



**BYLAWS, RULES AND REGULATIONS**

**OF THE MEDICAL STAFF**

**OF SEATTLE CHILDREN'S HOSPITAL**

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Bylaws Approval: Medical Executive Committee 1/30/2020 Board of Trustees 2/5/2020

Rules and Regulations Approval: Medical Executive Committee; 1/30/2020 Board of Trustees 2/5/2020

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**BYLAWS, RULES AND REGULATIONS  
OF THE MEDICAL STAFF  
OF SEATTLE CHILDREN'S HOSPITAL**

**PREAMBLE**

These Bylaws are adopted to provide for the organization of the Medical Staff of Seattle Children's Hospital and to provide a framework for self-governance 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 to participate in overseeing the quality of medical care and the standards of practice at the Hospital. The best interests of the Hospital's 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 Credentials and Medical Staff Committee, acting with the delegated authority of the Hospital's Board of Trustees, to the Medical Staff shall be permitted to independently provide care to patients in the Hospital. 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. **ADVANCED PRACTICE PROVIDER (APP)** means an Advanced Registered Nurse Practitioner (ARNP) or Physician Assistant-Certified (PA-C).
2. **ADVERSE** means an unfavorable action or outcome that may limit, restrict, reduce, suspend or terminate Medical or Allied Health Professional Staff membership and/or privileges.
3. **ALLIED HEALTH PROFESSIONAL (AHP)** means an individual, other than a Physician, Dentist or Clinical Psychologist 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.
4. **APPLICANT** means an individual applying for appointment or reappointment to the Medical or AHP Staff.
5. **ARNP** means an Advanced Practice Registered Nurse Practitioner.
6. **BOARD CREDENTIALS AND MEDICAL STAFF COMMITTEE** is a Board of Trustees committee, which provides a formal and informal medical-administrative liaison between the Board of Trustees, the Medical Staff and Hospital leadership to improve a mutual understanding of the challenges and activities of the Board of Trustees, the Medical Staff, and Hospital leadership. This committee has the Board of Trustees-delegated authority to approve specific Medical Staff related activities as outlined in the committee description in these Bylaws.
7. **BOARD OF TRUSTEES** means the governing body of the Hospital.

8. CLINICAL PRIVILEGES or PRIVILEGES means the permission granted by the Medical Executive Committee and the Board Credentials and Medical Staff Committee to a Member of the Medical Staff or AHP Staff to render specific patient services, based on the Provider's professional license and documented competence, experience, and judgment.
9. CHIEF MEDICAL OFFICER (CMO) means a Physician employed by, or otherwise engaged by the Hospital, whose duties include certain responsibilities that are both administrative and can be clinical in nature. Administrative duties include, but not limited to responsibility for the quality of clinical care provider by the Members of the Medical Staff and its departments. Responsible, in conjunction with the Medical Staff President, for administrative oversight of the credentialing and privileging processes and ensuring compliance with related federal and state laws and regulatory requirements.
10. 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 in the State of Washington.
11. COMPLETED APPLICATION means an application, either for initial appointment or reappointment to the Medical or AHP Staff or for Clinical Privileges, as determined by the applicable Medical Staff Division(s), Department(s), Credentialing and Professional Standards Committee, Medical Executive Committee, and Board Credentials and Medical Staff Committee to meet the requirements of these Bylaws and Rules and Regulations, and to contain sufficient information to act upon the application.
12. 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 business days after it was deposited in the United States mail, postage prepaid.
13. DAYS mean calendar days, unless otherwise specified as business days.
14. 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 in the State of Washington.
15. 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.
16. DIVISION means a clinical sub-specialty service of a Medical Staff Department, grouping Members within their sub-specialty as specified in Section R8 of the Rules and Regulations. The Medical Staff Division is not necessarily the same as the Hospital operating division or an equivalent division at the University of Washington School of Medicine.
17. 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.
18. HE/SHE means "he or she" and is intended to refer to an individual without respect to gender.
19. HOSPITAL means Seattle Children's Hospital located in Seattle, Washington and regional locations covered under the Hospital's license.

20. MEDICAL EXECUTIVE COMMITTEE means the Executive Committee of the Medical Staff, which shall constitute the governing body of the Medical Staff described in these Bylaws.
21. MEDICAL STAFF or STAFF means those Physicians, 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.
22. MEDICAL STAFF YEAR means the period from October 1 to September 30.
23. MEMBER means, unless otherwise expressly limited, any Physician, 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.
24. PA / PA-C means licensed physician assistant. Also referred to as Advanced Practice Provider (APP).
25. 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.
26. PRESIDENT OF THE MEDICAL STAFF means a Member of the Active / Active Community Medical Staff who is elected in accordance with these Bylaws to serve as Chief Officer of the Medical Staff. Responsible, in conjunction with the Chief Medical Officer, for administrative oversight of the credentialing and privileging processes and ensuring compliance with related federal and state laws and regulatory requirements.
27. PROVIDER means either a Member of the Medical or Allied Health Professional staff.
28. 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 the Hospital."

## **ARTICLE 2**

### 2.1 Purposes

The Medical Staff shall be accountable to the Board of Trustees for the following:

- 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 assure the appropriate professional performance and ethical conduct of its Members.
- 2.1.5 To initiate and maintain such rules and regulations and internal organization necessary to allow the Medical Staff to discharge its responsibilities 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 as verified through primary sources.

To be a Member of the Medical Staff 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.
- 3.1.2 Legally licensed to practice in the State of Washington, and other states as required for approved sites of practice. (See exception under Article 4.4 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 Credentials and Medical Staff Committee 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 Credentials and Medical Staff Committee.
  - 3.1.5 Willing to adhere to these Bylaws and Rules and Regulations and the professional standards of the Medical Staff, as well as the Hospital's ethical standards contained in its Corporate Compliance Program and its Compliance Code of Conduct, 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 or as required for applicable regulatory or billing purposes. DEA certificate must be specific to each site of practice.
- 3.2 Discrimination / Harassment Prohibited
- Discrimination and/or harassment by Members of the Medical Staff and AHP 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 or AHP membership or clinical privileges.
  - 3.3.2 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 Credentials and Medical Staff Committee 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 10 of these Bylaws.

- 3.3.4 All appointments shall be made by the Board Credentials and Medical Staff Committee for an initial provisional period of one year, thereafter reappointments are for a period of two years, or as otherwise specified by the Board Credentials and Medical Staff Committee.
- 3.3.5 Biennially, the Board Credentials and Medical Staff Committee 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 Credentials and Medical Staff Committee, upon recommendation of the Medical Executive Committee.
- 3.3.7 The Medical Executive Committee shall make recommendations to the Board Credentials and Medical Staff Committee on all Medical Staff and AHP staff appointments and reappointments. In any case in which the Board Credentials and Medical Staff Committee decision is inconsistent with the Medical Executive Committee's recommendations, they will confer with the Medical Executive Committee and the Board Credentials and Medical Staff Committee shall meet in an attempt to resolve any such differences. If such differences are not resolved, the Board Credentials and Medical Staff Committee shall make a recommendation to the Board of Trustees and shall communicate the Medical Executive Committee's recommendation. In such case, the Board of Trustees shall be the final decision maker.

#### 3.4 Initial Appointments to the Medical Staff

Initial appointments to the Medical 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 Credentials and Medical Staff Committee.

#### 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 Credentials and Medical Staff Committee shall consider the recommendation of the Medical Executive 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 Credentials and Medical Staff Committee the Applicant will be notified of the decision. 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 Provider 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, unless there is an extension approved by the Medical Executive Committee and the Board Credentials and Medical Staff Committee. A Provider 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 Provider 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 a 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 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 time period defined by appropriate specialty board, or to maintain board certification.

3.7.4 After the waiting period, the Applicant may reapply; however, any such reapplication shall be processed as an initial application, and the Applicant shall submit such additional in-

formation as may be required to demonstrate that the basis for the earlier adverse action no longer exists and/or that the Provider 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 Credentials and Medical Staff Committee 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 Credentials and Medical Staff Committee 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 Provider:

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 representatives of the Hospital and the Medical Staff who acts in accordance with the provisions of the Article.

3.9.1.3 Acknowledges that the provisions of these Bylaws that create applicable obligations or requirements are express conditions to the application for, or acceptance of, Staff membership and continuation of such membership, or to the exercise of Clinical Privileges or provision of specified patient services at the Hospital.

3.9.1.4 Agrees to adhere to medical records documentation requirements, including but not limited to, 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 within 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 Provider submitted, collected or prepared by any individual or any representative of the Hospital 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 on a need to know basis, 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 Hospital general 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 Medical 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 acting in good faith shall be liable to an Applicant or Provider for damages or other relief, for any action taken or statements or recommendations made within the scope of his/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 Provider

or Applicant for damages or other relief, by reason of providing information in good faith, including otherwise privileged or confidential information, to any health care facility, organization of health professionals, professional society or licensing authority concerning a Provider or Applicant.

### 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, including performance plans that are not considered corrective action.
- 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 Provider's or Applicant'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 Provider and Applicant 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 Credentials and Medical Staff Committee 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 Credentials and Medical Staff Committee 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 other federal healthcare benefit program or the Hospital Compliance Program;
- 3.11.1.5 Failure to complete medical records in a timely manner as required by the Medical Informatics Committee policies;
- 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 the Hospital;
- 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 Hospital 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 Credentials and Medical Staff Committee. Adverse actions under this Article 3.11 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 Chief Medical Officer, who shall determine what, if any, further proceedings are warranted and make a final decision. The Chief Medical Officer may, but shall not be obligated, to submit the matter to the Board Credentials and Medical Staff Committee for a final decision at that level. An Applicant who wishes to challenge an action that has been initiated by the Board Credentials and Medical Staff Committee may request reconsideration, and the Board Credentials and Medical Staff Committee will determine what, if any, further proceedings are warranted and make a final decision.

## **ARTICLE 4 THE MEDICAL STAFF**

The Medical Staff and Allied Health 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 Staff membership is available to Applicants and Members who are able to provide safe and timely patient care at the Hospital approved sites of practice and to participate in Hospital, Department and Committee activities and appointments consistent with their role.

4.1.2 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, Medical Executive Committee and Board Credentials and Medical Staff Committee of quality measures relevant to each active Member's scope of practice and Clinical Privileges. In certain instances additional review by the Risk Management department and Credentialing and Professionals Standards Committee may be required prior to review by the others previously noted. Specific review criteria are established for each Department with the approval of the Medical Executive Committee.

## 4.2 Active Community Staff

- 4.2.1 The Active Community Staff shall consist of Members of the Medical Staff actively involved in caring for the health needs of children in the community. Members in this staff category no longer wish to maintain Clinical Privileges to care for their patients in the Hospital inpatient or outpatient setting.
- 4.2.2 Continued partnership with Active Community Medical Staff Members is important and valuable to the Hospital. To foster this partnership, Members of this staff category shall be eligible to vote, hold office in the Medical Staff organization, and participate as voting members of committees.
- 4.2.3 Active Community Members shall apply for membership and meet the requirements for initial appointment and reappointment. Privileges will not be requested or approved for Members in this category.
- 4.2.4 Active Community Members are not subject to requirements such as: initial privilege competency assessments, 360° evaluations, immunizations or ongoing professional practice evaluation (OPPE). Exemption from similar requirements will be determined by the Credentialing and Professional Standards Committee and approved by the Medical Executive Committee.
- 4.2.5 Active Community Members are expected to meet a minimum of two of the following criteria to maintain staff membership:
- 4.2.5.1 Participate in a Hospital Medical Staff or Quality Improvement Steering Subcommittee;
  - 4.2.5.2 Maintain a teaching appointment at the University of Washington School of Medicine;
  - 4.2.5.3 Refer patients to the Hospital (inpatient or outpatient) every two years;
  - 4.2.5.4 Participate in a Hospital competency activity simulation every two years;
  - 4.2.5.5 Participate in a Hospital continuous performance improvement (CPI) activity every two years;
  - 4.2.5.6 Participate in Hospital based office-based research;
  - 4.2.5.7 Participate in Hospital Maintenance of Certification (MOC) activities; or
  - 4.2.5.8 Attend or participate online a minimum of five Grand Rounds every two years.



Other qualification criteria may be recommended by the Credentialing and Professional Standards Committee and approved by the Medical Executive Committee.

Members must attest at the time of reappointment that they meet the minimum requirements for continued Staff membership.

