included within core privileges for the specialty; this must be approved by the Department Chair. The physician may be responsible to find another practitioner to cover his call obligation. The Department Chair will review such requests and, if necessary, provide recommendations to the MEC regarding call coverage.
- C. Voluntarily relinquishing specific privileges may not relieve members of the Medical Staff from call obligations, as established by each department.
- D. Members of the Staff are authorized to exercise only those clinical privileges specifically granted by the Board, with the exception of emergency situations as outlined under Section 3 of this Appendix. A practitioner's clinical privileges may be suspended for failure to exercise only those clinical procedures specifically approved by the Board.
- E. Members of the Staff may, at any time, request additional privileges or may voluntarily relinquish privileges. All requests for additional privileges must meet established criteria and be accompanied by documented evidence of current training and clinical competence to support the request. Information from ongoing professional practice evaluation data sources is considered in the decision process.
- F. The hospital queries the National Practitioner Data Bank when clinical privileges are initially granted and registers the practitioner with the proactive disclosure service of the NPDB to receive continuous reporting regarding credentialed practitioners.
- G. The applicant shall have the burden of establishing his/her qualifications and competency based on his/her education, training, experience, demonstrated competence, references, ability to perform the requested privileges and other relevant information for the requested clinical privileges for physicians, and scope of services for Advanced Practice Professionals. To be eligible for privileges the practitioner must provide documentation of sufficient activity to assess current clinical competence.
- H. Applicants must provide a summary of hospital activity and/or procedures performed within the past two years. This may include procedure logs from residency and/or fellowship, letters from residency, fellowship, or department chairs and/or patient data from the most recent hospitals where the individual has practiced.

- I. Experience, ability, and current competence to perform the requested privilege is verified by a minimum of two peers with knowledge of the applicant's current professional performance. Responses will be requested following the outline of competency provided in Appendix B, Section 3.
- J. When during the initial credentials review process, or any subsequent review, there is not adequate clinical data to support the decision to grant the requested privilege, an initial focused professional practice evaluation may be arranged for a time-limited period. This initial focused evaluation may also be utilized for those who have not performed the required number of specific procedures, or in response to concerns regarding the provision of safe, high quality patient care. This may include any of the following.
 - 1. Chart review
 - 2. Monitoring clinical practice patterns
 - 3. Simulation
 - 4. Proctoring
 - 5. External peer review
 - 6. Evaluations of consulting physicians, procedure assistants, nursing, or administrative personnel
- K. Evaluations from treating physicians and/or a mutually agreed-upon health professional may be requested if there is doubt regarding an applicant's ability to perform the privileges requested.
- L. The Credentials Committee shall make periodic re-determination (at least every two years) as to whether the Staff members, or allied health professional's privileges/scope of service shall be continued, increased or curtailed. The re-determination shall be based on review of the member's credentials, peer recommendation, medical records, clinical department records, quality assessment records, and information obtained from other hospitals.
- M. The scope and extent of surgical procedures that each dentist, oral surgeon, and podiatrist may perform shall be specifically delineated and granted in the same manner as surgical privileges are granted to Staff members. Surgical procedures performed by dentists, oral surgeons and podiatrists shall be under the overall supervision of the chairperson of the Surgery Department. All dental and podiatry patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization. The general and department patient care rules further define the role of the dentist and podiatrist with the Staff.
- N. Clinical privileges for psychologists shall be limited to the usual and customary privileges as defined under state law. Consultation to determine the existence of a psychiatric disorder and/or recommendations for the treatment or disposition of patients with psychiatric disorders must be performed by a psychiatrist, and a physician member of the Staff shall be responsible for the diagnosis and treatment of patients seen by a psychologist.

- O. Approved current clinical privileges for each practitioner are maintained in the individual practitioner's credentials file, as well as available electronically for reference by all clinical staff.
- P. Practitioners may be granted remote/telemedicine privileges without membership. At the recommendation of the MEC, and with contracts in place which meet The Joint Commission standards and CMS guidelines, the credentialing and privileging decision from the distant/contracted site may be accepted in lieu of on-site credentialing. The hospital must maintain and provide information regarding quality of care, treatment, and services to the distant site for its use in ongoing privileging and performance improvement.

Section 2 – Temporary Privileges

- A. The COO, CMO, or designee, at the written recommendation of a Department Chair, Section Chair, Credentials Committee Chair, or Medical Staff President may, upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, grant temporary admitting and/or clinical privileges to an appropriately licensed individual under one of the following categories. In the exercise of such privileges, the applicant shall be subject to the Medical Staff Bylaws, policies, and procedures. Temporary privileges shall be in effect for no longer than (120) days. (Also see the medical staff approved *Temporary Privileges Policy* which amplifies the file review process to consider temporary privileges.)
 - 1. Practitioner is applying for full staff status and the complete application is awaiting MEC and/or Board approval if the following criteria are met. (Any files not meeting these criteria will not receive temporary privileges but must have discussion and approval by the MEC and Board Credentials Committee, or the full Board if the Board Credentials Committee so recommends.)
 - a. Current license with no current stipulations in place
 - b. Documentation of training and experience
 - c. Current competency verifications regarding privileges requested, including verification that no concerns exist which would prevent the provider from performing the requested privileges.
 - d. Query and evaluation of any NPDB reports with no patterns of concern noted
 - e. No current or previously successful challenge to licensure or registration.
 - f. No involuntary termination of medical staff membership at another organization
 - g. No involuntary limitation, reduction, denial, or loss of clinical privileges
 - 2. An important patient care need exists, which no currently credentialed staff member can meet. In this instance, licensure, training, and current competency must be verified. These temporary privileges will be time and/or patient specific according to the need. (*See policy: Credentialing for urgent patient care need.*)
 - 3. Practitioner has been approved by the Board and in good standing at one of the INWA hospitals and will be providing an important and temporary service to

another hospital within the INWA system. In this instance the hospital COO or Chief Medical Officer, if applicable, may approve the practitioner's privilege or privileges for a specified time. (Note that APP's have the same requirements for physician sponsorship at the requesting hospital; PA's must also have a Practice Plan approved by the State with a credentialed physician at the requesting hospital.)

4. Eligibility for Locum Tenens privileges are covered under the *Locum Tenens Policy* approved by the Medical Executive Committee. Locum Tenens providers are not members of the staff, and hold locum tenens status only, which expire at the end of their locum tenens assignment. Locum tenens providers must meet all current credentialing and privileging requirements. Locum tenens providers whose status is terminated as noted under B, below, do not have rights to a fair hearing.
- B. The Medical Staff President, CMO/designee, or Hospital COO/designee may at any time terminate a physician's or allied health professional's temporary privileges or locum tenens privileges when it is determined that quality or behavior issues exist which place patients or staff at risk or are not to the standards of the hospital (in an emergency situation, termination may be imposed immediately by any person entitled to impose a precautionary suspension pursuant to Appendix A of these Bylaws). The appropriate department chair, or in his or her absence, the Medical Staff President, shall assign a member of the Staff to assume responsibility for the care of such patient(s) until discharge from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of a substitute physician or allied health professional.
 - C. Special requirements of supervision and reporting may be imposed by the department chair on any physician granted temporary privileges. Temporary privileges shall be immediately terminated by the Medical Staff President, Hospital COO or their designees upon notice of any failure by the physician to comply with hospital or medical staff policy or any special conditions imposed upon the temporary privileges.

