BYLAWS, RULES AND REGULATIONS

OF THE MEDICAL STAFF

OF SEATTLE CHILDREN'S HOSPITAL

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BYLAWS, RULES AND REGULATIONS

OF THE MEDICAL STAFF

OF SEATTLE CHILDREN'S HOSPITAL

PREAMBLE

These Bylaws are adopted in order to provide for the organization of the Medical Staff of Seattle Children's Hospital (the "Hospital") and to provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes. The Board of Trustees of the Hospital has asked the Physicians, Dentists, and Clinical Psychologists practicing on its Medical Staff (the "Medical Staff") to participate in overseeing the quality of medical care and the standards of practice at the Hospital. The best interests of patients of the Hospital will be protected by carrying out this responsibility in an organized manner as an integral part of the overall Hospital governance structure, subject to the ultimate authority of the Board of Trustees.

Only Members duly appointed by the Board of Trustees to the Medical Staff shall be permitted to independently provide care to patients in the Hospital or in an Ambulatory setting. These Bylaws are to be constructed in conformity with applicable hospital licensing laws, applicable accreditation guidelines, and regulatory requirements. They do not constitute an express or implied contract between or among any individual, committee, or entity, unless otherwise expressly determined by state law.

DEFINITIONS

1. ALLIED HEALTH PROFESSIONAL or AHP means an individual, other than a licensed physician or dentist who by licensure exercises independent judgment within the areas of his or her professional competence and the limits established by the Medical Staff, the Board of Trustees, and the applicable state practice acts.

2. APPLICANT means an individual applying for appointment or reappointment to the Medical Staff.

3. ARNP means an Advanced Practice Registered Nurse Practitioner.

4. BOARD OF TRUSTEES or BOARD means the governing body of Seattle Children's Hospital.

5. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted by the Medical Executive Committee and the Board of Trustees to a Member of the Medical Staff to render specific patient services, based on the Member's professional license and documented competence, experience, and judgment.

6. CLINICAL PSYCHOLOGIST means an individual who has received a Doctoral Degree in Psychology (Ph.D.) from an American Psychological Association (APA) accredited graduate program, has completed an accredited internship and has a currently valid, unrestricted license to practice.

7. COMPLETED APPLICATION means an application, either for initial appointment or reappointment to the Medical Staff or for clinical privileges, as determined by the applicable Medical Staff Division(s), Department(s), Credentialing and Professional Standards Committee, Executive Committee, and Board to meet the requirements of these Bylaws and Rules and Regulations, and to contain sufficient information to act upon the application.

8. DATE OF RECEIPT of any notice or other communication shall be deemed to be the date it was received by personal delivery or, if sent by mail, five working days after it was deposited in the United States mail, postage prepaid.

9. DAYS means calendar days, unless otherwise specified as working days.

10. DENTIST means an individual who has received the Degree of Doctor of Dental Surgery or Dental Medicine and has a currently valid, unrestricted license to practice.

11. DEPARTMENT means a clinical service of the Medical Staff, grouping Members in accordance with their specialty or major practice interest as specified in Section R8 of the Rules and Regulations. The Medical Staff Department is not necessarily the same as the Hospital operating department or an equivalent department at the University of Washington School of Medicine.

12. EX-OFFICIO means to serve as a Member of a body by virtue of an office or position held and, unless otherwise expressly provided, without voting rights.

13. EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff, which shall constitute the governing body of the Medical Staff described in these Bylaws.

14. HE, HIS or HIM means “he or she,” “his or hers,” or “him or her” and are intended to refer to an individual without respect to gender.

15. HOSPITAL means Seattle Children’s Hospital located in Seattle, Washington and regional locations covered under the hospital license.

16. MEDICAL DIRECTOR means a Practitioner employed by, or otherwise engaged by, the Hospital on a full time basis, whose duties include certain responsibilities that are both administrative and can be clinical in nature. Clinical responsibilities may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner's direction. Administrative activities include responsibility for the quality of clinical care provided by members of the Medical Staff and its departments.

17. MEDICAL STAFF or STAFF means those physicians (M.D. or D.O.), dentists, and clinical psychologists who have been appointed Members of the Medical Staff and are privileged to provide patient care services in the Hospital within the scope of their licensure and approved clinical privileges, pursuant to the terms of these Bylaws.

18. MEDICAL STAFF YEAR means the period from October 1 to September 30.

19. MEMBER means, unless otherwise expressly limited, any Physician (M.D. or D.O.), Dentist or Clinical Psychologist holding a current license to practice within the scope of his or her license and who is appointed to the Medical Staff.

20. NP means licensed nurse practitioner.

21. PA means licensed physician assistant.

22. PHYSICIAN means an individual, possessing either a M.D. or D.O. degree, with a currently valid and unrestricted license to practice medicine in all its phases in the State of Washington.

23. PREROGATIVE means a participatory right granted, by virtue of staff category or otherwise, to a Member or AHP and exercisable subject to the conditions imposed in these Bylaws and in other Hospital and Medical Staff policies.

24. PRESIDENT OF THE MEDICAL STAFF means a Member of the active Medical Staff who is elected in accordance with these Bylaws to serve as Chief Officer of the Medical Staff of this Hospital.

25. SERVICE AUTHORIZATION means the permission granted to an allied health professional to participate in the provision of certain patient care services.

26. SPECIAL NOTICE means written notification sent by certified or registered mail, return receipt required, unless otherwise expressly provided.

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ARTICLE 1

1.1 Name

The name of the Medical Staff shall be "The Medical Staff of Seattle Children's Hospital."

ARTICLE 2

2.1 Purposes

The purposes of the Medical Staff shall be:

2.1.1 To ensure the delivery of the highest level of quality care to all patients admitted to the Hospital or treated in its ambulatory and regional sites consistent with the state of the healing arts and the resources locally available.

2.1.2 To continuously improve the quality of care including patient safety, effectiveness, efficiency, the patient and family experience, and the equity of care for all patients admitted to or treated in the hospital or in its ambulatory and regional sites.

2.1.3 To provide graduate, post-graduate and continuing education and maintain educational standards.

2.1.4 To support and promote medical research while maintaining and assuring appropriate protection to our human subjects.

2.1.5 To be accountable to the Board for the appropriateness of the professional performance and ethical conduct of its Members.

2.1.6 To initiate and maintain such rules and regulations and internal organization necessary to allow the Medical Staff to discharge its responsibility within the Hospital in an organized fashion.

2.1.7 To advise the Board of Trustees and Hospital Administration on any matters of a Medical or Medico-Administrative nature, including assisting the Hospital and its ambulatory sites with its Compliance Plan.

ARTICLE 3
MEMBERSHIP AND DELINEATED CLINICAL PRIVILEGES

3.1 Qualifications

Qualification is based on education, training and experience. To be a Member of the Medical Staff of Seattle Children's Hospital, an individual must be:

3.1.1 A graduate of a Liaison Committee on Medical Education (LCME) recognized school of medicine, dental medicine or osteopathy, or an allied health program. Exception requests will be considered and determined on the basis of equivalence of training to U.S. training programs.

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3.1.2 Legally licensed to practice in the State of Washington, and other sites as required for approved sites of practice. (See exception under Article 4.3 regarding Exempt Staff.)

3.1.3 Adequately experienced, educated, and trained, professionally competent, possessing good judgment and adequate physical and mental health, so as to demonstrate to the satisfaction of the Division Chief, Department Director, Medical Staff and the Board of Trustees that the individual is professionally and ethically competent to carry out any and all of the clinical privileges requested.

3.1.4 Determined, on the basis of current documented references and/or observed practices, to adhere to the ethics of the individual's profession, to be able to work cooperatively with others (including Members, AHPs, Hospital employees, Hospital management, patients and patients' families) in the care of patients, to refrain from disruptive behavior that interferes with patient care or the orderly operation of the Hospital, and to be willing to participate in and properly discharge those responsibilities determined by the Medical Staff and the Board of Trustees.

3.1.5 Willing to adhere to these Bylaws and Rules and Regulations of the Medical Staff, and the Principles of Medical Ethics of the American Medical Association, the Code of Ethics of the American Dental Association, by such principles or ethics as may be applicable for other specific allied professionals (such as Ethical Standards of the American Psychological Association) as well as the Hospital's ethical standards contained in its Code of Ethical Behavior and its Compliance Plan, and the approved Hospital Policies and Procedures.

3.1.6 Especially interested, involved and qualified by reason of training and/or experience in the care of infants, children, adolescents or other patients that are within the scope of their practice and approved privileges, and cared for in the hospital.

3.1.7 Protected by professional liability insurance in the amount required by the Hospital and with an insurer acceptable to the Hospital.

3.1.8 In possession of a Drug Enforcement Agency (DEA) certificate as required by the profession and approved privileges. DEA must be specific to each site of practice.

3.2 Discrimination / Harassment Prohibited

Discrimination and/or harassment by members of the Medical Staff is prohibited as outlined in the Hospital Policy and the Medical Staff's Rules and regulations.

3.3 Provisions Regarding Application for Membership and Granting\Renewal of Privileges

3.3.1 All applicants, including those serving in an administrative capacity for the Hospital, must provide a completed application to be considered for Medical Staff membership or privileges.

3.3.2 Until notice is received from the Board of Trustees regarding final action on an application for appointment, reappointment or new clinical privileges, the applicant shall be responsible for keeping the application current and complete by informing the Medical Staff, in writing, of any change in the information provided or new information that might reasonably have an effect on the applicant's candidacy.

3.3.3 An application that, at any time prior to the final action of the Board of Trustees with respect to such application, is determined to be incomplete shall not qualify for a credentialing recommendation (regardless of any assessment or determination that may have been made as to its completeness at any earlier stage in the process). Should the applicant fail to make the application complete after a period of 120 days the application shall be deemed withdrawn and the credentialing process shall be terminated. Termination of the credentialing process under this provision shall not entitle the applicant to review or appeal rights pursuant to Article X of these Bylaws.

3.3.4 All appointments shall be made by the Board of Trustees for an initial provisional period of one year, thereafter reappointments are for a period of two years, or as otherwise specified by the Board.

3.3.5 Biennially, the Board of Trustees shall consider all present Members of the Medical Staff and may reappoint any or all Members of the Medical Staff and approve their specific privileges to practice at the hospital.

3.3.6 Appointment and reappointment to the Medical Staff shall confer upon the appointee only those privileges defined and granted by the Board of Trustees, upon recommendation of the Medical Executive Committee and Joint Conference Committee.

3.3.7 The Medical Executive Committee, after review by the Joint Conference Committee, shall make recommendations to the Board of Trustees on all staff appointments and reappointments. On any case in which the Board of Trustees decision is inconsistent with the Medical Executive Committee's recommendations, the Board of Trustees will confer with the Medical Executive Committee through the Joint Conference Committee with respect to the reasons for its decision prior to final action. After discussion at the Joint Conference Committee the application will either be sent back to the Medical Executive Committee for further discussion or forwarded to the Board of Trustees for final action.

3.4 Initial Appointments to the Medical Staff

Initial appointments to the Medical Staff, except Honored Staff, shall be Provisional for a period of one year from the time of appointment and may be extended to a maximum of two years by approval of the Medical Executive Committee and concurrence of the Board.

3.5 Mechanism for Appointment and Reappointment to the Medical Staff

3.5.1 Applications shall be directed to the Medical Executive Committee, on a form provided by the Medical Staff Services Department, which shall require detailed statement of qualifications and references by the applicant. The specific process for appointment and reappointment is defined in the Rules and Regulations of the Medical Staff and its office.

3.5.2 The Board of Trustees shall consider the recommendation of the Medical Executive Committee and the Joint Conference Committee and, subject to the provisions of Article 3.3.7, either approve or disapprove the Applicant, or refer the application back to the Medical Executive Committee for further consideration.

3.5.3 When final action on an application has been taken by the Board of Trustees, a representative of the Board shall be authorized to transmit this decision to the applicant. Definite terms of appointment, or reappointment, shall be designated as well as the term of any Hospital and Clinic privileges, staff category, and clinical department assignments.

3.6 Failure to Submit Reappointment Application

3.6.1 A Practitioner who fails to submit a reappointment application, with the specified documentation before the established due date, shall be deemed to have resigned, effective immediately, as provided in these Bylaws. A Practitioner who fails to render a timely and complete application after being given an opportunity to respond to a request for additional information or assistance, and in consultation with the member's Department Director, shall be deemed to have withdrawn the application, and resigned as of the deadline given for the submission of the information. A Practitioner who is deemed to have resigned under this section may reapply for Medical Staff membership at any time as a new Applicant.

3.6.2 The Medical Executive Committee shall have the discretion to accept and consider information or comments on any issue, but there shall be no hearing rights pursuant to Article 10 for expirations or deemed resignations of Medical Staff membership and/or Clinical Privileges, or for the denial of temporary privileges, pursuant to this Section.

3.7 Reapplication After Adverse Appointment Decision Denying Application, Adverse Corrective Action Decision, Or Resignation In Lieu Of Medical Disciplinary Action

3.7.1 A waiting period of thirty-six (36) months shall apply to the following situations:

3.7.1.1 An applicant has received a final adverse decision regarding appointment.

3.7.1.2 An applicant who withdrew the application following an adverse recommendation by the Medical Executive Committee.

3.7.1.3 A former Medical Staff Member whose Staff membership and clinical privileges were terminated involuntarily.

3.7.1.4 A former Medical Staff Member who resigned from the Medical Staff following an Medical Executive Committee recommendation to terminate the Member's membership or privileges.

3.7.1.5 A Medical Staff Member who has received a final adverse decision resulting in termination of clinical privileges.

3.7.2 The waiting period will begin when the decision becomes final, which shall occur upon the date of the completion of all hearing, appellate review, and other proceedings conducted by the Hospital and all judicial proceedings bearing on the decision.

3.7.3 Actions which are not considered adverse for the purpose of this section include such actions as those based upon a failure to live geographically close to the Hospital or retirement from active medical practice, to pay dues, (which can be cured by paying dues); to maintain liability insurance (which can be cured by securing the insurance), to maintain medical or DEA licensure, complete Board certification within the required five year time period, or to maintain Board certification.

3.7.4 After the waiting period, the applicant or Member may reapply; however, any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists and/or that the Practitioner has complied with any specific requirements that the adverse decision may have included.

3.8 Granting and Renewal of Clinical Privileges

The granting and renewal of clinical privileges is Hospital-specific and based on evidence that the individual has provided and is likely to provide excellent clinical care, current competence and physical and mental capacity to perform functions inherent to the clinical privileges requested as well as relevant training/experience, current licensure, active board certification or certification within the prescribed time period. In addition privileges are site-specific within the Hospital and are dependent upon the physical capabilities and staff training and expertise on each clinical unit. Recommendations regarding requests for clinical privileges are forwarded to the Medical Executive Committee by the appropriate Division Chief and Department Director. Final recommendations are forwarded by the Medical Executive Committee to the Board of Trustees for approval.

Requests to add or modify clinical privileges will be subject to the process described above.

The appropriate Division Chief and Department Director reviews and forwards their recommendations to the Medical Executive Committee for all requests to withdraw clinical privileges. Final recommendations are forwarded by Medical Executive Committee to the Board of Trustees for approval.

Further details on granting and renewal of clinical privileges are set forth in the Rules and Regulations and are adopted and incorporated herein by this reference.

3.9 Provisions of Appointment

3.9.1 Authorization and Conditions.

By applying for or exercising Clinical Privileges, or providing specified patient care services within this Hospital, a Practitioner:

3.9.1.1 Authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing on his/her professional ability and qualifications.

3.9.1.2 Agrees to be bound by the provisions of this Article and to waive all legal claims, to the fullest extent permitted by law, against any representative who acts in accordance with the provisions of the Article.

3.9.1.3 Acknowledges that the provisions of this Article are express conditions to his/her application for, or acceptance of, Staff membership and continuation of such membership, or to his/her exercise of Clinical Privileges or provision of specified patient services at this Hospital.

3.9.1.4 Agrees to adhere to medical records documentation requirements, including medical histories and physicals, as outlined in the Rules and Regulations and Hospital policies.

A medical history and physical examination shall be completed no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician or other qualified licensed independent individual in accordance with Washington laws and Medical Staff and Hospital policy.

When the medical history and physical examination is completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient with 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician or other qualified licensed individual in accordance with Washington laws and Medical Staff and Hospital policy.

Further details on history and physical requirements are set forth in the Rules and Regulations and are adopted and incorporated herein by this reference.

3.9.2 Confidentiality of Information.

3.9.2.1 Information with respect to any Practitioner submitted, collected or prepared by any individual or any representative of this or any other health care facility, organization or Medical Staff for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research shall, to the fullest extent permitted by law, remain confidential. Such information shall not be disseminated to anyone other than a representative of the Hospital or Medical Staff, nor used in any way except as provided herein or except as otherwise required by law. This information shall not become part of any particular patient's file or of the general Hospital records.

3.9.2.2 Inasmuch as effective peer review and consideration of the qualifications of Members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff divisions or committees is prohibited and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Executive Committee may undertake such corrective action as it deems appropriate. Notwithstanding the foregoing, disclosure of confidential information is permitted pursuant to court order, and under limited circumstances to aid in the investigation of peer review bodies of other hospitals, professional societies, licensing authorities, and governmental agencies.

3.9.3 Immunity From Liability.

3.9.3.1 For action taken: To the fullest extent permitted by law, no representative of the Hospital or Medical Staff shall be liable to a Practitioner or AHP for damages or other relief, for any action taken or statements or recommendations made within the scope of /her duties exercised as a representative of the Medical Staff or Hospital.

3.9.3.2 For providing information: To the fullest extent permitted by law, no representative of the Hospital or Medical Staff and no third party shall be liable to a Practitioner or AHP for damages or other relief, by reason of providing information, including otherwise privileged or confidential information, to any health care facility, organization of health professionals, professional society or licensing authority concerning a Practitioner or AHP who is or has been an Applicant to, or a Member of, the Medical Staff, or who did or does exercise Clinical Privileges or provides specified services at the Hospital.

3.9.4 Activities and Information Covered.

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

3.9.4.1.1 Applications for appointment, Clinical Privileges or specified services.

3.9.4.1.2 Periodic reappraisals for reappointment, Clinical Privileges or specified services.

3.9.4.1.3 Corrective action.

3.9.4.1.4 Hearings and appellate reviews.

3.9.4.1.5 Patient care audits.

3.9.4.1.6 Quality or performance improvement activities, meetings, and reports.

3.9.4.1.7 Utilization reviews.

3.9.4.1.8 Peer review.

3.9.4.1.9 Other Hospital, Department, Medical Staff, or Committee activities related to monitoring and enhancing quality patient care and appropriate Medical Staff conduct.

3.9.4.2 Information: The acts, communications, reports, recommendations, disclosures and other information referred to in this Article may relate to a Practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or any other matter that might affect patient care.

3.9.5 Releases.

Each Practitioner shall, upon request of the Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article, subject to such requirements as may be applicable under the laws of this State. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

3.9.6 Cumulative Effect.

Provisions in these Bylaws and in application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof. In the event of conflict, the applicable law shall control.

3.10 Adverse Actions Based on Professional Competence or Conduct

Prior to making an adverse recommendation regarding appointment, reappointment or requested Clinical Privileges pursuant to Section 3.7 or Section 3.8 above, based on professional competence or conduct, the Medical Executive Committee shall give the Applicant a summary of its concerns and an opportunity to address them in writing or at a meeting. If the Medical Executive Committee then decides to go forward with the adverse recommendation, the Applicant shall be so notified and afforded the hearing rights described in Article 10. The issues at the hearing need not be limited to those already raised with the applicant, as long as the Applicant is given a fair opportunity to address all of the issues at the hearing. The Board of Trustees shall be informed of the Medical Executive Committee's adverse recommendation, but shall refrain from taking action until the Applicant's hearing rights have been either waived or exhausted.

3.11 Adverse Actions Based on Reasons Other Than Professional Competence or Conduct

3.11.1 The Medical Staff or the Board of Trustees may decline to consider or may deny an application for appointment, reappointment or Clinical Privileges for reasons other than the Applicant's professional competence or conduct, including, but not limited to:

3.11.1.1 Failure to meet established credentialing criteria that prescribe residency training or active board certification in a given specialty or other objective qualifications.

3.11.1.2 Failure to maintain adequate levels of professional liability insurance as required;

3.11.1.3 Suspension, revocation, failure to renew or any other action adversely affecting the Member's professional license or DEA certificate;

3.11.1.4 Imposition of sanctions or any other penalty or restriction imposed under the Medicare or Medicaid programs or the hospital Compliance Program;

3.11.1.5 Failure to complete medical records in a timely manner as required by the Medical Informatics/Records Committee Rules and Regulations;

3.11.1.6 Lack of sponsorship by, or affiliation with, a person or entity holding an exclusive right to cover or provide the services involved at this facility.

3.11.1.7 Any other hospital administrative considerations, including, but not limited to, lack of available positions, facilities or support personnel or

3.11.1.8 Institutional decision not to provide or accommodate the type(s) of services involved.

3.11.2 This Section may be invoked by the appropriate Department Director, the Credentialing and Professional Standards Committee, the Medical Executive Committee, or the Board of Trustees. Adverse actions shall not give rise to hearing rights as described in Article 10. An Applicant who wishes to challenge an action that has been initiated by a Department Director, the Credentialing and Professional Standards Committee, or the Medical Executive Committee may request review by the Medical Director, who shall determine what, if any, further proceedings are warranted and make a final decision. The Medical Director may, but shall not be obligated to, submit the matter to the Board of Trustees for a final decision at that level. An Applicant who wishes to challenge an action that has been initiated by the Board of Trustees may request reconsideration, and the Board of Trustees will determine what, if any, further proceedings are warranted and make a final decision.

ARTICLE 4
THE MEDICAL STAFF

The Medical Staff and other professional personnel will be appointed to the following categories, as appropriate:

4.1 Active Staff

4.1.1 The Active Staff shall consist of Physicians and Dentists, actively involved in caring for the health needs of children, and who have been appointed to perform the duties of the Medical Staff pursuant to Article III of these Bylaws. Clinical Psychologists and other independently licensed practitioners who qualify for staff membership may also be considered for active membership through the normal application process for Active Staff as outlined in the Rules and Regulations.

Active medical staff membership is only available to applicants and members who are able to provide safe and timely patient care at Children's approved sites of practice and to participate in hospital, department and Committee activities and appointments consistent with their role.

4.1.2 Only Members of the Active Staff shall be eligible to vote and hold office in the Medical Staff organization.

4.1.3 Members of the Active Staff shall be expected to attend regularly and participate actively in Department and Medical Staff activities as outlined in these Bylaws, Rules and Regulations, and division/department rules and regulations. Active Staff Members shall be expected to serve on Committees of the Hospital and Medical Staff when requested. Failure to meet these obligations may constitute grounds for changing the Medical Staff category of such Member. The Medical Executive Committee shall enforce this obligation, following its consultation with the appropriate Department Director(s), Committee Chairs or hospital leadership.