#### 4.3 Consulting Staff

- 4.3.1 The Consulting Staff shall consist of specialists with procedural or disease-specific expertise who provide care of a more episodic nature at the Hospital, 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 Hospital 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.
- 4.3.2 Consulting Staff shall apply for membership and meet the requirements for initial appointment and reappointment.
- 4.3.3 Consulting Staff are subject to requirements established by the Hospital, the Medical Staff, the Department and Division (if any), including but not necessarily limited to such requirements as initial privilege competency assessments, annual immunization requirements, annual Hospital Acquired Infections training (as defined by the Medical Executive Committee), and ongoing professional practice evaluation (OPPE). The initial privilege competency assessments and OPPE, including 360° evaluations, will be satisfied through receipt of a letter from the division or department leader at their primary site of practice.
- 4.3.4 The Consulting Staff must partner with an active staff Member of the Hospital Medical Staff. Active Staff members partnering with the Consulting Staff are responsible for verifying completion of all orders, documentation, communication and follow-up with families.
- 4.3.5 The Consulting Staff may consult up to six (6) times annually; more than this level will require application for Active Staff Membership and Clinical Privileges.
- 4.3.6 The Consulting Staff shall be granted consulting Clinical Privileges only. They may not hold active attending Clinical Privileges. No other category of Staff may be granted consulting privileges.
- 4.3.7 The Consulting Staff may not vote, hold office or serve on Medical Staff committees.

#### 4.4 Exempt Staff

- 4.4.1 Providers not licensed in the State of Washington but licensed to practice in another state in which he / she resides, will be granted, upon the recommendation of the Department Director and/or Division Chief, with the approval of the Chief Medical Officer, privileges of assisting with or observing their own or Hospital patients for a period not to exceed five

(5) days providing that such Providers shall not open an office or appoint a place of meeting patients or receiving calls within the state (RCW 18.71.030).

- 4.4.2 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.
  - 4.4.3 Evidence of active malpractice insurance must be provided.
  - 4.4.4 The Exempt Staff may not vote, hold office or serve on committees.
- 4.5 Affiliate Staff
- 4.5.1 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.
  - 4.5.2 The Affiliate Staff shall consist of those Providers who have previously maintained active 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 license.
  - 4.5.3 The Affiliate Staff shall not be required to complete the reappointment process. They will be required to keep their primary mailing and personal non-Hospital email address current by responding to an annual update request from Medical Staff Services.
  - 4.5.4 Upon recommendation by the Medical Executive Committee and approval by the Board Credentials and Medical Staff Committee, an Affiliate Member may become a member of the Honored Staff.
  - 4.5.5 An Affiliate Member may become an Active Staff Member with Clinical Privileges only by applying for Active Staff membership through application and the completion of an initial application in accordance with Article 3.
- 4.6 Honored Staff
- 4.6.1 The Honored Staff shall consist of Physicians, Dentists and Clinical Psychologists not active on the Medical Staff, who are honored for their contributions to the Hospital.
  - 4.6.2 Candidates shall be identified by the Honored Medical Staff Nominating Committee, a subcommittee of the Nominating Committee as outlined in Rules and Regulations R10.1.3.
  - 4.6.3 Members of the Honored Staff shall not have assigned duties or responsibilities or vote. They may serve on committees in a non-voting advisory capacity. Their membership on the Honored Medical Staff is in perpetuity.
- 4.7 Allied Health Professionals (“AHPs”)

The following are approved categories of Allied Health Professionals:

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Bylaws Approval: Medical Executive Committee 1/30/2020 Board Credentials and Medical Staff Committee 2/5/2020

Rules and Regulations Approval: Medical Executive Committee 1/30/2020 Board Credentials and Medical Staff Committee 2/5/2020

- 4.7.1 Advanced Registered Nurse Practitioners (ARNP), also referred to as Advanced Practice Providers (APPs)
- 4.7.2 Physician Assistants (PA-C), also referred to as Advanced Practice Providers (APPs)
- 4.7.3 Surgical Assistants
- 4.7.4 Acupuncturists
- 4.7.5 Optometrists
- 4.7.6 Mental Health Therapists
- 4.7.7 Licensed Behavioral Analysts
- 4.7.8 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 Credentials and Medical Staff Committee 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.

#### 4.8 Clinical Psychologists

All independent licensed Clinical 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 Provider.

#### 4.9 Postgraduate Trainees (Residents and Fellows)

4.9.1 Included in this category are Physicians and Dentists, graduates of approved Medical or Dental Schools who are at the 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 School of Medicine 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 unless they request and successfully complete reappointment as an Active / Active Community Medical Staff Member.

- 4.9.2 Physicians who are enrolled in ACGME, ABMS-accredited programs or Non-ACGME fellowships who do not bill for services are not Members of the Medical Staff, are not granted Clinical Privileges and are not entitled to any rights afforded to Providers on the Medical Staff, including hearing and appeal rights, under these Bylaws. The Hospital's GME office is responsible for their credentialing and privileging. 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 privileges for each specialty that are developed by the program directors and the Director of Medical Education. 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 Hospital's GME Council and the Medical Executive Committee.
- 4.9.2.1 Residents and Fellows in ACGME accredited programs are required to document their professional liability insurance coverage which is provided through their supporting institution.
- 4.9.2.2 Participants in GME education programs and must follow approved Hospital policies.
- 4.9.3 Non-Accredited Programs
- 4.9.3.1 Physicians or dentists who are not enrolled in ACGME, ABMS or ADA accredited programs must be credentialed and privileged through the Medical Staff process administered by the Medical Staff Services department.
- 4.9.3.2 The Medical Staff appointment of Fellows in non-accredited programs will terminate upon completion of or departure from the fellowship unless the fellow will continue as a Medical Staff Member. Any fellow in a non-accredited program who wishes to continue on the Medical Staff following the fellowship completion must contact Medical Staff Services prior to the end of his/her fellowship to determine updates needed to make the transition to his/her new role. This change of status must be recommended by the Medical Executive Committee and approved by the Board Credentials and Medical Staff Committee prior to the individual working in the new role.
- 4.9.3.3 Physicians and dentists who are post-residency trainees (also called Fellows) who are enrolled in non- 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 appropriate accreditation requirements as approved by the Medical Executive Committee.

#### 4.9.4 Accountability and Supervision

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 Active Medical Staff. All such activities shall be under the supervision and direction of a Member of the Active 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 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.

#### 4.9.5 Evaluation

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 the Hospital. 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.

#### 4.9.6 Contracted Services Outside of Training Program ("Moonlighting")

Medical Staff Membership and specific Clinical 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"). Documented permission from the appropriate training program director is required as part of the credentialing process. Requirements and conditions of Medical Staff membership will be identical to those of any other Medical Staff Applicant who independently provides those services.

#### 4.9.7 Residents and Fellows may be invited to attend medical staff and department meetings but shall hold no voting rights.

#### 4.10 Observers

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

Post-graduate physicians or dentists who are visiting the Hospital 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 accompa-

nied 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 Chief Medical Officer, 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 Chief Medical Officer (CMO)** shall be appointed by the Hospital's Chief Executive Officer upon the recommendation of a Search Committee appointed by the Chief Executive Officer, subject to ratification by the Board of Trustees. The Chief Medical Officer shall be responsible to the Chief Executive Officer. The Chief Medical Officer may act through a written delegation of authority to one or more Members of the Medical Staff who can function as the Chief Medical Officer's designee. He/she shall be responsible for the function of the clinical organization including the quality of care provided throughout the health system. The Chief Medical Officer shall be a voting 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 Credentials and Medical Staff Committee. He/she shall be an ex-officio member of all other standing Committees of the Medical Staff unless otherwise noted 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. He/She shall be a voting Member of the Medical Executive Committee as President-Elect, President and Immediate Past President and shall serve as co-chairperson of the Medical Executive Committee with the Chief Medical Officer unless otherwise determined by the Medical Executive Committee and Board Credentials and Medical Staff Committee. As President, he/she will co-chair the Board Credentials and Medical Staff Committee with a member of the Board of Trustees. As President, he/she will chair the Credentialing and Professional Standards Committee during the first year of his/her term, Nominating Committee when there is no Immediate Past President, and the 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 / her two-year term as President. During

such time, the Immediate Past President shall serve as the chair of the Nominating Committee and 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 / Active Community 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. He/She will chair the Credentialing and Professional Standards Committee during the second year of his/her term. The President-Elect shall become President on October 1<sup>st</sup> or earlier in the event that the office of the President should become vacant before this time.
- 6.5 **Elected Medical Staff Advisors** shall be elected from a slate prepared by the Nominating Committee. Elected Medical Staff Advisors shall be selected as follows:
- 6.5.1 Two Elected Medical Staff Advisors shall be elected from a slate 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. Each of the two Elected Medical Staff Advisors shall serve a term of three (3) years.
- 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 / Active Community 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 Credentials and Medical Staff Committee. Consideration for removal may be brought by any member of the Medical Executive Committee.
- 6.7 In a situation where the President is unable or unwilling 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 or unwilling to fulfill his/her respective responsibilities. In a situation where there is no Medical Staff Officer capable of serving, a temporary appointment will be made by the Chief Medical Officer 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. The Medical Staff President and Chief Medical Officer 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 Credentials and Medical Staff Committee.

### 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 Providers authorized to practice in the Hospital through assurance that the following measures occur.
  - 8.1.1.1 Review and evaluate the quality of patient care through a comprehensive continuous quality and performance improvement program.
  - 8.1.1.2 Monitor and trend patient care practices and outcomes on an ongoing basis through appropriate organizational structures and mechanisms.
  - 8.1.1.3 Oversee 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 Oversee 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 Oversee 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 its 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 Medical 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.
- 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 make recommendations concerning reappointments, terminations, the granting or restricting of privileges and the assignment of Staff Members to various services.
- 8.1.7 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 Chief Medical Officer 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 Medical Staff, Hospital policies and applicable organization's (e.g., DNV GL, CMS and the Washington State Department of Health) regulatory requirements regarding patient care and hospital accreditation.
- 8.1.11 Recommend action to the Credentials and Medical Staff Committee with respect to appointments, reappointments, staff category, Clinical Department assignment, Clinical Privileges, 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 and effectiveness of physician wellness programs.
- 8.1.14 Review completeness, timeliness, confidentiality and clinical pertinence of patient medical and related records, both paper and electronic.
- 8.1.15 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.

- 8.1.16 Develop policies that diminish the risk of nosocomial transmission of infection in the health care system. Investigate and control Hospital-acquired infections and monitor the performance of the Hospital's Infection Control Program.
- 8.1.17 Assist in the planning for response to fire, bioterrorism and other disasters and overall patient, staff and visitor safety concerns.
- 8.1.18 Participate in planning for Hospital and facility expansion and renovations to meet changing community needs.
- 8.1.19 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 of Trustees 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 Credentials and Medical Staff Committee. The Chief Medical Officer and Medical Staff President shall serve as co-chairs unless the voting members of the Medical Executive Committee choose to elect another member as co-chair. All Physician / Dentist voting members shall be Members of the Active or Active Community Medical Staff.
- 8.2.1.1 Composition of the Medical Executive Committee shall be constituted so as to assure that at least thirty percent (30%) of its voting Members are community providers with the balance of the voting members representing Children's University Medical Group (CUMG) and Hospital employed staff providers. Voting members are:
- Chief Medical Officer
  - President of the Medical Staff
  - President-Elect of the Medical Staff
  - Immediate Past President of the Medical Staff, as applicable
  - Elected Medical Staff Advisor(s)
  - At least five (5) elected at-large Hospital-based and/or CUMG Representative Members-at-Large (e.g., community Physicians elected by the Medical Staff and Physicians not employed by the Hospital, University of Washington Physicians 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 Neurology
  - Director, Department of Pediatrics
  - 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 or designee
  - Chief Nursing Officer
  - Chief, Advanced Practice Services

8.2.1.2 Nonvoting Members may be proposed by the co-chairs and approved by the MEC. Current non-voting members include:

Chief Executive Officer or designee  
 Director, Graduate Medical Education  
 Senior Vice President / Chief Legal Officer  
 Vice President, Associate Chief Medical Officer

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, Elected Medical Staff Advisor (in those years in which an Elected Medical Staff Advisor is to be elected) and Members-At-Large. The Nominating Committee will be charged with maintaining a slate of candidates that recognizes the diversity of race, age, creed, color, national origin, sex, sexual orientation, 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 1<sup>st</sup>.