Section 3 – Emergency Privileges – See Article V, Section 2.

Section 4 – Disaster Privileging

The hospital's *Emergency Operations Plan* and the medical staff's policy, *Disaster Credentialing* provide detail regarding how qualified physicians and Advanced Practice Providers may be approved to assist in the event of an emergency or disaster event, as well as documentation forms to be utilized. Documentation regarding physicians and APPs so activated will be retained in the command center and as a permanent record in the Medical Staff Office.

- A. If the Emergency Operations Plan has been activated, the Hospital Chief Operating Officer or designee will confirm that the hospital requires services of non-credentialed practitioners to meet immediate patient needs and the COO or designee may approve the services of a non-credentialed practitioner who meets criteria outlined in the above medical staff policy.

- B. Before providing any services, the volunteer must present a current license to practice, government-issued photo identification such as a valid driver's license, and the name of the hospital(s) where the individual is currently affiliated or has recently practiced. (If available, identification of membership in a Disaster Medical Assistance Team, the Medical Reserve Corps, or the Emergency System for Advance Registration of Volunteer Health Professionals may be substituted.)
- C. Practitioners who are confirmed to be on staff in good standing at any INWA hospital may provide care at another INWA hospital during an emergency or disaster event.
- D. The practitioner granted emergency privileges will be paired with and supervised by a currently credentialed medical staff member or hospital employee.
- E. All individuals granted emergency privileges will be issued a temporary ID badge through Security. These badges will be clearly marked as 'Temporary Staff' and will be returned to hospital security when the services of these individuals are no longer needed.
- F. Credentialed practitioners will be informed regarding their role in an emergency response and to whom they will report.
- G. Primary source verification of licensure will occur as soon as possible. At 72-hour intervals, the hospital COO or designee will determine whether services continue to be required. If primary source verification of licensure is not possible due to the nature of the disaster, this will be documented, including the steps taken to assure the practitioner has demonstrated ability to continue to provide adequate care, treatment, and services.
- H. All emergency privileges terminate immediately at the conclusion of the emergency or disaster situation which gave rise to the need for this policy to be implemented.

Section 5 – Special Privileges for a Visiting Physician/Professor

A visiting physician/professor who is a recognized expert in his/her field may be granted special privileges specifically for educational or instructional reasons. If proctoring or observing procedures to verify competency, the visitor must be in good standing and currently credentialed for the particular procedure at his institution of practice; evidence of licensure and malpractice coverage will be obtained. The CMO or his designee, at the recommendation of the Medical Staff President or Chair of the department where the privilege will be exercised, may grant special privileges as defined in this section. See Medical Staff policies regarding *Visiting Surgeon or Proceduralist* for detail and forms to be utilized. Visiting surgeons who assist in procedures must also be approved through a similar process.

Section 6 – Medical Students and Residents

Medical students and residents are authorized by the INWA Graduate Medical Education.

Written description of the roles, responsibilities, and patient care activities of the participants in graduate medical education are housed in the Graduate Medical Education office; approved patient care activities for each resident are available electronically to hospital personnel.

The Medical Staff *Student Observer* policy outlines instances where a student observer may accompany a medical staff member to observe only. These observations are normally for one day only, and the student must provide required documentation to the MSO a minimum of two days prior to observation.

APPENDIX D. VOLUNTARY CHANGES IN MEMBERSHIP

Section 1. Voluntary Resignation of Medical Staff Membership

A Medical Staff member may resign from the Medical Staff by submitting a written resignation to the Credentials Committee specifying the date the resignation will be effective. Active Staff members are requested to provide at least 30 days advance notice of their resignation. If less than 30 days' notice is given, and if the Medical Staff member has not made arrangements for other members of the Medical Staff to cover his call obligation for at least 30 days after submitting his resignation, that fact may be reflected in any references provided thereafter.

If a provider leaves a group practice without notifying the medical staff office of his/her new practice location and call group, this will be determined an automatic resignation. The provider's Epic access will be closed. The provider will be so notified by letter to their home address. The provider may request reinstatement if within his/her reappointment period if all requirements of membership and privileges are met.

Section 2. Voluntary Request for Change in Medical Staff Status

At any time, a Medical Staff member in good standing may voluntarily request a change in staff status to another category. The request must be submitted in writing to the Credentials Committee and will be reviewed by the Department before the Credentials Committee makes a recommendation to the MEC. The MEC will approve the change if the Medical Staff member meets the criteria for the category requested. This process will take approximately 45 days. Call responsibilities will remain in effect for all published call schedules until a change is approved, and the next call schedule is issued.

Section 3. Leave of Absence (LOA)

If a credentialed staff member will be absent from patient care responsibilities for more than three consecutive-months s/he must request a leave of absence. The MEC may also place a staff member on a Leave of Absence if the MEC becomes aware that the provider is unable to fulfill the responsibilities of membership or the privilege/s the staff member currently holds. A credentialed staff member who is absent from patient care responsibilities for more than three consecutive months and has not requested a leave of absence shall be deemed to have voluntarily resigned from the Medical Staff and must reapply for Medical Staff membership and clinical privileges.

- A. Requests for leaves of absence must be submitted on an approved medical staff LOA form. This includes an explanation of the reason for the leave and the anticipated length of the leave.
- B. The MEC may grant or deny a leave of absence, with recommendations from Department Chair and Credentials Committee, if needed. Granting leaves of absence are matters of courtesy, not of right, and the determination of the MEC shall be final. There is no right to a hearing or appeal if a request for a leave of absence is denied.
- C. The medical staff member is encouraged to designate a practice manager to communicate with the Medical Staff Office during the period of the leave, to include timely coordination of the request to return from a Leave of Absence.

- D. All clinical privileges, call responsibilities and other obligations of Medical Staff membership are suspended during a leave of absence.
- E. With the exception of an unanticipated medical condition or military orders that do not permit the Medical Staff member to give notice, staff members must request a leave a minimum of 45 days prior to the leave to minimize disruption of the call schedule.
- F. Request to Return from Leave of Absence
 - 1. A minimum of 30 days prior to when the practitioner desires to return to the Medical Staff, the practitioner must request reinstatement on an approved return from LOA form.
 - 2. Members must provide a summary of activities while on leave and are responsible to provide information and documentation sufficient to demonstrate current competence and all other applicable qualifications. If medical leave is for other than maternity or paternity leave, the provider must provide a written release from their physician that they are fit for duty/able to perform their requested privileges and specify any applicable restrictions. The Credentials Committee reserves the right to request further documentation or evaluation of fitness to perform the privileges requested if there remains a question regarding the provider's ability to provide safe patient care.
 - 3. All requirements for reappointment must be satisfied prior to reinstatement.
 - 4. Any request for privileges the practitioner did not hold at the time the LOA was granted will be considered as set forth elsewhere in these Bylaws provided the request for reinstatement is granted.
 - 5. The Credentials Committee will confer with the Department Chair and make recommendation to the MEC whether to grant or to deny reinstatement.
 - 6. The MEC has the authority to grant a return from LOA. The MEC's recommendation to deny a return will be referred to the Board, which may approve, modify, or deny the request to reinstate membership and privileges.
- G. See the *Leave of Absence* Policy, request, and request to return from LOA for greater detail.