4.1.4 Granting and renewal of Active Medical Staff membership and clinical privileges shall be contingent on satisfactory review by the Division Chief, Department Director, Credentialing and Professional Standards Committee, Medical Executive Committee, Joint Conference Committee and the Board of Trustees of quality measures relevant to each active member's scope of practice and clinical privileges. Specific review criteria are established for each Department with the approval of the Medical Executive Committee.

4.2 Consulting Staff

4.2.1 The Consulting Staff shall consist of regionally recognized specialists who provide care of a more episodic nature at Children's, are invited to consult, and who have signified willingness to accept appointment, and whom the Medical Executive Committee may consider worthy of appointment. A written recommendation by the Program Chief or Division Chief, and Department Director shall be a prerequisite to such an appointment. Proposed Members shall be invited to submit an application for appointment, which shall contain the same information, and be processed in the same manner, as all other applications for Medical Staff membership and privileges. Physicians in this category will be subject to normal divisional and departmental quality oversight during their biannual reappointment process.

4.2.2 The Consulting Staff may not vote, hold office or serve on committees.

4.3 Exempt Staff

4.3.1 Practitioners not licensed in the State of Washington but licensed to practice in another state in which he or she resides, will be granted, upon the recommendation of the Department Director and/or Division Chief, with the approval of the Medical Director, privileges of assisting with or observing their own or Children's patients for a period not to exceed five (5) days providing that such practitioners shall not open an office or appoint a place of meeting patients or receiving calls within the state (RCW 18.71.030).

4.3.2 Primary source verification required: licensure in the state in which he or she resides, National Practitioner Data Bank, Washington State Patrol background check, Drug Enforcement Agency (DEA) and Medicare/Medicaid sanctions and exclusions.

4.3.3 Evidence of active malpractice insurance must be provided.

4.3.4 The Exempt Staff may not vote, hold office or serve on committees.

4.4 Affiliate Staff

4.4.1 Members of the Affiliate Staff are not granted admitting and attending patient care privileges and may not sit on fully constituted hospital or medical staff committees as voting members. Affiliate staff may, however, be asked to serve in an advisory or consultative capacity.

4.4.2 The Affiliate Staff shall consist of those Practitioners who have previously maintained active or consulting membership in good standing on the Medical Staff at the Hospital, who are respected Members of the professional community and who wish to retain an affiliation with the Hospital, but who no longer wish to practice, maintain malpractice insurance, or maintain an active Washington State licensure.

4.4.3 Upon recommendation by the Medical Executive Committee and approval by the Board of Trustees, an Affiliate Member may become an Honored Member.

4.4.4 An Affiliate Member may become an Active Staff Member with patient care privileges only by applying for Active Staff membership through reapplication and the completion of an initial application in accordance with Article III.

4.5 Honored Staff

4.5.1 The Honored Staff shall consist of Physicians, Dentists and Psychologists not active on the Medical Staff, who are honored for their contributions to Seattle Children's.

4.5.2 Candidates shall be identified by the Honored Medical Staff Nominating Committee, a subcommittee of the Medical Executive Committee appointed by the co-chairs of the Medical Executive Committee (President of the Medical Staff and Medical Director) whose membership is approved by the Medical Executive Committee according to the policy outlined in the Medical Staff Rules and Regulations. The nominations are presented to the Medical Executive Committee for review and approval of each candidate to the Honored Medical Staff. If the candidate is approved by the Medical Executive Committee for nomination to the Honored Medical Staff the nomination is forwarded to the Joint Conference Committee for review and action on behalf of the Board of Trustees.

4.5.3 Members of the Honored Staff shall not have assigned duties or responsibilities. Their membership on the Honored Medical Staff is in perpetuity.

4.6 Allied Health Professionals ("AHPs")

The following are approved categories of Allied Health Professionals:

4.6.1 Advanced Registered Nurse Practitioners (ARNP)

4.6.2 Physician Assistants (PA-C)

4.6.3 Surgical Assistants

4.6.4 Acupuncturists

4.6.5 Other Categories

Other categories of licensed allied health professionals may be considered for service authorization by the Medical Staff with the approval of the Board of Trustees when necessary to provide for optimal patient care and clinical outcomes.

The process for appointment and reappointment of Allied Health Professionals is outlined in the Rules and Regulations.

4.7 Clinical Psychologists

All independent licensed psychologists (PhD), regardless of their department of practice, are afforded full membership on the Medical Staff. The same credentialing and privileging process is utilized as for all other members of the Medical Staff, regardless of the employment status of the Practitioner.

4.8 Postgraduate Trainees (Residents and Fellows)

4.8.1 Included in this category are Physicians and Dentists, graduates of approved Medical or Dental Schools who are at Seattle Children's Hospital for additional training. For physicians enrolled in an Accreditation Council on Graduate Medical Education (ACGME)-approved or American Board of Medical Specialties (ABMS)-approved graduate training program sponsored by the University of Washington Medical, and for dentists enrolled in a dental training program sponsored by the University of Washington Dental School, or other medical or dental institutions with which the Hospital has entered into a formal institutional relationship for educational purposes, the Graduate Medical Education (GME) Office is responsible for credentialing and monitoring the trainee's performance. For physicians or dentists who are not enrolled in ACGME, ABMS, or ADA-accredited programs, the Medical Staff Services Department is responsible for their credentialing and monitoring.

The medical staff appointment of Fellows in non-accredited programs will terminate upon completion of or departure from the fellowship. Any fellow in a non-accredited program who wishes to continue on the Medical Staff following the fellowship must reapply for membership and privileges.

4.8.2 Physicians who are enrolled in ACGME or ABMS-accredited programs are not members of the Medical Staff, are not granted clinical privileges and are not entitled to any rights afforded to practitioners on the Medical Staff, including hearing and appeal rights, under these Bylaws. The individual residency or fellowship program defines the individual scope of practice for each trainee. The Residency Review Committee (RRC) of the ACGME or member Board of the ABMS for each specialty specifies the learning, experiential and competency content required. These requirements are included in job descriptions for each specialty that are developed by the program directors and the Director of Medical Education. These job descriptions are reviewed and approved by Children's Graduate Medical Education (GME) Council and the Medical Executive Committee. Similarly, dentists who are enrolled in American Dental Association (ADA)-accredited programs are not members of the medical staff. Their individual scope of practice is based on their institutional and ADA accreditation requirements as approved by the Children's GME Council and the Medical Executive Committee.

4.8.3 Physicians and dentists who are post-residency trainees (also call Fellows) who are enrolled in non-ACGME or non-ADA accredited subspecialty training programs (offered by the Hospital) must have completed the credentialing and privileging in their primary specialty area by the Medical Staff. The category of Medical Staff membership is based upon their prior background and training in their primary specialty. Direct patient care as a licensed independent practitioner may be provided by such individuals based on their institutional and ADA accreditation requirements as approved by the Children's GME Council and the Medical Executive Committee.

4.8.4 Physicians and dentists (Residents and Fellows) enrolled in a training program at the Hospital may perform patient care services under the direction and accountability for specific patient care activities by a member of the Medical Staff (attending physician). All such activities shall be under the supervision and direction of a member of the Medical Staff (training program director) while carrying out their patient care responsibilities. All services occur with supervision by an attending physician on the Medical Staff as approved by the Children's GME Council and the Medical Executive Committee to the extent that such services do not exceed or conflict with the Medical Staff Bylaws, Rules and Regulations, or policies of the Medical Staff or Hospital policies. Residents and Fellows shall comply with the Medical Staff Bylaws, Rules and Regulations, Medical Staff and Hospital policies and procedures.

4.8.5 Residents and Fellows in ACGME-accredited programs are required to document their professional liability insurance coverage in the amount required by the Medical Staff Bylaws for members of the Medical Staff through their supporting institution. Non-ACGME fellows must document personal liability insurance at the time of their initial appointment.

4.8.6 Whether in an accredited program or not, residents and fellows will be formally evaluated in writing by their program director. The formal evaluation must include assessment of the trainee's knowledge, patient care, personal practice patterns and their improvement over time, interpersonal and communication skills, professionalism and participation in improvements of systems of care and practice at Seattle Children's. In addition, a final assessment of overall performance including whether there has been successful progression toward independent practice without supervision must be completed. Formal evaluation must take place on a regular basis (at least annually) throughout the training period, and the written documentation maintained in the trainee's permanent education file. Notice of any failure to meet program requirements must be shared with the Director of Medical Education and the Chief Academic Officer within seven (7) days from the time the concern is identified.

4.8.7 Residents and Fellows may be invited to attend Medical Staff and department meetings but shall hold no voting rights.

4.8.8 Medical Staff membership and specific privileges in the discipline in which they will practice are required for any Residents or Fellows who provide contracted services outside of their required training program (also known as "moonlighting"). Requirements and conditions of medical staff membership will be identical to those of any other medical staff applicant who independently provides those services.

4.9 Observers are neither members of the Medical Staff or members of a sanctioned training program.

Post-graduate physicians or dentists who are visiting Seattle Children's to observe patient care activities but who are not formally enrolled in a residency or fellowship program may be allowed to observe patient care under the direct supervision of a member of the Medical Staff. These individuals are not allowed to provide direct patient care or services, are not allowed to write orders, nor are they allowed in patient care areas without being accompanied by their Medical Staff supervisor or another designated supervisor. The Medical Staff Services Department credentials licensed physician observers for a period of up to 93 days at which time their observer status ceases. Rarely an observer may remain in observer status for an additional 93 days. To do so, the observer and their supervisor submit to Medical Staff Services Department a request for an extension at or before 21 days before the end of the original observation period. The request for extension must be reviewed and approved by Division Chief, Department Director and the Director of Medical

Education or Chief Academic Officer. This review is to include assessment of the performance of the observer during their initial observation period and the reason for the extension. This category is not an intended or acceptable alternative to enrollment in a training program. Thus, observation periods longer than 186 days are not allowed.

ARTICLE 5
ORGANIZATION OF PROFESSIONAL SERVICES

The Medical Executive Committee shall establish the organization of the professional services as outlined in the Rules and Regulations.

ARTICLE 6
OFFICERS AND DUTIES

The officers of the Medical Staff shall be the Medical Director, President, President-Elect, Immediate Past President (when applicable) and The Elected Medical Staff Advisor or Advisors, the number and selection of which in any given year shall be determined as described below.

6.1 The Medical Director shall be appointed by the Chief Executive Officer upon the recommendation of a Search Committee appointed by the Chief Executive Officer, subject to ratification by the Board of Trustees, following presentation to the Medical Executive Committee. The Medical Director shall be responsible to the Chief Executive Officer. He/she shall be responsible for the function of the clinical organization including the quality of care provided throughout the health system. Annually, he/she shall review and revise the membership of the standing Committees of the Medical Staff, assisted by the President of the Medical Staff. The Medical Director shall be a member of the Medical Executive Committee and shall serve as Co-chair with the Medical Staff President unless otherwise determined by the Medical Executive Committee and the Board of Trustees. He/she shall be a member ex-officio of all other standing Committees of the Medical Staff and may preside in the absence of any Committee Chairperson. He/She shall represent the Medical Staff in appropriate community and regional activities.

6.2 **The President's** tenure shall entail a schedule of five years, two years each as President-Elect and President, and one year as Immediate Past-President. The President shall be responsible to the Board of Trustees. He/She, in consultation with the Medical Director, shall call and preside over the meetings of the Medical Staff and may, in consultation with the Medical Director, appoint ad hoc Committees as required. He/She shall participate with the Medical Director in the making of annual assignments to the standing Committees of the Medical Staff and be a member ex-officio of these Committees. He/She shall be a voting Member of the Medical Executive Committee as President-Elect, President and Immediate Past President and may serve as co-chairperson of the Medical Executive Committee with the Medical Director. As President, he/she will co-chair the Joint Conference Committee (JCC) with a member of the Board of Trustees. As President, he/she will chair the Credentialing and Professional Standards Committee, Nominating Committee when there is no Immediate Past President, and Bylaws Committee. He/She shall assist in establishing the policies of the Hospital relating to patient care.

6.3. **The Immediate Past President** will assist the President during transition and will serve a one-year term immediately following the conclusion of his or her two-year term as President. During the period in which an Immediate Past President is serving his or her one-year term, he/she will serve as the chair of the Nominating Committee. During the period in which an Immediate Past President is serving his or her one-year term, he/she shall be a voting Member of the Medical Executive Committee.

6.4 **The President-Elect** shall be elected from a slate provided by the Nominating Committee. The candidate shall be chosen from the Active Staff. The President-Elect's tenure shall entail a

schedule of five years: two years each as President-Elect and President, and one year as Immediate Past President. The President-Elect, in the absence of the President, shall assume all duties of the President. He/She shall serve as a voting Member of the Medical Executive Committee and as Chairperson of the Program and Recognition Committee. The President-Elect shall become President on October 1st or earlier in the event that the office of the President should become vacant before this time.

6.5 **The office of "Elected Medical Staff Advisor** is hereby created. At any given time, there shall be two Elected Medical Staff Advisors, each of who shall serve a term of three years, except that a period of one year following the effective date of this Section E, there shall be one and only one Elected Medical Staff Advisor, who shall serve a term of two years. Elected Medical Staff Advisors shall be selected as follows:

6.5.1 Two Elected Medical Staff Advisors shall be elected from a slates prepared by the Nominating Committee as described in this paragraph. The Elected Medical Staff Advisor's terms will be staggered such that their terms do not expire during the same year, and such that there are two Elected Medical Staff Advisors during any period when there is no Immediate Past President who is a voting Member of the Medical Executive Committee. Each of the two Elected Medical Staff Advisors be elected every four (4) years and shall serve a term of three (3) years and each Elected Medical Staff Advisor position shall be vacant during the fourth years of the four-year election cycle.

6.5.2 There shall always be two Elected Medical Staff Advisors during any year in which no person serves as Immediate Past President, and one Elected Medical Staff Advisor during the year in which there is a person serving as Immediate Past President.

Each Elected Medical Staff Advisor shall be chosen from the Active Medical Staff and shall serve as a voting Member of the Medical Executive Committee. The Elected Medical Staff Advisor, or in the case there are two such Advisors, the Elected Medical Staff Advisor who has held office for a longer time, shall assume the role of President in the event that office becomes vacant and the President-Elect is unable to serve out the months of the medical staff year.

6.6 Elected Officers and members of the Medical Executive Committee may be removed for failure or inability to perform duties of their elected position. They may be so removed by a two-thirds majority vote of the Medical Executive Committee with the approval of the Board of Trustees. Consideration for removal may be brought by any member of the Medical Executive Committee.

6.7 In a situation where the President is unable to perform the duties of the office, the President-Elect will automatically assume those duties. If the President-Elect is unable to perform the duties, the Elected Medical Staff Advisor, in case there are two such Advisors, the Elected Medical Staff Advisor who has held office for a longer time, will automatically assume the duties and serve out the remaining months of the medical staff year. A special election for President or President-Elect, as applicable, shall be held if at the conclusion of the medical staff year, the elected President or President-Elect remains unable to fulfill his or her respective responsibilities. In a situation where there is no Medical Staff Officer capable of serving, a temporary appointment will be made by the Chair of the Medical Executive Committee until a formal election can be held. The temporary appointment will require approval by the Medical Executive Committee.

ARTICLE 7
STAFF MEETINGS

Staff meetings may be held at intervals to assure that the business of the Medical Staff is effectively carried out. The process for scheduling regular and special meetings is outlined in the Rules and Regulations.

ARTICLE 8
FUNCTIONS AND RESPONSIBILITIES OF THE MEDICAL STAFF

The majority of Medical Staff functions will be carried out through standing and special Committees and Sub-Committees, which are appointed as hereafter indicated. Unless otherwise specified, the Medical Staff President and Medical Director shall recommend the composition of the standing Committees for approval by the Medical Executive Committee. The Medical Staff President and Medical Director shall have authority to appoint special Committees and Sub-committees, defining in each case the purpose and authority of the Committee. Minutes must be kept that adequately reflect the deliberations, conclusions and recommendations of all meetings of the standing Committees of the Medical Staff. These minutes will be reviewed by the Medical Executive Committee in its oversight role for quality improvement in the hospital, its departments and the Members of the Medical Staff. Approved minutes will be forwarded to the Board of Trustees.

8.1 Functions

The major functions of the Medical Staff shall include the following:

8.1.1 Promote quality, safety and efficiency of patient care provided by all Practitioners authorized to practice in the Hospital through assurance that the following measures occur.

8.1.1.1 Review and evaluation of the quality of patient care through ~~a~~ comprehensive continuous quality and performance improvement programs.

8.1.1.2 An organizational structure and mechanisms that allow ongoing monitoring and trending of patient care practices and outcomes.

8.1.1.3 A credentials program, including mechanisms for the appointment and reappointment and the matching of clinical privileges to be exercised or of specified services to be performed with the verified credentials and current demonstrated experience and performance of the applicant, Member or AHP.

8.1.1.4 A continuing education program that assures that all providers offer health services that are current, safe and evidence-based. This program is also expected to address the personal and career needs of the Medical Staff.

8.1.1.5 A utilization review program to assure that only necessary and needed services are provided to patients in need of them.

8.1.2 Conduct audits and monitor specific care delivery processes and trends through it various quality subcommittees.

8.1.3 Conduct, coordinate, and review credentials investigations and recommendations regarding Medical Staff membership and the granting of Clinical Privileges.

8.1.4 Evaluate in conjunction with Division Chiefs and Department Directors the credentials, competence, training, experience and qualifications of health care professionals applying for Staff membership and to make recommendations on such applications in conformity with the Bylaws.

8.1.5 Evaluate the physical, mental and ethical capacity of applicants for membership and/or privileges after their credentials have been otherwise reviewed and approved.

8.1.6 Review biennially (or more often where appropriate) in conjunction with Division Chiefs and Department Directors all available information and the recommendations of Division Chiefs and Department Directors regarding the credentials, physical and mental capacity, behavioral, ethical standards, competence, qualifications, health, and activities of current Members of the Medical Staff, and to make recommendations concerning reappointments, terminations, the granting or restricting of privileges and the assignment of Staff Members to various services.

8.1.7 To review the quality of care delivered by Staff Members at such other times as questions may be referred to the Medical Executive Committee by the Medical Director or President of the Medical Staff directly or through quality oversight activities performed by quality subcommittees within the Hospital.

8.1.8 Continuously monitor and evaluate care provided and develop clinical policy for: special care areas such as intensive care units, oncology services, operating rooms, transplant and dialysis services and the emergency department; patient care support services such as respiratory therapy, nutrition, physical medicine, pain management, sedation, wound care, ethical consultation, physical and occupational therapy; and emergency, outpatient, home care, and other ambulatory care services.

8.1.9 Enforce these Bylaws and Rules and Regulations uniformly and consistently.

8.1.10 Develop, administer, recommend~~,~~ amendments to, and seek compliance with these Bylaws, the Rules and Regulations of the staff, Hospital policies and external guidelines (e.g., Joint Commission and the State Department of Health) regulating patient care and hospital accreditation.

8.1.11 Recommend action to the Joint Conference Committee and the Board with respect to appointments, reappointments, staff category, clinical Department assignment, clinical privileges, service authorizations and medical staff policies.

8.1.12 Provide continuing education responsive to the findings of the performance and quality improvement oversight activities and its committees, new state-of-the-art developments and other defined needs of the members.

8.1.13 Oversee the function of the Hospital's professional library services.

8.1.14 Oversee the function and effectiveness of the Physician Wellness Program.

8.1.15 Review completeness, timeliness, confidentiality and clinical pertinence of patient medical and related records both paper and electronic.

8.1.16 Develop and maintain surveillance over the hospital formulary, support efforts to assure medication safety and adverse drug reaction reporting and participate in drug utilization policies and practices.

8.1.17 Develop policies that diminish the risk of noscocomial transmission of infection in the health care system. Investigate and control Hospital-acquired infections and monitor the performance of the Hospital's Infection Control Committee.

8.1.18 Assist in the planning for response to fire, bioterrorism and other disasters and overall patient, staff and visitor safety concerns.

8.1.19 Participate in planning for hospital and facility expansion and renovations to meet changing community needs.

8.1.20 Direct Medical Staff organizational activities, including regular Medical Staff Bylaws review and revision, Medical Staff officer and Committee nominations, Department credentialing and quality oversight activities, and coordination with the Board and Hospital Administration of review and maintenance of Hospital accreditation(s) activities.

8.2 Standing Committees and Subcommittees of the Staff shall be constituted as follows:

8.2.1 New members of **the Medical Executive Committee** shall be approved annually by the Board of Trustees. The Medical Director and Medical Staff President shall serve as co-chairs unless the voting members of the Committee choose to elect another member. At-large Members for the Committee shall be elected from Medical Staff members representing the community, individuals employed by the hospital and members of Children's University Medical Group (CUMG) and the University of Washington Physicians (UWP).

8.2.1.1 Composition of the Medical Executive Committee shall be constituted so as to assure that at least a simple majority of its voting members are community providers with the balance of the voting members representing CUMG and Children's employed staff providers all of whom are members of the active medical staff.

Senior Vice President / Medical Director
President of the Medical Staff
President-Elect of the Medical Staff
Immediate Past President of the Medical Staff
Elected medical Staff Advisor(s)
At least one elected at-large CUMG Representative
Members-at-Large (community physicians elected by the Medical Staff, i.e., physicians not employed by the Hospital, UWP or CUMG)
Director, Department of Anesthesiology and Pain Management
Director, Department of Child Psychiatry and Behavioral Medicine
Director, Department of Dentistry
Director, Department of Laboratories and Pathology
Director, Department of Medicine
Director, Department of Orthopedics and Sports Medicine
Director, Department of Radiology
Director, Department of Rehabilitation Medicine
Director, Department of Surgery (Surgeon-in-Chief)
Pediatrician-in-Chief
Senior Vice President / Chief Nursing Officer

8.2.1.2 Nonvoting Members:

President and Chief Executive Officer
Executive Vice President and Chief Operating Officer (CEO designee)
Associate Medical Director, Quality Improvement
Director, Graduate Medical Education
Senior Vice President / General Counsel
Vice President, Continuous Performance Improvement

8.2.1.3 A simple majority of the voting membership of the Committee shall constitute a quorum. Action shall be taken by a simple majority vote of the voting Members present and voting, or in the case of electronic voting, a simple majority vote of the voting Members who sent a vote on or before the announced close of voting.

8.2.1.4 The Nominating Committee will propose candidates for President-Elect and the Elected Medical Staff Advisor (in those years in which an Elected Medical Staff Advisor is to be elected. The Nominating Committee will be charged with maintaining a slate of candidates that recognizes the diversity of provider specialty and employment status. Candidates will be selected by the Nominating Committee. Ballots will then be sent to all voting members of the Medical Staff. Elected Officers will take office effective October 1st.

8.2.1.5 Terms of at-large members will be staggered with approximately one-half of the numbers elected annually. At-large members may serve no more than 2 consecutive 2-year terms. The prevailing proportion of community to hospital/CUMG and UWP employed physicians and specialty type, as well as the diversity of Active Medical Staff category of membership will be maintained through the choice of candidates presented for election by the Nominating Committee. Candidates will be selected by the Nominating Committee. Ballots will then be sent to all voting members of the Medical Staff. Elected members will take office effective October 1st.