8.2.1.5 Terms of Medical Executive Committee at-large members will be staggered with approximately one-half of the numbers elected annually. At-large members may serve no more than two consecutive two-year terms. The prevailing proportion of community to Hospital/CUMG and UWP employed physicians and specialty type, as well as the diversity of race, creed, color, national origin, sex, sexual orientation and Active / Active Community 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 be sent to all voting members of the Medical Staff. Elected members will take office effective October 1<sup>st</sup>.

8.2.1.5.1 The nominating process for Medical Executive Committee At-Large members shall be:

8.2.1.5.1.1 A call for candidates will be sent to all Members in good-standing of the Active / Active Community Medical Staff. A description of each position will be provided as background information.

8.2.1.5.1.2 Candidates may self-identify or be nominated by a peer; if nominated by a peer, the nominated individual must agree to the nomination.

8.2.1.5.1.3 Candidates will be required to submit a short biographical summary of their experience, current practice, and the reason they want to serve in the position.

- 8.2.1.5.1.4 In preparing the slate, the Nominating Committee will review the candidate's biographical summary, internal / external reputation, and any issues documented in the candidate's credentialing or quality improvement file. The candidate's Department Director will be consulted to assure there are no known concerns or conflicts. Diversity as described in Article 8.2.1.4 and 8.2.1.5 will be considered in the development of the final slate.
- 8.2.1.5.1.5 Prior to presentation to the Medical Executive Committee for approval of the slate, the Medical Staff Leadership group will verify that the proposed Member-at-Large meets the criteria set forth in Article 8.2.1.5.
- 8.2.1.5.1.6 The Medical Executive Committee will approve the slate prior to distribution of ballots for voting by the Active / Active Community Medical Staff.
- 8.2.1.5.1.7 Voting results will be presented to the Medical Executive Committee for approval and subsequently forwarded to the Board Credentials and Medical Staff Committee for final approval.
- 8.2.1.5.1.8 All nominees will be notified of the election results.
- 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 Credentials and Medical Staff Committee 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 on behalf of the Medical Staff.
  - 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 survey processes from the applicable organizations (e.g., DNV GL, CMS, and the Washington State Department of Health) assessing regulatory requirements regarding patient care and hospital accreditation.
- 8.2.2 The **Board Credentials and Medical Staff Committee** will be constituted with members of the Board of Trustees, Hospital Administration and the Medical Staff. The Medical Staff will be represented by the President and the President-Elect. Hospital Administration will be represented by the Chief Medical Officer and one to two members of Hospital

Administration appointed by the Chief Executive Officer. The Board of Trustees will appoint a minimum of three members.

The Board Credentials and Medical Staff Committee shall be the Board-delegated committee that approves appointments, reappointments, changes of status to the Medical Staff, taking into account the recommendations of the Medical Executive Committee. The Board Credentials and Medical Staff Committee, as delegated by the Board, shall review and approve Medical Staff policies and procedures, including changes to the Medical Staff Bylaws, Rules and Regulations and other policy and procedure changes. The Board Credentials and Medical Staff Committee shall be responsible to communicate to the Board of Trustees to permit the Board of Trustees to resolve any differences between the Board Credentials and Medical Staff Committee and Medical Staff that cannot otherwise be resolved by the Board Credentials and Medical Staff Committee. The Board Credentials and Medical Staff Committee shall communicate the position of the Medical Executive Committee to the Board of Trustees on any such matters.

The Board Credentials and Medical Staff Committee shall initiate a conflict resolution management process to address a disagreement between Members of the Medical Staff and the Medical Executive Committee about an issue relating to the Medical Staff's documents or functions. This includes but is not limited to a proposal to adopt or amend the Medical Staff Bylaws, Rules and Regulations, or Policies; or a proposal to remove some authority delegated to the Medical Executive Committee by the Medical Staff under these Bylaws.

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)

The Quality Improvement Steering Committee is one of the quality improvement committees established as part of the Hospital's Coordinated Quality Improvement Program under RCW 70.41.200.

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 R10.7.6.

## 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 and Allied Health Professional Staff 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 mission and values based behaviors, at the 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 Credentialing and Professional Standards 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 Credentialing and Professional Standards 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, or 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 Chief Medical Officer of the concern. If the Chief Medical Officer is the subject of the concern, the concerned person shall notify the President of the Medical Staff. 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. If multiple people contemporaneously report similar concerns about the same Medical or Allied Health Professional Staff Member, the person receiving notification of the concerns may describe the concerns in a single written summary. Thereafter, the person receiving notification of the concerns 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. All such information shall be confidential and protected as records relating to peer review and quality improvement activities.

- 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 Chief Medical Officer, 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 Chief Medical Officer, the concerned person shall notify the President of the Medical Staff.
- 9.4.2 The Chief Medical Officer shall designate a Responsible Officer to conduct the informal corrective action process. The Responsible Officer may be the Chief Medical Officer, or the Chief Medical Officer may designate another appropriate Medical Staff leader to serve as the Responsible Officer, including, but not limited to, 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 or credentialing 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 Chief Medical Officer. The Chief Medical Officer will confer with the Credentialing and Professional Standards Committee 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 or Allied Health Professional Staff membership of the affected individual the recommendations must be submitted by the chair of Medical Executive Committee 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 Medical or Allied Health Professional Staff to the hearing rights set forth in Article 10.
- 9.4.6 The Responsible Officer or the Chief Medical Officer or the Chief Medical Officer's designee 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 Chief Medical Officer, Department Director and Division Chief will be notified.

- 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 Chief Medical Officer will be responsible for implementing the recommendation. The affected Medical or Allied Health Professional Staff 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 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.
- 9.5 **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 Chief Medical Officer, or any Medical Staff Officer. A copy of the written request must be forwarded to the Chief Medical Officer, who will designate a Responsible Officer in the same manner as described in Section 9.4 of this Article 9. The Responsible Officer will promptly notify the President of the Medical Staff, the Hospital's Chief Executive Officer 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 Chief Medical Officer is the subject of the concern, the President of the Medical Staff shall act as the Responsible Officer and both the CEO and Chair of the Board of Trustees will be notified.
- 9.5.3 If the affected Provider is part of Children's University Medical Group (CUMG 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 provider's department will confer with the appropriate Division Chief, if any, and promptly investigate the issues identified in the request. In conjunction with the Hospital Human Resources department, as may be appropriate the investigation will include, but is not limited to, an interview with the Provider who is the subject of the request, and with the person submitting the request. The investigation may include other interviews,

including interviews with other relevant parties. 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 Provider.

- 9.5.5 The Department Director or Division Chief will complete the investigation and submit a report within sixty (60) days to the Responsible Officer.
- 9.5.6 If the misconduct is alleged to be directed at 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 or Division Chief, the Responsible Officer will confer with the elected officers of the Medical Staff, and the Chief Medical Officer and develop a recommended course of action. The recommended course of action will be brought to Credentialing and Professional Standards Committee who will finalize the plan subject to approval of the Medical Executive Committee, which may include any 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 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 Provider shall entitle the Provider to the hearing rights set forth in Article 10.
- 9.5.9 The Responsible Officer will advise the person submitting the request for investigation and the affected Provider 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 Provider of the Medical or Allied Health Professional Staff are satisfied with the recommendations of the Credentialing and Professional Standards Committee, then the Chief Medical Officer is responsible for implementing them. The affected Provider 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 Provider is not satisfied with the recommendations of the Credentialing and Professional Standards Committee, then either may request 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 Providers of the Medical or Allied Health Professional Staff appointed jointly by the President of the Medical Staff and the Chief Medical Officer, including an individual representing the requesting person's area appointed by the Chief Medical Officer. The Chief Medical Officer 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 Chief Legal Officer 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 Provider and the person requesting the investigation, and may include review of any relevant files.
- 9.6.4 Upon completion of the investigation, the Professional Review Committee will promptly make a written report to the Chief Medical Officer. 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 recommendations are presented to the Credentialing and Professional Standards Committee for approval. The Chief Medical Officer will be responsible for carrying out the recommendations of the Professional Review Committee. If the recommendations of the Professional Review Committee would adversely affect the Clinical Privileges or Medical or Allied Health Professional Staff membership of the affected Provider, 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 Provider shall entitle the Provider 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 **Administrative Suspension.** These provisions regarding administrative suspension apply regardless of whether any of the provisions outlined in Article 9 above also apply.

9.7.1 The Chief Medical Officer may administratively suspend a Provider's membership and/or Clinical Privileges whenever the Chief Medical Officer reasonably determines in good faith that the failure to take such action may (a) significantly disrupt or distract from the Medical Staff or Hospital's operations (but the criteria for summary suspension are not met, i.e., no one's health or safety is threatened); or (b) cause the Medical Staff or Hospital to suffer significant reputational harm; or (c) failure to comply with established Hospital infection control requirements, including documentation of required immunizations and annual tuberculosis (TB) testing; or (d) failure to follow the applicable Hospital policies and procedures including but not limited to those of the Medical Informatics Committee as approved by the Medical Executive Committee, including the requirement to complete and maintain medical records in a timely manner or (e) failure to comply with Hospital required training including, but not limited to, professional behavior. When the Chief Medical Officer is considering an administrative suspension, he or she will discuss the concern(s) with the involved Provider, and there will be no administrative suspension if the Provider takes an administrative leave of absence voluntarily, pending resolution of the concern(s). An administrative suspension will be effective immediately upon notice. If notice is given orally, it will be confirmed by the Chief Medical Officer promptly in writing to the involved Medical or Allied Health Professional Staff member and the Provider's Department Director.

9.7.2 If the Provider resolves the issue related to the reason for administrative suspension the Chief Medical Officer may remove the administrative suspension and notify the Provider and the Provider's Department Director.

9.7.3 If the reason for the administrative suspension has not been resolved within 14 business days after an administrative suspension has been imposed, the Credentialing and Professional Standards Committee or its designee(s) shall convene a meeting to consider the circumstances and determine whether the administrative suspension shall be reversed, modified or continue in effect. Both the Chief Medical Officer and the Provider 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. The involved Provider and the Chief Medical Officer shall be excused while the Credentialing and Professional Standards Committee / designee(s) discuss(es) the matter, deliberate(s), and vote(s). If the Credentialing and Professional Standards Committee / designee(s) decide(s) not to relieve the Provider entirely of the suspension, the Provider shall be entitled to request a hearing in accordance with Article 10 of the Bylaws, if the Credentialing and Professional Standards Committee / designee(s) determine(s) that the administrative suspension constitutes a "professional review action" under the federal Health Care Quality Improvement Act.

- 9.8 **Summary Suspension.** These provisions regarding summary suspension apply regardless of whether any of the provisions outlined in Article 9 above also apply.
- 9.8.1 The Chief Medical Officer 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 or safety of any patient, family member, visitor or member of the Hospital's workforce. A summary action will be effective immediately upon notice. If notice is given orally, it will be confirmed by the Chief Medical Officer promptly in writing to the Medical or Allied Health Professional Staff and the Provider's Department Director.
- 9.8.2 In lieu of summary suspension, the Chief Medical Officer may offer the Provider the option to voluntarily relinquish some or all of his or her Clinical Privileges, as applicable under the circumstances, pending resolution of the concerns.
- 9.8.3 Within ten (10) business days after summary action has been taken, the Credentialing and Professional Standards Committee shall convene a meeting to consider the circumstances and determine whether the action shall be reversed, modified or continued in effect. Both the Chief Medical Officer and the Provider 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. The involved Provider and the Chief Medical Officer shall be excused while the Credentialing and Professional Standards Committee discusses the matter, deliberates and votes. Any action must be approved by the Medical Executive Committee before it is considered final. If the Credentialing and Professional Standards Committee decides not to relieve the Provider entirely of the suspension, reduction or restriction, the Provider shall be entitled to request a hearing in accordance with Article 10 of the Bylaws.
- 9.9 **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 Chief Medical Officer or President of the Medical Staff will notify any Provider suspended pursuant to this Section 9.9. The events resulting in automatic suspension are as follows:
- 9.9.1 Any adverse action by the Medical Executive Committee or the Board Credentials and Medical Staff Committee that results in suspension, denial of reappointment.
- 9.9.2 Suspension, revocation, failure to renew, loss of or any other action adversely affecting the Member's professional license, DEA certificate or professionally liability insurance.
- 9.9.3 Imposition of sanctions, exclusion, or any other penalty or restriction under any government health care program (including Medicare and Medicaid) or the Hospital Compliance Program or the Provider's compliance program (e.g. CUMG suspension for compliance violation).
- 9.9.4 Lack of sponsorship, affiliation or employment by an entity holding an exclusive right to provide designated services at the Hospital.