APPENDIX E. TIME PERIODS

The time periods specified in these Bylaws and the Fair Hearing Plan are intended to provide guidelines for the routine processing of applications, requests for reappointment, requests for corrective action, requests for a hearing, and the conduct of meetings. Deviations from the time periods set forth herein shall not be grounds for invalidating the action taken.

APPENDIX F. CATEGORIES OF MEDICAL STAFF MEMBERSHIP

Section 1. Active Staff

Qualifications: Active Staff are Medical Staff members who regularly admit, see in consultation, or treat patients at PSHMC and/or PHFH and/or PSLRMC. Active Staff members are assigned to one or more departments. Medical Executive Committee policy will specify if a volume of activity is required to qualify for or maintain active staff privileges.

In the event an appointee to the Active category does not meet the qualifications for reappointment to the Active category, and if the appointee is otherwise abiding by all bylaws, rules, regulations, and policies of the Staff, the appointee may be appointed to an alternative category.

Prerogative: Appointees to the Active category may:

- A. Exercise clinical privileges without limitation, except as otherwise provided in these Bylaws and Medical Staff policies, or by specific exception.
- B. Vote on bylaws and all matters presented at general and special meetings of the Staff, and of the appropriate department and committee of which he/she is a member.

Responsibilities: Appointees to the Active category must:

- A. Pay all dues and assessments promptly.
- B. Contribute to the organizational and administrative affairs of the Staff.
- C. Actively participate in recognized functions of Staff appointment including quality improvement, monitoring activities, clinical privilege development, and other staff functions as may be required.
- D. Participate in the emergency room and other specialty coverage responsibilities unless exempted by the MEC individually, by policy, or unless otherwise contracted by Providence. Granting a request for exemption is at the discretion of the MEC at the recommendation of the department chair and call group, if applicable.

Section 2. Associate Staff

Qualifications: Associate Staff are Medical Staff members who are qualified for active staff status but have been granted exemption from serving on the Active Staff because they infrequently admit, see in consultation, or treat patients within PSHMC, PHFH, or PSLRMC who only assist in surgical procedures. Assignment to Associate Staff must be approved by the Medical Staff member's department and the MEC. If the majority of admissions or patient activity are at a hospital other than PSHMC, PHFH, or PSLRMC verification of good standing at that hospital must be obtained for initial appointment and reappointment.

Prerogatives: Appointees to this category may:

- A. Exercise those privileges as granted by the Board, which will include admission of patients to the hospital unless otherwise specified.
- B. Attend meetings as a non-voting member of the staff and department of which he/she is an appointee, and any staff or Hospital education programs.

Responsibilities: Appointees to this category must:

- A. In exceptional circumstances, upon appropriate request from an attending staff member, provide emergency department or inpatient consultation.
- B. Participate, if assigned, as a member of staff committees, and in quality assessment review activities upon request by the respective clinical departments.

Section 3. Community-Based Staff

Community-based providers must have an active office practice in the immediate geographical area, hold current Board Certification in the specialty in which they are practicing AND be affiliated with PSHMC, PHFH, or PSLRMC in one or more of the following ways:

- A. Utilizes the hospitalist services to manage patients requiring inpatient services
- B. Regularly refers patients to Providence for emergency, inpatient, or noninvasive outpatient tests and procedures, including transfusion of blood and blood products (according to medical staff policy, ordering infusions or invasive procedures requires active or associate status)
- C. Accepts referrals from the Emergency Department for follow-up care as may be required by their specialty

Community-based providers are subject to all requirements for initial appointment and reappointment, with the exception of privileging.

Community-based providers may participate on committees and in quality assessment review activities upon request by the respective clinical departments.

Providers not appointed to any category of staff may refer patients for noninvasive tests and procedures (including transfusion of blood products), as allowed by licensure and regulation. To order infusions or invasive procedures, the provider must hold Active, Associate, or APP 1 status.

Section 4. Medico-Administrative Staff

The Medico-Administrative Staff consists of Medical Staff members who hold administrative positions at PSHMC, PHFH, PSLRMC or in the community and whose responsibility is not clinical in nature. They may not vote on bylaws amendments or during elections or serve as an officer of the Medical Staff. Community medico-administrative staff may attend and be appointed to Medical Staff committees, with or without voting privileges as designated at the time of their appointment. They are not required to participate in Emergency Department call. As they do not admit or consult on any patients, they are exempted from maintaining liability insurance in the amount specified by the hospital.

Section 5. Honorary Staff

Retired Medical Staff members who have made significant contributions to PSHMC, PHFH, or PSLRMC may become Honorary Staff members at PSHMC, PHFH, or PSLRMC upon nomination by their department, recommendation by the MEC and approval by the

Board. Honorary Staff members are not eligible to admit, consult or treat patients, nor to vote, hold office, or serve on committees. They do not have to be reappointed.

Section 6. The Advanced Practice Providers Staff consists of Medical Staff members who are Advanced Practice Providers or ancillary providers who provide care under the supervision of a member of the Active Staff. With the exception of psychologists, Advanced Practice Providers must be employed by a Providence entity, an Active Staff member, or a corporation, limited liability corporation, partnership or similar entity, which is owned by at least one Active Staff member. (The MEC may approve an APP sponsored by an Associate Staff member if recommended by the Department Chair and Credentials Committee.) Psychologists are not required to have a physician supervisor but the care they provide within the Medical Center must be in concert with a member of the Active Medical Staff. Psychologists may not admit patients and their practice within the medical center is limited to consultation at request of the attending practitioner.

1. There are two categories of APP Staff:

1. APP-Category 1 consists of Physician Assistants (PA), Nurse Practitioners (ARNP), Psychologists, Genetics Counselors, and Clinical Pharmacists.
2. APP-Category 2 consists of all other APP's.

B. Appointments and granting of privileges to Advanced Practice Providers and subsequent reappointments shall be accomplished in a manner consistent with the procedures detailed in Articles V. of these Bylaws, as well as in Appendices B and C. APPs are assigned to the department of their supervising physician (psychologists are assigned to the Department of Medicine). Initial appointment and reappointment of all APP's licensed through the state nursing commission will include review and recommendation by the Chief Nurse Executive (CNE).

C. Advanced Practice Providers are subject to these bylaws, including the Fair Hearing Plan, in the same manner as members of the Medical Staff. However, an APP is not entitled to hearing rights if terminated from the Allied Health Professional Staff solely because s/he is no longer employed by a Medical Staff member, or by a corporation, limited liability corporation, partnership, or similar entity which is owned by at least one Active Medical Staff member, or by the Medical Center.

APPENDIX G. DEPARTMENTS OF THE MEDICAL STAFF

There are nine Medical Staff Departments, five of which are hospital-based.

Department of Medicine

Department of Surgery

Department of Pediatric Medicine

Department of Anesthesiology (hospital-based)

Department of Emergency Medicine (hospital-based)

Department of Pathology (hospital-based)

Department of Radiology (hospital-based)

Department of Obstetrics and Gynecology

Department of Physical Medicine and Rehabilitation (or Physical Medicine and Rehabilitation)

The chairs of the Medicine, Surgery, and Pediatric Departments are appointed by the President of the Medical Staff with the concurrence of the COO. The terms of office for the chairs of Medicine, Surgery, and Pediatrics are two years beginning on the first day of the Medical Staff Year.

The chairs of Medicine, Surgery, and Pediatrics may be appointed for two subsequent terms (a total of six years). The chairs of the hospital-based departments (Anesthesiology, Emergency Medicine, Pathology and Radiology), and the Department of Obstetrics and Gynecology are appointed by the COO, and do not have set terms. They serve at the pleasure of the COO but may be removed for cause by the MEC.