8.2.1.6 The Committee Member representing CUMG shall be selected biennially by that group from a slate prepared by the CUMG board.

8.2.1.7 The Medical Executive Committee shall conduct meetings at least ten times a year and maintain minutes of its proceedings and conclusions, recommendations and actions. Electronic meetings to conduct necessary business including approval of candidates for membership and reappointment are permitted with the approval of the committee. Functions and responsibilities of the Committee shall include, but not limited to:

8.2.1.7.1 Making recommendations to the Board of Trustees pertaining to:

8.2.1.7.1.1 The structure, functions and duties of the Medical Staff;

8.2.1.7.1.2 The mechanism used to review credentials and delineate individual clinical privileges;

8.2.1.7.1.3 Individuals suitable for Medical Staff membership;

8.2.1.7.1.4 The Delineated Clinical Privileges for each eligible individual;

8.2.1.7.1.5 Policies that relate to the function of the Medical Staff or its quality oversight function(s);

8.2.1.7.1.6 The organization of the quality assessment/improvement activities of the Medical Staff, as well as the mechanism used to conduct, evaluate, and revise such activities;

8.2.1.7.1.7 The mechanisms by which membership on the Medical Staff may be restricted, suspended or terminated;

8.2.1.7.1.8 The mechanism for fair-hearing procedures.

8.2.1.7.2 Establishment of new quality sub-committees, based on recommendations from the Quality Improvement Steering Committee (QISC), when deemed these will enhance their overall quality oversight.

8.2.1.7.3 Receiving, reviewing and acting upon the reports and recommendations from Medical Staff.

8.2.1.7.4 Implementing the approved policies and procedures of the Medical Staff and reviewing and revising these on a regular basis.

8.2.1.7.5 Acting for the Medical Staff in the intervals between Medical Staff meetings.

8.2.1.7.6 Fulfilling the Medical Staff's accountability to the Board of Trustees for the quality of the overall medical care rendered to all patients cared for in the Hospital.

8.2.1.7.7 Initiating and pursuing corrective action when warranted, in accordance with the Medical Staff Bylaws.

8.2.1.7.8 Actively participating in the accreditation processes from the state, federal government and independent survey organizations such as the Joint Commission survey.

8.2.2 The **Joint Conference Committee** is a committee of the Board of Trustees as outlined in the Corporate Bylaws. The Committee will be constituted with members of the Board of Trustees, Hospital Administration and Medical Staff. The Medical Staff will be represented by the elected Medical Staff Officers: President, President-Elect, Immediate Past President during the years when this office is part of the rotation and Elected Medical Staff Advisor or Advisors. A fifth Medical Staff representative will be elected by the Medical Staff Officers for a one (1) year term commencing on October 1.

The Joint Conference Committee shall be responsible to provide formal and informal medical-administrative liaison between the Board of Trustees, Administration and the Medical Staff to improve a mutual understanding of the problems and activities of the

Board of Trustees, Administration and the Medical Staff. The Joint Conference Committee shall be the body that evaluates appointments and reappointments to the Medical Staff, taking into account the recommendations of the Medical Executive Committee, and makes recommendations to the Board of Trustees for its approval on such appointments. It shall also be the committee responsible for resolving differences between the Board of Trustees and the Medical Staff concerning clinical appointments. The Joint Conference Committee shall be responsible to communicate to the Board of Trustees in order to permit the Board to resolve any differences between the Board of Trustees and Medical Staff that cannot be resolved by the Joint Conference Committee. The Joint Conference Committee shall communicate the position of the Medical Executive Committee to the Board of Trustees on any such matters.

8.2.3 There shall also be the following Committees, which are described in the Rules and Regulations:

8.2.3.1 Credentialing and Professional Standards Committee

8.2.3.2 Program and Recognition Committee

8.2.3.3 Nominating Committee

8.2.3.4 The Bylaws-Committee

8.2.3.5 (reserved)

8.2.3.6 (reserved)

8.2.3.7 The Quality Improvement Steering Committee (QISC)

For purposes of RCW 70.41.200, the Quality Improvement Steering Committee shall be deemed the “Quality Improvement Committee”.

The QISC will recommend to the Medical Executive Committee the establishment of new sub-committees when they deem these necessary to enhance their oversight responsibilities. The descriptions of quality subcommittees are documented in the Rules and Regulations, Section R10.7.5.

8.2.4 **The Institutional Review Board (IRB)** shall be composed of at least eight (8) Members with varying backgrounds, including Medical Staff, hospital, community representatives, to promote and assure adequate review and ongoing monitoring of research protocols conducted within the Hospital so that children as research subjects are provided mandated protections and that acceptable ethical principles guide the conduct of research at Children’s. The IRB has the authority to approve, require modifications in (to secure approval), allow for expedited review, define exempt categories of investigation, or disapprove or discontinue research protocols. Members of the IRB shall be qualified through experience, expertise, ongoing education, diversity of backgrounds (including consideration of the racial and cultural backgrounds), and sensitivity to such issues as community attitudes, sufficient to promote respect for the rights and welfare of children as human subjects. The Chair and Members shall be appointed by the President of the Medical Staff and Medical Director with the concurrence of the Medical Executive Committee and approval of the Board. All members, except ex-officio, of the IRB, regardless of profession, shall be entitled to vote. Members are approved for three year terms of office and are permitted to serve consecutive terms.

Membership shall include at least one Member whose primary concern is in non-scientific areas (e.g., lawyer, ethicist, clergy) and include Members who are not otherwise affiliated with the Hospital or part of the immediate family of a person affiliated with the Hospital.

The IRB may invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that presently available on the IRB.

The Duties of the IRB shall be to:

8.2.4.1 Review all biomedical and behavioral research (including experimental devices or investigational drugs) involving human subjects conducted at or sponsored by the Hospital or enrolling hospital patients in order to assure that the rights of human subjects participating in such research is protected. Reviews are conducted objectively and in a manner to ensure the exercise of independent judgment of the Members. Members are excluded from review of protocols or research activities in which they have an active role, or when any real or potential conflict of interest exists.

8.2.4.2 Maintain appropriate records of review of applications and active protocols, or documentation of approved informed consent forms, and of other documentation that may pertain to the selection, participation, and protection of subjects, as well as reviews of circumstances that adversely affect the rights or welfare of individual subjects.

8.2.4.3 Develop policies and/or procedures for the duties as noted.

8.2.4.4 Assure each approved study has established appropriate data safety monitoring.

ARTICLE 9
PROFESSIONAL CONDUCT, COMPETENCY AND CORRECTIVE ACTION

9.1 **Professional Conduct**. Members of the Medical and Allied Health Professional Staff must conduct themselves in a professional and courteous way to demonstrate a respect for the rights of others and foster high-quality patient care. Actions of members that fall below accepted standards of professional conduct or courtesy outlined in the Medical Staff Professional Standards and Performance Expectations, that violate Medical Staff or Hospital policies or procedures, or that are inconsistent with the values of ART (Accountability, Respect and Teamwork) at Seattle Children's Hospital, will be considered misconduct and will be subject to action under these Bylaws. Misconduct includes conduct that has the purpose or effect of interfering with an individual's work performance, interfering with hospital activities or creating an intimidating, hostile or offensive work environment.

In some cases, misconduct may be due, in whole or in part, to substance abuse (including alcohol or drug abuse) or mental health impairment. When substance abuse or mental health impairment is a suspected contributor to misconduct, the Department Director or Division Chief of the Member accused of misconduct should consult with the Practitioner Well-Being Committee to determine the need for further assessment of these issues before initiating **informal or formal corrective action** as outlined in this Article 9. The

decision to consult with the Practitioner Well-Being Committee shall be made by the relevant Department Director or Division Chief.

Section 9.7 of this Article 9, providing for summary suspension in certain cases, is applied regardless of any provision or process set forth in Section 9.3 – 9.6 below.

9.2 **Professional Competency.** Members of the Medical and Allied Health Professional Staff shall exercise all privileges granted under these Bylaws consistent with accepted and prevailing standards of care and applicable hospital and Medical Staff policies.

9.3 **Problem Resolution at the Local Level Whenever Possible.** Whenever any person believes that the professional conduct of any Member of the Medical or Allied Health Professional Staff, including those with temporary privileges, fails to meet the standards of Professional Conduct and Professional Competency set out above, and adversely affects the quality of care or is disruptive to the operations of the hospital, the concerned person shall first notify the relevant Department Director or Division Chief of the concern. In the event that the subject of the concern is the Department Director, the concerned person shall notify the Medical Director of the concern. Notification of the concern may be oral or in writing. The person receiving notification of the concern shall prepare a written summary of the concern for the affected Medical or Allied Health Professional Staff Member's credentials file, and shall attempt to resolve the concern informally by discussion with and agreement among the Member who is the subject of the concern, the concerned person, and any other relevant individuals. If this attempt to resolve the issues is successful, the Department Director or Division Chief shall document the resolution in writing.

9.4 **Corrective Action – Informal Process.** If attempts to resolve the issues at the local level have been unsuccessful, then there shall first be an attempt to resolve the issues informally as described in this section:

9.4.1 This informal process shall be initiated by the concerned person notifying the Medical Director, in writing, of the nature of the concern, the facts supporting it, and the person contacted in an attempt at local resolution. In the event that the subject of the concern is the Medical Director, the concerned person shall notify the President of the Medical Staff.

9.4.2 The Medical Director shall designate a Responsible Officer to conduct the informal corrective action process. The Responsible Officer may be the Medical Director, or the Medical Director may designate another appropriate Medical Staff leader to serve as the Responsible Officer, including the President of the Medical Staff, the Past President of the Medical Staff, the President-Elect of the Medical Staff, a Medical Staff Advisor, The Pediatrician-in-Chief or the Surgeon-in-Chief.

9.4.3 The Responsible Officer shall meet with the Member about whom the concern was raised to discuss the concern and seek a mutually agreeable resolution. This meeting may include the person raising the concern at the discretion of the Responsible Officer. Part of the Responsible Officer's assessment should include a review of any existing personnel files of the Member about whom the concern was raised and a review of information available from the attempt at local resolution.

9.4.4 At the conclusion of this informal process, the Responsible Officer will make a recommendation to the Medical Staff President. The Medical Staff President will confer with the Medical Director before determining a course of action, which may include one or more of the following:

9.4.4.1 closure of the review for lack of sufficient supportive evidence;

9.4.4.2 a letter of reprimand;

9.4.4.3 a requirement for professional evaluation, treatment or both;

9.4.4.4 a reduction, suspension, or revocation of clinical privileges;

9.4.4.5 a suspension from membership in the Medical or Allied Health Professional Staff;

9.4.4.6 such other assistance, consulting, rehabilitative services or reasonable accommodations as may be appropriate under the circumstances.

9.4.5 If the recommendation of the informal process would adversely affect the clinical privileges or Medical / Allied Health Professional Staff membership of the affected Member, the recommendations must be submitted by the President of the Medical Staff to the Medical Executive Committee for action. Any action by the Medical Executive Committee that would adversely affect the clinical privileges or Medical or Allied Health Professional Staff membership of the affected Member shall entitle the Member to the hearing rights set forth in Article 10.

9.4.6 The Responsible Officer will advise the person initially raising the concerns and the affected Member of the Medical or Allied Health Professional Staff of the resolution or course of action determined. The Responsible Officer will similarly advise the Medical Director, Department Director and Division Chief.

9.4.7 If the person initially raising the concern, the Responsible Officer, and the affected Member of the Medical or Allied Health Professional Staff are satisfied with the recommendation of this informal process, then the President of the Medical Staff will be responsible for implementing them. The affected Member must agree to waive any hearing rights under Article 10 in connection with the voluntary implementation of the recommendations.

9.4.8 The informal process described in this section shall be documented. Written documentation shall be maintained in the affected Medical of Allied Health Professional Staff Member's file and in the Medical Staff Services department.

9.5 **Formal Process.** If the informal process described above fails to resolve the concern to the satisfaction of the affected persons, a formal professional investigation may be requested by the member of the Medical or Allied Health Professional Staff, the person raising the concern, or any member of the Medical or Allied Health Professional Staff.

9.5.1 Any such request must be in writing, stating the specific concern and the specific activities, events or conduct constituting the grounds for the requested investigation.

9.5.2 The written request may be submitted to the Division Chief, Department Director, the Medical Director, or any Medical Staff Officer. A copy of the written request must be forwarded to the Medical Director, who will designate a Responsible Officer in the same manner as described above in Section 9.4. The Responsible Officer will promptly notify the President of the Medical Staff, the Chief Executive Officer (CEO) and the affected Member's Department Director and Division Chief

(if any) in writing of the request, and will keep them fully informed of all action taken in connection with the request. If the Medical Director is the subject of the concern, the President of the Medical Staff shall act as the Responsible Officer and both the CEO and Board Chair will be notified.

9.5.3 If the affected Member is part of Children's University Medical Group (or any successor organization), or is a faculty member of the University of Washington School of Medicine, the Responsible Officer will in addition forward any request for investigation to the President of CUMG and to the relevant academic department chair of the Member's academic department. If the affected Member is employed at another physician group, the Responsible Officer will in addition forward any request for investigation to the physician group practice leader for the affected Member. The provisions of this article do not infringe on the ability of CUMG, the University of Washington School of Medicine or any other practice group from exercising their rights to separately investigate or sanction a provider with regard to concerns related to the professional conduct of a member.

9.5.4 On receipt of a request for investigation from the Responsible Officer, the Department Director of the Member's department will confer with the appropriate Division Chief, if any, and he, she, or they will promptly investigate the issues identified in the request. The investigation will include, but is not limited to, an interview with the Member who is the subject of the request, and with the person submitting the request. The investigation may include other interviews, including interviews with Hospital staff, other relevant Members of the Medical Staff, and affected patients or families. Any such interview shall not be considered to be a hearing. The investigation will also include a review of any existing personnel or medical staff files of the affected Member.

9.5.5 The Department Director will complete the investigation and submit a report within 30 days of receipt of the request for investigation. The Department Director will submit the report, which will set forth the results of the investigation, to the Responsible Officer.

9.5.6 If the misconduct is alleged to be directed to anyone involved in the investigation process, that person's investigation duties will be assumed by the person's superior.

9.5.7 Following receipt of the written report from the Department Director, the Responsible Officer will confer with the officers of the Medical Staff, including the Medical Director. The officers of the Medical Staff will then determine a recommended course of action, by consensus if possible, and by majority vote otherwise, which course of action may include one or more of the following:

9.5.7.1 closure of the review for lack of sufficient supportive evidence;

9.5.7.2 a letter of reprimand;

9.5.7.3 a requirement for professional evaluation, treatment or both;

9.5.7.4 a reduction, suspension, or revocation of clinical privileges;

9.5.7.5 a suspension from membership in the Medical or Allied Health Professional Staff;

9.5.7.6 such other assistance, counseling, rehabilitative service or

reasonable accommodations as may be appropriate under the circumstances.

9.5.8 If the recommendations of the officers of the Medical Staff would adversely affect the clinical privileges or Medical Staff membership of the affected Member, and the matter is not referred to a Professional Review Committee pursuant to Section 9.6 below, the recommendation must be submitted by the President of the Medical Staff to the Medical Executive Committee for action. Any action of the Medical Executive Committee that would adversely affect the clinical privileges or Medical or Allied Health Professional Staff membership of the affected Member shall entitle the Member to the hearing rights sect forth in Article 10.

9.5.9 The Responsible Officer will advise the person submitting the request for investigation and the affected Member of the Medical or Allied Health Professional Staff of the course of action determined.

9.5.10 If the person submitting the request for investigation and the affected Member of the Medical or Allied Health Professional Staff are satisfied with the recommendations of the officers of the Medical Staff, then the Medical Director is responsible for implementing them. The affected Member must agree to waiver any hearing rights under Article 10 in connection with the voluntary implementation of the recommendations.

9.5.11 The formal investigation process described in this section shall be documented. Written documentation will be maintained in the affected Medical or Allied Health Professional Staff Member's file and in the Medical Staff Services department. All such information shall be confidential and protected as records relating to peer review and quality improvement activities.

9.6 **Professional Review Committee.** If the person requesting the investigation or the affected Member is not satisfied with the recommendations of the officer of the Medical Staff, then either may requested that a Professional Review Committee be convened to investigate the issues.

9.6.1 Any such request must be in writing and directed to the President of the Medical Staff. Upon receipt of such a written request, the President of the Medical Staff will promptly convene a Professional Review Committee.

9.6.2 The Professional Review Committee will consist of Members of the Medical or Allied Health Professional Staff appointed jointly by the President of the Medical Staff and the Medical Director, including an individual representing the requesting person's area appointed by the Medical Director. The Medical Director may also, in appropriate cases, appoint an administrative representative. The Professional Review Committee will be staffed by the Medical Staff Services department and the Hospital General Counsel or designee.

9.6.3 The Professional Review Committee will investigate the matter. The investigation will include, but not necessarily be limited to, an interview with the affected Member and the person requesting the investigation, and may include review any relevant files.

9.6.4 Upon completion of the investigation, the Professional Review Committee will promptly make a report to the President of the Medical Staff. The Professional Review Committee will recommend one or more of the following:

9.6.4.1 the closure of the investigation for lack of sufficient evidence
9.6.4.2 a letter of reprimand
9.6.4.3 a requirement for professional evaluation, treatment or both
9.6.4.4 a reduction, suspension or revocation of clinical privileges
9.6.4.5 a suspension from membership in the Medical or Allied Health Professional Staff
9.6.4.6 such other assistance, counseling, rehabilitative services or reasonable accommodations as may be appropriate under the circumstances.

9.6.5 The President of the Medical Staff will be responsible for carrying out the recommendations of the Professional Review Committee, and notifying the Medical Director of the recommendations. If the recommendations of the Professional Review Committee would adversely affect the clinical privileges or Medical or Allies Health Professional Staff membership of the affected Member, the recommendations must be submitted by the President of the Medical Staff to the Medical Executive Committee for action. Any action by the Medical Executive Committee that would adversely affect the clinical privileges or Medical or Allied Health Professional Staff membership of the affected Member shall entitle the Member to the hearing rights set forth in Article 10.

9.6.6 The Professional Review Committee process described in this section shall be documented. Written documentation will be maintained in the affected Medical or Allied Health Professional Staff Member's file and in the Medical Staff Services department. All such information shall be confidential and protected as records relating to peer review and quality improvement activities.

9.7 **Summary Suspension.** These provisions regarding summary suspension apply regardless of whether any of the provisions outlined in Article 9 above also apply.

9.7.1 The Medical Director may summarily suspend, reduce or restrict a Member's clinical privileges whenever the failure to take such action may result in imminent danger to the health of any patient. A summary action will be effective immediately upon notice. If notice is given orally, it will be confirmed promptly in writing to the Medical or Allied Health Professional Staff Member and the Member's Department Director.

9.7.2 Within 10 business days after summary action has been take, the Medical Executive Committee shall convene a meeting to consider the circumstances and determine whether the action shall be reversed, modified or continued in effect. Both the Medical Director and the Member involved will be invited to attend the meeting to present their respective positions and respond to questions, if any. Other individuals may present information at the request of the President of the Medical Staff. the meeting shall be informal, and not in the nature of a hearing. If the Medical Executive Committee does not decide to relieve the Member entirely of the suspension, reduction or restriction, the Member shall be entitled to request a hearing in accordance with Article 10 of the Bylaws.

9.8 **Automatic Suspension.** In addition to the procedures described above, the following events shall automatically result in suspension of Medical or Allied Health Professional Staff membership, clinical privileges, or both, until the event giving rise to the suspension is resolved. If the event remains unresolved for a period exceeding 180 days inactivation of the Member's membership and clinical privileges may be recommended. The President

of the Medical Staff will notify any Member suspended pursuant to this Section 9.8. The events resulting in automatic suspension are as follows:

9.8.1 Failure to meet the established credentialing criteria that prescribed residency training or board certification in a given specialty, or other similar objective criteria established by the respective Department, the Medical Executive Committee or the Board of Trustees.

9.8.2 Suspension, revocation, failure to renew, loss of or any other action adversely affecting the Member's professional license, DEA certificate or professionally liability insurance, or any other certification (such as but not limited to specialty board or PALS certification) required for specific privileges held by the Member.

9.8.3 Imposition of sanctions, exclusion, or any other penalty or restriction under the Medicare or Medicaid programs or the hospital Compliance Program or the Member's compliance program (e.g. CUMG suspension for compliance violation).

9.8.4 Failure to follow the policies and procedure of the Medical Informatics/Records Committee as approved by the Medical Executive Committee, including the requirement to complete and maintain medical records in a timely manner.

9.8.5 Lack of sponsorship by or affiliation or employment by a person or entity holding an exclusive right to cover or provide designated services at the hospital.

9.8.6 An institutional decision not to provide or accommodate the services involved.

9.8.7 Failure to comply with established hospital infection control requirements, including documentation of required immunizations and annual tuberculosis (TB) testing.

9.8.8 Any other hospital administrative considerations, including but not limited to lack of available positions, facilities or support personnel to safely provide patient care.

9.9 **Procedures Following Automatic Suspension.**

9.9.1 A Member whose clinical privileges or membership have been automatically suspended pursuant to Section 9.8 above shall be entitled to meet with the Medical Director to discuss the matter, but shall not be entitled to a hearing as described in Article 10. If the Member is dissatisfied with the result of the meeting with the Medical Director, the Member may request review by the Board of Trustees. The Board of Trustees shall determine what, if any, additional proceedings to conduct and shall issue a final decision.

9.9.2 Immediately upon the imposition of a suspension under Section 9.8 above, the Medical Director, after consultation with the Department Director, may make provision for alternative medical coverage for the patients of the suspended Member who remain in the hospital at the time of the suspension. The wishes of the patients shall be considered in the selection of such alternative medical coverage, provided that no suspended Member may provide any such coverage while the suspension remains in effect.

9.10 **Matters Governed by Employment or Other Agreement.**
A Practitioner employed by or under contract with the hospital in a purely administrative capacity, with no clinical responsibilities or prerogatives, is subject to the normal personnel policies of the hospital or the terms of the Practitioner's contract, and need not be on the Medical or Allied Health Professional Staff. Conversely, a Practitioner who is employed by or under contract with the hospital and has responsibilities or prerogatives involving the care of patients must be a Member of the Medical or Allied Health Professional Staff with clinical privileges awarded in accordance with these Bylaws. The Medical or Allied Health Professional Staff membership and privileges of such a Practitioner shall not be contingent on the Practitioner's continued employment or contractual relationship unless otherwise provided in the Practitioner's employment agreement or contract. In the event of an inconsistency between terms of an employment agreement or contract and the provisions of these Bylaws, the terms of the employment agreement or contact shall prevail.

9.11 **Initiation by the Board of Trustees.**
If in any particular event the officers of the Medical Staff or the Medical Executive Committee fail to investigate or take disciplinary action, contrary to the weight of the evidence, the Board of Trustees may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to take action in response to that consultation with the Board of Trustees, the Board of Trustees may initiate corrective action,, and in doing so shall comply with Articles 9 and 10 of these Bylaws. The Board of Trustees shall provide written notice to the Medical Executive Committee of any actions it takes under this section.