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

**9.10 Procedures Following Automatic Suspension.**

9.10.1 A Provider whose Clinical Privileges or membership have been automatically suspended pursuant to Section 9.9 of this Article 9 above shall be entitled to meet with the Chief Medical Officer to discuss the matter. The Chief Medical Officer will make the final decision. The Provider shall not be entitled to a hearing as described in Article 10. If the Provider is dissatisfied with the decision of the Chief Medical Officer, the Provider may request review by the Board Credentials and Medical Staff Committee. The Board Credentials and Medical Staff Committee shall determine what, if any, additional proceedings to conduct and shall issue a final decision.

9.10.2 Immediately upon the imposition of a suspension under Section 9.9 of this Article 9 above, the Chief Medical Officer, 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.

**9.11 Matters Governed by Employment or Other Agreement.**

A Provider 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 Provider's contract, and need not be on the Medical or Allied Health Professional Staff, unless required by his / her job description. Conversely, a Provider who is employed by or under contract with the Hospital and has responsibilities or Privileges 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 Provider shall not be contingent on the Provider's continued employment or contractual relationship unless otherwise provided in the Provider'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 contract shall prevail.

**9.12 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 Medical Staff or Allied Health Professional Staff membership and/or 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 Credentials and Medical Staff Committee that an application for appointment or reappointment to the Medical or Allied Health Professional Staff, or for the granting or renewal of Clinical Privileges, be denied based on the Provider'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 Credentials and Medical Staff Committee 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 an administrative suspension of a Provider's membership and/or Clinical Privileges, following imposition by the Chief Medical Officers, and the Medical Executive Committee / designee(s) determine(s) that the administrative suspension constitutes a "professional review action" under the federal Health Care Quality Improvement Act; or
- 10.1.4 The Medical Executive Committee has decided to perpetuate a summary suspension, reduction or restriction of a Member's Clinical Privileges, following imposition by the Chief Medical Officer, based on professional competence or conduct and the action remains in effect for more than fourteen (14) days; or
- 10.1.5 The Medical Executive Committee has decided to recommend to the Board of Trustees that a Provider's Medical Staff or Allied Health Professional Staff membership be revoked, or that a Provider'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 Provider shall be given prompt written notice by the Chief Medical Officer, Chief Medical Officer designee or 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 Provider has a right to request a hearing.

10.2.4 A summary of the Provider'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 Provider shall have thirty (30) days following receipt of the above Notice to submit a written request for a hearing to the President or Chief Medical Officer. In the event the Provider does not request a hearing within the time and in the manner described, the Provider 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 Provider 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 Provider is charged. This supplemental notice shall provide a list of the charges, 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 Chief Medical Officer 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 Provider, 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 Chief Medical Officer. If that person, too is in direct economic competition with the Provider, the Hearing Committee shall be appointed by one of the Medical Staff Advisors, to be specified by the Chief Medical Officer. If the hearing is based upon an action by the Board Credentials and Medical Staff Committee, the Board of Trustees' co-chair of Board Credentials and Medical Staff Committee 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 three Members of the Active / Active Community Medical Staff (including, to the extent consistent with the other provisions of this paragraph, both community Physicians and Children's University Medical Group Physicians) who are not in economic competition with the Provider 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. If the subject of the hearing is an AHP, an AHP member of the Active / Active Community staff shall be on the Hearing Committee. 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 / Active Community 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 Provider 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 Provider, 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. The affected staff Provider shall be entitled to be accompanied by a representative. If the representative is an attorney, the affected Provider must notify the Chief Medical Officer five days prior to the hearing regarding the presence of the attorney. The Medical Executive Committee shall appoint an individual to represent it at the hearing and to present the facts upon which the request for corrective action was based and to examine witnesses.

## 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 Provider 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 Provider 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 Provider 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 of this Article 10 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 Provider shall provide the President of the Medical Staff with a list of witnesses who are reasonably anticipated to testify on the Provider'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 accus-

tomed 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 of 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 Provider 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 Provider 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 thirty (30) 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 Provider, the President of the Medical Staff, the Chief Medical Officer 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. However, the Board of Trustees 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 of Trustees level, or an opportunity for oral or written argument, or both, at the Board of Trustees level. Where the Board of Trustees grants an opportunity for further fact-finding or oral or written argument at the Board of Trustees level, in reviewing the facts and arguments, the Board of Trustees may exercise its independent judgment and is not required to grant deference to the Hearing Committee's decision. In the case of any contract providing for appeal to the Board Credentials and Medical Staff Committee, such oral or written argument shall constitute the appeal to the Board. The Board of Trustees shall endeavor to take final action as soon as possible.

10.17.2 If the Board of Trustees 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 of Trustees 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 of Trustees 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

- 11.1 The Rules and Regulations may be amended by a two-thirds vote of the voting Members of the Medical Executive Committee (MEC) present at a meeting called for that purpose or by electronic means. Amendments shall become effective when approved by the Board Credentials and Medical Staff Committee. Subject to approval by the Board Credentials and Medical Staff Committee, the MEC may supplement these Bylaws with Rules and Regulations and Policies that provide associated details, as the MEC deems necessary to implement more specifically the general principles established in these Bylaws.
- 11.2 Proposals for new Medical Staff Rules and Regulations or Policies, or amendments to existing Rules and Regulations or Policies, may be submitted to the MEC by any voting Member(s) of the Medical Staff, or by the Hospital CEO or his/her designee on behalf of Hospital Administration, or proposed by the MEC on its own initiative.
- 11.3 A proposal under Section 11.2 of this Article 11 bearing the signature of 20% or more of the voting Members of the Active / Active Community Medical Staff (which will constitute notice of the proposal to the MEC) must identify two Active / Active Community Medical Staff Members who will serve as representatives and act on behalf of the proposed signers in the processes described below (including any conflict management processes):
- 11.3.1 If the MEC supports the proposal as submitted, the proposal will be disseminated to the Medical Staff for comment as described below, before the MEC submits the proposal to the Board Credentials and Medical Staff Committee, for approval.
- 11.3.2 If the MEC does not support the proposal, it will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process described in Section 8.2.2 of Article 8 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposal will be deemed withdrawn.
- 11.3.3 If the conflict is not resolved by withdrawal of the proposal, or by MEC support of the proposal as modified in the conflict management process, then the proposal will be submitted (in original form or, if the original proposal has been modified in the conflict management process, then as modified) to the Medical staff for comments as described below before the proposal is submitted to the Board Credentials and Medical Staff Committee for approval.
- 11.4 With respect to any proposal under Section 11.2 of this Article 11 that does not bear the signatures of 20% of Active / Active Community Medical Staff Members, the MEC has discretion to do any of the following:
- 11.4.1 Disseminate the proposal, as submitted, to the Medical Staff for comment; or
- 11.4.2 Modify the proposal and disseminate it, as modified, to the Medical Staff for comment; or
- 11.4.3 Reject the proposal and not disseminate it to the Medical staff for consideration.

- 11.5 Except as otherwise provided in this Article, before the MEC submits any proposal for adoption or amendment of Rules and Regulations to the Board Credentials and Medical Staff Committee for approval, the MEC shall disseminate the proposal to the Medical Staff in a reasonable manner, which may include posting in a newsletter or bulletin, electronic message, or any other method regularly used by the Medical Staff Services department to provide notices to Members. Voting Members of the Medical Staff shall be given the opportunity to submit written comments, through the Medical Staff Services department, for a period of not less than 10 days.
- 11.6 After considering any comments that have been received within the allotted period, the MEC may modify the proposal in light of the comments. The MEC will disseminate any such modified proposal to the Medical Staff, and may, in the MEC's discretion, solicit further comments in the manner described above.
- 11.7 If a proposal under Article 11.2 did not include the signatures of 20% or more of the voting Members of the Active / Active Community Medical Staff, but the MEC disseminated the proposal to the Medical Staff for comment, then after the comment period ends the MEC in its discretion may do either of the following:
- 11.7.1 Submit the proposal to the Board Credentials and Medical Staff Committee for approval, in its original form or as modified in light of the comments; or
  - 11.7.2 Reject the proposal and not submit it to the Board Credentials and Medical Staff Committee.
- 11.8 Upon approval by the Board Credentials and Medical Staff Committee, new Medical Staff Rules and Regulations, Policies, or amendments to existing Rules and Regulations or Policies, shall be announced promptly to the Medical Staff in a reasonable manner, as described above.
- 11.9 Duly adopted Rules and Regulations and Policies shall be binding on all Applicants to and Members of the Medical and Allied Health Professional Staff, as well as to any providers who are granted temporary Privileges.
- 11.10 If a proposal under Article 11.3 is not approved by the Board Credentials and Medical Staff Committee, then the MEC (or the designated representatives of the group of Medical Staff Members who submitted a non-MEC-supported proposal that went directly to the Board Credentials and Medical Staff Committee), may invoke the conflict management process set forth in Article 8.2.2 of these Bylaws within 15 days of receiving notice that the proposal was not approved by the Board Credentials and Medical Staff Committee.
- 11.11 If the MEC receives documentation of an urgent need to amend the Medical Staff Rules and Regulations to comply with law or regulation, the MEC may adopt the necessary amendment provisionally and submit it to the Board Credentials and Medical Staff Committee for provisional approval, without prior notification of the Medical Staff. Immediately following the MEC's adoption of such an urgent provisional amendment to the Rules and Regulations, the MEC will notify the Medical Staff (by an acceptable method as described above), and offer opportunity for any interested Medical Staff Member to submit written comments to the MEC with 15 days of the date of notice. The amendment will become final at the end of the comment period if the comments indicate there is no substantial conflict regarding the provisional amendment. There is no substantial conflict unless at least 20% of voting Active / Active Community Medical Staff Members express opposition to the amendment in writing.

- 11.12 If the comments indicate a substantial conflict over the provisional approval then the MEC will implement the conflict management process set forth in Article 8.2.2 of these Bylaws, and may submit a revised amendment to the Board Credentials and Medical Staff Committee for approval if necessary.
- 11.13 In the event of a conflict between these Bylaws and any provision of the Medical Staff Rules and Regulations, as determined by the MEC, the Bylaws shall prevail.

## **ARTICLE 12 AMENDMENTS OF BYLAWS**

- 12.1 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 Credentials and Medical Staff Committee.
- 12.2 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 / Active Community 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 / Active Community Staff voting shall be approved. The amendments approved by the Active Staff shall become effective when approved by the Board Credentials and Medical Staff Committee.
- 12.3 A proposal to amend the Bylaws may be initiated by submitting to the Medical Staff Services department a petition signed by at least 20% of the voting Active / Active Community Medical Staff Members proposing a specific Bylaws amendment or amendments (which will constitute notice of the proposed Bylaws amendments to the Medical Executive Committee). Any such petition must identify two Active / Active Community Medical Staff Members who will serve as representatives and act on behalf of the petition signers in the processes described below (including any conflict management processes).
- 12.3.1 Upon submission of such a petition, the MEC will determine whether it supports the proposed Bylaws amendment(s), and if so, the Medical Staff Services department will arrange for a vote on the proposed Bylaws amendments by the voting Members of the Active / Active Community Medical Staff according to the process described above for voting on MEC-proposed Bylaws amendments.
- 12.3.2 If the Medical Staff adopts the MEC-supported Bylaws amendment(s) by a vote of the Active / Active Community Medical Staff conducted according to the process described above, then the proposed Bylaws amendment(s) will be submitted to the Board Credentials and Medical Staff Committee for approval. If the Medical Staff does not adopt the MEC-supported proposed amendment(s) by vote, then the MEC-supported proposed Bylaws amendment will be deemed withdrawn.

- 12.3.3 If the MEC does not support the proposed Bylaws amendment(s), the MEC will notify the designated representatives in writing, and they will have 30 days from receipt of the notice to invoke the conflict management process as described in Section 8.2.2 of Article 8 of these Bylaws. If the conflict management process is not invoked within 30 days, it will be deemed waived and the proposed Bylaws amendment(s) will be deemed withdrawn.
- 12.3.4 If the conflict is not resolved by withdrawal of the proposed Bylaws amendment(s), or MEC support of the proposed Bylaws amendment(s) as modified in the conflict management, then the proposed Bylaws amendment(s) will be submitted (in original form or, if the original Bylaws amendment(s) have been modified in the conflict management process, then as modified) to the Medical Staff for a vote. The proposed Bylaws amendment(s) will be submitted to the Board Credentials and Medical Staff Committee if a majority of the eligible voting Active / Active Community Medical Staff Members cast their ballots in favor of the proposed Bylaws amendment(s).
- 12.3.5 A copy of the MEC's written statement of its decision and reasons are issued at the conclusion of the conflict management process shall be provided to the Board Credentials and Medical Staff Committee along with any proposed Bylaws Amendment(s) submitted to the Board Credentials and Medical Staff Committee.
- 12.3.6 Such proposed Bylaws amendment(s) will become effective immediately upon approval, which shall not be withheld unreasonably.
- 12.3.7 If the Board Credentials and Medical Staff Committee does not approve the Bylaws amendment(s) then the matter will be referred to the conflict management process set forth in Section 8.2.2 of Article 8 of these Bylaws for management of conflicts between the Board Credentials and Medical Staff Committee and the Medical Staff.