APPENDIX H. COMMITTEES OF THE MEDICAL STAFF

Section 1. Medical Executive Committee

1.1 Composition of the MEC is as follows:

- President
- President Elect
- Credentials Chair
- Childrens Hospital designee
- PSHMC and PHFH (2) Surgery Chairs— (Surgery Division Chief also invited, but without vote)
- PSHMC and PHFH (2) Medicine Chairs (Medicine Chair must be from a hospitalist service)
- PSHMC and PHFH (2) Emergency Medicine Chairs
- PSLRMC Physical Medicine and Rehabilitation chair
- CMO attends, without vote
- COO and CNOs attend, without vote
- Division chiefs and other medical or hospital leaders may be invited per topic, but do not have a vote
- Community Board member may attend without vote

1.2 Duties of the Medical Executive Committee

1.2.1. Oversee the quality of care provided by credentialed staff members

1.2.2 Represent and act for the Medical Staff between meetings of the medical staff, within the following scope.

1.2.3. Receive, review and act on recommendations from departments and Medical Staff committees.

1.2.4. Create a formal liaison between the Medical Staff, the hospital COO's and the Board regarding quality, safety, and satisfaction.

1.2.5. Forward recommendations to the Board regarding Medical Staff membership, credentialing and privileging of the professional staff, quality improvement programs, and other staff functions.

Approve required reports and documents

1.2.6. Serve as the coordinating body for all utilization matters including inquiries and directives from the fiscal intermediary; the MEC may delegate specific responsibilities to the departments.

Act upon recommendations from the Medical Leadership Committee and PPEC.

1.2.7. Investigate reports of misconduct and activities by members of the Medical or Allied Health Professional Staff which are considered to be lower than the standards of the Medical Staff, to be detrimental to patient safety or to the delivery of quality patient care within the Medical Center, or to be disruptive to the operations of the hospitals.

1.2.8. Commence formal investigations as outlined in the Fair Hearing Plan (Appendix A).

1.2.9. Recommend to the Board corrective action for Medical Staff and Allied Health Professional members.

1.2.10. Meet on a regular basis, but not less than quarterly.

1.2.11. Recommend to the Board amendments to the Medical Staff Bylaws, which include both general and department rules.

1.2.12. Develop and approve medical staff policies which amplify the medical staff bylaws.

1.2.12. Enforce these Bylaws.

1.2.13. Maintain records of its proceedings and actions.

1.3 In the same way delegated authority to the Medical Executive Committee is established through these Medical Staff Bylaws, removal of this delegated authority to the Medical Executive Committee requires amendment to the bylaws.

1.4 Meetings: The MEC usually will meet monthly, but no less than seven times per year. In months that the MEAC meets, and any other months when there is not substantial or urgent business requiring in person discussion, the MEC may conduct its business through secure email or hosted secure website.

Section 2. Medical Executive Advisory Committee (MEAC)

2.1 Composition of the MEAC is as follows:

MEC members as listed above

Division Chiefs

- Women's/OB
- Surgery
- Childrens CMO

Department Chairs

- Pathology (joint/appointed Medical Director)
- Anesthesiology (joint/appointed Medical Director)
- Radiology (joint/appointed Medical Director)
- Physical Medicine and Rehabilitation (joint/appointed Medical Director)

Committee Chairs

- Utilization Review (joint/appointed Medical Director)
- Trauma (2 appointed Chairs)
- Professional Practice Evaluation Committee chair

Service Leaders

- PSHMC and PHFH (2) Intensive Care Unit (ICU) Medical Directors
- OB Chair-PHFH (rotated appointment by groups)
- Ethics (joint – Providence employee)
- Graduate Medical Education (INWA - employed)
- Psychiatry (joint appointed Medical Director)
- Cancer representative (appointed)
- Orthopedics (appointed, yearly reporting jointly with Orthopedics and Sports Medicine Institute)
- Heart and Vascular (appointed, yearly reporting jointly with PHVI medical director)
- Neuro (appointed, yearly reporting jointly with Providence Spokane Neuroscience Institute)
- Epidemiology Medical Director
- At-Large members (4) (one must be involved in medical or residency education, one must be from a pediatric subspecialty)

Additional administrative staff w/o vote

- Chief Medical Information Officer
- Finance

- PI
- Mission Services
- Senior Director, Support Services
- Community Board member may attend without vote

2.2 Duties of the MEAC:

2.2.1. Receive reports and provide input to Administration, Finance, VBP initiatives

2.2.2 Quality oversight

2.2.3. Present department/service line quality achievements and challenges to the MEC and administration

2.2.4. Discuss issues requiring insight and recommendations from the broader spectrum of services

2.2.5. Bring forth time sensitive issues as needed direct to the MEC between quarterly meetings

2.3 Meetings: The MEAC is planned to meet quarterly but must meet no less than three times per year.

Section 3. Medical Leadership Committee

3.1. Composition:

The Division Chief is empowered to enlist a small group of leaders to meet with providers to collegially intervene and bring behaviors into the acceptable standards of the organization. The CMO will be an invited participant and members are appointed specific to the meeting need. Members may include the department chair, senior practice partners, experienced specialty peers, and past medical staff leaders.

3.2. Duties:

Meetings are held ad hoc specific to each hospital with the primary function to collegially review and address concerns about practitioners' professional conduct as outlined in the Medical Staff Professionalism Policy and to review and address possible health issues that may affect a practitioner's ability to practice safely as outlined in the Practitioner Health Policy. The Medical Staff Leadership Committee has the authority to develop performance improvement plans which focus on behavior and citizenship. The committee will strive to resolve concerns collegially and confidentially. The Medical Staff Leadership Committee will refer issues to the Medical Executive Committee only when collegial efforts have failed.

Minutes will be maintained for Medical Staff Leadership committee meetings, and providers who are under collegial review shall receive a written summary of meetings held and be provided with an opportunity to respond with their comments included as part of the record.

The Medical Staff Leadership Council shall report to the PPEC, the MEC, and others

as described in the Policies noted above.

3.3. Meetings:

The Medical Staff Leadership Council shall meet as needed to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. Providers who are under collegial review shall receive a written summary of meetings held and be provided with an opportunity to respond with their comments included as part of the record.

Section 4. Professional Practice Evaluation Committee (PPEC)

4.1. Composition:

The Professional Practice Evaluation Committee ("PPEC") shall consist of the following voting members:

A past Medical Staff President, who shall serve as Chair. If a Past President is unwilling or unable to serve, the Medical Staff Leadership Council shall appoint another former physician leader (e.g., Medical Staff Officer, department chair, section chief, or committee chair) who is experienced in credentialing, privileging, PPE/peer review, or Medical Staff matters.

Additional Medical Staff members who are broadly representative of the clinical specialties on the Medical Staff; experienced and/or interested in credentialing, privileging, PPE/peer review, or other Medical Staff affairs; supportive of evidence-based medicine protocols; and appointed by the Medical Staff Leadership Council.

The following individuals shall serve as *ex officio* members, without vote, to facilitate the PPEC's activities:

Hospital Chief Medical Officer; and

PPE Support Staff representative(s).

To the fullest extent possible, PPEC members shall serve staggered, three-year terms, so that the committee always includes experienced members. Members may be reappointed for additional, consecutive terms.