ARTICLE 10
HEARINGS

10.1 Grounds for Hearing

Applicants for and persons holding clinical privileges shall be entitled to exercise the hearing rights described in this Article whenever:

10.1.1 The Medical Executive Committee has decided to recommend to the Board of Trustees that an application for appointment or reappointment to the Medical Staff, or for the granting or renewal of clinical privileges, be denied based on the Practitioner's professional competence or conduct. "Professional competence or conduct" means that which affects or could affect adversely the health or welfare of a patient or patients; or

10.1.2 The Medical Executive Committee has decided to recommend to the Board of Trustees that requested clinical privileges be granted or renewed with restrictions, other than proctoring or observation normally associated with new clinical privileges, based on professional competence or conduct: or

10.1.3 The Medical Executive Committee has decided to perpetuate a summary suspension, reduction or restriction of a Practitioner's clinical privileges, following imposition by the Medical Director, based on professional competence or conduct and the action remains in effect for more than fourteen (14) days; or

10.1.4 The Medical Executive Committee has decided to recommend to the Board of Trustees that a Practitioner's Medical Staff membership be revoked, or that a Member's clinical privileges be restricted, reduced or revoked, based on professional competence or conduct, or both.

10.2 Notice of Action or Recommendation

When action has been taken or recommended as described in Section 10.1 above, the Practitioner shall be given prompt written notice by the President of the Medical Staff. This notice shall include all of the following elements:

10.2.1 A description of the action or recommendation.

10.2.2 A concise statement of the reasons for the action or recommendation. (In the event a hearing is requested, a more detailed notice of reasons or charges may be provided subsequently.)

10.2.3 A statement that the Practitioner has a right to request a hearing.

10.2.4 A summary of the Practitioner's rights in the hearing.

10.2.5 The time limit within which a hearing may be requested, as specified in Section 10.3, below.

10.3 Request for Hearing

The Practitioner shall have thirty (30) days following receipt of the above Notice within which to request a hearing. The request shall be in writing, addressed to the President of the Medical Staff with a copy to the Medical Director, and must be received by the President of the Medical Staff within the allotted period. In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to challenge the action or recommendation and it shall become final and effective immediately. The Board of Trustees shall be notified.

10.4 Notice of Hearing

If a hearing is requested as provided above, the Practitioner shall be sent a Notice of Hearing stating:

10.4.1 The place, time and date of the hearing, which date shall not be less than thirty (30) days after the date of the Notice of Hearing.

10.4.2 A list of the witnesses (if any) who are then expected to testify at the hearing on behalf of the Medical Executive Committee.

10.4.3 If known that the time that the Notice of Hearing is sent, the composition of the Hearing Committee and the name of the Hearing Officer.

10.5 Notice of Reasons or Charges

A Notice of Reasons or Charges may be sent along with or separate from the Notice of Hearing, further specifying, as appropriate, the acts or omissions with which the Practitioner is charged. This supplemental notice shall provide a list of the charts, if any, which are to be discussed at the hearing, if that information has not been provided previously.

10.6 Hearing Committee

10.6.1 The President of the Medical Staff in consultation with the Medical Director shall appoint a Hearing Committee within 10 business days following receipt of a request for a hearing.

If the President is in direct economic competition with the Practitioner, the Hearing Committee shall be appointed by the Immediate Past President or President-Elect in years with no Past President or in the case of economic conflict with the Immediate Past President, in consultation with the Medical Director. If that person, too, is in direct economic competition with the Practitioner, the Hearing Committee shall be appointed by one of the Medical Staff Advisors, to be specified by the Medical Director. If the hearing is based upon an action by the Board of Trustees, the Chairman of the Board shall fulfill the functions assigned in this section to the President of the Medical Staff.

10.6.2 The Hearing Committee shall be comprised of not less than 3 Members of the Active Medical Staff (including, to the extent consistent with the other provisions of this paragraph, both community physicians and CUMG physicians) who are not in economic competition with the Practitioner and have not been involved previously as accusers, investigators, fact finders, or initial decision-makers concerning the issues or events leading up to the action or recommendation being challenged. Knowledge of the matter involved shall not preclude a Member of the Medical Staff from serving on the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the Active Medical Staff, Members from other staff categories or individuals who are not Members of the Medical Staff may be appointed. A Chairperson shall be designated by the person(s) appointing the Hearing Committee.

10.6.3 The person authorized to appoint a Hearing Committee as provided above shall have the discretion, in lieu of appointing such a Committee, to enter into an agreement with the Practitioner to hold the hearing before an arbitrator or arbitrators mutually acceptable to both parties. In no event shall the failure or refusal to exercise this discretion be construed as a denial of a fair hearing.

10.7 Hearing Officer

10.7.1 The person who is authorized to appoint a Hearing Committee shall also appoint a Hearing Officer to preside at the hearing. The Hearing Officer should be an attorney-at-law qualified to preside over a quasi-judicial hearing, and may not be an individual who is in direct economic competition with the Practitioner, or otherwise retained or employed by the hospital.

10.7.2 The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing, and shall have the authority to make all rulings on questions of law, procedure or the admissibility of evidence. If the Hearing Officer determines that either party is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such action as the Hearing Officer considers to be warranted.

10.7.3 If requested by the Hearing Committee, the Hearing Officer may participate in the deliberations of the Committee, serve as a legal advisor to the Committee, and/or assist the Committee in the preparation of its decision and report, but the Hearing Officer shall not be entitled to vote.

10.8 Representation

Hearings under this Article are for the purpose of resolving peer review disputes concerning professional competence or conduct. Accordingly, neither party may be represented by an

attorney at law during the hearing, unless the Chairperson of the Hearing Committee permits both sides to be so represented or the parties both agree on representation by legal counsel. In the event that legal counsel is not allowed at the hearing, the Practitioner shall be entitled to be accompanied and represented at the hearing by a person of his choice, and the Medical Executive Committee shall appoint a representative from the Medical Staff, which may be the Medical Director, to present its case. Nothing in the foregoing shall be deemed to deprive either party of the right to advice of legal counsel in connection with preparation for the hearing.

10.9 Postponements and Extensions

Once a timely request for a hearing is received, postponements and extensions of time beyond those prescribed in these Bylaws may be requested by anyone and shall be permitted by the Hearing Committee, or its Chairperson acting on its behalf, upon agreement by the parties or upon a showing of good cause.

10.10 Failure to Appear or Proceed

Failure without good cause of the Practitioner to appear and proceed at the hearing shall be deemed to constitute a voluntary acceptance of the action or recommendation involved and a waiver of all hearing rights. The issue of good cause shall be determined by the Hearing Committee.

10.11 Record of Hearing

A court reporter shall be present at the hearing to make a record of the proceedings, as deemed appropriate by the Hearing Officer. The cost of the attendance of the reporter shall be borne by the Medical Staff and/or Hospital. The Practitioner shall be entitled to receive a copy of the transcript upon paying the reasonable cost of preparing it. The Hearing Committee may, but shall not be required to, order that testimony be given under oath.

10.12 Prehearing Procedure

10.12.1 Challenges to Hearing Committee Members or Hearing Officer

The Practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality or qualifications of the Hearing Committee Members and the Hearing Officer. The Hearing Officer shall establish the procedure by which this right may be exercised, which may include a requirement that questions or challenges be presented in writing in advance of the hearing. The Hearing Officer shall rule on any challenges in accordance with the standards and qualifications set forth in Sections 10.6 and 10.7, above.

10.12.2 Exchange of Information

At least ten (10) days prior to the commencement of the hearing, the parties shall exchange copies of all reasonably anticipated exhibits; the Practitioner shall provide the President of the Medical Staff with a list of witnesses who are reasonably anticipated to testify on the Practitioner's behalf, and the President of the Medical Staff shall update the Medical Executive Committee's witness list as previously provided pursuant to Section 10.4 above.

10.12.3 Procedural Disputes

It shall be the responsibility of each party to exercise reasonable diligence in notifying the Chairperson of the Hearing Committee or the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the commencement of the hearing as possible, so that decisions concerning such matters may be made with the least possible disruption of the hearing process. Objections to any pre-hearing decisions shall be noted in the hearing record.

10.13 Hearing Procedure

Both parties may call, examine and cross-examine witnesses, present documentary or other exhibits, and submit written statements at the close of the hearing. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The Hearing Committee and the Hearing Officer may ask questions of any witness.

10.14 Burden or Presenting Evidence and Burden of Proof

The Medical Executive Committee shall have the burden of initially presenting evidence to support the charges and its action or recommendation. The Practitioner shall then have the burden of presenting evidence which demonstrates that the Medical Executive Committee's action or recommendation is arbitrary, unreasonable or not supported by substantial evidence. If the Practitioner is unable to rebut the Medical Executive Committee's case in this manner, the Hearing Committee shall find in favor of the Medical Executive Committee.

10.15 Adjournment and Conclusion

In consultation with the Chairperson of the Hearing Committee, the Hearing Officer may adjourn and reconvene the hearing at such times and intervals as may be reasonable and warranted, with due consideration for the importance of reaching an expeditious conclusion. After the evidentiary presentations have been completed and any closing written statements have been submitted, the hearing shall be concluded.

10.16 Decision of the Hearing Committee

The decision of the Hearing Committee shall be based on the evidence produced at the hearing and any written statements submitted. Within fifteen (15) days following the conclusion of the hearing, the Hearing Committee shall issue a written decision, with a report articulating the connection between the evidence presented at the hearing and the result. The decision and report shall be delivered to the Practitioner, the President of the Medical Staff, the Medical Director and the Chairperson of the Board of Trustees.

10.17 Review and Final Action by the Board of Trustees

10.17.1 Except as provided by separate written contract, there shall be no right of appeal to the Board of Trustees ("the Board"). However, the Board shall have the discretion to defer taking final action pending such further proceedings as it may direct or allow, including, but not necessarily limited to, further proceedings before the Hearing Committee, further fact-finding at the Board level, or an opportunity for oral or written argument, or both, at the Board level. In the case of any contract providing for appeal to the Board, such oral or written argument shall constitute the appeal to the Board. The Board shall endeavor to take final action as soon as possible.

10.17.2 If the Board is satisfied that the Hearing Committee's decision follows from a fair hearing and is consistent with the applicable burden of proof as described in Section 10.14, above, it shall adopt that decision as the final action of the Hospital. If the Board concludes that the Hearing Committee's decision did not follow from a fair hearing or is not consistent with the applicable burden of proof, or both, `the Board shall proceed as it deems necessary and appropriate to address any unfairness and render a final decision that is consistent with the applicable burden of proof.

ARTICLE 11
RULES AND REGULATIONS

The Rules and Regulations may be amended by a two-thirds vote of the voting Members of the Medical Executive Committee present at any regular meeting or by electronic means. Amendments shall become effective when approve by the Board of Trustees.

ARTICLE 12
AMENDMENTS OF BYLAWS

These Bylaws may be amended by any regular meeting of the Medical Staff by a two-thirds vote of the voting Members present and voting, provided there is a quorum and provided that the Staff was informed of the proposed amendment at the previous meeting or by written notice to each voting Member one month prior to the time of voting. Amendments so made shall become effective when approved by the Board of Trustees.

Alternatively, these Bylaws may be amended by solicitation of written ballots. The Bylaws Committee may solicit approval of one or more proposed amendments by mailing/emailing/faxing a ballot and a copy of the proposed changes, which shows both the additions to and deletions from the current Bylaws, to each Member of the Active Staff. The Bylaws Committee may (but is not required to) include a statement of reasons for and/or against one or more of the proposed amendments. The written solicitation shall specify a date by which the ballots must either be physically returned or postmarked in order to be counted, which date shall not be sooner than ten (10) days after the date that the solicitation is mailed. Only timely ballots will be counted, and any proposed amendment that receives the written approval of a majority of the Active Staff shall be approved. The amendments approved by the Active Staff shall become effective when approved by the Board of Trustees.

ARTICLE 13
ADOPTION OF BYLAWS

These Bylaws, together with the appended Rules and Regulations, shall be adopted by a two-thirds vote of the voting Members present and voting, provided there is a quorum, at any regular meeting of the Medical Staff, or by two-thirds of a quorum of the voting Members voting conducted electronically, by mail, or both. They shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Board of Trustees. They shall, when adopted and approved, be equally binding on the Medical Staff and the Board of Trustees.

Originally adopted April 26, 1940.

Revisions:

May 1943	May 1970	May 1993	Rules & Regulations: July 26, 2006
September 1946	December 1974	November 1995	Rules & Regulations, Section 19 & 26: February 06, 2007
September 1948	January 1977	November 1997	Rules and Regulations, Section 7, B 1; Section 10, A, 6, v and vii; Section 19; March 26, 2008
December 1951	June 1979	April 1999	Bylaws – February 24, 2010
October 1954	August 1981	April 2003	January 2011 Rules and Regulations: R3.4, R5.2, R7.1, R10.7.5, R23.1.3.10; R23.4.1
December 1955	June 1986	Bylaws: April 27, 2005	February 2011 Rules and Regulations R6, new section R24 (Anesthesia)
September 1957	March 1987	Rules & Regulations: June 21, 2005	February 2011 Bylaws 3.8, 3.9.1.4,
September 1960	February 1990	Bylaws October 26, 2005	
June 1963	March 1991	Rules & Regulations September 22, 2005	
December 1967	June 1991	Rules & Regulations: May 10, 2006	

Bylaws revisions approved by the Board of Trustees on _____February 15, 2011_____.

Chair, Board of Trustees

Secretary, Board of Trustees

Senior Vice President, Medical Director
Co-Chair, Medical Executive Committee

President, Medical Staff
Co-Chair, Medical Executive Committee

Bylaws Approval: Medical Executive Committee 01/28/10; 2/15/11 Board of Trustees 02/24/10; 2/15/11

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MEDICAL STAFF RULES AND REGULATIONS

SECTION R1
MEMBERSHIP AND DELINEATED CLINICAL PRIVILEGES

R1.1 Medical Staff members must comply with assigned privileges and Medical Staff department requirements, if defined, regarding their availability to provide patient care.

R1.2 All members of the Active, Consulting, and Professional staff must have an email address to assure timely communication of Medical Staff and Hospital information. The Medical Executive Committee must approve exceptions.

R1.3 In specialties in which a specialty certifying board exists, Medical Staff members must become and maintain active certification by the American Board of Medical Specialties of the American Medical Association, or equivalent requirements of the American Dental Association or of another appropriate professional association or society within five (5) years of completion of residency and/or fellowship training. Board certification is necessary to maintain an active appointment status on the Medical Staff. This requirement may be waived for Staff members appointed prior to 1976, or for others upon recommendation of the Medical Executive Committee and approval of the Board of Trustees.

SECTION R2

DISCRIMINATION / HARASSMENT PROHIBITED

R2.1 No aspect of Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, sexual orientation, the type of procedures or patients in which the practitioner specializes or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws, Rules and Regulations of the Medical Staff. However, privileges can be denied if the Hospital cannot safely provide the services requested based upon the availability of the necessary equipment or the training and/or experience of the staff.

R2.2 Harassment by a Medical Staff member, applicant, or Allied Health Professional (AHP) against any individual (e.g., against another Medical Staff member, applicant, AHP, Hospital employee, patient, volunteer or visitor) for any reason including, but not limited to the following: race, religion, color, national origin, ancestry, physical disability, mental disability, marital status, age, sex, gender, sexual orientation, financial status, ability to pay, source of payment or business relationships, shall not be tolerated.

R2.3 “Harassment” is unwelcome verbal or physical conduct which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters, electronic (email) versions of same).

R2.4 “Sexual harassment,” in addition to the above description, is unwelcome verbal or physical conduct of a sexual nature including unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when either:

R2.4.1 Submission to or rejection of this conduct by an individual could be used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment or Medical Staff or AHP status; or

R2.4.2 This conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct that indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

SECTION R3
APPLICATION FOR MEMBERSHIP

R3.1 A completed application must include the following:

R3.1.1 A written application, using the prescribed form, in which all of the requisite information is provided. All entries and attachments must be legible, understandable, and substantively responsive on every point of inquiry.

R3.1.2 Disclosure of previously successful and currently pending challenges to any licensure or registration (state or district, Medicare or Medicaid participation, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

R3.1.3 Disclosure of voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges at another Hospital, health plan, or any other healthcare facility.

R3.1.4 Disclosure of involvement in a professional liability action which is pending or resolved and any final judgments and settlements.

R3.1.5 Relevant information regarding the applicant's experience and current competence as required by the Medical Staff.

R3.1.6 Disclosure of involuntary loss of Medicare or Medicaid provider status.

R3.1.7 Disclosure of conviction for a criminal felony.

R3.1.8 Disclosure of any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect ability to practice with or without reasonable accommodation.

R3.1.9 Disclosure of inability to perform any of the assigned privileges, with or without reasonable accommodation, according to accepted standards of professional standards.

R3.1.10 Disclosure of any present or past monitoring by any body (such as Washington Physician Health Program (WPHP)), including any state agency or private entity, as a condition of maintaining professional licensure in any jurisdiction or clinical privileges at any health care provider.

R3.2 Reappointment of Active Staff shall be dependent on participation in Hospital activities during the previous appointment period and, if required by their staff category, participation in patient care activities at the Hospital and its ambulatory sites and in the business activities of the department and its general medical staff meetings. The level of activity required will be dependent upon the type of appointment and the level of privileges conferred.

R3.3 Any Practitioner who discloses or manifests a qualified physical or mental disability will have his/her application processed in the usual manner without reference to the condition. Only after the determination is made that the Practitioner is otherwise qualified for membership and/or to exercise the privileges requested will the Medical Staff determine if the Practitioner is fit to perform the functions associated with membership and/or the clinical privileges requested. In connection with the foregoing, an applicant shall be required to submit any reasonable evidence of current health status that may be requested by the Medical Executive Committee. As required by law, the Medical Staff and Hospital will attempt to provide reasonable accommodations to a Practitioner with a known physical or mental disability, if the Practitioner is otherwise qualified and can perform the essential function of the Staff appointment and privileges requested in a manner which meets the Hospital and Medical Staff quality of care standards.

R3.4 Peer references are part of the basis for the application for membership or granting/delineation of privileges. These references should have direct and first hand knowledge of the candidate's experience, competence and ability to safely perform the privileges requested and be able to attest to the applicant's moral and ethical behavior.

R3.5 For reappointments to the Medical Staff or renewal/revision of Clinical Privileges, additional information considered about each Applicant includes:

R3.5.1 Evidence of the individual's training and/or certification.

R3.5.2 Evidence of the individual's past and recent professional performance.

R3.5.3 Evidence of the individual's judgment.

R3.5.4 Assessment of any physical condition, mental health condition, or chemical dependency condition (alcohol or other substance) that affects or will affect ability to practice with or without reasonable accommodation.

R3.5.5 Assessment of ability to perform any of the assigned privileges, with or without reasonable accommodation, according to accepted standards of professional standards.

R3.5.6 Assessment of any present or past monitoring by any body (such as Washington Physician Health Program (WPHP)), including any state agency or private entity, as a condition of maintaining professional licensure in any jurisdiction or clinical privileges at any health care provider.

R3.5.7 Activity level at the Hospital.

R3.5.8 Participation in Medical Staff and Department functions.

R3.5.9 Quality oversight activities at other institutions.

Evidence of the individual's recent clinical and/or technical skills, as indicated in part by the results of quality assessment and improvement activities at this Hospital or at other facilities in which the applicant has practiced and held active privileges, the frequency with which the clinical privileges are exercised, continuing education participation, or the

attainment of board certification. These can be evaluated at Children's or another institution at which the practitioner is active.

R3.6 As described in the Practitioner's Right to Review Credentials File policy, applicants and members of the Medical and Allied Health Professional Staff have the right to review their credentialing and privileging files. They have the right to submit documentation to clarify any information they perceive as being erroneous. The process for review and correction is outlined in the Resolution of Discrepancies between Practitioner's Application, Response and Primary Source Verification Information Received policy.

In addition, the applicants and members have the right to know the status of their initial or reappointment application.

SECTION R4
PROVISIONAL PRIVILEGES

R4.1 Applicability and Duration

All Practitioners newly appointed to the Staff, or newly granted clinical privileges (including temporary privileges or new privileges for a Member), are subject to a period of close observation of the quality and competence of the clinical care they provide to their patients. The usual period of focused oversight occurs during the year of provisional privileges. However, this period can be extended by the appropriate Clinical Department's Director or through action of the Medical Executive Committee or Board of Trustees, though it may not exceed twenty-four (24) months. Members may be subjected to continuation as a condition of renewal of Membership and/or Privileges based upon their activity level or performance concerns. The level of oversight required will be determined by the Department and its Director and commensurate with the frequency and potential patient risk of the care they provide. Within these guidelines, each Department may, subject to approval of the Medical Executive Committee and the Board of Trustees, establish a greater minimum length of time, include case review requirements, and/or describe different review schedule methods (e.g., retrospective review, concurrent review, mandatory consultation, or direct observation). During this period, a Practitioner's performance will be reviewed and evaluated by the Division Chief and Department Director in the clinical department in which the Practitioner exercises initial or new privileges (or such person's designee). For Department Directors, oversight will be provided by the Medical Director who may use additional consultative assistance in making this determination.

R4.2 Status and Privileges during a period of Provisional privileges

R4.2.1 During the provisional period, a Practitioner must demonstrate that the qualifications for membership and clinical privileges are being met, and all of the obligations of the Practitioner's Medical Staff category are being fulfilled. A Practitioner's exercise of prerogatives and clinical privileges during the Provisional period is subject to any conditions or limits imposed as part of the Practitioner's staff appointment or granting of privileges, or which may be imposed during the Provisional period as a result of corrective action taken pursuant to the Medical Staff Bylaws.

R4.2.2 During the period of Provisional privileges, the following shall apply to Practitioners:

R4.2.2.1 Practitioners may admit patients if permitted by their staff category and exercise approved clinical privileges.

R4.2.2.2 Practitioners may attend meetings of the Medical Staff and the Department of which the Individual is a Member, including educational programs, and shall have the right to vote at such meeting.

R4.2.2.3 Practitioners shall also be eligible to hold office in the Medical Staff organization, and serve on committees if permitted by their staff category.

R4.3 Requirements for Successful Completion

The Provisional period shall be deemed completed when the Practitioner successfully concludes the first year on the Medical Staff or the period established by the Department's rules and regulations, and the Practitioner's professional performance has met the standard of care of the Hospital as documented by their Division Chief or Department Director. Their file will be presented to the Medical Executive Committee, Joint Conference Committee and the Board of Trustees for advancement to an active staff category. Inactivity can result in a recommendation and decision to extend the provisional period for another year or lead to appointment in a non-active staff category.

SECTION R5
MECHANISM FOR APPOINTMENT AND REAPPOINTMENT TO THE MEDICAL STAFF

R5.1 The Applicants shall receive copies of the Bylaws, Rules and Regulations of the Medical Staff and other materials to familiarize them with the Hospital and activities of the Medical Staff. He/She shall agree in writing to the following:

R5.1.1 To abide by the Bylaws of the Medical Staff, such Rules and Regulations as from time to time may be enacted, and by all other lawful standards and policies of the Hospital.