### **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 Credentials and Medical Staff Committee. They shall, when adopted and approved, be equally binding on the Medical Staff and the Board Credentials and Medical Staff Committee. Neither the Medical Executive Committee nor the Board Credentials and Medical Staff Committee, acting on behalf of the Board of Trustees or the Board of Trustees, may unilaterally amend the Medical Staff Bylaws.

### **ARTICLE 14 TECHNICAL CORRECTIONS**

The Medical Executive Committee shall have the authority to adopt non-substantive changes to the Bylaws, Rules and Regulations, and Policies such as reorganization or renumbering, and technical corrections needed due to errors in punctuation, spelling, grammar or syntax, and/or inaccurate or missing cross-references. Such changes shall not affect the interpretation or intent of the sections being changed. The MEC may take action to implement such non-substantive changes by motion, in the same manner as any other motions before the MEC. After approval by the MEC, such technical corrections shall be communicated promptly in writing to the Board Credentials and Medical Staff Committee. Such

corrections are subject to approval by the Board Credentials and Medical Staff Committee, which approval shall not be withheld unreasonably. Following approval by the Board Credentials and Medical Staff Committee, technical corrections will be communicated to the Medical Staff within a time that is reasonable under the circumstances (which may be when the Medical Staff is notified of any substantive changes to the Bylaws, Rules and Regulations, or Policies affected.



Originally adopted April 26, 1940.

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Revisions:

May 1943	May 1970	May 1993	Rules & Regulations: July 26, 2006
September 1946	December 1974	November 1995	Rules & Regulations, Section 19 & 26: Febru- ary 06, 2007
September 1948	January 1977	November 1997	Rules and Regulations, Section 7, B 1; Section 10, A, 6, v and vii; Sec- tion 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 (Anes- thesia)
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 2011: Bylaws 4.1.2; 4.2 (Active Com- munity); 8; 8.2.1; 8.2.2; 8.2.4; 11; 12; 13; 14. Rules and Regulations R5; R7.2.3; R26
June 1963	March 1991	Rules & Regulations September 22, 2005	September 2011: Re- move R23.1.3.4 and re- number remaining
December 1967	June 1991	Rules & Regulations: May 10, 2006	February 2012 Remove IRB description from Bylaws (Article 8.2.4); move to Rules and Reg- ulations (Section R10.1.5); renumber re- maining items in section.

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Bylaws Approval: Medical Executive Committee 1/30/2020 Board Credentials and Medical Staff Committee 2/5/2020

Rules and Regulations Approval: Medical Executive Committee 1/30/2020 Board Credentials and Medical Staff Committee 2/5/2020

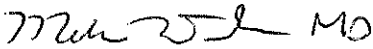
<p>October 2012 Remove Tissue Committee description from Rules and Regulations (Section R10.6.19) and re-numbered remaining items in section.</p>	<p>March 2013 Corrected titles of QISC co-chairs.</p>	<p>April 2013 Revise MEC membership in Article 8.2.1 and allow attorney representation in Article 10.8 of Hearings.</p>	<p>March 2015 Change Medical Director to Chief Medical Officer; Revise Article 4.3; Add Optometrists and renumber Article 4.7.5 and 4.7.6; Revise Article 8.2.1.1 adding Chief Advanced Practice as MEC Voting member; Correct title Article 8.2.1.2 SVP, CPI; Revise R1.3 – Synchronize timeframe to achieve board certification with specialty board; Revise R6.4.2.1.2 to reflect current practice; Add R7.2.4 Optometrists; Revise R8.1.2 clarify language; Add R10.1.3.3 Honored Staff Nominating Committee; Revise R10.1 sub-committee descriptions and functions to align with current practice; added Patient Safety sub-committee; Revise R11.1 to align with current practice; Add R17.4 Naturopathic orders; Revise R17.6 to align with current practice; Revise Section R23.1.1 and R23.4.1 to align with current practice;</p>
<p>December 2015: Revised 8.2.1.5 and 8.2.1.5 Nominating Committee; R10.1.3 Nominating Committee</p>	<p>February 2020 – changes are summarized in Addendum A</p>		

Bylaws. Rules and Regulations approved by the Board Credentials and Medical Staff Committee on February 2, 2020.



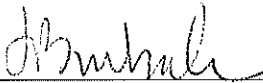
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Jeffrey Avansino, MD, MBA  
Vice President, Medical Affairs  
Medical Executive Committee Co-Chair



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Melissa Walsh, MD  
Medical Staff President  
Medical Executive Committee Co-Chair  
Board Credentials and Medical Staff Committee Co-Chair



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Jill Brubaker, MD  
Board of Trustees  
Board Credentials and Medical Staff Committee Co-Chair

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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.
- R1.1.1 Medical Staff Members on-call or on-service at a Hospital inpatient site of care are required to be available for in-person consultation or patient care within sixty (60) minutes for any urgent or emergent clinical patient care needs.
- R1.2 All Members of the Active, Active Community, 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 the timeframe specified by the specialty Board. 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 by the Board Credentials and Medical Staff Committee.

**SECTION R2  
DISCRIMINATION / HARASSMENT PROHIBITED**

- R2.1 No aspect of Medical Staff or Allied Health Professional Staff membership or particular Clinical Privileges shall be denied on the basis of race, age, creed, color, national origin, sex, sexual orientation, sex stereotyping, gender identity, veteran status, the type of procedures or patients in which the Provider 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, age, creed, color, national origin, sex, sexual orientation, sex stereotyping, gender identity, veteran status, the type of procedures or patients in which the Provider specializes or any physical or mental impairment if, after any necessary reasonable accommodation shall not be tolerated
- R2.3 “Gender identity” means an individual’s internal sense of gender, which may be male, female, neither or a combination of male and female, and which may be different from an individual’s sex assigned at birth. The way an individual expresses gender identity is frequently called “gender expression,” and may or may not confirm to social stereotypes associated with a particular gender. A transgender individual is an individual whose gender identity is different from the sex assigned to that person at birth.
- R.2.4 “Sex Stereotypes” means stereotypical notions of masculinity or femininity, including expectations of how individuals represent or communicate their gender to others, such as behavior, clothing, hairstyles, activities, voice, mannerisms, or body characteristics. These stereotypes can include the expectation that individuals will consistently identify with only one gender and that they will act in conformity with the gender-related expressions stereotypically associated with that gender. Sex stereotypes also include gendered expectations related to the appropriate roles of a certain sex.
- R.2.5 “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.-6 “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 oral, written, visual, or physical conduct of a sexual nature when either:
- R2.6.1 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
- R2.6.2 This conduct substantially interferes with the individual’s occupation or 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 During the processing of initial appointments, reappointments, changes of status and privilege requests, primary source verification will be obtained using industry-recognized resources as described in Medical Staff Services operational policies and procedures.
- R3.2 A completed application must include the following:
- R3.2.1 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.
  - R3.2.2 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.
  - R3.2.3 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.
  - R3.2.4 Disclosure of incomplete, interrupted or termination from any training programs.
  - R3.2.5 Disclosure of involvement in a professional liability action which is pending or resolved and any final judgments and settlements.
  - R3.2.6 Relevant information regarding the applicant's experience and current competence as required by the Medical Staff.
  - R3.2.7 Disclosure of involuntary loss of Medicare or Medicaid provider status.
  - R3.2.8 Disclosure of conviction for a criminal felony.
  - R3.2.9 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.
  - R3.2.10 Disclosure of inability to perform any of the assigned privileges, with or without reasonable accommodation, according to accepted professional standards.
  - R3.2.11 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.
- R3.3 Reappointment of Active / Active Community 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.

- R3.4 Any Provider 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 Provider is otherwise qualified for Membership and/or to exercise the privileges requested will the Medical Staff determine if the Provider 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 Provider with a known physical or mental disability, if the Provider is otherwise qualified and can perform the essential functions of the Staff appointment and privileges requested in a manner which meets the Hospital and Medical Staff quality of care standards.
- R3.5 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.
- R3.6 For reappointments to the Medical Staff or renewal/revision of Clinical Privileges, additional information considered about each Applicant includes:
- R3.6.1 Evidence of the individual's training and/or certification.
  - R3.6.2 Evidence of the individual's past and recent professional performance.
  - R3.6.3 Evidence of the individual's judgment.
  - R3.6.4 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.
  - R3.6.5 Assessment of ability to perform any of the assigned privileges, with or without reasonable accommodation, according to accepted standards of professional standards.
  - R3.6.6 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.
  - R3.6.7 Activity level at the Hospital.
  - R3.6.8 Participation in Medical Staff and Department functions.
  - R3.6.9 Quality oversight activities at other institutions.

Evidence of the Provider'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 the Hospital or another institution at which the provider is active.

- R3.7 As described in the applicable Medical Staff Services operational 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 an applicable Medical Staff Services operational 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 Providers newly appointed to the Medical or Allied Health Professional 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 Credentials and Medical Staff Committee 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 Credentials and Medical Staff Committee, 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 Provider's performance will be reviewed and evaluated by the Division Chief or designee and Department Director or designee in the clinical department in which the Provider exercises initial or new privileges. For Department Directors, oversight will be provided by the Chief Medical Officer 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 Provider must demonstrate that the qualifications for membership and Clinical Privileges are being met, and all of the obligations of the Provider's Medical Staff category are being fulfilled. A Provider's exercise of prerogatives and Clinical Privileges during the Provisional period is subject to any conditions or limits imposed as part of the Provider'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 Providers:

- R4.2.2.1 Providers may admit patients if permitted by their staff category and exercise approved Clinical Privileges.

R4.2.2.2 Providers 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 Providers shall also be eligible to hold office in the Medical Staff organization, vote 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 Provider successfully concludes the first year on the Medical Staff or Allied Health Professional Staff or the period established by the Department's rules and regulations, and the Provider'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, and the Board Credentials and Medical Staff Committee 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 himself/herself 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 regulatory requirements, (e.g., DNV GL, CMS and the Washington State Department of Health) regarding patient care and Hospital accreditation.

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, 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 Medical Staff Department's policies or as determined by their Director or Division Chief.
- R5.1.12 To advise the Chief Medical Officer or Medical Staff Services department 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 Chief Medical Officer or the Medical Staff Services department 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 Chief Medical Officer or the Medical Staff Services department 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 Chief Medical Officer or the Medical Staff Services department 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 peer references that address the Applicant's skill and competence, by those who have worked with the Applicant within the last two (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 peer reference should come from the applicant's department director or division chief at the most recent hospital, or other site of practice. The other two peer references should come from providers in the same discipline (physicians, dentists, clinical psychologists, nurse practitioner or physician assistant) who have worked with the applicant for at least six months. If this Provider is within three (3) years of completing residency, one peer reference 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, gaps in practice, issues related to current competency, and interpersonal concerns) will be reviewed by Risk Management and 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 Risk Manager and 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 receive notification and have the opportunity for

an informal meeting, which shall include the Credentialing and Professional Standards Committee, Medical Staff President, Chief Medical Officer, Department Director and/or Division Chief to 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 Credentials and Medical Staff 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 Board Credentials and Medical Staff Committee. 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 Provider 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 Provider:
- 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 or Allied Health Professional 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 Board Credentials and Medical Staff Committee, the approval or disapproval of the delineated Clinical Privileges requested.