Before any PPEC member begins serving, the member must review the expectations and requirements of the position and affirmatively accept them. Members must also participate in periodic training on professional practice evaluation, with the nature of the training to be identified by the Medical Staff Leadership Council or the PPEC.

Other Medical Staff members or Hospital personnel may be invited to attend a

particular PPEC meeting (as guests, without vote) in order to assist the PPEC in its discussions and deliberations regarding issues on its agenda. These individuals shall be present only for the relevant agenda items and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and shall be bound by the same confidentiality requirements as the standing members of the PPEC.

4.2. Duties:

The PPEC shall perform the following functions:

4.2.1. Oversee the implementation of the Professional Practice Evaluation Policy (Peer Review) ("PPE Policy") and ensure that all components of the process receive appropriate training and support. The focus of the PPEC shall be collegial and educational.

4.2.2. Review reports showing the number of cases being reviewed through the PPE Policy, by department or specialty, and the dispositions of those cases, in order to help ensure consistency and effectiveness of the process and recommend revisions to the process as may be necessary.

4.2.3. Approve Ongoing Professional Practice Evaluation ("OPPE") data elements that are identified by individual Departments and adopt Medical Staff-wide OPPE data elements.

4.2.4. Approve the specialty-specific quality indicators identified by the Departments that will trigger the professional practice evaluation/peer review process.

4.2.5. Identify those variances from rules, regulations, policies, or protocols which do not require physician review, but for which an Informational Letter may be sent to the practitioner involved in the case.

4.2.6. Review, assist in the development of, and approve patient care protocols that are recommended by Departments, specialties, or others.

4.2.7. Review cases referred to it as outlined in the PPE Policy.

4.2.8. Develop, when appropriate, Performance Improvement Plans for practitioners, as described in the PPE Policy.

4.2.9. Monitor and determine that system issues that are identified as part of professional practice evaluation activities are successfully resolved.

4.2.10. Work with Department Chairs to disseminate educational lessons learned from the review of cases pursuant to the PPE Policy, either through educational sessions or through some other mechanism; and

4.2.11. Perform any additional functions as may be set forth in applicable policy or as requested by the Medical Staff Leadership Council, the MEC, or the Board.

4.2.12. Interface with the hospital committee overseeing the high reliability/serious safety event review process.

4.3. Meetings:

The PPEC shall meet as often as necessary to perform its duties and shall maintain a permanent record of its findings, proceedings, and actions. The PPEC shall submit reports of its activities to the MEC and Board on a regular basis.

Section 5. Credentials Committee

5.1. Chair:

The chair shall be appointed by the Medical Staff President with concurrence of the COO. The chair must be or have been a member in good standing of the medical staff for the past five years, preferably with Medical Staff leadership experience, such as a Past-President or a past Department Chair. The chair shall fulfill the responsibilities specified in documents relating to responsibilities and expectations approved by the MEC and the COO. The chair may appoint subcommittees to assist in accomplishing the work of the Credentials Committee, as necessary. The chair will serve a two-year term and may be reappointed.

5.2. Membership:

The Credentials Committee shall consist of at least three members in addition to the chair, preferably including physicians who are current or past members of the Medical Executive Committee. A majority of the Committee shall be members of the Active Staff and shall represent various specialties. All members are appointed by the chair of the Credentials Committee and serve two-year terms. They may be re-appointed. The CMO is an ad hoc member of Credentials Committee, without vote. The Committee may ask persons who are not members of the committee, or the professional staff, to assist the committee on specific issues.

5.3. Duties:

1. Develop policies governing the credentialing process.
2. Review and recommend credentialing/privileging criteria developed by the departments.
3. Research national criteria and credentialing standards when needed.
4. Review initial applications, privilege requests, and reappointment applications.
5. Recommend appropriate staff category and department assignments.
4. Make recommendations to the MEC on all of the above.
5. Meet as frequently as needed.

Section 6: Bylaws Committee

- 1.3.1. Chair: President Elect
- 1.3.2. Membership: President Elect, and Credentials Chair. The CMO and Director and Manager of Medical Staff Services participate without vote; hospital legal counsel serves in an advisory capacity, as needed, without vote).
- 1.3.3. Duties: Periodic review of these Bylaws and associated documents, recommendation to MEC
- 1.4. Finance Committee
 - 1.4.1. Chair: President Elect
 - 1.4.2. Membership: President Elect, President, Credentials Chair, CMO (without vote), Director of Medical Staff Services (without vote)
 - 1.4.3. Duties: Oversee the receipt and disbursement of Medical Staff funds; receive and evaluate requests for charitable donations for presentation to and final decision by MEC; and make decisions on investments in accordance with Finance Committee Charter as approved by the MEC.
- 1.5. Nominating Committee
 - 1.5.1. Chair: Immediate Past President
 - 1.5.2. Membership: Immediate Past President, President, President Elect, CMO, and Director and Manager of Medical Staff Services
 - 1.5.3. Duties: Selection and presentation to the MEC of nominees for MEC President Elect and Members-at-Large
- 1.6. Transfusion Committee
 - 1.6.1. Chair: Physician staff member in good standing appointed by Medical Staff President with concurrence of CE.
 - 1.7.1. Membership: Appointed pathologist, Medical Director of Blood Bank, representatives invited from pediatrics, orthopedics, hematology, oncology, emergency medicine, anesthesia, surgery.
 - 1.7.3. Duties: Oversight of the Hospital's blood bank services, transfusion and blood administration policies, and provide blood/blood product education for physicians and staff. Serve as liaison between the hospital and the Inland Northwest Blood Center.
- 1.7. Cancer Committee
 - 1.7.1. Chair: Active staff physician appointed by the COO with concurrence of Medical Staff President.
 - 1.7.2. Membership: Shall consist of at least one board certified, Active Medical Staff member from each of the following specialties: oncology, surgery, radiation oncology, diagnostic radiology, pathology, and pain control/palliative care. Other members will include the cancer physician liaison, cancer registrar, oncology nurse, social worker/case manager, performance improvement representative, palliative care team member, a clinical research representative, a genetics professional and the administrative representative responsible for the Providence Cancer Center.
 - 1.7.3. Duties:
 - a. Monitors, assesses and identifies changes that are needed to maintain compliance with ACS eligibility criteria.
 - b. When appropriate, the Cancer Committee may delegate responsibility

to a specified individual, subcommittee or department and document this in its minutes.

- c. Ensures that the program meets all American College of Surgeons (ACoS) requirements as described in the current standards.
- d. Develops and evaluates the annual clinical and programmatic goals and objectives.
- e. Ensures that clinical/working and pathologic American Joint Committee on Cancer (AJCC) stage and prognostic indicators and evidence-based guidelines are utilized in treatment planning.

1.8 Utilization Management Committee

- 1.8.1. Chair: Medical Staff Member of any category appointed by the President of the Medical Staff with concurrence by the COO.
- 1.8.2. Membership: Medical staff from key specialties, as appointed by the Chair.
- 1.8.3. Duties: Provide oversight and direction to the hospital's utilization management staff to comply with the Medicare Conditions of Participation and report to the MEC.

All committees may meet jointly with other INWA hospitals if approved by the MEC at each participating hospital.

Section 4. Standing Committees

The MEC may as needed establish standing committees as needed.