R5.1.2 To abide by all applicable laws and regulations of governmental agencies and to comply with applicable standards of The Joint Commission ("TJC"), the State of Washington Department of Health or other applicable governmental or oversight organizations.

R5.1.3 To participate in the teaching program of this Hospital and to involve patients in the teaching program to the extent that this involvement contributes to their care and well-being.

R5.1.4 To participate in such emergency services coverage or consultation as may be determined by the Member's Department Director and Division Chief.

R5.1.5 To prepare and complete medical records in a timely fashion as outlined in these Rules and Regulations and applicable Hospital policies.

R5.1.6 To abide by the lawful ethical principles of his/her profession.

R5.1.7 To work cooperatively with Members, Hospital employees including nurses, Hospital administration, and other support staff, so as not to adversely affect patient care or be disruptive to Hospital operations.

R5.1.8 To participate in inpatient and outpatient duties as appropriately assigned.

R5.1.9 To refuse to engage in improper inducements for patient referral.

R5.1.10 To participate in continuing education programs as required by the Medical Staff.

R5.1.11 To attend staff meetings and service conferences as specified by their individual Department's policies or as determined by their Director or Division Chief.

R5.1.12 To advise the Medical Director in writing immediately if at any time he/she has been convicted of, pled guilty, or no contest, to a felony.

R5.1.13 To advise the Medical Director in writing immediately if at any time notification is received that he/she has been excluded from participation in any state or federal programs for the payment of healthcare services, including, but not limited to, Medicare and Medicaid.

R5.1.14 To advise the Medical Director in writing immediately if at any time notification is received that licensure, DEA registration or Hospital privileges and/or medical staff membership elsewhere has been revoked, suspended, curtailed or otherwise restricted.

R5.1.15 To advise the Medical Director in writing immediately of involvement in any professional liability action or change in medical liability coverage.

R5.1.16 In his or her absence, to arrange for appropriate coverage of his/her patients as determined by the Medical Staff.

R5.2 For initial applications, three letters of recommendation that address the applicant's skill and competence, by those who have worked with the applicant within the last 2 years, and are familiar with the applicant's behavior, ethics and clinical practice and technical skill are required. At a minimum, the following core competencies should be addressed: patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and systems-based practice. One letter of recommendation should come from the applicant's department director or division chief at the most recent hospital, or other site of practice. The other two letters of recommendation should come from practitioners in the same discipline (physicians, dentists, psychologists, nurse practitioner or physician assistant) who have worked with the applicant for at least six months. If this individual is within 3 years of completing residency, one letter of recommendation must come from the residency director and should clearly define the cognitive and procedural skills that have been mastered during training as well as address the applicant's interpersonal and professional behavior.

R5.3 The appropriate Department Director and Division Chief and/or Clinic Chief at the Hospital shall make a recommendation regarding any Applicant within such Director's department. Applications with identified red flags (e.g. licensure actions, litigation history) will be reviewed by the Credentialing and Professional Standards Committee before consideration by the Medical Executive Committee. All other applications will go directly to the Medical Executive Committee.

R5.4 The Medical Executive Committee shall consider the recommendation of the Department Director and Division Chief and/or Clinic Chief, as well as the Credentialing and Professional Standards Committee when applicable, following investigation and verification of the application. Prior to forwarding an adverse recommendation with respect to an application to the Medical Executive Committee, the applicant will received notification and have the opportunity for an informal meeting which shall include the Credentialing and Professional Standards Committee, Medical Staff President, Medical Director, Department Director and/or Division Chief discuss the recommendation.

R5.5 After considering the recommendation of the Department Director and/or Division Chief, the Medical Executive Committee shall forward its recommendation to the Board of Trustees of the Hospital, after review by the Joint Conference Committee. If the Medical Executive Committee has an adverse recommendation with respect to an application, the Medical Executive Committee may meet informally with the Applicant to discuss the recommendation before it is forwarded to

the Joint Conference Committee or Board of Trustees. If the adverse recommendation is based on professional competence or conduct, the Medical Executive Committee shall follow the procedure outlined in Article 3 of the Bylaws.

R5.6 Appointment or reappointment to the Medical Staff must necessarily be subject to consideration of available positions, facilities, support personnel, and the needs of the Hospital, the Rules and Regulations of the Medical Staff and its Departments, in addition to the personal qualifications of the Applicant.

R5.7 Completed applications for appointment and reappointment shall be considered in a timely manner (generally within 120 days) by all persons and Committees required by the Medical Staff Bylaws, Rules and Regulations to act thereon.

R.5.8 A Practitioner whose appointment and clinical privileges are subject to expiration may be granted temporary clinical privileges pursuant to Rules and Regulations Section R6.4 to facilitate continued practice at the Hospital, provided that the Practitioner:

R5.8.1 Shall have submitted an application for reappointment and renewal of clinical privileges by the established due date, and

R5.8.2 Shall have rendered the application complete, as necessary, by responding promptly and fully to any requests for additional information or assistance in obtaining it.

SECTION R6
GRANTING AND RENEWAL OF CLINICAL PRIVILEGES

R6.1 Mechanism

R6.1.1 As part of the process of appointment and reappointment to the Medical Staff, a Department Director and the appropriate Division and/or Clinic Chief shall recommend to the Medical Executive Committee the approval or disapproval of delineated clinical privileges for an Applicant requesting such privileges within the Director's discipline.

R6.1.2 If review by the Credentialing and Professional Standards Committee is required, the committee shall review the delineated clinical privileges requested and the recommendations of the Department Director, the appropriate Division and/or Clinic Chief. The committee's recommendation regarding the approval or disapproval of the delineated clinical privileges requested will be forwarded to the Medical Executive Committee.

R6.1.3 The Medical Executive Committee, upon review of the delineated clinical privileges requested and the recommendations of the Credentialing and Professional Standards Committee if required, Department Director, and the appropriate Division and/or Clinic Chief, shall recommend to the Joint Conference Committee and then the Board of Trustees the approval or disapproval of the delineated clinical privileges requested.

R6.1.4 The Board of Trustees, upon review of the application for clinical privileges, and the recommendation of the Medical Executive Committee, shall approve or disapprove the delineated clinical privileges requested.

R6.2 Basis

R6.2.1 The granting of clinical privileges is Hospital specific and based on evidence that the individual has provided and is likely to provide excellent clinical care, demonstrates

current competence, sound judgment, and physical and mental capacity to perform functions inherent to the clinical privileges requested as well as relevant training/experience, current licensure, active board certification or certification within the prescribed time period. In addition, the clinical privileges are site-specific within the Hospital and are dependent upon the physical capabilities and staff training and expertise on each clinical unit. Privileges are related to:

R6.2.1.1 The individual's documented experience in categories of diagnostic and treatment areas or procedures.

R6.2.1.2 The results of treatment.

R6.2.1.3 The conclusions drawn from quality assessment and performance improvement activities when available.

R6.2.2 Board certification for graduates of United States programs is required within five (5) years of the completion of clinical training (residency or fellowship) when delineating clinical privileges unless the candidate qualifies for the exceptions granted in these Rules and Regulations, Section R1.3

R6.3 Limitations

R6.3.1 The delineation of an individual's clinical privileges includes the limitation, if any, to admit, examine, consult and treat or direct the course of treatment for the conditions of the patients seen, evaluated or admitted.

R6.3.2 Individuals granted the privilege to admit to inpatient services are members of the Medical Staff.

R6.3.3 Individuals who diagnose or treat patients, including performing surgical and other invasive procedures, must function solely within the scope of their delineated clinical privileges.

R6.3.4 All individuals with delineated clinical privileges are assigned to, and have clinical privileges in, one clinical department/service and may be granted clinical privileges in other clinical departments/services. The exercise of that department is subject to the policies and procedures of that department and to the authority of the Department Director and Division and/or Clinic Chief.

R6.4 Temporary Privileges

R6.4.1 Conditions. Temporary privileges may be granted in the limited circumstances and under conditions described in Section R6.4.1.2, as shown below, to an appropriately licensed Practitioner, when:

R6.4.1.1 The information available reasonably supports a favorable determination regarding the requesting Practitioner's qualifications, ability and judgment to exercise the privileges requested; and

R6.4.1.2 The Practitioner has satisfied the Hospital's credentialing requirements which are found in Bylaws Article 3. The Medical Director in consultation with the appropriate Department Director may impose such conditions and restriction on temporary privileges as he/she deems necessary, including, but not limited to, requirements of consultation, proctoring and

restrictions on the number and/or types of patients that may be treated. Except as allowed by the Medical Director for good cause, before temporary privileges are granted, a physician must acknowledge in writing that he/she has received, or been given access to, and read the Medical Staff Bylaws, Rules and Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to the temporary privileges including rules and regulations of the designated Medical Staff Department. If granted temporary privileges, a Practitioner shall act under the supervision of the Department Director in which he/she has been assigned, and shall insure that the Department Director or Department Director's designee is closely informed as to the Practitioner's activities within the Hospital.

R6.4.2 Circumstances. Upon the written recommendation of the Director of the Department where privileges will be exercised, the Medical Director, acting on the authority of the Chief Executive Officer of the Hospital, may grant temporary privileges in the following circumstances:

R6.4.2.1 **Pending application:** to an appropriately licensed Applicant to the Medical Staff prior to the Medical Executive Committee making the recommendation on such application and the Board of Trustees taking final action on such recommendation, but only after:

R6.4.2.1.1 A completed application which includes a request for specific temporary privileges has been received;

R6.4.2.1.2 Verification is completed regarding current licensure, DEA registration, professional liability insurance, relevant training or experience, current competence, ability to perform the privileges requested;

R6.4.2.1.3 The National Practitioner Data Bank (NPDB) and Washington State Patrol background queries have been completed;

R6.4.2.1.4 Verification that there are no current or previous successful challenges to licensure or registration;

R6.4.2.1.5 Verification that the Applicant has not been subject to involuntary termination of medical staff membership at another organization;

R6.4.2.1.6 Verification the Applicant has not been subject to limitation, reduction, denial or loss of clinical privileges;

R6.4.2.1.7 Verification that the Applicant has not been excluded from Medicare or Medicaid program participation;

R6.4.2.1.8 Letters of reference have been received;

R6.4.2.1.9 A favorable recommendation has been made by the appropriate Department Director or his/her designee; and

R6.4.2.1.10 Confirmation of compliance with TB screening and immunization requirements.

Temporary privileges may be granted in this circumstance for a time-limited period, not to exceed 120 days.

Temporary privileges are not to be routinely granted for administrative purposes such as the practitioner failing to provide all information necessary to the processing of his/her reappointment in a timely manner or failure of the staff to verify performance data and information in a timely manner.

R6.4.2.2 Care of Specific Patient: Temporary privileges may be granted to meet a specific patient care need, to include a situation where a practitioner becomes ill, takes a leave of absence or where the practitioner's specific skills are needed to provide care to a patient that another privileged Medical Staff member does not possess, but only after:

R6.4.2.2.1 Receipt of a written request for the specific privilege desired;

R6.4.2.2.2 Verification of appropriate licensure, DEA registration and adequate professional liability insurance coverage;

R6.4.2.2.3 The National Practitioner Data Bank (NPDB) and Washington State Patrol background queries have been completed; and

R6.4.2.2.4 A fully positive oral or written reference specific to the privileges being requested from a responsible Medical Staff authority at the Practitioner's current principle Hospital affiliation, preferably one who is known to the Department Director and/or the Medical Director.

Temporary privileges of this nature may not be granted in more than two (2) instances in any twelve-month (12) period, after which the Practitioner must apply for Staff appointment. Temporary privileges of this nature are restricted to the specific patient(s) and privilege(s) for which they were granted.

R6.4.2.3 **Locum Tenens**: To a practitioner who will be serving as a locum tenens for a current Medical Staff member but only after:

R6.4.2.3.1 A complete application for appointment, including a request for specific privileges has been received;

R6.4.2.3.2 Verification is completed regarding current licensure, DEA registration, relevant training or experience, current competence, ability to perform the privileges requested;

R6.4.2.3.3 The National Practitioner Data Bank (NPDB) and Washington State Patrol background queries have been completed;

R6.4.2.3.4 Verification that there are no current or previous successful challenges to licensure or registration;

R6.4.2.3.5 Verification the Applicant has not been subject to involuntary termination of medical staff membership at another organization;

R6.4.2.3.6 Verification the Applicant has not been subject to limitation, reduction, denial or loss of clinical privileges;

R6.4.2.3.7 Verification that the Applicant has not been excluded from Medicare or Medicaid program participation;

R6.4.2.3.8 The application has been processed to the point of letters of recommendation having been received;

R6.4.2.3.9 Favorable recommendation has been made by the appropriate Department Director or his/her designee; and

R6.4.2.3.10 Confirmation of compliance with TB screening and immunization requirements.

Locum tenens privileges may be granted for a maximum period of ninety (90) days, but shall not exceed the duration of services as a locum tenens.

R6.4.2.4 **Termination**. Temporary privileges may at any time be terminated by the Medical Director, after consultation with the Department Director responsible for supervision or his/her designee. In the event of any such termination, the Practitioner's patients then in the Hospital will be assigned to another Practitioner by the supervising Department Director, or the Medical Director in the absence of the Department Director. The wishes of the patient will be considered, when feasible, in choosing a substitute Practitioner.

R6.4.2.5 **Hearing Rights**. A Physician is entitled to hearing rights under Article 10 of the Bylaws when his/her request for temporary privileges is refused in whole or in part, or when, as it relates to professional competence, they are terminated, not renewed, restricted, suspended, or limited in any way.

R6.5 Emergency Privileges

In case of an emergency in which serious permanent harm or aggravation of injury or disease is imminent, or the life of a patient is in immediate danger, and any delay in administering treatment would add to that danger, any Medical Staff member is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the member's license but regardless of Department affiliation, Medical Staff category, or level of privileges. A Medical Staff member acting in such an emergency may request such assistance as may be required to treat the condition causing the emergency. In an emergency situation, a Practitioner providing services that are outside his/her usual scope of privileges shall obtain

consultative assistance if available, as deemed necessary, and shall arrange for appropriate follow-up care.

The Medical Director or his/her designee may grant emergency privileges under circumstances in which there are insufficient Medical Staff members who can perform the service(s) in the time frame that would be beneficial to the patient(s).

R6.6 Leave of Absence

Individuals appointed to the Medical or Professional Staff may, for good reason, be granted leave of absence by the Board of Trustees for a specifically defined period of time, not to exceed the lesser of one year or the remaining period of the current reappointment. Absences for longer than one year constitutes voluntary resignation of Medical or Professional Staff appointment and clinical privileges unless an exception is made by the Joint Conference Committee upon recommendation of the Medical Executive Committee.

SECTION R7
ALLIED HEALTH PROFESSIONALS ("AHPS")

R7.1 Service Authorization (Scope of Practice)

The Board of Trustees, after considering the recommendations of the Medical Staff, may grant Service Authorization to fully licensed AHPs in accordance with their training, experience and demonstrated competence and judgment. Possessing Service Authorization does not otherwise entitle the individual to membership on the Medical Staff. Persons granted Service Authorization must comply with all applicable Medical Staff Bylaws, Rules and Regulations. AHPs must:

R7.1.1 Hold a license, certificate or other legal credential in a category of AHPs which the Board of Trustees has identified as eligible to apply for practice privileges;

R7.1.2 Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise Service Authorization within the Hospital; and

R7.1.3 Adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

AHPs may include qualified, independently licensed practitioners who will be credentialed through the Medical Staff but not granted full staff privileges.

AHPs may not admit patients on their own initiative, but may co-admit patients with a member of the Medical Staff entitled to admit patients. Documentation by the AHP, including patient history and physical examination,, admission, discharge, daily orders, and all clinic and inpatient care for services provided by the AHP must meet all Hospital policies and community standards of care.

AHPs function as licensed independent practitioners in designated settings, including ambulatory clinics, and are individually accountable for evaluation of patients, ordering diagnostic tests, formulation of management plans, writing prescriptions and other orders, patient follow-up, referrals as clinically indicated, appropriate documentation and billing per applicable policies and the AHP's assigned job duties and privileges granted.

The scope and extent of an AHPs Service Authorization must be specifically defined. The clinical work performed shall be under the overall supervision of the Director of the Department in which the AHP possess Service Authorization and the specific supervision of the Physician/Dentist responsible for that particular patient. The nature and degree of supervision is a matter of determination in each individual case. The AHP may document orders within the scope of his/her license.

R7.2 Delineation of Categories of AHPs Eligible to Apply for Service Authorization

R7.2.1 Nurse Practitioners, Physician Assistants and Certified Nurse Anesthetists (ARNP, PA-C And CRNA)

Nurse Practitioners, Physician Assistants and Certified Nurse Anesthetists are credentialed and privileged according to the process described in the Medical Staff Bylaws, Rules and Regulations. The process, which requires Nurse Executive, Medical Executive Committee and Board of Trustees approval is followed for Children's employed and non-employed mid-level practitioners. For Children's employed mid-levels practitioners, all steps in the process must be completed, and approval must be granted by the Board of Trustees prior to the first day of employment. Employment by Children's is a separate process managed through the Human Resources Department. All ARNP, PA-C and CRNA practitioners must maintain current Washington State professional licensure and practice only within their approved scope of practice as well as credentials and privileges. Any non-employed ARNPs, PA-Cs and CRNAs may see patients at Children's only after the completed application file is favorably acted upon by the Board of Trustees.

Nurse Practitioner, Physician Assistant and Certified Nurse Anesthetist status at Children's Hospital may include:

Pediatric Nurse Practitioner (PNP)
Neonatal Nurse Practitioner (NNP)
Family Nurse Practitioner (FNP)
Certified Registered Nurse Anesthetist (CRNA)
Nurse Practitioner or Clinical Nurse Specialist (CNS) in Psychiatric/Mental Health
Certified Physician Assistants (PA-C)

R7.2.1.1 <u>ARNPs, PA-Cs and CRNAs employed by the hospital:</u> It is the responsibility of the practitioner to assure that he/she meets all employment and credentialing / privileging requirements and that all documents are returned within established timeframes.

R7.2.1.2 <u>ARNPs, PA-Cs and CRNAs not employed by Children's:</u> It is the responsibility of the practitioner to assure that he/she meets meet all credentialing/privileging requirements and that all documents are returned within established timeframes.

R7.2.1.3 <u>ARNPs, PA-Cs and CRNAs employed by Children's:</u>

R7.2.1.3.1 It is the responsibility of the Department Manager/Director to assure that all individuals working as ARNPs, PA-Cs or CRNAs_meet employment, licensure, credentialing and privileging requirements in the expected timeline.

R7.2.1.3.2 In addition to the required Children's employment paperwork, newly hired ARNPs, PA-Cs and CRNAs must submit a fully completed application for credentialing and privileging at acceptance of employment. For those employees who are advancing to ARNP, PA-C and CRNA roles (e.g. to an ARNP role) but are not newly hired, a completed application for credentialing and privileging must be completed. Newly hired ARNPs, PA-Cs and CRNAs may not be hired into other temporary roles (e.g. registered nurses or technicians) during the credentialing and privileging process. Persons employed in another role at Seattle Children's Hospital who are hired into ARNPs, PA-Cs and CRNAs positions may not begin orientation or any responsibilities in the department, division, or role until credentialing and privileges are granted by the Board of Trustees.

R7.2.1.3.3 No applicant will be allowed by the Human Resources Department to participate in "Day One" employee onboarding activities until the above credentialing and privileging process has been completed and privileges have been granted by the Board of Trustees

R7.2.1.3.4 Any ARNP, PA-C or CRNA who changes their role or wishes to perform new/additional procedures within Children's Hospital must submit a revised privilege request form, which requires Nurse Executive, Medical Executive Committee and Board of Trustees approval prior to activation of the new role or privileges.

R7.2.1.3.5 ARNPs, PA-Cs and CRNAs employed by Children's: As a condition of their employment, ARNPs, PA-Cs and CRNAs employed by Children's do not receive any privileges of membership on the Medical Staff and specifically waive any rights to the Fair Hearing process provided for under the Medical Staff Bylaws, Rules and Regulations. The Human Resources Dispute Resolution policy/procedures will instead be implemented in those situations where needed.

R7.2.1.3.6 Persons who are educated and/licensed for ARNP, PA-C or CRNA roles that are employed in positions that do not require this level of licensure should refrain from using the designations such as nurse practitioner, ARNP, PA-C or CRNA in communications and clinical documentation at Seattle Children's Hospital.

R7.2.2 Surgical Assistants

Licensed assistants to an Active member of the Medical Staff will be credentialed and have an approved Scope of Practice and Work Content Description approved through normal credentialing processes. A letter of request from the Active staff member will accompany the application. Licensed nurses serving in this role will also receive

signature approval of the Nurse Executive. The applicant will have primary source verification of licensure training and active liability insurance. Proper training and qualification will be confirmed as well as the competency of practice in other Hospitals or healthcare institutions in which the applicant has practiced. Acceptance of an individual to serve as an assistant is granted by the Hospital only to those qualified and continually meeting the standards and requirements of the Medical Staff Bylaws, Rules and Regulations. Acceptance does not grant status as an agent, employee or Medical Staff member. If the membership or clinical privileges of a member of the Medical Staff responsible for the Assistant is rescinded, terminated or restricted in any way, the permission to the Assistant will automatically be terminated.

R7.3 Procedure for Granting Service Authorization

R7.3.1 AHPs credentialed through the Medical Staff must apply and qualify for Service Authorization. Applications for initial granting of Service Authorization and biennial renewal thereof shall be submitted and processed in a parallel manner to that provided for Practitioners, unless otherwise specified in the Medical Staff Rules and Regulations.

R7.3.2 An AHP who does not have licensure or certification in an AHP category identified as eligible for Service Authorization in the manner required by this Section may not apply for Service Authorization, but may submit a written request to the CEO of the Hospital, asking that the Board of Trustees consider identifying the appropriate category of AHPs as eligible to apply for Service Authorization. The Board of Trustees may refer the request to the Medical Executive Committee for recommendation and the Board of Trustees shall consider such request either before or at the time of its annual review of the categories of AHPs.

R7.3.3 Each AHP shall be assigned to the clinical department appropriate to the AHP's occupational license or professional training, and, unless otherwise specified in the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in Article 3 (membership) as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession.

R7.4 Prerogatives

R7.4.1 The prerogatives which may be extended to an AHP shall be defined in the Medical Staff Rules and Regulations or Hospital polices. Such prerogatives may include:

R7.4.1.1 Provision of specified patient care services under the supervision or direction of a physician member of the Medical Staff consistent with the Service Authorization granted to the AHP and with the scope of the AHP's license or certification;

R7.4.1.2 Service on Medical Staff, Department, and Hospital committees; and

R7.4.1.3 Attendance at educational programs in the AHP's field of practice.

R7.4.2 An AHP's prerogatives shall automatically terminate in the event:

R7.4.2.1 The Staff membership of the supervising physician (when required) is terminated, whether such termination is voluntary or involuntary;

R7.4.2.2 The supervising physician no longer agrees to act as the supervising physician for any reason, or the relationship between the AHP and the

supervising physician, if any, is otherwise terminated, regardless of the reason; and

R7.4.2.3 The AHP's certification expires, is revoked or is suspended.