R6.1.4 The Board Credentials and Medical Staff Committee, 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 the timeframe outlined by the applicable specialty board 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 Privilege is subject to the policies and procedures of that applicable 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 described in Section R6.4.2 and the under conditions described in Section R6.4.2, as shown below, to an appropriately licensed Provider, when:

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

R6.4.1.2 The Provider has satisfied the Hospital's credentialing requirements which are found in Bylaws Article 3. The Chief Medical Officer 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 Chief Medical Officer for good cause, before temporary privileges are granted, a physician must acknowledge in writing that he/she has received, or been given access to 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 Provider 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 Provider'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 Chief Medical Officer, may grant temporary privileges in the following circumstances:

R6.4.2.1 **Pending application:** to an appropriately licensed Applicant to the Medical Staff or Allied Health Professional Staff prior to the Medical Executive Committee making the recommendation on such application and the Board Credentials and Medical Staff Committee, 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, education and experience, current competence, ability to perform the privileges requested;

R6.4.2.1.3 The National Practitioner Data Bank (NPDB), Washington State Patrol background queries have been completed; and national / international background checks if time permits;

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 Peer references 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 Provider 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 Provider becomes ill, takes a leave of absence or where the Provider'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, education and experience, 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 and, if time permits, a national / international background check have been completed;
- 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 Provider's current principle Hospital affiliation, preferably one who is known to the Department Director and/or the Chief Medical Officer.

Temporary privileges of this nature may not be granted in more than two (2) instances in any twelve-month (12) period, after which the Providers 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 Provider 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 education and 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, and if time permits, a national / international background check 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 tuberculosis (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 Chief Medical Officer, after consultation with the Department Director



responsible for supervision or his/her designee. In the event of any such termination, the Provider's patients then in the Hospital will be assigned to another Provider by the supervising Department Director or the Chief Medical Officer in the absence of the Department Director. The wishes of the patient will be considered, when feasible, in choosing a substitute Provider.

**R6.4.2.5 Hearing Rights.** A Provider 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. Article 10 hearing rights do not attach when denial of temporary privileges is pursuant to Article 3.6 of the Bylaws.

#### 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 or Allied Health Professional 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 or Allied Health Professional Staff category, or level of privileges. A Medical or Allied Health Professional 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 Provider 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 Chief Medical Officer or his/her designee may grant emergency privileges under circumstances in which there are insufficient Medical or Allied Health Professional 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, according to the Medical Staff Leave of Absence policy, be granted leave of absence by the Board Credentials and Medical Staff Committee, for a specifically defined period of time, not to exceed one (1) year. Absences for longer than one year constitutes voluntary resignation of Medical or Allied Health Professional Staff appointment and Clinical Privileges unless an exception is made by the Board Credentials and Medical Staff Committee upon recommendation of the Medical Executive Committee.

### **SECTION R7 ALLIED HEALTH PROFESSIONALS ("AHPS")**

#### R7.1 Privileges (Scope of Practice)

The Board Credentials and Medical Staff Committee, after considering the recommendations of the Medical Staff, may grant Privileges to fully licensed AHPs in accordance with their training, experience, scope of practice, and demonstrated competence and judgment. Possessing Privileges does not otherwise entitle the individual to membership on the Medical Staff. Persons granted Privileges 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 Credentials and Medical Staff Committee 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 privileges 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 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 Privileges must be specifically defined. The clinical work performed shall be under the overall oversight of the Director of the Department in which the AHP possess privileges. The nature and degree of oversight 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 Privileges

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

Nurse Practitioners, Clinical Nurse Specialists holding ARNP licenses, 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 Chief Nursing Officer, Medical Executive Committee and Board Credentials and Medical Staff Committee approval is followed for Hospital employed and non-employed Allied Health Professionals practitioners. For Hospital employed AHPs all steps in the process must be completed, and approval must be granted by the Board Credentials and Medical Staff Committee prior to the first day of employment. Employment by the Hospital 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 the Hospital only after the completed application file is favorably acted upon by the Board Credentials and Medical Staff Committee.

Nurse Practitioner, Physician Assistant and Certified Nurse Anesthetist status at the 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  
 Clinical Nurse Specialist – ARNP (CNS-ARNP)  
 Certified Physician Assistants (PA-C)

R7.2.1.1 ARNPs, PA-Cs and CRNAs not employed by the Hospital: It is the responsibility of the Provider to assure that he/she meets all credentialing/privileging requirements and that all documents are returned within established timeframes.

R7.2.1.2 ARNPs, PA-Cs and CRNAs employed by the Hospital:

R7.2.1.2.1 ARNPs, PA-Cs and CRNAs employed by the Hospital: It is the responsibility of the Provider to assure that he/she meets all employment and credentialing / privileging requirements and that all documents are returned within established timeframes.

R7.2.1.2.2 It is the responsibility of the Hospital 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.

R7.2.1.2.3 In addition to the required Hospital 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 submitted for approval. 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 the 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 Credentials and Medical Staff Committee.

R7.2.1.2.4 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 Board Credentials and Medical Staff Committee.

- R7.2.1.2.5 Any ARNP, PA-C or CRNA who changes their role or wishes to perform new/additional procedures within the Hospital must submit a revised privilege request form, which requires Chief Nursing Officer, Medical Executive Committee and Board Credentials and Medical Staff Committee, approval prior to activation of the new role or privileges.
- R7.2.1.2.6 Persons holding the Washington state license, Clinical Nurse Specialist, ARNP (CNS-ARNP) with prescriptive authority are employed in positions designed to manage the care for specific populations of patients, generally disease-specific.
- R7.2.1.2.7 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 the Hospital.

#### R7.2.2 Surgical Assistants

Licensed assistants to an Active Medical Staff Member will be credentialed and have an approved Privileges 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 Chief Nursing Officer. 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 Board Credentials and Medical Staff Committee 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.

#### R7.2.3 Acupuncturists

Applicants for appointment and reappointment must meet qualifications regarding licensure, training, experience and documented competency. The acupuncturist, unless otherwise approved for medical staff privileges under another category or discipline, can not independently practice medicine. They may, however, determine the appropriate acupuncture therapy for the patient's condition and administer a course of treatment. The request for acupuncture consultation must come from a Physician on the Medical Staff. During the provisional period the acupuncturist will be supervised by an anesthesia member with acupuncture qualifications. Upon successful completion of the provisional period, the acupuncturist will have the treatment plan approved by a Member of the De-

partment of Anesthesiology and Pain Medicine (Pain Service). The treatment can subsequently proceed independently without supervision of the acupuncturist. A member of the pain team is always available for consultation as needed by the acupuncturist.

#### R7.2.4 Optometrists

Applicants for appointment and reappointment must meet qualifications regarding licensure, training, experience and documented competency. The optometrist scope of practice includes examination of the human eye, examination and ascertaining any defects of the human vision system and the analysis of the process of vision; and performance of optometric services within the practice as defined by the Pediatric Ophthalmology division. The optometrist performs problem-focused patient assessment (including appropriate history and optometric examinations); establishes plans of care for all patients; completes charting and documentation, including electronic signatures; interprets and follows-up on test results, response to treatment and medications, and consultant's recommendations; and orders medications and diagnostic tests. The optometrist does not practice medicine.

#### R7.2.5 Mental Health Therapists

Applicants for appointment and reappointment must meet qualifications regarding licensure, training, experience and documented competency. Mental health therapists provide counseling that follows the principles of human development, learning theory, psychotherapy, group dynamics, and etiology of mental illness and dysfunctional behavior to individuals, couples, families, groups, and organizations, for the purpose of treatment of mental disorders and promoting optimal mental health and functionality. Mental health counseling also includes, but is not limited to, the assessment, diagnosis, and treatment of mental and emotional disorders, as well as the application of a wellness model of mental health.

#### R7.2.6 Licensed Behavior Analysts

Applicants for appointment and reappointment must meet qualifications regarding licensure, training, experience and documented competency. Behavior Analysts practice applied behavior analysis, which includes: (1) the design, implementation, and evaluation of instructional and environmental modifications based on scientific research and the direct observation and measurement of behavior and the environment to produce socially significant improvements in human behavior; (2) empirical identification of functional relations between behavior and environmental factors, known as functional assessment and analysis; and (3) utilization of contextual factors, motivating operations, antecedent stimuli, positive reinforcement, and other consequences to assist individuals in developing new behaviors, increasing or decreasing existing behaviors, and emitting behaviors under specific environmental conditions.

R7.2.7 For Allied Health Professionals, including Physician Assistants, who are required to have a supervising physician: Within 30 days of sponsoring physician notice or within 30 days of the Hospital's Medical Staff Services department being aware that the sponsoring physician is no longer able to perform their duties for any reason, the AHP must identify a new supervising physician. The AHP's privileges will be automatically suspended if a new supervising physician is not identified within the 30 days. . If an appropriate sponsor is obtained the appropriate Committee may recommend reinstatement of privileges at the

next regularly scheduled meeting. Physician Assistants must provide an updated copy of the updated Physician Assistant Delegation Agreement and Standardized Procedures Reference and Guidelines from the Washington State Medical Quality Assurance Commission to Medical Staff Services department.

## **SECTION R8 ORGANIZATION OF PROFESSIONAL SERVICES**

### **R8.1 Departments**

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

R8.1.2 In the event a Department Director must be replaced, the Chief Medical Officer, in consultation with the University of Washington Department Chair, 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 Chief Medical Officer regarding Department Director candidates. Upon initiation of a search and receipt of a recommendation regarding a Department Director from the Search Committee, the Chief Medical Officer 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 Chief Medical Officer will then appoint the Department Director. Such appointment shall be subject to the ratification of the Board Credentials and Medical Staff Committee, 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 acting through its Board Credentials and Medical Staff Committee. 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, resignation or relocation, the Chief Medical Officer, in consultation with the University of Washington department chair, may appoint a replacement on an interim basis. For the Director of the Hospital's Department of Pediatrics Department Director, the Hospital's CEO and the Dean of the University of Washington School of Medicine will lead the interim appointment process. These interim appointments will be reported at the next Medical Executive Committee for approval and their recommendation will be forwarded to the Board Credentials and Medical Staff Committee for approval.

R8.1.3 The Department Director shall be responsible through the Chief Medical Officer and 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 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 re-appointment based upon the level of provide activity and/or the outcomes achieved.
- R8.1.3.11 Monitoring, in conjunction with their home department, 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 assuring the ongoing competency of persons in the Department / Service;

- R8.1.3.15 Participating in the complaint/grievance process when these are directed to Members of their Department.
  - R8.1.3.16 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 as requested or required.
  - R8.1.3.17 Implementing programs to assure attainment of Hospital and Medical Staff goals as established annually.
  - R8.1.3.18 Maintaining compliance with, as pertinent to their Department, applicable organization's (e.g., DNV GL, CMS, and the Washington State Department of Health) regulatory requirements regarding patient care and hospital accreditation.
- R8.1.4 The Department Director shall be responsible to the Medical Executive Committee and Board Credentials and Medical Staff Committee through the Chief Medical Officer, for the professional care of all inpatients and outpatients assigned to the Divisions and Services within his/her Department.
- R8.1.5 Surgeon-in-Chief and Pediatrician-in-Chief work with the Chief Medical Officer on matters related to quality, safety and Provider competency.
- R8.1.6 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 the Hospital.
- R8.1.7 The Director of Continuing Medical Education shall be responsible to the Chief Academic Officer for the management of all continuing education programs sponsored by the Hospital

## 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 Chief Medical Officer and the Medical Executive Committee and with the approval of the Board Credentials and Medical Staff Committee.
- R8.2.2 Division Chiefs shall be appointed by the Department Director with the concurrence of the Chief Medical Officer and the Medical Executive Committee. Such appointment shall be subject to ratification by the Board Credentials and Medical Staff Committee. All Division Chiefs serve at the pleasure of the Board Credentials and Medical Staff Committee, 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 Credentials and Medical Staff Committee.

In the event of a Division Chief's death, disability, resignation or relocation, the Department Director, may appoint a replacement on an interim basis. The interim appointment



will be reported at the next Medical Executive Committee for approval and their recommendation will be forwarded to the Board Credentials and Medical Staff Committee 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 Provider performance.

### R8.3 Clinics

R8.3.1 Clinics may be developed working with Hospital leadership 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 Chief Medical Officer. Such appointments shall be subject to ratification by the Board Credentials and Medical Staff Committee following presentation and approval of the proposed appointment to the Medical Executive Committee. All Clinic Chiefs shall serve at the pleasure of the Board Credentials and Medical Staff Committee, 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 Provider performance.

### R8.4 Programs

R8.4.1 Programs may be developed working with Hospital leadership 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 Chief Medical Officer. Such appointments shall be subject to ratification by the Board Credentials and Medical Staff Committee following presentation and approval of the proposed appointment to the Medical Executive Committee. All Program Directors and Clinical Program Directors shall serve at the pleasure of the Board Credentials and Medical Staff Committee 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, but not limited to, the:

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

R8.4.3.2 Results of improvement activities related to Provider performance, and Hospital goals.