Section 5. Special Committees

Special committees may be appointed by the Medical Staff President to address specific time-limited needs of the Medical Staff and the hospital/s. Special committees report to the MEC. Charters for special committees must be developed, including the duration, scope, and authority of the Committee; in most cases they will be chaired by members of the Active Staff. (Special committees may also be developed between one or more INWA hospital professional staffs.)

Section 6 External Committees

4.1 The Medical Staff President and the COO/s of the hospital/s may jointly appoint representatives of the Medical Staff to serve on committees external to the hospital/s which coordinate specific medical staff functions among local health care organizations. Such committees (such as the City-wide Infection Control Committee) may perform activities on behalf of the Medical Staff, but shall not engage in any activity which would be confidential or protected from discovery if conducted by a committee comprised only of members of the Medical Staff and/or persons appointed by the hospital/s.

4.2 The MEC may designate specific decision-making authority to a PH&S Committee or INWA regional committee when a central process promotes increased patient safety, quality, and coordinated care.

APPENDIX I – GENERAL AND DEPARTMENT PATIENT CARE RULES

A. GENERAL RULES

1. All members of the Active and Associate Medical Staff agree to provide for the continuous care of their hospitalized patients. Active and Associate Staff members must provide written documentation of call arrangements should their patients present to the Emergency Department for care.
2. At PHFH and PSHMC, Progress notes shall be recorded by the attending physician or his designee at the time of observation, at least daily, and shall be sufficient to allow continuity of care and transferability. The patient's clinical problems shall be identified and correlated with specific orders, results of tests and treatment. Rounding and progress note entry for patients who are medically stable and on custodial care, as designated by hospital policy, while awaiting placement for non-acute services will be seen at least every seven (7) days. Rounding may be more frequent if medical issues arise.

At PSLRMC inpatients will be evaluated by their attending physician at least three (3) days a week. A progress note shall be written by the attending physician (or properly credentialed designee) at the time of each visit in order to document the patient's condition and continuation of care.

3. Patients shall be seen by the attending physician, or his designee, within twelve (12) hours of admission, unless a clinical department specifically exempts this policy. Failure to do so shall be grounds for suspension.
4. Patients admitted to critical care units shall be seen by the attending physician or his/her assigned resident or APP designee within two (2) hours unless a clinical department specifically exempts this policy. If the attending physician cannot see the patient within the two-hour limit, the attending will contact an appropriate alternate practitioner who shall assume responsibility for the patient. If the patient is not seen within the stated time period, the clinical Department Chair, CMO or administrator on call will be contacted.
5. The attending physician shall be responsible for the medical care and treatment of his/her patients, for the medical record, for special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to the patient's family.
6. All credentialed practitioners must utilize the electronic health record (EHR) according to policy. Orders are entered electronically; verbal orders are only allowed when the physician is unable to immediately access computer resources. See *Epic Use and Training Policy* which includes detail regarding verbal orders, as adopted by the MEC.
7. Consultations by qualified practitioners shall be obtained for patients who have or develop conditions that are beyond the approved privileges of the attending practitioner. Emergency treatment can be initiated at any time. The medical record shall show evidence of timely review by the consultant and documentation of the consultant's findings and recommendations. While the patient has active issues pertaining to the consultant's area of expertise, the consultant will be continually available to the patient, the patient's family and the attending of record and shall document his or her input with regular progress notes. Should the patient's active issues pertaining to the consultant's area of expertise become quiescent, the consultant may formally sign off the case by documenting this in the medical record.
8. Consultation requests shall be made by personal contact from provider (physician or APP1) to provider (physician or APP1). (Exceptions to this may include policies and protocols for patient management as approved by the MEC.)
9. Transfer of care by the inpatient attending physician to another physician is not complete until a physician-to-physician contact has been made and the receiving physician has agreed to accept the transfer. Transfer is then accomplished by a

physician progress note in the medical record and a change in the electronic health record 'treatment team' data field.

10. Orders for treatment and/or medication shall be entered into the hospitals electronic health record (EHR). See the medical staff's approved *Verbal Order Policy*, which provides for certain exceptions, as well as the policy '*Orders: Authorization to Accept Telephone Orders*' regarding the professions who are approved to accept verbal orders.

Telephone orders from office personnel are not permitted.

Verbal orders must be signed within 48 hours of the order being given. Verbal orders may be signed by any member of the practice group, including ARNP's and PA's.

11. If an operative or procedure note is immediately entered into the electronic health record (by voice recognition or template) before the patient moves to the next level of care, a brief post-procedure note is not required. If the operative or procedure note is dictated, an immediate post-procedure note must be completed and shall contain a description of the findings, the technical procedure used, the specimen removed (if any), the estimated blood loss (if any), the post-operative diagnoses, the name of the primary surgeon or operator and the name/s of any assistant/s. Specifically, interventional radiology and Cath lab cases do not require documentation of specimen removed and estimated blood loss.
12. Operative and procedure reports should be completed immediately after surgery or invasive procedure, but in no case later than 24 hours following the procedure. The dictated transcription shall become part of the medical record as soon as it is available. See the Medical Records Completion and Suspension Policy approved by the MEC which outlines progressive consequences for failure to abide by this bylaw requirement.
13. Practitioners must use the approved formulary. The hospital and its providers delegate authority for formulary decision-making to the centralized PH&S formulary process, led by a representative PH&S formulary committee of experts in medicine, pharmacy, and nursing throughout the system and continuum of care, which ensures patients of Providence, and its affiliates are provided with safe, high-quality, and affordable medications throughout the continuum of care.
14. For patients with serious illness, practitioners are expected to discuss code status with the patient and family and to communicate the results of those discussions with the patient care team.
15. In the event of death, the patient shall be pronounced as deceased by the attending physician or physician designee. The body shall not be released until an entry has been made and signed in the medical record by the attending physician or physician designee. Exceptions are those instances of irreversible terminal

disease in which the patient's course has been documented within a few hours of death. Policies with respect to release of bodies shall conform to local law.

16. The attending practitioner shall attempt to secure autopsies when appropriate, particularly when death is under unusual circumstances, has medico-legal or educational interest, or as directed by statute. Autopsies shall be performed with proper consent. Provisional anatomic diagnoses shall be recorded in the medical record within three (3) days and the complete protocol within ninety (90) days.
17. Unless otherwise provided or contracted by the hospital/s, all members of the Active Staff shall participate in the Emergency Department call schedule as described in the policy: *'Emergency Department On-Call Coverage'*.
18. Each clinical department may establish further rules and regulations, including specifying activity guidelines upon which to assign practitioners to active or associate staff.
19. Each member of the Medical Staff and Allied Health Professional Staff is required to maintain current licensure and malpractice insurance coverage in the amount specified by the Board and to provide evidence of both in order to maintain membership and privileges.
20. Physicians, ARNP's, and PA's who are not members of the Medical Staff may refer patients to the Hospital for specific outpatient diagnostic tests and/or selected procedures. See policy approved by the MEC: Non-staff ordering outpatient tests and procedures.
21. The Chain of Command policy approved by the MEC guides the process for hospital staff resolving concerns regarding care provided by credentialed staff.
22. All credentialed providers must abide with PH&S policy (*Corrective actions – Integrity, Compliance, Privacy or Security*) and HIPAA requirements regarding accessing and releasing medical records. Non-compliance is subject to the medical staff disciplinary process.
23. All credentialed providers must comply with the Medical Staff Policy, *'Self-Treatment and Treatment of Family Members'*. Non-compliance is subject to the medical staff disciplinary process.