R7.4.3. An AHP's prerogatives may also be terminated by the Director of the Department to which the AHP is assigned, the Nurse Executive (for ARNPs and PA-Cs), the President of the Medical Staff, the Medical Director or the Board of Trustees acting with or without cause.

R7.4.4 For physician assistants: In the event that a sponsoring physician is no longer on the Medical Staff, the AHP's privileges will automatically terminate and the AHP will have thirty (30) days, from the date the sponsoring physician leaves the Medical Staff, in which to obtain another sponsor. If a sponsor is obtained, the appropriate Committee may recommend reinstatement of privileges at the next regularly scheduled meeting.

R7.5 Responsibilities

Each AHP shall:

R7.5.1 Strictly abide by the applicable provisions of the Medical Staff and Hospital Bylaws, all standards, policies and Rules and Regulations of the Medical Staff and Hospital, all applicable laws and regulations of government agencies, applicable ethical code(s) and the Hospital's ethical standards contained in its Compliance plan;

R7.5.2 Exercise appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the Hospital for whom the AHP is providing services; and

R7.5.3 Participate as appropriate in quality assurance assessments and other quality review, evaluation, and monitoring activities required of AHPs, in supervising initial appointees of the same occupation or profession, or of a lesser, included occupation or profession, and in discharging such other functions as may be required from time to time.

SECTION R8
ORGANIZATION OF PROFESSIONAL SERVICES

R8.1 Departments

R8.1.1 The Departments shall be Anesthesiology and Pain Management, Child Psychiatry and Behavioral Health, Dental Medicine, Laboratory Medicine and Pathology, Medicine, Orthopedics and Sports Medicine, Radiology, Rehabilitation Medicine, and Surgery, and such other departments as may be designed by the Medical Executive Committee and approved by the Board of Trustees.

R8.1.2 In the event a Department Director must be replaced, the Medical Director shall appoint the members of a Search Committee and a chair of the Committee. They shall be responsible to identify and make recommendations to the Medical Director regarding Department Director candidates. Upon initiation of a search and receipt of a recommendation regarding a Department Director from the Search Committee, the Medical Director shall discuss the appointment with the Hospital administrative staff and the Chair of the Department of the University of Washington in which the candidate would be appointed. The Medical Director will then appoint the Department Director. Such

appointment shall be subject to the ratification of the Board of Trustees, which shall be made following presentation of the proposed appointment to the Medical Executive Committee. All Department Directors shall serve at the pleasure of the Board of Trustees and shall be subject to annual reappointment by the Board. All Department Directors must become members of the Active Staff and maintain that appointment in good standing.

In the event of a Department Director's death, disability or relocation, the Medical Director and Medical Staff President may appoint a replacement on an interim basis. For the Director of Children's Department of Medicine who is also the University of Washington Chair of Pediatrics, Children's CEO and the Dean of the University of Washington School of Medicine will lead the interim appointment process. The interim appointment will be reported at the next Medical Executive Committee and their recommendation will be forwarded to the Board of Trustees for approval.

R8.1.3 The Department Director shall be responsible through the Medical Director and Quality Improvement Steering Committee to the Medical Executive Committee for the quality of care, treatment and services provided within his/her department. Responsibilities include:

R8.1.3.1 Oversight of the safety and medical standards of clinical care and research activities of the Department.

R8.1.3.2 Administrative oversight of related activities within the Department, unless otherwise provided by the Hospital, including inpatient, ambulatory and satellite services.

R8.1.3.3 Integrating the Department into the operations and goals and improvement methodology (CPI) of the organization.

R8.1.3.4 Working with Hospital administration to define the appropriate scope of services provided by the department, its divisions and its members.

R8.1.3.5 Coordinating and integrating interdepartmental and intradepartmental services.

R8.1.3.6 Developing, implementing, and regularly reviewing policies and procedures that guide and support the provision of clinical services.

R8.1.3.7 Recommending and recruiting a sufficient number of qualified and competent providers to provide safe, timely, effective, efficient, family-centered and equitable care.

R8.1.3.8 Continuing surveillance of the professional performance and behavior of all individuals who have delineated clinical privileges in the department. This includes tracking and communicating to the appropriate parties the findings, conclusions, recommendations and actions taken to prospectively and reactively improve practitioners, division and department performance.

R8.1.3.9 Recommending to the Medical Executive Committee the criteria for clinical privileges in the department with regular review and revisions based upon changing clinical practice.

R8.1.3.10 Recommending clinical privileges for each member of the department at the time of initial appointment and at the biennial reappointment based upon the level of provide activity and/or the outcomes achieved.

R8.1.3.11 Monitoring the qualifications and competence of department/service personnel who are not licensed independent Practitioners and who provide patient care services.

R8.1.3.12 Continuously assessing and improving the quality of care and services provided, including safe, timely, effective, efficient, family-centered and equitable care.

R8.1.3.13 Working in paired accountability with their administrative counterpart to maintain performance improvement and utilization management programs, as outlined in the Hospital's Quality Improvement Plan, including the monitoring of department-specific performance measures.

R8.1.3.14 Orienting and providing for the continuing education of all persons in the Department/Service.

R8.1.3.15 Recommending appointees for membership on medical staff and Hospital committees, workgroups, and taskforces.

R8.1.3.16 Participating in the complaint/grievance process when these are directed to members of their Department.

R8.1.3.17 Recommending the space and other resources needed by the Department/Service.

R8.1.3.18 Assessing and recommending to the Hospital the off-site services and resources for needed patient care services not provided by the Department/Service or the organization, including the annual review and approval of departmental-specific contracted services.

R8.1.3.19 Implementing programs to assure attainment of Hospital and Medical Staff goals as established annually.

R8.1.3.20 Maintaining all external regulatory standards as they apply to their Department, including Joint Commission, Washington State Department of Health, NCQA, etc.

R8.1.4 The Department Director shall be responsible to the Medical Executive Committee and Board of Trustees, through the Medical Director, for the professional care of all inpatients and outpatients assigned to the Divisions and Services within his/her Department.

R8.1.5 The Associate Medical Directors shall be responsible to the Medical Director for overall functioning of the Quality and Safety Performance Improvement Program.

R8.1.6 Surgeon-in-chief and Pediatrician-in-chief work with the Medical Director on matters related to quality, safety and practitioner competency.

R8.1.7 The Director of Graduate Medical Education shall be responsible to the Chief Academic Officer for all post-graduate and undergraduate medical education programs carried out within Children's.

R8.1.8 The Director of Continuing Medical Education shall be responsible to the Chief Academic Officer for the management of all continuing education programs sponsored by Children's.

R8.2 Divisions

R8.2.1 A Department may have two or more Divisions if appropriate. Approval to create a division shall be made with the concurrence of the Medical Director and the Medical Executive Committee and with the approval of the Board of Trustees.

R8.2.2 Division Chiefs shall be appointed by the Department Director with the concurrence of the Medical Director and the Medical Executive Committee. Such appointment shall be subject to ratification by the Board of Trustees. All Division Chiefs serve at the pleasure of the Board of Trustees, and shall be subject to annual reappointment. All Division Chiefs must be members in good standing of the Active Medical Staff. Division Chiefs shall maintain continuous certification in their sub-specialty board unless specifically exempted from this requirement by the Board of Trustees.

In the event of a Division Chief's death, disability or relocation, the Medical Director and Medical Staff President, based on the Department Director's recommendation, may appoint a replacement on an interim basis. The interim appointment will be reported at the next Medical Executive Committee and their recommendation will be forwarded to the Board of Trustees for approval.

R8.2.3 A Division Chief shall be responsible to the Department Director for the clinical activities within his/her Division, including the safe, timely, effective, efficient, family-centered and equitable care provided to patients seen by providers in their areas of clinical responsibility, which includes communication to the appropriate parties of the findings, conclusions, recommendations and actions taken to improve practitioner performance.

R8.3 Clinics

R8.3.1 Clinics may be developed within each Division or Department as appropriate.

R8.3.2 The Department Directors, in consultation with their Division Chiefs, shall appoint Clinic Chiefs with the concurrence of the Medical Director. Such appointments shall be subject to ratification by the Board of Trustees following presentation of the proposed appointment to the Medical Executive Committee. All Clinic Chiefs shall serve at the pleasure of the Board of Trustees and shall be subject to annual reappointment. All Clinic Chiefs must become members of the Active Medical Staff.

R8.3.3 A Clinic Chief shall be responsible to the Division Chief and/or Department Director for the clinical work within his/her service, including the safe, timely, effective, efficient, family-centered and equitable care provided to patients seen by providers in their area of clinical responsibility, which includes communication to the appropriate parties of the findings, conclusions, recommendations and actions taken to improve practitioner performance.

R8.4 Programs

R8.4.1 Programs may be developed within each Division or Department as appropriate.

R8.4.2 The Department Directors, in consultation with their Division Chiefs, shall appoint Program Directors and Clinical Program Directors with the concurrence of the Medical Director. Such appointments shall be subject to ratification by the Board of Trustees following presentation of the proposed appointment to the Medical Executive Committee. All Program Directors and Clinical Program Directors shall serve at the pleasure of the Board of Trustees and shall be subject to annual reappointment. All newly appointed Program Directors and Clinical Program Directors must become members of the Active Medical Staff.

R8.4.3 Program Directors and Clinical Program Directors shall be responsible to the Division Chief and/or Department Director for the clinical work within his/her program, including the:

R8.4.3.1 Safety, timely access, effectiveness, efficiency, family-centeredness, equity of care, and effectiveness of care.

R8.4.3.2 Communication of diagnoses, results and clinical handoffs to relevant practitioners.

R.8.4.3.3 Results of improvement activities related to practitioner performance.

R8.5 Committees and Sub-Committees

R8.5.1 Medical Staff Committee and Sub-committee chairs shall be appointed by the Medical Staff President and Medical Director. Such appointments shall be subject to ratification by the Board of Trustees following presentation of the proposed appointment to the Medical Executive Committee. All Medical Staff Committee and Sub-committee chairs shall serve at the pleasure of the Board of Trustees and shall be subject to annual reappointment.

R8.5.2 Medical Staff Committee and Sub-committee chairs shall be responsible to the Medical Staff President and Medical Director for the work within his/her committee/sub-committee, including the

R8.5.2.1 Safety, timely access, effectiveness, efficiency, family-centeredness, equity of care, and effectiveness of care.

R8.5.3.2 Communication of diagnoses, results and clinical handoffs to relevant practitioners.

R.8.5.3.3 Results of improvement activities related to practitioner performance.

R8.6 Review Process for Administrative Matters

R8.6.1 Consultation with Department Director.

Medical Staff Members should consult with their responsible Department Director, Division Chief, Clinic Chief or Committee/Sub-committee chair regarding any administrative matter about which the Medical Staff Member has a concern. It is the duty of Department Director, Division Chief, Clinic Chief and Committee/Sub-committee chair

to work with the involved Medical Staff Member to attempt to resolve the administrative matter in a reasonable manner consistent with the best interests of the Hospital and its patients. If the Medical Staff Member's concern is not resolved to their satisfaction after this initial consultation reaches the level of the Department Director, the Medical Staff Member may request that the Medical Director review the administrative matter. The Medical Director's review of the administrative matter will be limited to determining whether the Department's response to the concern raised by the Medical Staff Members is reasonable and supported by the circumstances. If, after review by the Medical Director, the Medical Staff Member's concern is not resolved to their satisfaction that Member may request that the Medical Executive Committee review the matter. The Medical Executive Committee's review will again be limited to determining whether the response to the concern raised by the Medical Staff Member is reasonable and supported by circumstances. If it determines that the response is not reasonable and supported by the circumstances, the Medical Executive Committee shall refer the matter back to the Medical Director for further evaluation and review.

R8.6.2 Medical Executive Committee Consideration and Recommendations.

Whenever a Medical Staff Member requests a review by the Medical Executive Committee under this section, the Medical Staff Member shall be entitled to appear before the Medical Executive Committee to present information about the administrative concern. Any other person with relevant information, including the Medical Director and any affected Department Director, Division Chief or Service or Clinic Chief, may also appear and provide information. The Medical Executive Committee may make recommendations to the Medical Director concerning any administrative concern brought to its attention. All involved parties shall seriously consider these recommendations, and the Medical Director and any affected Department Director, Division Chief, or Service or Clinic Chief shall give great weight to them in resolving the concern. In every case where the Medical Executive Committee reviews an administrative concern, the Medical Staff President shall make a written report to the Medical Executive Committee describing the resolution of the concern. This report will be forwarded to the Board of Trustees.

R8.6.3 No Further Review.

Review by the Medical Executive Committee of administrative matters shall be final. The provisions of this section, "Review of Administrative Matters," shall not be deemed to create or modify any legal rights now or later held by any Medical Staff Member.

SECTION R9
MEDICAL STAFF MEETINGS

R9.1 Annual Meeting

An annual meeting of the Medical Staff may be held. The Medical Staff will be informed of the meeting not less than 30 days before the chosen date. This meeting will represent a gathering of the entire medical staff and may include a business meeting to conduct any necessary functions of the medical staff. The officers may make such reports as desirable or necessary.

In addition, business may be conducted through electronic or written means.

R9.2 Special Meetings

R.9.2.1 Special meetings of the Medical Staff may be called at any time by the President and/or the Medical Director, the Board of Trustees, the Medical Executive Committee or a Department Director upon a majority vote of their active members.

R9..2.2 At a special meeting, no business shall be transacted except that stated in the announcement of the meeting. Sufficient notice of any special meeting shall be considered to be seven (7) days and a written and/or electronic notice shall be sent to each voting Member of the Medical Staff.

R9.3 Attendance at Meetings

R9.3.1 The Medical Staff meetings shall conduct the necessary business of the Medical Staff. Other media (including Internet and other electronic modalities) will be utilized to keep the Medical Staff informed about changes in policy, Hospital events, Medical Staff actions and continuing education activities. These meetings may serve a social and self-educational need in addition to conducting the necessary business of the Medical Staff. The Program and Recognition Committee in consultation with the President of the Medical Staff and its officers will choose topics, speakers and activities.

R9.3.2 In the uncommon situation where a specific clinical case is to be presented at a meeting, the Medical Staff Member in charge of the case shall be notified verbally at least twenty-four (24) hours in advance and will be invited to be present at the meeting. The same requirement shall hold for case presentations that are planned for department meetings. If, after notification, they are absent the case will be discussed unless he/she requests postponement of the discussion.

R9.4 Quorum and Manner of Action

R9.4.1 For the regular Medical Staff meetings, or for special meeting of the Medical Staff, ten percent (10%) of the voting members shall be constitute a quorum. A quorum will include those present as well as those represented by mailed or electronically-received ballots.

R9.4.2 The quorum for a departmental meeting shall be determined by the Department Rules and Regulations or in their absence, Robert's Rules of Order.

R9.4.3 Action for any Medical Staff, Committee or Department meeting shall be taken by a majority vote of the voting members present and voting.

R9.5 Minutes

Minutes of the Medical Staff meetings shall be prepared and shall include a record of attendance and the vote taken on each matter. Copies of such minutes shall be approved by the attendees, and are available to the Medical Staff and the Board of Trustees. A permanent file of the minutes of each meeting shall be maintained.

SECTION R10
FUNCTIONS AND RESPONSIBILITIES OF THE MEDICAL STAFF

R10.1 Standing Committees

R10.1.1 **The Bylaws Committee** shall consist of five or more Members of the Active Staff who represent diversity of specialty and site of practice and are representative of the composition and diversity of the Active Medical Staff. The Medical Staff President shall chair the committee. They shall maintain a continuing surveillance of the Bylaws and Rules and Regulations of the Medical Staff. This surveillance shall include a comprehensive review, with recommended revisions (if any), of Medical Staff Bylaws and Rules and Regulations at least every two (2) years. Members shall be appointed by the Medical Director and the President of the Medical Staff and be approved by the Medical Executive Committee. The activities of this Committee will be closely integrated with the Board of Trustees through the Joint Conference Committee.

R10.1.2 **The Credentialing and Professional Standards Committee** shall consist of no less than six (6) Active Medical Staff Members selected to ensure representation of the major specialties. They need not be members of the Medical Executive Committee and are appointed by the Medical Director and the Medical Staff President.. Members are approved for two-year terms and are permitted to serve two consecutive terms. The chair will be the President of the Medical Staff. The duties of the Credentialing and Professional Standards Committee shall be as follows:

R10.1.2.1 To evaluate, in conjunction with the Division Chiefs and Department Directors, the credentials, competence, training and experience, and qualifications of health care professionals applying for Staff membership and to make recommendations on such applications in conformity with the Bylaws.

R10.1.2.2 To evaluate the physical, mental and moral capacity of applicants for membership and/or their requested privileges after their credentials have been otherwise reviewed and approved.

R10.1.2.3 To review biennially (or more often where appropriate), in conjunction with Division Chiefs and Department Directors, all available information and the recommendations of Division Chiefs and Department Directors regarding the credentials, physical and mental capacity, behavioral, ethical standards, competence, qualifications, health, and professional activities of current Members of the Medical Staff, and to make recommendations to the Medical Executive Committee concerning reappointments, terminations, the granting or restricting of privileges and the assignment of Staff Members to various services.

R10.1.2.4 To review the quality of care delivered by Staff Members at such other times as questions may be referred to this Committee by the Medical Director or President of the Medical Staff directly or through quality

oversight activities performed by quality sub-committees within the Hospital or Medical Staff.

R10.1.2.5 To evaluate privilege delineation changes recommended by Division Chiefs and Department Directors to assure clarity regarding training, education, experience and qualification requirements and to forward these recommendations to the Medical Executive Committee.

R10.1.2.6 To evaluate and provide recommendations to MEC regarding requests for new practitioner categories to determine whether to credential and privilege at Seattle Children's.

R10.1.2.7 Receive from Department Directors preliminary recommendations concerning new procedures/techniques. When a Division Chief and Department Director propose to offer a significantly new procedure/technique, the Credentialing and Professional Standards Committee and the Executive Committee shall make a preliminary recommendation about whether the new procedure should be offered, including consideration of the Hospital's capabilities to do so. Before a decision is made to offer the new procedure, the Credentialing and Professional Standards Committee, shall receive recommendations from the Department Director regarding (1) criteria and/or indications for when the new procedure/technique is appropriate; (2) the minimum education, training, and experience necessary to perform the new procedure/technique and (3) the extent of monitoring and supervision that should occur if the privileges are granted. The Credentialing and Professional Standards Committee shall forward its recommendations to the Executive Committee, which shall review the matter and forward its recommendations to the Board for final action.

R10.1.2.8 To evaluate and recommend, in conjunction with the Division Chiefs and Department Directors, to the Medical Executive Committee criteria regarding professional standards, performance expectations, and competency assessment processes.

R10.7.3 **The Nominating Committee** shall consist of at least six members of the Active Medical Staff broadly representative of the composition of the Active members of the Medical Staff, and shall be appointed annually by the Medical Director and the Medical Staff President. The Past President of the Medical Staff shall serve as the chair. In the years where no Past President is in office, the Medical Staff President shall serve as the committee chair. The Nominating Committee shall be charged with maintaining diversity in the selection of the Medical Staff Officers, recognizing over time the diversity of specialty and site of practice of the Active Medical Staff. The Nominating Committee shall also prepare a slate for the election of Members-at-Large of the Medical Executive Committee. There shall be at least one candidate for each position and an opportunity for write-in candidates provided.

R10.7.4 **The Program and Recognition Committee** shall be chaired by the Medical Staff President-Elect. Members of the committee will be appointed by the Chair and Medical Staff President. The Physicians Relations and Medical Staff Services Directors will be standing members of the committee. The Committee shall be responsible for the oversight of medical staff recognition activities and programs, including the Medical Staff social event.

R10.7.5 **The Quality Improvement Steering Committee (QISC)** shall consist of the Medical Director and the Hospital Chief Operating Officer as Co-Chairpersons. Included on the Committee are representatives from the Board of Trustees, Hospital Administration, the Hospital Staff and the Medical Staff. Several members participate as permanent members on the Committee due to the nature of their positions. At-large members shall be appointed for three-year terms by the Co-Chairs. The Quality Improvement Steering Committee shall meet at least 10 times per year. The functions of the Committee may be carried out by the Committee as a whole, or by an appointed sub-committee, task force, workgroup or other delegated agent. These functions shall include:

R10.7.5.1 Reviewing, evaluating, trending, and benchmarking the services rendered in the Hospital, in order to improve the safety, timeliness and ease of access, family experience, effectiveness of all services and care offered to patients; to maintain the appropriate standard of patient care, and to limit Hospital and professional liability.

R10.7.5.2 Overseeing and coordinating the performance improvement activities to maintain the highest standard of medical care, and assure that the information gathered pursuant to the program is used to review and revise Medical Staff and Hospital policies and procedures, inform the purchase and assignment of Hospital resources, establish program and Hospital performance improvement goals and benchmark Hospital clinical performance against similar peer organizations.

R10.7.5.3 Assuring that relevant and appropriate information gathered by the QISC, other Medical Staff Quality Sub-committees and the various Continuous Quality Improvement (CQI) activities of the departments and units is maintained in each individual Medical Staff Member's confidential credentials file maintained by the Medical Staff Office.

R10.7.5.4 Provide a monthly review of its quality oversight activities in the form of minutes and report to the Medical Executive Committee. Quality Improvement Sub-committee minutes will be presented to the Quality Improvement Steering Committee (QISC) for review and/or action.

The Hospital and Medical Staff's Quality Improvement Program. The Hospital, in conjunction with its Medical Staff, shall engage in an organized program of continuous quality improvement directed to enhance patient safety and assure the highest standards of healthcare services to the patients they serve. For purposes of RCW 70.41.200, the Quality Improvement Steering Committee (QISC) shall be deemed the "Quality Improvement Committee" with Board designated overall responsibility for quality-improvement activities at the Hospital. This Quality Improvement program shall be organized and coordinated by the QISC and conducted through standing Sub-committees of the Medical Staff as well as within the individual clinical departments, divisions, sections, Hospital units and programs described in this section. The Medical Executive Committee shall report the results of the organized Quality Improvement program through the Medical Director to the Board Quality Committee and Board of Trustees. All quality improvement activities described in this section shall be confidential and shall be entitled to protection under Washington law as provided in RCW4.24.240, 4.24.250 and 70.41.200 and other applicable state and federal law. This protection exists to encourage candor, constructive criticism, and careful self-assessment. The confidentiality of all information contained in the proceedings, reports, and written records of the Committees shall be carefully maintained. All reports and records shall be marked confidential and secured appropriately.