## R8.5 Committees and Sub-Committees

R8.5.1 Medical Staff Committee and Sub-committee chairs shall be recommended by the Chief Medical Officer. Such appointments shall be subject to ratification by the Board Credentials and Medical Staff Committee following presentation and approval 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 Credentials and Medical Staff Committee, 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 Chief Medical Officer for the work within his/her committee/sub-committee, including the:

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

R8.5.3.2 Results of improvement activities related to Provider performance and Hospital goals.

## 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 Chief Medical Officer review the administrative matter. The Chief Medical Officer'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 Chief Medical Officer, the Medical Staff Member's concern is not resolved to their satisfaction that Member may request that the Medical Executive Committee review the matter. According to Section R8.6.2 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 the circumstances

### 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 Chief Medical Officer 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 Chief Medical Officer concerning any administrative concern brought to its attention. All involved parties shall seriously consider these recommendations, and the Chief Medical Officer 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 Credentials and Medical Staff Committee.

#### 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 Chief Medical Officer, the Board Credentials and Medical Staff Committee, the Medical Executive Committee or a Department Director upon a majority vote of their active Members.

R.9.2.2 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.

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, including committee and sub-committee meetings, or for special meeting of the Medical Staff, ten percent (10%) of the voting Members shall 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, the Board Credentials and Medical Staff Committee 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 / Active Community Staff who represent diversity of specialty and site of practice and are representative of the composition and diversity of the Active / Active Community Medical Staff. The Medical Staff President shall chair the committee. They shall maintain a continuing review 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 three (3) years. Members shall be appointed by the Chief Medical Officer and the President of the Medical Staff.

R10.1.2 **The Credentialing and Professional Standards Committee** shall consist of no less than six (6) Active / Active Community Medical Staff Members selected to ensure representation of the major specialties. Appointed members shall include at least one of each of the following: at-large Allied Health Professional, a Children's University Group (CUMG) member, at-large community member (not including the President or President-Elect) and division chief from the Department of Pediatrics. A single member may fulfill more than one of the previously stated roles. Standing members will be the elected Medical Staff Officers, the Chief Medical Officer and the Chief, Advanced Practice Providers. All members have voting rights. They need not be members of the Medical Executive Committee and are appointed by the Chief Medical Officer and the Medical Staff President. Members are approved for two-year terms. The chair will be the President of the Medical Staff for the first year of his/her term. The President-Elect will chair dur-

ing the second year of his/her term. The Hospital's Chief Legal Officer, Medical Staff Services Director, the Credentialing Operations Supervisor and, on a rotating basis, one Trustee serving on the Board Credentials and Medical Staff Committee, shall be standing members without vote.

The Credentialing and Professional Standards Committee is one of the quality improvement committees established as a part of the Hospital's Coordinated Quality Improvement Program under RCW 70.41.200, which along with Medical Executive Committee has the responsibility for overseeing the process for periodic review of the credentials, physical and mental capacity, professional conduct, and competence in the delivering health care services of all Applicants to and members of the Medical and Allied health Professional Staff. Information and documents created specifically for, and collected and maintained by, the Credentialing and Professional Standards Committee to further the purposes of the Coordinated Quality Improvement Program are confidential and not subject to review or disclosure, or discovery or introduction into evidence in any civil action except as provided by applicable law. People who attend meetings of the Credentialing and Professional Standards Committee or who participate in the creation, collection, or maintenance of information or documents specifically for the Credentialing and Professional Standards Committee to further the purposes of the Coordinated Quality Improvement Program, or who participate in the Credentialing and Professional Standards Committee, in substantial good faith, enjoy statutory protections from civil actions for damages arising out of such activities.

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, professionalism, training and experience, and qualifications of health care professionals applying for Medical Staff or Allied Health Professional Staff membership and to make recommendations on such applications in conformity with the Bylaws.
- R10.1.2.2 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, professionalism, ethical standards, competence, and qualifications of current Members of the Medical or Allied Health Professional Staff, and to make recommendations to the Medical Executive Committee concerning reappointments, terminations, the granting or restricting of privileges and the assignment of Providers to various services.
- R10.1.2.3 To review the quality of care delivered by Providers at such other times as questions may be referred to this Committee by the Chief Medical Officer or President of the Medical Staff directly or through quality oversight activities performed by quality subcommittees within the Hospital or Medical Staff.

- R10.1.2.4 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.
- R10.1.2.5 To evaluate and provide recommendations to MEC regarding requests for new provider categories to determine whether to credential and privilege at the Hospital.
- R10.1.2.6 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 Credentials and Medical Staff Committee for final action.
- R10.1.2.7 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.
- R10.1.2.8 To biennially review, make recommendations for revision, and approve credentialing and privileging operational policies and procedures. Regulatory updates may require more frequent review.
- R10.1.3 **The Nominating Committee** shall consist of at least six Members of the Active / Active Community Medical Staff broadly representative of the composition of the Active / Active Community Members of the Medical Staff, and shall be appointed annually by the Chief Medical Officer 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.
- R10.1.3.1 The Nominating Committee shall be charged with maintaining diversity in the selection of the elected Medical Staff Officers, recognizing over time the diversity of race, age, creed, color, natural

origin, sex, sexual orientation, specialty and site of practice of the Active / Active Community Medical Staff.

R10.1.3.2 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. Diversity of race, gender, ethnicity, specialty and site of practice of the Medical Staff should be considered in developing the slate.

R10.1.3.3 The Honored Medical Staff Nominating Committee is a subcommittee of the Nominating Committee. Membership, including the chair, shall consist of five members who periodically convene to review providers eligible for nomination and forward their recommendations for Honored Medical Staff to the Nominating Committee. The Nominating Committee will include these recommendations when presenting the slate outlined above to the Medical Executive Committee.

#### Selection Criteria

R10.1.3.3.1 Candidates for the Honored Medical Staff may be nominated annually from all Affiliate, Inactive or former Members of the Medical Staff who meet one or more of the following selection criteria.

R10.1.3.3.2 **Clinical Activities:** Inpatient attending time of significance and / or (1) major involvement in clinics; (2) block time in surgery; (3) major consulting activities, (4) significant Hospital contributions in a pediatric subspecialty.

R10.1.3.3.3 **Medical Staff Activities:** (1) has been President of the Medical Staff and/or (2) chair of a major Medical Staff or Hospital committee; (3) member of the Medical Executive Committee; (4) clinic chief, division chief, or department director; or (5) Chief Medical Officer.

R10.1.3.3.4 **Contributions:** (1) major contributions to education and research; (2) significant community, state or national contributions; and (3) has held a state or national office of major significance.

R10.1.3.3.5 **Length of Service:** Candidates should typically be considered after a minimum of 10 years of service on the Medical Staff.

R10.1.3.3.6 **Eligibility Period:** Candidates shall not be

recommended for appointment until a two-year period of time has elapsed since their retirement, move from the area or change to Affiliate or inactive medical staff membership.

Exceptions can be granted by the Medical Executive Committee and the Board Credentials and Medical Staff Committee.

- R10.1.4 **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 Physician Relations and Medical Staff Services Directors will be standing non-voting 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.
- R10.1.5 **The Institutional Review Board (IRB)** scope, procedures and oversight is governed by the Seattle Children's Research Institute and the applicable federal or other applicable standards and regulations for research. The IRB approves and works in concert with the appropriate hospital departmental leadership or other hospital functions as they relate to compassionate / emergency use of Investigational pharmaceuticals or devices.
- R10.1.6 **The Quality Improvement Steering Committee (QISC)** shall be chaired by the Vice President, Chief Quality and Safety Officer (CQSO). Included on the Committee are representatives from Hospital Administration, the Hospital staff and the Medical Staff representing clinical and support services from across the organization. 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:
- R10.1.6.1 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.
  - R10.1.6.2 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.
  - R10.1.6.3 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 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. The Quality Improvement Steering Committee is one of the quality improvement committees established as a part of the Hospital's Coordinated Quality Improvement Program under RCW 70.41.200, with Board of Trustees designated overall responsibility for quality-improvement activities at the Hospital. The Quality Improvement program shall be organized and coordinated by the QISC and conducted through other committees (including the Credentialing and Professional Standards Committee) and 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 Chief Medical Officer to the Board Quality and Safety Committee of the 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 RCW 4.24.240, 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.

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 Program with oversight provided by the QISC. Except as otherwise provided in this section, the Sub-committee Chair shall appoint the Members of the Medical Staff standing Sub-committees and report such appointments annually to the QISC. The various Sub-committees include:

**R10.1.6.5 Blood Usage Sub-committee:** shall be chaired by a representative from the Division of Hematology/Oncology who is appointed by the Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. The Transfusion Nurse Consultant serves as co-chair. The Sub-committee will consist of at least ten (10) members appointed by the Co-Chairs for two-year terms. Terms are extendable by the Co-Chairs. Members may represent more than one area. Membership should include representation from the Department of Anesthesiology and Pain Medicine, Department of Surgery, Intensive Care units, a Chief Resident, Nursing, Department of Pathology, Clinical Laboratories, Bloodworks Northwest, and Seattle Cancer Care Alliance Transfusion Services Office.

Non-Voting sponsors and other ex-officio members include the VP Clinical Support Services and Seattle Cancer Care Alliance

Medical Director. The Sub-committee shall meet at least quarterly or more often at the call of the Chair. For those members with particular roles, expertise, or interest, there is no pre-determined limit to the number of terms that can be served.

The Blood Usage Sub-Committee provides oversight and direction for improvement work and quality management of processes related to the safe and effective use of blood products. The sub-committee accomplishes this function by:

- R10.1.6.5.1 Suggesting, reviewing and revising Hospital policies that relate to the collection, preparation, ordering or delivery of blood products in compliance with applicable regulations.
- R10.1.6.5.2 Providing staff training and education and promoting a program of continuing education of Providers.
- R10.1.6.5.3 Monitoring blood use and wastage.
- R10.1.6.5.4 Reviewing transfusion errors and accidents, providing feedback and recommending corrective action when needed.
- R10.1.6.5.5 Initiating performance improvement activities in response to transfusion-related safety events or proactive assessments of transfusion processes.
- R10.1.6.5.6 Fostering collaboration with clinicians and clinical departments within the Hospital, the regional blood center and Seattle Cancer Care Alliance Transfusion Services Office.
- R10.1.6.5.7 The Blood Usage Committee monitors and reviews:
  - R10.1.6.5.7.1 Blood product utilization and wastage;
  - R10.1.6.5.7.2 Appropriateness of RBC transfusion;
  - R10.1.6.5.7.3 Crossmatch to the Transfusion ratio;
  - R10.1.6.5.7.4 Uncrossmatched O negative blood use;
  - R10.1.6.5.7.5 Transfusion-related specimen labeling errors;

R10.1.6.5.7.6 Adverse events;

R10.1.6.5.7.7 Quality improvement efforts.

R10.1.6.5.8 The Blood Usage Sub-Committee has the authority to:

R10.1.6.5.8.1 Analyze transfusion metrics and transfusion-related safety events to identify and implement process improvement initiatives.

R10.1.6.5.8.2 Prioritize quality improvement activities and request resource allocation, if needed.

R10.1.6.5.8.3 Escalate serious concerns or barriers to the QISC or Hospital Administration.

R10.1.6.5.8.4 Create or revise Hospital policies and procedures in accordance with best practices and regulatory requirements.

R10.1.6.6 **Cancer and Blood Disorders Center (CBDC) Quality Governance Sub-committee:** Committee provides oversight for the CBDC Quality Program, coordinates with Seattle Cancer Care Alliance (SCCA) Quality Program to ensure the requirements outlined in the most current Foundation for the Accreditation of Cellular Therapy (FACT) standards are followed. The sub-committee shall consist of Provider members with cross-divisional / institutional representation. The Chair shall be the Cancer and Blood Disorders Division Chief and the CBDC Quality Medical physician. The chair shall be appointed by the Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. Members shall be appointed by the Chair for two-year terms. Terms are extendable by the Chair. The Sub-committee shall meet at least four (4) times 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:

R10.1.6.6.1 Oversight of the annual goals and objectives for the clinical, educational and programmatic activities related to CBDC Quality Program;

R10.1.6.6.2 Promote a coordinated, multidisciplinary approach to patient management;

R10.1.6.6.3 Monitor and coordinate process improvement related to patient and staff safety;

R10.1.6.6.4 Uphold medical ethical standards.