B. ADMISSION AND DISCHARGE

1. Patients shall be admitted to the Hospital with a provisional diagnosis or valid reason for admission and a statement of intent as to inpatient or outpatient status. In an emergency, such statement shall be recorded as soon as possible. PSLRMC shall accept patients based upon admission criteria developed for each rehabilitative program available.

2. Informed consent shall be obtained prior to each special treatment or invasive procedure
3. Patients shall be discharged upon the order of the attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, the patient shall be requested to sign a release. Information on the incident shall be recorded in the medical record.
4. Provisional diagnoses shall be recorded in full by the attending practitioner at the time of discharge.

C. MEDICAL RECORDS

1. Article III, Section 2, Obligations of Credentialed staff outline the specific requirements for the admission history and physical to meet safe patient care and regulatory requirements. See also medical staff *History and Physical Policy*.

2. The medical record shall contain sufficient information to accurately identify the patient, support the diagnosis, justify the treatment, and document the course and results.

3. A discharge summary shall be provided for all patients hospitalized over 60 hours except for normal obstetrical deliveries, normal newborns, and certain categories of patients identified by the Executive Committee. For patient stays 60 hours and under, a final discharge progress note shall be documented.

4. Discharge summaries should be completed within 24 hours of discharge, but in no case later than 72 hours from time of discharge. See the Medical Records Completion and Suspension Policy approved by the MEC which outlines progressive consequences for failure to abide by this bylaw requirement.

5. All practitioners shall utilize the hospital's electronic health record according to hospital and medical staff policy. (See medical staff policy: *Epic Use and Training*.) Practitioners must use system-approved clinical order sets when available. The hospital and its providers delegate clinical order set development, review, revision, and approval to Providence Health & Services System and affiliate clinical expert collaboration groups, such as Clinical Program Services institute focus groups and clinical decision teams. Clinical practice guidelines and standardized order sets are considered approved by the hospital's medical staff upon approval by designated review expert groups. When a new/revised order set has been approved, PH&S is responsible to communicate these updates to clinical caregivers. If the MEC has concerns or feedback regarding order sets, the MEC or designee can communicate with clinical expert collaboration leaders for consideration.

Medical record suspension will occur whenever any portion of the patient's health record remains incomplete for more than 31 days, or coding queries are not

responded to in time frames approved by the Medical Executive Committee. (See specific requirements for H&P's, operative and procedural notes, and discharge summaries which may also result in an automatic transfer to inactive status pending completion of the required element.) Refer to the *Medical Records Completion and Suspension Policy* for details regarding the medical record completion notification process, as well as enforcement by the Medical Executive Committee.

Physicians are responsible to assure medical record completion by their sponsored midlevel providers.

Medical record suspension will suspend the practitioner's admissions or scheduling of surgical cases or procedures until medical records have been brought up to date. See the Medical Records Completion and Suspension Policy for additional clarifications.

A 24-hour exemption from medical record suspension of privileges may be granted to a physician who is managing an emergency situation. The exemption will be for the emergency situation only and will not extend to other hospitalized, scheduled or non-emergent patients. The physician is responsible to obtain authorization for the emergency exemption from the Chief Medical Officer or his designee.

When all delinquent records have been completed, the physician will be automatically returned to the status that was in effect prior to the suspension and all privileges (admitting and clinical) will be reinstated.

Providers with pattern of medical record suspensions must provide a plan to the MEC for managing their medical record obligations.

The MEC may suspend all privileges, elective or emergent, for continuing medical record delinquency issues. According to the fair hearing plan, this full suspension of privileges takes effect at all INWA hospitals, and full suspensions which remain in place for more than 30 days are reportable to the National Practitioner Data Bank and to the State. See the Medical Records Completion and Suspension Policy approved by the MEC which outlines progressive consequences for failure to abide by regulatory requirements, bylaws, or medical staff policies relating to completion of medical records. In the case of a full suspension of privileges, a fine may also be imposed to return a staff member to his/her prior privileges after medical records are verified as complete.

6. Medical records shall not be permanently filed until completed or ordered filed by the Executive Committee in extraordinary circumstances.

D. EMERGENCY DEPARTMENT (ED)

1. Any patient admitted on an emergency basis who does not have a private practitioner may request any appropriate member of the Active Staff. If this

practitioner is not available, or if a preference is not indicated, a member of the Active Staff shall be assigned to the case based on the Emergency Department on-call schedule.

2. Any person seeking evaluation and treatment in the Emergency Department is entitled to a medical screening exam. Someone acting on the person's behalf may also request medical care. The medical screening exam must be performed by an emergency physician, emergency physician assistant, an ARNP, or an attending physician credentialed through the medical staff. Additionally, for purposes of the obstetrical service, the qualified medical personnel able to perform the medical screening exam may be a designated and trained labor and delivery registered nurse.
3. After patients requiring admission are evaluated in the Emergency Department, their primary or specialty care provider or their designated hospitalist shall be contacted, unless other arrangements have been made in advance. If the attending practitioner or designated alternate cannot be reached in twenty (20) minutes, the ED may contact the appropriate primary or specialty provider based on the ED on-call schedule.
4. A medical record shall be kept for each patient receiving emergency services and it shall become part of the patient's permanent record. The emergency record shall include:
 - a. Adequate patient identification.
 - b. Time of arrival, means of arrival, and by whom transported.
 - c. History of injury or illness including details of first aid or emergency care given prior to arrival.
 - d. Description of clinical, laboratory and radiologic findings.
 - e. Diagnoses.
 - f. Description of treatment given.
 - g. Condition on discharge or transfer; and
 - h. Final disposition, including written instructions given to the patient or responsible adult for follow-up care.
5. Patients admitted to the hospital will have all emergency department documentation complete within 24 hours; all other emergency room documentation must be complete within 48 hours.
6. There shall be a monthly review of Emergency Department medical records to evaluate the quality of emergency medical care. There shall be periodic summary reports of this peer review function to the Medical Executive Committee.
7. There shall be a plan for care of mass casualties in the event of a major disaster in conjunction with other emergency facilities in the community. In such circumstances, members of the Medical Staff agree to relinquish direction of the clinical care of their patients to the clinical Department Chair or designee.

E. LABORATORY MEDICINE

1. The Department of Laboratory Medicine recommends that permission to perform an autopsy be obtained for a death in which the cause is not known with certainty on clinical grounds and/or an autopsy may help explain unknown and unanticipated medical complications. The hospital's *Comprehensive Autopsy Policy* summarizes current recommendations for consideration of autopsy as well as required authorization. The Medical Staff Policy, Autopsy Criteria, amplifies the process of review of autopsy results.

Autopsy information, when available, is incorporated into the hospital's medical/surgical death review process. In order to facilitate this quality improvement function, preliminary autopsy diagnoses will be entered into the medical record within three days. A final report will be available within 30 days, unless the complexity of the case necessitates special studies and/or consultations. In these cases, the final report may take up to 60 days.

F. OBSTETRICS

1. The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record with an interval admission note that includes pertinent additions to the history and changes in the physical findings (refer to General and Department Patient Care Rules, Medical Records, Rule #3 for discharge summary requirements).