The Quality and Performance Improvement program with oversight and direction provided by the QISC will establish a number of Sub-committees whose purpose is to monitor internal and benchmark data, review and provide directional guidance on improvement plans and policies, and to address important components of Hospital and Medical Staff patient care activities. Similarly clinical departments, divisions, sections, clinical areas and clinics will also develop local quality oversight programs that will be informed by the action of these Sub-committees and report their activities at regular intervals through the Hospital's Quality Improvement Department with oversight provided by the QISC. These reports, after review, will be forwarded to the Board of Trustees. Except as otherwise provided in this section, Members of these Sub-committees shall serve staggered terms of two years and may be appointed to two consecutive terms. The Medical Director, in consultation with the Sub-committee Chair shall annually appoint the Members of the standing Sub-committees and report such appointments annually to the Medical Executive Committee and the Board for approval. The various Sub-committees include:

R10.7.5.5 **Blood Usage Sub-committee:** shall be chaired by a representative from the Division of Hematology/Oncology who is appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. The Sub-committee will consist of at least ten (10) members appointed by the Chair and the Medical Staff President. Members may represent more than one area, membership will include representation from the Department of Anesthesiology and Pain Medicine, Department of Surgery (thus including the Operating Room), Intensive Care units, Medical Staff, House Staff (one Chief Resident to be identified each year), Nursing, the Transfusion Nurse Consultant, Department of Laboratory Medicine, representatives from the Puget Sound Blood Center and Hospital Administration. The duties of this Sub-committee shall be to deal with all aspects of the safe and effective use of blood and its derivatives during inpatient or ambulatory care. The Sub-committee shall meet at least quarterly or more often at the call of the Chair. Members are approved for two-year terms, with the exception of the one year Chief Resident term. For those members with particular roles, expertise, or interest, there is no pre-determined limit to the number of terms that can be served. Membership is reviewed yearly by the Chair.

The Sub-committee will suggest, review and revise all Hospital policies that relate to the collection, preparation, ordering or delivery of blood products to patients cared for in the Hospital. Blood product ordering and safe administration practices will be an educational focus of the Sub-committee. Utilization practices by the Medical Staff will be monitored and feedback provided to departments, clinical units and practitioners.

R10.7.5.6 **Cancer Sub-committee:** The requirements outlined in the most current Commission on Cancer Program Standards will be followed. The sub-committee shall consist of physician and non-physician members in accordance with the Cancer Program Standards published by the Commission on Cancer and in a manner complementary to the Cancer Committee with the Seattle Cancer Care Alliance (SCCA). The Chair shall be recommended by the Medical Staff President and approved by the Board of Trustees. Members will be appointed by the Chair and President of the Medical Staff. The Sub-committee shall meet at least three (3) time a year or more often at the call of the Chair. The duties of the Sub-committee shall be to assure safe and effective care as follows:

R10.7.5.6.1 Develop and evaluate the annual goals and objectives for the clinical, educational and programmatic activities related to cancer;

R10.7.5.6.2 Promote a coordinated, multidisciplinary approach to patient management;

R10.7.5.6.3 Ensure that educational and consultative cancer conferences cover all major diagnoses and related issues;

R10.7.5.6.4 Ensure that an active supportive care system is in place for patients, family and staff;

R10.7.5.6.5 Monitor quality improvement through completion of quality management studies which focus on quality, access to care, and outcomes;

R10.7.5.6.6 Promote clinical research;

R10.7.5.6.7 Supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up reporting;

R10.7.5.6.8 Perform quality control of registry data;

R10.7.5.6.9 Encourage data usage and regular reporting; and

R10.7.5.6.10 Uphold medical ethical standards

The Cancer Sub-committee shall have the following sub-groups:

R10.7.5.6.11 **General Oncology Tumor Board, Neuro-Oncology Tumor Board and Non-Malignant Board:** shall consist of weekly (every two weeks for the Non-malignant Board) patient-oriented and consultative discussions with didactic presentations. The purpose of Tumor Boards is to improve patient care by providing consultative services to patients and educating the Medical Staff. Information discussed at the tumor boards is confidential and considered part of the Quality Improvement and Performance Improvement process. Physician representatives from Surgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology and other appropriate disciplines shall attend and participate in the General Tumor Board. Physician representatives from Neurosurgery, Medical Oncology, Radiation Oncology, Diagnostic Radiology, Pathology and other appropriate disciplines shall attend and participate in the Neuro-Oncology Tumor Board. Physician representatives from Hematopoietic Cell Transplantation, Hematology, Immunology, Infectious Diseases, and other appropriate disciplines shall attend and participate in the Non-Malignant Board. The ultimate treatment decision rests with the managing

physician, who is responsible for considering various opinions and determining what management is most appropriate for the patient.

R10.7.5.6.12 Seattle **Cancer Care Alliance (SCCA) Pediatric Operations Leadership Continuous Quality Improvement Committee:** shall meet at least quarterly to identify program performance or quality improvement issues, review ongoing monitors, oversee areas of improvement, and assist in implementing and evaluating change. These activities will be reported to and reviewed by the Cancer Sub-committee and from there to the QISC, the MEC and the Board of Trustees. Membership shall include representatives of the following disciplines: Physicians, Advanced Practice and Staff Nurses, Pain Management, Pharmacy, Dietary, Social Work, Recreational Therapy, and Cancer Registry. The Cancer Sub-committee Chair and the Hospital's cancer liaison physician shall be members of this Sub-committee, providing input and direction as appropriate.

R10.7.5.7 **Clinical Standards Sub-committee**

The Clinical Standards Committee (CSC) will be a multidisciplinary clinical committee responsible for the recommendation, review and approval of clinical standard work. Clinical standards will be judged according to evidence based or best practice guidelines to improve patient safety, quality, delivery, cost, and effectiveness of clinical care and in keeping with Seattle Children's Hospital use of continuous performance improvement philosophy and principles. Clinical standard work will include the following elements: consciously developed and documented, always followed, owned by someone (clinical service leader), measured as the basis for improvement and includes the application of time whenever possible.

The CSC will be co-chaired by a medical staff member physician and a nursing representative. The CSC shall consist of a minimum of five (5) Medical Staff Members with at least one voting member from Medicine, Surgery, Orthopedics, Radiology and Anesthesia. Additional voting members should include a Chief Medical Resident, and representatives from Nursing, Respiratory Therapy, Information Services, Clinical Effectiveness, Pharmacy, Health Information Management, Hospital Administration and Compliance. Additional members shall also ensure representation from Rehabilitation Medicine, Psychiatry and Behavioral Medicine, Pain Service, Oncology, Critical Care, and the Emergency Department.

The physician co-chair shall be appointed by the Medical Staff President and Medical Director upon approval by MEC and the nursing co-chair by the Chief Nursing Officer and both will be approved by the Board of Trustees. The members of the Sub-committee shall be appointed by the co chairs with input from the Medical Staff President, Medical Director, Pediatrician in Chief, Surgeon in Chief and Chief Nursing Officer. Members are approved for two-year terms. The chairs will manage the

rotations on and off the CSC to ensure the continued representation above and continuity of the CSC mission and knowledge base. The Sub-committee shall meet monthly or more often at the call of the Chairs, to perform the following duties:

R10.7.5.7.1 The committee will work closely with related existing committee structures including but not limited to the Quality Improvement Steering Committee (QISC), Pharmacy and Therapeutics (P&T) Committee, the Medical Informatics/Records Committee, the Nursing Evidence Based Practice Committee as well as the Nursing Quality Practice Council (QPC) to create, review and revise policies and procedures to further the development, implementation and monitoring of the use and the effectiveness of clinical standard work in all SCH settings. The CSC will develop the criteria to govern the level of review required by CSC. The CSC will be accountable for reporting the implementation and results of clinical standard work to the Medical Executive Committee, QISC, Board Quality Committee and other groups as appropriate.

R10.7.5.7.2 The CSC will review changes to the configuration of the Clinical Information System (CIS) or any other part of the electronic medical record that affect clinical standards and that are not governed by the P&T or Medical Informatics/Records Committees.

R10.7.5.7.3 The CSC will receive and review the proposals from Clinical Effectiveness prior to the submission of these proposals to the Medical Executive Committee for final approval and signature by the Pediatrician in Chief and the Chief Nursing Officer.

R10.7.5.8 **Code Blue Sub-committee:** shall be responsible for the development, revision and oversight of all policies and procedures relating to the management of cardiopulmonary arrests and resuscitation throughout each of the Hospital's practice sites. They will assume the responsibility of assuring safe and effective care, standardization of equipment, training, medications/doses, response teams and resuscitation carts. The Sub-committee is charged with determining the level of readiness of all staff at the Hospital and its practice sites, minimal competency training, the composition and roles of the Code Blue Team, and the team notification process. The Sub-committee will organize routine training exercises (mock codes) on the clinical units and care delivery sites. The Sub-committee is responsible for the review of all Code Blue Team responses regardless of site of occurrence, The Sub-committee will review the timeliness of the response, the overall management of the team and the level of pre-arrest recognition of impending cardiac-respiratory compromise. The Chair will be recommended by the Medical Staff President and Medical Director, approved by the Board of Trustees and will be a member of the Critical Care, Neonatology, Emergency Medicine Divisions or Anesthesiology and Pain Management Department. The Chair and the Medical Staff President will appoint at least eight (8) members, including representatives of the

Departments/Divisions of Surgery, Anesthesiology and Pain Management, Emergency Medicine, Neonatology, Critical Care, Pharmacy, Nursing and Respiratory Therapy.

R10.7.5.9 **Ethics Sub-committee:** is a multidisciplinary committee composed of Medical Staff, Nursing, Social Work, other clinical providers, Ethicists, Pastoral Care, and Administrative staff, and at least one person who will fill the role of advocate for persons with developmental disabilities.. The Sub-committee serves as a consultative body to members of the Medical and Hospital Staff, and to families and patients in the area of individual patient care concerns. The Sub-committee also provides educational opportunities to all Hospital providers as well as forums for discussion of broad ethical issues or concerns in the complex delivery of pediatric health care. The Chair of the Sub-committee is appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. The Chair and the Medical Staff President will appoint a minimum of eight (8) members to the Sub-committee representing the named disciplines. In making the appointment of a member to fill the role of advocate for persons with developmental disabilities, the Chair, the Medical Director of their delegate will consult with Disability Rights Washington (the successor name for Washington Protection and Advocacy System) so long as an agreement exists between Children's and such organization providing for such consultation. Ad-hoc membership will be utilized by the Chair as necessary to assure adequate experience and expertise, including experience and expertise on issues involving individuals with developmental disabilities, is available for consultation and education.

R10.7.5.10 **Infection Prevention Sub-committee:** shall be chaired by a member of the Division of Infectious Disease and appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. Members of the Sub-committee are appointed by the Chair and the Medical Staff President. Members shall consist of at least six (6) members and shall include representatives of the Medical Staff, Nursing Services, Hospital Infection Prevention, Occupational Health and other clinical providers and Hospital Administration. Members, with the exception of the Director of Infection Prevention, are appointed for two-year terms and are permitted to serve two consecutive terms.

The Sub-committee provides consultative resources for infection prevention functions that apply broadly within the organization and that require multi-disciplinary coordination. The committee delegates to infection prevention practitioners (ICPs) daily and on-going management of programs and policies for the surveillance of healthcare associated infections, the isolation of patients with communicable diseases, the maintenance of standards of asepsis and sanitation and, in conjunction with the Pharmacy and Therapeutics Sub-committee, the review of activities which monitor the use of antibiotics. The Associate Medical Director for Patient Safety has the responsibility and authority, working in conjunction with the Medical Director, to institute appropriate control and prevention measures or studies when it feels that there may be an infection hazard to patients, personnel and/or visitors. This committee meets on an as-needed basis.

R10.7.5.11 **Medical Informatics / Medical Records Sub-committee:** shall consist of a minimum of eight (8) Medical Staff Members with representation from Medicine, Surgery, Psychiatry and Behavioral Health, Rehabilitation Medicine, Orthopedics and Dental Medicine, a Chief Medical Resident, representatives from Nursing, Hospital Administration, Information Services, Compliance and the Director of Health Information Management (HIM). The Chair shall be appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. The members of the Sub-committee shall be appointed by the Chair and the Medical Staff President. Members are approved for two-year terms and are permitted to serve two consecutive terms. The Director of HIM will be a permanent member of the Committee. The Sub-committee shall perform the following duties:

R10.7.5.11.1 Create, review and revise Medical Staff and Hospital policies, rules and regulations relating to medical records (paper or electronic), including medical record completion, approved forms, formats, filing, indexing, storage, destruction, availability, privacy, confidentiality, and recommend methods of enforcement thereof.

R10.7.5.11.2 Maintain a record of all actions taken and submit periodic reports and recommendations to the Medical Executive Committee concerning medical records practices and performance and the Medical Staff's adherence to established standards.

R10.7.5.11.3 Assure that the medical records conforms to all external regulatory requirements and the forms selected assist providers in assuring compliance with the regulations while maintaining a complete and accurate historical account of the patient's care.

R10.7.5.11.4 Establish and monitor record completion standards including the imposition of restrictions and suspensions of Medical Staff privileges for failure to complete medical records in a timely fashion. This information will be provided to the Medical Staff Office for inclusion with the Member's file at the time of reappointment.

R10.7.5.11.5 Conduct regular chart pertinence reviews that focus on areas of patient safety, areas of high potential risk management, Hospital goals and external regulatory standards. The results of these audits are forwarded to the clinical department and the QISC at regular intervals for review and action.

R10.7.5.11.6 Assume an institutional leadership role in the development of an electronic medical record and the security and confidentiality provisions necessary to maintain patient privacy.

R10.7.5.12 **Nutrition Sub-committee:** is responsible for the development, review and revision of standards, policies, and systems that relate to the nutritional (both enteral and parenteral) management and support of children cared for in any location within Children's Health Care System. The Co-chairs of the Sub-committee are appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. The Co-chairs will include one member of the Division of Gastroenterology and the Director of Clinical Nutrition. The Sub-committee will be multidisciplinary, be comprised of a minimum of six (6) members that will include Nutrition, Pharmacy, Surgery, Medicine and Nursing. Sub-committee members will be appointed by the Chair and the Medical Director.

Quality goals for the Sub-committee will include:

R10.7.5.12.1 Review and assist with the implementation of nutritional risk screening and the evaluation of physical growth and nutritional status of children served at all of the Hospital's sites.

R10.7.5.12.2 Establish standardized tools to monitor growth and adequate nutrition in all children seen within the Hospital's practice sites.

R10.7.5.12.3 Establish, review and revise, as appropriate, written guidelines, policies and procedures, and standing order forms related to the provision of total parenteral nutrition (TPN) and enteral feedings at Children's.

R10.7.5.12.4 Establish and approve any changes to the enteral formulary and make recommendations for parenteral products.

R10.7.5.12.5 Establish competencies for non-physician practitioners to assist in documenting orders for parenteral and enteral nutrition.

R10.7.5.12.6 Identify and address the educational needs of students, residents, and the Medical Staff in the areas of pediatric nutrition.

R10.7.5.12.7 Audit regularly the provisions of their services and appropriately report findings to the QISC and the Medical Executive Committee.

R10.7.5.13 **Pain Management Sub-committee:** shall consist of the Pain Treatment Service Director as its Chair and a minimum of eight (8) members including the Chair. The Chair will be appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. Members will be appointed by the Chair and the Medical Staff President and shall include representatives from those disciplines and clinical services most frequently involved with the evaluation and treatment of acute, chronic, terminal and procedural pain. Consideration will be given

to representation of all clinical service areas (Ambulatory, Emergency Services, Inpatient and Surgical Center). The ARNPs on the Pain Treatment Service and a Family Advisory Council member shall also be included.

The Sub-committee shall focus on the following areas:

R10.7.5.13.1 System-wide quality improvement efforts related to pain management by analyzing selected trends and patterns, choosing priority indicators for improvement efforts, and communicating the results and recommendations to clinical services.

R10.7.5.13.2 Advising clinical units and services on management of quality improvement efforts.

R10.7.5.13.3 Designing system-wide improvement efforts for the detection, evaluation and treatment of pain (e.g., policy development and documentation changes).

R10.7.5.14 **Professional Review Committee**: Any professional review committee created under Article 9 of the Medical Staff Bylaws shall function as a sub-committee of the Quality Improvement Steering Committee.

R10.7.5.15 **Pharmacy and Therapeutics Sub-committee**: shall consist of a minimum of four (4) Medical Staff members and representatives of Pharmacy, Nursing, and Hospital Administration. The Co-chairs shall be appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. Members are appointed by the Chair and Medical Staff President with input from the Director of Pharmacy. Representation from Oncology, Critical Care, Anesthesiology, Surgery, Medicine and the Emergency Department will be assured. The Sub-committee shall be responsible for overseeing all medication use processes of the organization, including but not limited to creating a reporting system for medication errors and “close calls”, developing and maintaining an up-to-date online formulary for the organization and investigating adverse drug reactions. The Sub-committee shall serve in an advisory capacity to the Director of the Pharmacy in regards to drugs stocked.

The Sub-committee will play a critical role in supporting a culture of medication safety and incident reporting throughout the institution. They will create, revise and oversee all organizational policies, including unit-based policies that deal with any aspect of medication use within the institution. They will conduct drug usage evaluations (DUEs) for the clinical departments and clinical units to assist them in developing more standardized and evidence-based patterns of medication usage throughout the organization. The Sub-committee will bear overall responsibility for safe and informed medication usage at each site of care within the organization.

R10.7.5.16 **Practitioner Well-Being Sub-committee** is an advocacy committee for distressed and/or high risk members of the Medical Staff including, if applicable, Allied Health Professionals who have been credentialed. The Sub-committee shall consist of at least six (6) Members of the Medical Staff. The Chairperson will be a member of the Department of Psychiatry and Behavioral Medicine and will be appointed by the Medical Staff President and Medical Director and approved by the Board of Trustees. Members shall be appointed by the Chair and the Medical Staff President and will be representative of the various departments with representation from both CUMG faculty and community Medical Staff Members. Members are approved for two (2) year terms and are permitted to serve two consecutive terms. To the extent possible, Members of the Sub-committee shall not serve concurrently on another performance review or disciplinary committee, such as a Peer Review Committee, which has review authority over Members of the Medical Staff. In no event shall such Sub-committee members participate in the concurrent peer review of a Member who has been referred to this Sub-committee. The Sub-committee shall include at least one member with special interest/knowledge of impairment issues.

The Sub-committee shall meet semi-annually, or as necessary, to perform the following duties:

R10.7.5.16.1 Hear complaints against any Medical Staff member for whom there are suspicions of physical or mental health impairment that adversely affect the clinical practice or behavior of that individual. The Sub-committee may deal directly with the provider involved. If it is felt health impairment is not a factor and/or that disciplinary action is warranted, the Sub-committee will furnish its recommendations to the Medical Director to present to the Medical Executive Committee for discussion and resolution. The Medical Director or Medical Executive Committee may refer the issues to a Professional Review Committee for evaluation and recommendations.

R10.7.5.16.2 Receive reports related to the health, well-being, or impairment of Medical Staff Members and, as it deems appropriate, investigate such reports. Its investigations shall be confidential, and it will respond and make recommendations only to the referral source and to the practitioner in question. All contacts with the Sub-committee will be confidential and will be protected under applicable state law.

R10.7.5.18.3 Provide advice and recommendations, including education for the Medical Staff Member in question. The Sub-committee shall not provide treatment for a practitioner but shall refer to appropriate sources for treatment. The Sub-committee shall be concerned primarily with the needs of the Member in question. However, in the event the information received by the

Sub-committee demonstrates that the health or known impairment of a Medical Staff Member poses a risk of harm to patients seen within the Hospital, that information shall be referred to the Medical Director for corrective action. The Medical Director and President of the Medical Staff shall be advised of any significant discussions. The Sub-committee shall have no authority to take disciplinary action.

R10.7.5.16.4 Educate its members and Members of the Medical Staff about physician health, well-being and impairment, about the appropriate responses to different levels and kinds of distress and impairment, and about appropriate resources for prevention, treatment, and rehabilitation.

R10.7.5.16.5 All records shall be kept confidential and will be protected under applicable state law. General activities of the Sub-committee (e.g., educational functions) may become part of general Medical Staff records. However, any record regarding an individual practitioner to whom assistance is offered or provided shall be kept secured and separate, not circulated with other Medical Staff records, and maintained absolutely confidential.

R10.7.5.17 **Sedation Sub-committee (Sub-committee)** is chaired by an anesthesiologist. He/She is appointed by the Medical Staff President and Medical Director following nomination by the Director, Department of Anesthesiology and Pain Medicine. The Sub-committee members will consist of at least one representative for each site in which procedureal sedation is performed. In addition, there will be at least one representative from each of Medical Staff Services, Quality Improvement, and Regulatory Compliance. The responsibilities of this Sub-committee will be:

R10.7.5.17.1 Recommend criteria for privileging and ongoing competency of sedation providers;

R10.7.5.17.2 Develop, revise and disseminate evidence-based best practice policies and guidelines addressing procedural sedation through the Hospital and its practice sites;

R10.7.5.17.3 Ensure that hospital policies regarding procedural sedation are revised at regular intervals;

R10.7.5.17.4 Ensure that hospital policies comply with state and federal requirements and accreditation standards (e.g. WA Department of Health, The Joint Commission and CMS);

R10.7.5.17.5 Provide education to staff regarding safe and appropriate use of procedural sedation;

R10.7.5.17.6 Provide consultation from Sub-committee members, as requested to address specific patient or clinical unit concerns or questions; and

R10.7.5.17.7 Coordinate all quality and performance improvement activities through the Hospital that relate to procedural sedation.

R10.7.5.18 **Solid Organ Transplantation Sub-committee** (Sub-committee): shall consist of physician and non-physician members and include but not be limited to the major clinical programs (cardiac, kidney, liver, small bowel) and the major clinical services (surgery/transplant surgery, urology, cardiac surgery, gastroenterology, nephrology) as well as essential support services (medical imaging and laboratory medicine). The Co-Chairs and administrative lead shall be appointed by the Medical Director and the President of the Medical Staff, and approved by the Board of Trustees. The Co-Chairs will appoint the members of the Sub-committee. The Co-Chairs will be composed of a surgical and medical physician who practice transplant medicine. The administrative lead will be the Director of the Transplant Service Line. Some members of the Sub-committee will be permanently appointed by virtue of their administrative position(s) in transplant medicine. The Sub-committee will meet at least quarterly or more often at the call of the Co-Chairs.

The duties of the Subcommittee shall be as follows:

R10.7.5.18.1 Develop, approve and evaluate the performance of the annual goals and objectives of the clinical, educational and quality improvement programs for transplant medicine at Children's.

R10.7.5.18.2 Promote a coordinated, multidisciplinary approach to patient management that is consistent with Children's policies and procedures and consistent (when appropriate) across each of the transplant programs and clinical units on which transplant patients are cared for.

R10.7.5.18.3 Assure that Children's is in compliance with, and assumes a leadership role in devising and implementing the policies relating to regional and national organ procurement agencies (UNOS), state regulations (DOH) and national accreditation bodies (JCAHO) as they relate to organ procurement and transplantation.

R10.7.5.18.4 Ensure that internal and external communication and education of Children's staff and the public supports the national UNOS goals of assuring maximal access for all patients to life saving organ transplants.

R10.7.5.18.5 Review the outcome data for each of the transplantation programs and track these compared to national and regional rates. Define outlier indicators and conduct internal reviews of programs in which performance falls below national norms.

R10.7.5.18.6 Suggest the need for external program reviews to the Medical Director when indicated.