G. Physical Medicine and Rehabilitation (PSLRMC only)

1. The patient shall be admitted to the Hospital only by a member of the Active Medical Staff with admission privileges, or as designated a member of the Consulting Medical Staff providing coverage. All practitioners shall be governed by the official admitting.
2. Prior to admission to the Institute, a licensed or certified clinician (or group of clinicians) must conduct the preadmission screening within 48 hours of the actual admission to Providence St. Luke's Rehabilitation Medical Center. A rehabilitation physician must review and concur with the findings and results of the preadmission screening after the screening has been completed and prior to the IRF admission. The rehabilitation physician's review and concurrence must be documented by himself or herself prior to the IRF admission. Further, since these documents document the decision-making of the rehabilitation physician, this review and concurrence may not be delegated to an Advanced Practice Provider. Additionally, a rehabilitation physician consultation note may serve as the preadmission screening as long as the rehabilitation physician consultation note contains the required information and is completed within the 48 hours immediately preceding the IRF admission (or is completed more than 48 hours immediately preceding the IRF admission and is updated within the 48 hours immediately preceding the IRF admission).
3. Order to admit the patient and admission diagnosis order will be provided by the admitting physician, or by the Advanced Practice Provider with countersignature by the supervising physician at the time of admission.

4. An overall Plan of Care must be completed by the end of the 4th day immediately following the IRF admission by the SLRI Rehabilitation Physician. The purpose of the overall Plan of Care is for the rehabilitation Physician to bring together all of the information that has been collected on the patient's medical and functional treatment needs and goals in the beginning of the IRF stay, and to synthesize this information into an overall plan of care that will guide the patient's treatment during the IRF stay. Advanced Practice Providers working in collaboration with the rehabilitation physician can assist the rehabilitation physician in developing the overall plan of care for his or her approval and signature.

G. PSYCHIATRY (PSHMC only)

1. Prior to initiating electroconvulsive therapy for a patient under the age of 18, consultation shall be obtained from one child psychiatrist not involved in the care of the patient and a psychiatrist with ECT privileges. The consultants shall examine the patient, consult with the attending psychiatrist, and document in the medical record their concurrence with the decision to administer such therapy.

H. SURGERY

1. A history and physical as outlined in C.1., including updates, must be recorded in the medical record by the surgeon or proceduralist or their designee prior to surgery or a procedure requiring anesthesia, unless the attending practitioner states in writing that performing the history and physical would cause a detrimental delay in care to the patient.
2. A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.
3. A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services.
4. Preoperative diagnosis and required laboratory test results must be recorded on the medical record prior to a surgical procedure. If not recorded, the procedure shall be canceled. In an emergency, the practitioner shall record a comprehensive note regarding the patient's condition following the procedure.
5. Specimens removed during a surgical procedure shall be sent to the Hospital's Pathology Department for evaluation, and the report shall become part of the medical record. The Surgery Department, in consultation with the Pathology Department, may make exceptions.
6. Surgeons shall be in the operating room and ready to commence surgery at the time scheduled.

7. Dentists/Podiatrists: Patients admitted for dental and/or podiatric care are the dual responsibility of the dentist/podiatrist and a Doctor of Medicine/Osteopathy. Oral surgeons who have demonstrated competency and have been granted the specific privilege may perform an admission history and physical examination. PSHMC and PHFH only: Podiatrists may be granted privileges to perform the H&P and required update for outpatient surgical procedures on American Society of Anesthesia (ASA) Category 1 and 2 patients; this may cover overnight admission for pain management. A current H&P for outpatient procedures may be accepted from a provider not currently credentialed. See 'History and Physical' policy approved by the MEC.

Dentists/podiatrists responsibilities are to provide:

- a. Detailed dental/podiatric history justifying admission.
- b. Detailed description of examination and pre-operative diagnosis.
- c. Complete operative report describing the findings and technique.
- d. Progress notes and daily orders for care.
- e. Written order for discharge.

Attending practitioner's responsibilities (inpatients):

- a. Medical history pertinent to the patient's general health.
- b. A physical examination to determine the patient's condition prior to surgery; and
- c. Supervision of the patient's general health status while hospitalized.

I. MEDICAL EDUCATION AND GRADUATE MEDICAL EDUCATION

1. The Spokane Teaching Health Center Graduate Medical Education Committee (STHC GMEC) oversees resident education in Spokane in compliance with the Accreditation Council for Graduate Medical Education (ACGME) Institutional, Common and Specialty-specific Program Requirements. Effective communication between the GMEC and the Medical Staff and Board is achieved by reporting at least annually and more frequently if needed, by the GMEC chair to the MEC and Board. This report includes information regarding the safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of the participants in the programs. One or more members of the INWA executive staff also serve as members of the GMEC.
2. The appointed Director of Medical Education is responsible for oversight of the hospital-based professional graduate medical education programs. Each program also must have a Medical Director.
3. All graduate medical education programs must be approved by the ACGME.
4. Resident staff shall be supervised by the Director of each residency program, the faculty of the residency program and/or the attending staff physician of the patient/s for whom he or she is caring. Each program designates the supervision level and progression of patient care activities delivered by the resident and this summary is available electronically to hospital staff.
5. The '*Resident Scope of Practice*' policy of the Medical Staff provides additional

detail regarding the activities of residents within the Hospital. This is available in Medical Staff Services and on the PSHMC Intranet.

6. GME policies and procedures are approved by the GMEC and are available for staff review on the PSHMC Intranet.
7. Members of the Medical Staff who elect to participate in the graduate medical education program receive from the respective graduate medical education program the specific requirements for supervision. Those policies include minimum standards for chart documentation and co-signature requirements.
8. The supervising attending (whether the attending of record or consultant) supervises the resident and is ultimately responsible for the patient care delivered by the resident/s. The supervising attending physician must be an active or associate member of the Medical Staff and may supervise only those activities for which they themselves are credentialed to perform in the Hospital.
9. Members of the Resident Staff may write patient care orders as specified by each program. The attending practitioner shall review all orders with the resident on a timely basis and may add further orders. Requirements for countersignature are defined by each program.
10. *The Guidelines on Medical Student Clerkships*, as approved by the GMEC, define the process for authorization and supervision of medical students in the Hospital.
11. All requests for visiting medical student and resident experience must be approved through the GME office.

J. PEER REVIEW PROCESS


1. The Professional Practice Evaluation/Peer Review Process, as approved by the Medical Executive Committee and Board outlines the current methods for case review, focused and ongoing monitoring, behavior management, and practice improvement, and as such, those documents are considered part of these Bylaws.

Bylaws Of
THE MEDICAL STAFF OF
PROVIDENCE HOLY FAMILY HOSPITAL
and
PROVIDENCE SACRED HEART MEDICAL CENTER
and
PROVIDENCE ST. LUKE'S REHABILITATION MEDICAL CENTER

This document replaces Bylaws and Appendices last approved by the Unified Medical Staff of Providence Holy Family and Providence Sacred Heart Medical Center on March 8, 2022.

BYLAWS AND APPENDICES APPROVED by the Medical Staff on August 1, 2022.

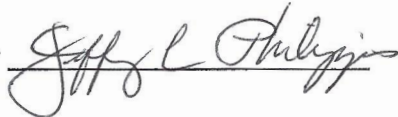
Unified PHFH/PSHMC President of the Medical Staff:



Nolan McMullin, MD

BYLAWS AND APPENDICES APPROVED by the Board on 08/24/2022

Inland Northwest Washington Community Ministry Board Chair



Jeffery L. Phillips