R10.7.5.18.7 Evaluate Children's utilization and outcome performance (e.g. charges, LOS) compared to other CHCA participating children's hospitals.

R10.7.5.18.8 Report annually in writing to the Quality Improvement Steering Committee on program data trends and results of efforts to improve transplant services.

R10.7.5.19 **Tissue Sub-committee:** shall consist of an Anatomic Pathologist as Chairperson appointed by the Medical Staff President and Director of Laboratories and approved by the Board of Trustees. The Chair and the Medical Staff President shall appoint the members of this Sub-committee. They shall include a minimum of eight (8) members including at least two representatives from the Department of Surgery, and the remaining members from departments actively involved in tissue acquisition and handling, such as Gastroenterology, Nephrology, Dermatology, Oncology and Radiology. The Sub-committee shall meet quarterly or more often at the call of the Chair. Members are approved for two-year terms and are permitted to serve two consecutive terms.

The Tissue Sub-committee shall review the macroscopic and microscopic analysis of all tissues removed in operations and procedures conducted by the Medical Staff and identify any major discrepancy, or a pattern of discrepancies, between preoperative and postoperative (including pathologic) diagnoses. The Sub-committee shall also evaluate the appropriateness and adequacy of tissue handling, the completeness of sample collection at surgery, and other aspects of tissue collection such as adequacy of provided clinical information deemed necessary by the committee.

R10.7.5.20 **Utilization Review Sub-committee (URC)** will be a multidisciplinary clinical committee that monitors the utilization review process. The utilization review process ensures that all patients (regardless of type of insurance or source of payment) admitted to the hospital are initially reviewed and are concurrently monitored for the appropriateness of admission, continued stay necessity and discharge appropriateness. The review process is based on the Severity of Illness and Intensity of Service criteria. The guidelines from Interqual® are utilized for all reviews. Other utilization improvement opportunities identified through the admission and concurrent review activity are addressed on a patient specific basis.

The URC will be Co-Chaired by a medical staff member physician and the Director of Care Coordination. The URC shall consist of a minimum of three (3) Medical Staff Members (one of whom is the Co-Chair) with at least one voting member from Medicine and Surgery. Additional members shall also ensure representation from Social Work, Shift Administrator, Revenue Cycle, Corporate Compliance, utilization review, and RN Care Coordinator.

The physician co-chair shall be appointed by the Medical Staff President and Medical Director upon approval by MEC and the Co-Chairs will be approved by the Board of Trustees. The members of the Sub-committee shall be appointed by the co chairs with input from the Medical Staff President, Medical Director, Pediatrician in Chief, Surgeon in Chief and the Vice President for Continuous Performance Improvement. Members are approved for two-year terms. The chairs will manage the rotations on and off the USC to ensure the continued representation above and continuity of the URC mission and knowledge base. The Sub-committee shall meet monthly or more often at the call of the Chairs, to perform the following duties:

R10.7.5.20.1 Implement procedures for reviewing all stages of hospital admissions, including but not limited to medical necessity for admission, assignment of appropriate levels of care, potential over/under utilization of ancillary services, delays in services, lengths of stay and timeliness of discharge.

R10.7.5.20.2 Report review findings and recommendations to the QISC, Medical Executive Committee and/or other Medical Staff and hospital entities as appropriate.

R10.7.5.20.2 Review trend reports on third party payer denials, make recommendations relative to contracting language, take appropriate actions on findings as needed.

R10.7.5.20.3 Collect and analyze data necessary to carry out these responsibilities.

R10.7.5.20.4 Analyze issues, problems (system, or individual case) or individual cases identified through utilization review activities. Make recommendations for resolution and/or refer to the appropriate entities for resolution.

R10.7.5.20.5 Evaluate all hospital specific communications from inter and external entities related to utilization review activities.

R10.7.5.20.6 Monitor compliance to utilization review policies and procedures. Update the applicable policies and procedures to assure an effective utilization review program.

SECTION R11
ADMISSION OF PATIENTS

R11.1 The Hospital shall provide care for any child in our referral area, regardless of their ability to pay, up until the age of twenty-one (21) years unless otherwise defined by Department protocol and/or Hospital policy. Under special circumstances, as outlined in the Hospital's "Over Age 21 Years" Policy, young adults may be provided with transitional care at the Hospital.

R11.2 Except in emergency, all patients shall have a provisional diagnosis made at the time of admission.

R11.3 Physicians and dentists admitting a patient shall be held responsible for disclosing information reasonably known to them as may be necessary to assure the protection of other patients or Hospital personnel from any danger that might be posed by such patient.

R11.4 Only physicians, dentists, and other licensed independent practitioners who have been duly appointed to membership of the Medical Staff or have been granted temporary privileges in accordance with the Bylaws may admit and accept responsibility for the care of patients in conformance with the specific privileges as granted by the Board.

SECTION R12
ASSIGNMENT OF PATIENTS

R12.1 Every patient admitted to the Hospital will have a responsible physician/dentist in charge. If the patient is admitted to a dual service, the Attending whose name appears first on the admission record is the physician/dentist in charge. Attending Staff shall be notified in a timely fashion of any admissions scheduled to their service.

R12.2 Attending physicians agree to provide continuous care to any patient admitted to their service. The patient may be transferred to another attending physician's service with the concurrence of the receiving physician. The transferring physician is responsible for notifying the patient and family of this transfer and this change should be clearly identified in the medical record.

R12.3 High quality and ethical care to patients requires objective patient assessment and medical decision making. To assure this principle is adhered to in each patient encounter medical staff members agree not to, except in life threatening emergencies where appropriate specialty assistance is not available, provide medical care or treatment at Children's Hospital to their immediate family members. "Immediate family member" is defined at Children's as the provider's children, stepchildren, foster children, grandchildren or nieces and nephews. Physicians are not precluded from treating the children of colleagues, close friends or neighbors but the medical staff member should consider his/or her ability to provide objective care.

R12.4 Patients without an attending physician who will care for the patient during admission will be assigned to the on-call attending physician on the service most appropriate to meet the patient's medical need.

R12.5 The physician/dentist who attends the child in the Hospital must adhere to the rules of the Hospital as they apply to service rendered, including the Hospital's Compliance Program and the rules applying to documentation of services and the reporting of physician services.

R12.6 All patients without an attending physician and who do not definitely fall within a surgical discipline and who enter directly through a clinic without a definite diagnosis or plan of treatment,

shall be assigned to the Medical Service. Treatment, consultation or transfer to another service shall be undertaken only with the approval of the attending physician.

R12.7 All surgical patients without a defined attending physician entering directly or through clinic without definite diagnosis or plan of treatment shall be assigned to General Surgery. Treatment, consultation or transfer to another service shall be undertaken only with the approval of the assigned attending physician.

R12.8 Dentists and psychologists who admit patients shall assume primary responsibility for the patients, but in each case shall designate a staff physician who will be available for consultation and responsible for management of any medical problems, which may be present or arise during the Hospitalization. Such patients requiring admission shall have a history and physical examination performed by a licensed Practitioner within the thirty (30) days prior to admission and recorded on the chart.

SECTION R13
AUTOPSIES

R13.1 No autopsy shall be performed without written or verbal consent from parent or legal guardian.

R13.2 Criteria for performing autopsies are identified in Hospital policy and approved by the Medical Executive Committee.

R13.3 In all medical examiner's cases, regulations set by the coroner or Medical Examiner's office shall be followed.

SECTION R14
CONSULTATIONS

R14.1 Consultations are strongly encouraged in all major cases in which the patient is at high risk for mortality or morbidity (except in an emergency), when the diagnosis is obscure, a known or suspected pregnancy will be interrupted, or in operations performed for the sole purpose of sterilization of either male or female patients. Consultation is urged prior to performance of a surgical procedure involving more than one specialty field.

R14.2 A record of consultation shall be documented in the medical record and shall be signed by the consultant.

R14.3 The attending physician/dentist/psychologist, requesting a consultation, shall document the request, indicate the specific components of the consultation that are requested, and the urgency of the consult in the medical record.

R14.4 In any case where consultation is requested solely for the protection of the Hospital, the consultant shall give his/her services without charge.

SECTION R15
DISCHARGES

R15.1 The resident or intern may document a discharge order only on approval of the attending physician or dentist.

R15.2 At the time of discharge, all medical records must have a final diagnosis, follow-up plan and discharge medications indicated on the discharge order or discharge form of the medical record.

SECTION R16
LABORATORY

R16.1 General laboratory services shall be provided in the Hospital and may be increased in scope as warranted by demand and facilities. Laboratory procedures, which cannot be carried out in the Hospital, may be referred to outside laboratories when requested by the Director of Laboratories. The Director and the Medical Executive Committee are responsible for the quality oversight of these outside referral labs.

R16.2 Policies concerning laboratory examinations on private outpatients, when requested by staff physicians, will be determined by the Director of Laboratories. Arrangements must be made through the Laboratory Department and the clinic supervisor must be advised when such service is being provided.

R16.3 All tissues and foreign bodies removed at surgical operation in the Hospital shall be handled in accordance with the requirements of The Joint Commission as outlined by the Tissue Sub-committee. The pathologist shall conduct examinations as necessary to arrive at a diagnosis and shall submit a signed report.

R16.4 The Hospital Laboratory shall be the center for the dispensing of blood and blood products obtained from the Puget Sound Blood Center.

SECTION R17
MEDICAL CARE

R17.1 Members of the Medical and Allied Health Professional staff will comply with all policies regarding communication of orders and results, including any required documentation and read-back of results.

R17.2 Medical Staff Members shall be responsible for all medical orders for patients in their care. This is true whether orders are written by house officers or by the attending doctors themselves. All paper orders shall be dated, timed, and have legible name, signature and pager number as outlined in the applicable organizational policies and procedures. Orders placed electronically will follow the policies outlined in the applicable organizational policies and procedures. All active staff are required to complete Clinical Information System (CIS) training.

R17.3 Dentists, oral surgeons and psychologists shall give such orders as are legally recognized to fall within their province.

R17.4 A Staff Member caring for the house or clinic patients shall notify their Department Director and Division Chief of an unexpected absence and arrange for coverage of his/her service when for any reason he is unable to take care of his/her assignments. The Department Director and Division Chief will notify all concerned as to whom to call during the absence of the Staff Member.

R17.5 A "Code Status or Do Not Resuscitate (DNR)" order is written in the CIS, Forms tab, Other Patient Information section and displayed on the Yellow Banner to alert all staff involved in the care of a patient about which measures, if any, are to be instituted in an attempt to resuscitate the patient or otherwise prolong life in the event of a cardio-pulmonary arrest. The decision should be made after discussion with the patient's family or legal guardian and, when appropriate, the patient, consultants, Ethics Committee or assigned Committee consultant, House Staff and Nursing Staff intimately involved with the patient's care. Whenever possible, a Code Status order should be written by the attending physician of record. In certain emergent situations another physician may document a verbal order from the attending physician who must then countersign the order within forty-eight (48) hours and encouraged to do so within twenty-four (24) hours. (See Policy and Procedure on Withdrawing or Withholding of Life-sustaining Medical Intervention).

SECTION R18
MEDICAL RECORDS

R18.1 The appropriately privileged Medical or Allied Health Professional Staff member shall be responsible for the timely completion of the medical record for each patient on his/her service as defined in the policies and procedures of the institution including but not limited to the medical record documentation policies.

R18.2 Although information for a patient's chart may be obtained and reported by a medical student, resident or fellow or other trainee, the attending Medical Staff member shall have final responsibility for the accuracy and timely completion of the chart. The attending Medical Staff member is responsible for the final completion of the medical record within thirty (30) days. Certain note types (e.g., Emergency Department, operative and clinic notes) may have specific timeframe requirements as defined in the Medical Record Documentation policy. No chart may be filed permanently until the chart is complete, except on order of the chair of the Medical Informatics/Medical Records Committee.

R18.3 A complete history and physical examination on each patient shall be documented within twenty-four (24) hours after admission, except if:

R18.3.1 A copy of a history and physical examination completed within thirty (30) days prior to admission is acceptable if an updated medical record entry documents an examination for any changes in condition within twenty-four (24) hours after admission.

R18.3.2 The above section also applies to a patient readmitted for treatment of the same or related problem within thirty (30) days.

R18.4 Progress notes shall be entered on the chart of each patient frequently enough to provide an accurate and complete chronological record of the patient's care and this shall be the responsibility of the attending physician. Significant changes in the patient's status must be documented.

R18.5 A final discharge diagnosis for each Hospital admission shall be recorded in the discharge order without abbreviations or symbols.

R18.5 Discharge and expiration summaries should be documented according to the Medical Record Documentation policy but not longer than twenty-four (24) hours after discharge to facilitate communication within the primary care provider. The discharge summary should include

pertinent instructions given to the patient and/or family, particularly in regard to physical activity limitations, medications, diet and follow-up care.

Discharge summary must be dictated for any of the following reasons if the patient is :

- Hospitalized over 48 hours (for SCCA patients - over 72 hours)
- In the ICU and does not have an Interim Summary dictated that is less than 48 hours old
- Transferred to another Hospital or care facility
- Transferred/admitted from another health care facility (including newborns)
- Referred to Child Protective Services (CPS) or is treated for child abuse/neglect

R18.6 The attending Medical Staff member shall complete the record within thirty (30) days of the discharge of his/her patient. No chart may be filed permanently until the chart is complete, except on order of the Medical Informatics/Medical Records Committee.

R18.7 In case of readmission of a patient, all previous records shall be available for the use of the Medical Staff.

R18.8 All medical records are the property of the Hospital, and may be removed from the Hospital only in response to a subpoena *duces tecum*, statute or court order. The legally authorized representative may review a patient's records and request copies of any portion of those records in accordance with Medical Records policy and in keeping with applicable state and federal regulations (e.g. Health Insurance Portability and Accountability Act – HIPAA). Radiology films may be loaned, with permission of Radiology, upon physician/dentist request for patient care purposes.

R18.9 All medical student admission notes and orders require countersignature by a resident, fellow or staff physician.

R18.10 All verbal orders should be co-signed within 48 hours.

R18.11 Failure to follow the rules and regulations or the applicable documentation policies may be grounds for suspension of privileges according to the Delinquent Medical Records / Sanctions policy.

SECTION R19
MEDICINES

Medication ordering will follow the policies and procedures of the Pharmacy and Therapeutics Committee. Whenever possible, the Hospital drug formulary shall be used. When drugs other than those listed in the formulary are used for private patients, a special charge may be made to the patient.

SECTION R20
AMBULATORY SERVICE(S)

R20.1 An attending physician shall be responsible for each patient seen in the Emergency Department unless the patient is referred in for a diagnostic test as outlined in the Emergency Services Organizational Structure policy.

R20.2 Doctors serving in the Ambulatory Department(s) shall document or dictate their findings and recommendations in sufficient detail that an adequate summary report can be sent to the referring physician or agency when appropriate.

SECTION R21
ORGANIZED HEALTH CARE ARRANGEMENT

R21.1 Purpose. The Medical Staff and the Hospital participate in a clinically integrated care setting where patients receive treatment from the Medical Staff (consistent with their clinical privileges) and from Hospital employees, contract staff, residents, and students. This clinically integrated care setting qualifies as an organized health care arrangement (OHCA) under the HIPAA Privacy Standards (45 CFR Part 164). This section of the Medical Staff Rules and Regulations documents the OHCA between the Hospital and the Medical Staff, and sets forth the obligations of Staff Members in relation to their participation in the OHCA.

R21.2 Requirements. As participants in the OHCA, each Staff Member shall:

R21.2.1 Use and disclose Protected Health Information (PHI) to the Hospital for treatment, payment and health care operations of the OHCA.

R21.2.2 Comply with and be subject to Hospital policies and procedures when using or disclosing PHI (personal health information) maintained or to be maintained by the Hospital for OHCA purposes.

R21.2.3 Abide by the Hospital's Notice of Privacy Practices when engaging in treatment, payment, and health care operations related to activities of the OHCA.

R21.2.4 Comply with all applicable laws and regulations, including without limitation, state and federal laws and regulations related to health information privacy, security, confidentiality, consent, access and disclosure, including the Privacy Standards and Washington Uniform Health Information Act, RCW Chapter 70.02.

R21.3 Limitations. The OHCA described in this section is established for the sole and limited purpose of meeting the OHCA requirements set forth in the HIPAA Privacy Standards. The OHCA shall not: (a) be construed to establish the Hospital, the Medical Staff, or any independent member of the Medical Staff, as partner, joint venturers or otherwise as participants in a joint or common undertaking of any kind, or (b) allow the Hospital, the Medical Staff, or any independent member of the Medical Staff to create or assume any obligation or liability on behalf of each other.

SECTION R22
RESEARCH

R22.1 Charts pulled for research or review must be studied as soon as possible. Chart review must be approved (usually expedited review) by the Hospital's IRB. Charts shall be returned to the medical record files in a timely manner.

R22.2 Requests for permission to initiate research projects involving patients or patient records shall be submitted to Children's Institutional Review Board (IRB) on forms provided by the Hospital for this purpose.

R22.3 Summaries and findings of all research projects carried out in the Hospital shall be filed with the IRB.

SECTION R23
OPERATIVE AND INVASIVE PROCEDURES

R23.1 Except in emergency attested to in writing on the patient's chart by the attending surgeon:

R23.1.1 A child may not be operated upon nor given an anesthetic unless an authorization for inpatient or outpatient medical care has been signed by the competent patient, the parent or guardian.

R23.1.2 An informed consent form must be signed by the patient or other legally authorized representative prior to performance of any surgical procedure requiring informed consent.

R23.1.3 Every patient scheduled to undergo an operative or invasive procedure with or without anesthesia must have a written history and physical examination completed within thirty (30) days of the procedure. A pre-operative History and Physical Exam requires sufficient information for safe conduct of a planned operative procedure. Those elements that at a minimum must be addressed in that pre-operative History and Physical Exam include:

R23.1.3.1 A date and time of completion

R23.1.3.2 Signature of the individual completing the History and Physical Exam

R23.1.3.3 A description of the condition(s) requiring the proposed procedure(s)

R23.1.3.4 The duration of the condition(s)

R23.1.3.5 Associated medical condition(s)

R23.1.3.6 Present medications

R23.1.3.7 Medical, food, latex, or other allergies (may be documented in CIS)

R23.1.3.8 Pertinent family history (e.g., malignant hyperthermia) and review of systems

R23.1.3.9 The procedure or surgery

R23.1.3.10 A focused physical exam that supports the presence of the pathology that will be treated and the overall health of the child that will allow the child to safely undergo the procedure or surgery

The pre-operative history and physical examination may be performed by a physician, an oromaxillofacial surgeon, or other qualified individual in accordance with State law. In addition, resident physicians at any level of training may perform the documentation of the History and Physical Exam. The clinician performing the procedure must indicate review of the History and Physical Exam and assumes responsibility for the findings. The documentation of the History and Physical Exam may be documented by a combination of the anesthesiologist and proceduralist in any format that reliably conveys the necessary elements in a legible format to the operating team, including a dictated note such as a clinic or office note, or a printed Children's form. Examples of acceptable forms include the "Surgical Admit / Day Surgery form (#52047), the Emergency

Department (#51678), Initial Consult (#51772), Outpatient Clinic Visit (#51596), or any other Hospital approved form that includes the necessary elements itemized above.

The clinician performing the operative or invasive procedure(s) is responsible for:

R23.1.3.11 The presence of the History and Physical Exam before the procedure begins.

R23.1.3.12 Verifying the date and the format of the History and Physical Exam by documenting that on the Surgery Boarding Pass (#52192) or any other form approved for this purpose.

R23.1.3.13 A history and physical examination, if performed within thirty (30) days, must be updated within twenty-four (24) hours of the procedure with a medical record entry documenting an examination for any changes in the patient's condition.

R23.1.3.14 Sufficient evaluation of any medical condition or comorbidity that might adversely affect the conduct of or recovery from the invasive procedure.

If anesthesia is to be administered, there must be written documentation by an anesthesiologist or his or her designee that a pre-anesthetic assessment was performed. This may include referenced documentation completed by other approved practitioners. The proposed anesthetic plan should be part of this documentation.

The combination of the pre-operative History and Physical Exam, the Boarding Pass, and the pre-anesthetic assessment should provide a comprehensive and complete pre-operative record that will optimize the conduct of a safe peri-operative course.

R23.1.4 A child may not be given an anesthetic in the absence of a documented preoperative examination made within twenty-four (24) hours prior to the time of surgery. The patient is reevaluated immediately before anesthesia induction.

R23.2 The processes outlined in the Universal Protocol will be followed to prevent wrong-site, wrong-procedure and wrong-person procedures.

R23.3 Each surgeon or appropriately credentialed provider performing a procedure shall assume complete responsibility for any operation that he/she performs or the portions of which he/she assigns to a resident.

R23.4 The primary clinician performing a procedure performed under anesthesia must document the following:

R23.4.1 A brief post-operative note must be documented on an approved form (operative procedure note) or other method approved by the Medical Informatics/Medical Records Committee. It should include: pre-operative diagnosis, post-operative diagnosis, the name of the primary clinician performing the procedure and assistants involved, procedure performed and description of the procedure, findings, type of anesthesia administered, estimated blood loss and specimen removed (if applicable).

R23.4.2 The operative note must be documented (dictated) immediately following the procedure.

R23.5 Surgical procedures and the administration of anesthetics and sedative agents shall be done only by those physicians to whom these privileges have been given.

R23.6 Treating physicians/dentists document a post-anesthetic visit on short-stay cases.

R23.7 Rules and regulations governing the operating suite shall be formulated through the cooperation of the Surgeon-in-Chief or designee, the Director of Anesthesiology and Pain Management and the Director of Surgery. Unresolved problems shall be referred to the Operating Room Committee for discussion and recommendation. If the problem is still not resolved the problem should be submitted to the Medical Director for resolution or for presentation to the Medical Executive Committee.

R23.8 Failure to comply with the above provisions is grounds for suspension of operative or procedural privileges pending formal review or resolution.

SECTION R24
PROVISION OF ANESTHESIA SERVICES

R24.1 Anesthesia services are provided by qualified individuals according to their training/education, experience, current competency and privileges approved by the Board of Trustees. (Details of the general privileging process are found in Rules and Regulations Section R6.)

R24.2 General anesthesia, regional anesthesia, monitored anesthesia care (MAC), and deep sedation can only be administered by an appropriately privileged anesthesiologist, other qualified physician, dentist or oral surgeon, or a CRNA (with supervision).

R24.3 Topical anesthesia, local anesthesia, minimal sedation, and moderate sedation may be administered by an appropriately trained and privileged medical practitioner (including licensed independent practitioners) working within the scope of practice.

R24.4 Anesthesia services providers are expected to follow hospital policies.

SECTION R25
TRANSFERS

R24.1 Transfer of any patient to another Attending physician must be approved by the then-current attending physician.

SECTION R26
AMENDMENT OF THE RULES AND REGULATIONS

These Rules and Regulations may be amended by a two-thirds vote of the voting Members of the Medical Executive Committee present at any regular meeting or by electronic means. Amendments shall become effective when approved by the Board of Trustees.

Adopted: April 1940
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