The CBDC Quality Governance Sub-committee shall have the following subgroups:

R10.1.6.6.5 **Cancer Committee:** The sub-group 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).

R10.1.6.6.5.1 Ensure that educational and consultative cancer conferences cover all major diagnoses and related issues.

R10.1.6.6.5.2 Ensure that an active supportive care system is in place for patients, family and staff.

R10.1.6.6.5.3 Monitor quality improvement through completion of quality management studies which focus on quality, access to care, and outcomes.

R10.1.6.6.5.4 Promote clinical research.

R10.1.6.6.5.5 Supervise the cancer registry and ensure accurate and timely abstracting, staging and follow-up reporting.

R10.1.6.6.5.6 Perform quality control of registry data.

R10.1.6.6.5.7 Encourage data usage and regular reporting.

R10.1.6.6.6 **Chemotherapy Safety Committee:** Shall consist of bi-monthly meetings and Information discussed is confidential and considered part of the Quality Improvement and Performance Improvement process. These meetings shall be multidisciplinary and require Physician participation, 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. Treatment decisions are documented in the individual medical record,

R10.1.6.6.7 **Seattle Cancer Care Alliance Blood and Marrow Transplant (BMT) and Immuno-therapy Quality 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 CBDC Quality Governance Committee and from there to the Quality Improvement Steering Committee.

R10.1.6.7 **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 the 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 Surgery, Orthopedics, Pediatrics, 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 non-voting members may include representation from Rehabilitation Medicine, Psychiatry and Behavioral Medicine, Critical Care, Nutrition, Ambulatory Care and the Emergency Department.

The physician co-chair shall be appointed by the Chief Medical Officer and the nursing co-chair by the Chief Nursing Officer and both will be approved by the Board Credentials and Medical Staff Committee. The members shall be appointed by the Co-Chairs for two-year terms. Terms are extendable by the Co-Chairs. The Sub-committee shall meet at a minimum quarterly or more often at the call of the Chairs, to perform the following duties:

- R10.1.6.7.1 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 Committee, Nursing Quality Practice Council (QPC) and Clinical Informatics Committee (CIC) 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 be accountable for reporting the implementation and results of clinical standard work to the QISC,
- R10.1.6.7.2 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 Pharmacy and Therapeutics or Medical Informatics Committees.
- R10.1.6.7.3 The CSC will receive, review and provide recommendations for proposals from a variety of committees and work groups including, but not limited, to those requested by the Clinical Effectiveness sub-committee.
- R10.1.6.8 **Code Blue Sub-committee:** The Hospital's Code Blue Sub-committee provides the oversight of the Code Blue / Green team responses system. The committee accomplishes this function by establishing the policies and procedures for Code Blue / Green, ensuring delivery of equipment and supplies for us by the Code Blue / Green team, and integrating the Code Blue / Green process into Hospital locations and functions.
- R10.1.6.8.1 The Code Blue Sub-committee monitors and reviews all activity by the Code Blue / Green team which includes recognition of medical emergency, activation of Code Blue / Green team, resuscitation events and documentation and continuous quality improvement.
- Other functions of the Resuscitation Committee include:
- R10.1.6.8.2 Integration with all sites of care on training and equipment.
- R10.1.6.8.3 Training for all Code Blue / Green team responders.

R10.1.6.8.4 Maintenance of emergency medication worksheet.

R10.1.6.8.5 Collaboration with units / locations regarding all aspects of resuscitation.

The Chair will be recommended by the Chief Medical Officer, approved by the Board Credentials and Medical Staff Committee and will be a member of the Critical Care, Neonatology, Emergency Medicine Divisions or Anesthesiology and Pain Management Department. The Chair will appoint to two-year terms 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. Terms are extendable by the Chair.

R10.1.6.9 **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 Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. The Chair will appoint to two-year terms 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 Chief Medical Officer or their delegate will consult with Disability Rights Washington so long as an agreement exists between the Hospital 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. Terms are extendable by the Chair.

R10.1.6.10 **Infection Prevention Program Quality Program** is the responsibility of the Infection Prevention Leadership: The Medical Director and Director of Infection Prevention. The Medical Director is a member of the Division of Infectious Disease who is appointed as Medical Officer of Infection Prevention by the Board Credentials and Medical Staff Committee. The Medical Director and Director of Infection Prevention work in conjunction with the Chief Medical Officer, the Chief Clinical Officer, the Chief Quality and

Safety Officer and the SVP for Continuous Improvement and Innovation.

Infection Prevention Program staff provide daily and ongoing management of programs and policies for the surveillance of healthcare associated infections, the isolation of patients with communicable disease, and the maintenance of standards of asepsis and sanitation, investigation of incidents involving hospital-acquired infections for patients, families and staff and quality improvement in Infection Prevention to prevent these infections. The Director and Medical Director of Infection Prevention have the responsibility and authority, working in conjunction with the Chief Medical Officer, to institute appropriate control and prevention measures or studies when there may be an infection hazard to patients, personal and/or visitors.

**R10.1.6.11 Medical Informatics Sub-committee:** shall consist of a minimum of eight (8) Medical Staff Members with representation from Medicine, Surgery, and Child Psychiatry and Behavioral Health, and representatives from Nursing, Hospital administration, Information Services, Compliance, Medical Informatics, Privacy, and the Director of Health Information Management (HIM). The Chair shall be appointed by the Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. The members of the Sub-committee shall be appointed by the Chair. Members are approved for two-year terms. Terms are extendable by the Chair. The Director of HIM will be a permanent member of the Committee. The Sub-committee shall perform the following duties:

**R10.1.6.11.1** 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.

**R10.1.6.11.2** 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.

**R10.1.6.11.3** 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.



R10.1.6.11.4 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 Services department for inclusion with the Member's file at the time of reappointment.

R10.1.6.11.5 Conduct regular chart pertinence reviews that focus on areas of patient safety, areas of high potential risk management, Hospital policies and external regulatory standards. The results of these audits are forwarded to the QISC at regular intervals for review and action.

R10.1.6.11.6 Work in conjunction with the Hospital's Privacy Program and IT Security Team to develop and maintain health record and the security and confidentiality provisions necessary to maintain patient privacy.

R10.1.6.12 **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 Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. The Co-chairs will include one member of the Division of Gastroenterology and the Director of Nutrition or his/her qualified dietician manager. The Sub-committee will be multidisciplinary, and represent the following disciplines or sites of care: Nutrition, Pharmacy, Surgery, Pediatrics, Intensive Care, Occupational Therapy, Home Care and Nursing. Sub-committee members will be appointed by the Chair for two-year terms. Terms are extendable by the Chair.

Quality goals for the Sub-committee will include:

R10.1.6.12.1 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.

R10.1.6.12.2 Establish standardized tools to monitor growth and adequate nutrition in all children seen within the Hospital's practice sites.

R10.1.6.12.3 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 the Hospital.

- R10.1.6.12.4 Establish and approve any changes to the enteral formulary and make recommendations for parenteral products.
- R10.1.6.12.5 Establish competencies for non-physician providers to assist in ordering parenteral and enteral nutrition.
- R10.1.6.12.6 Identify and address the educational needs of students, residents, and the Medical Staff in the areas of pediatric nutrition.
- R10.1.6.12.7 Audit regularly the provisions of their services and appropriately report findings to the QISC and the Medical Executive Committee.

R10.1.6.13 **Pain Champions Sub-committee:** shall consist of the Director of Pain Medicine as its Chair. The Chair will be appointed by the Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. Members will be appointed by the Chair to two-year terms 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. Terms are extendable by the Chair,

The Sub-committee shall focus on the following areas:

- R10.1.6.13.1 System-wide quality improvement efforts related to pain management by analyzing selected trends and patterns, choosing priority indicators for improvement efforts facilitating operational definitions of outcomes, facilitating evidence-based care, recommending educational endeavors related to pain prevention and treatment, and communicating the results and recommendations to clinical services and QISC.
- R10.1.6.13.2 Advising clinical units and services on management of quality improvement efforts.
- R10.1.6.13.3 Designing system-wide improvement efforts for the detection, evaluation and treatment of pain (e.g., policy development and documentation changes).

R10.1.6.14 **Patient Safety Sub-committee:** The Patient Safety Sub-committee provides oversight and direction for improvement work to eliminate preventable harm throughout the organization.

The Patient Safety Sub-committee shall be co-chaired by the Medical Director for Patient Safety and the Patient Safety Director. Members shall be appointed by the Co-Chairs to two-year terms. Terms are extendable by the Co-Chairs. The multidisciplinary Sub-committee shall consist representatives from patient safety, medication safety, QISC subcommittees targeting high-risk clinical processes, Hospital acquired condition (HAC) workgroups, key clinical and support services, the Family Advisory Council and a Pediatric Chief Resident. Members of the Sub-committee are safety leaders with responsibility for major Hospital services or high-risk conditions. The Sub-committee will meet at least quarterly and will provide reports of its activity and recommendations to QISC. The Sub-committee accomplishes this function by:

- R10.1.6.14.1 Systematically analyzing organizational safety goal outcome and process data, common cause analysis on serious safety event (SSE) data and root cause analysis data to identify processes, services or conditions that represent a risk to Patient Safety.
- R10.1.6.14.2 Highlighting and making recommendations to appropriate organizational structure(s) regarding priorities and resource allocation for improvement work in response to these data.
- R10.1.6.14.3 Fostering collaboration among quality improvement committees and workgroups across the organization targeting Patient Safety, both internal and external to the organization, aligning efforts and developing metrics to track impact.
- R10.1.6.14.4 Working to optimize detection of Patient Safety events through internal and external reporting system(s) and the development and deployment of triggers.
- R10.1.6.14.5 Interfacing with clinical leaders to develop, support and monitor the effective integration of safety improvement strategies into leader standard work, including reliable methods for response to attain organizational goals and reduce risk.
- R10.1.6.14.5 Establishing a robust plan to share and disseminate lessons learned, transportable safety risks, common causes and recommendations for action across the organization, including but not

limited to a plan for communication and effective training. This includes appropriate escalation of concerns or barriers to QISC.

R.10.1.6.15 **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.

R10.1.6.16 **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 Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. Medical Staff members are appointed by the Medical Co-Chair to two-year terms and with input from the Director of Pharmacy. Terms are extendable by the Co-chairs. Representation from Oncology, Critical Care, Anesthesiology, Surgery, Medicine, Emergency Department, Nursing Professional Development, Medication Safety, and Information Services will be assured. The Sub-committee shall be responsible for overseeing all medication use processes of the organization, develop and maintain 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 and standards that deal with any aspect of medication use within the institution. They will conduct medication usage evaluations to assist development of 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.

R10.1.6.17 **Sedation Sub-committee** is chaired by an anesthesiologist and is appointed by the Chief Medical Officer following nomination by the Director, Department of Anesthesiology and Pain Medicine and approved by the Board Credentials and Medical Staff Committee. The Sub-committee members are appointed for two-terms and will consist of at least one representative for each site in which procedural sedation is performed. In addition, there will be at least one representative from each of Medical Staff Services, Quality Improvement, and Regulatory Compliance. Terms are extendable by the Chair, The responsibilities of this Sub-committee will be:

R10.1.6.17.1 Recommend criteria for privileging and ongoing competency of sedation providers.

- R10.1.6.17.2 Develop, revise and disseminate evidence-based best practice policies and guidelines addressing procedural sedation through the Hospital and its practice sites.
- R10.1.6.17.3 Ensure that Hospital policies regarding procedural sedation are revised at regular intervals.
- R10.1.6.17.4 Ensure that applicable organization's (e.g., DNV GL, CMS and the Washington State Department of Health) regulatory requirements regarding patient care and hospital accreditation.
- R10.1.6.17.5 Provide education to staff regarding safe and appropriate use of procedural sedation.
- R10.1.6.17.6 Provide consultation from Sub-committee members, as requested to address specific patient or clinical unit concerns or questions and
- R10.1.6.17.7 Advise and participate in performance improvement activities related to procedural sedation.

#### **R10.1.6.18**

**Solid Organ Transplantation 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, intensive care medicine, nursing, anesthesia) and administration. The Co-Chairs and administrative lead shall be appointed by the Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. The Co-Chairs will appoint the members of the Sub-committee to two-year terms. Terms are extendable by the Co-Chairs. 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 (e.g., Medical Director of 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:

- R10.1.6.18. Develop, approve and evaluate the performance of the annual goals and objectives of the clinical, and quality improvement programs for organ transplantation medicine at the Hospital..
- R10.1.6.18.2 Promote a coordinated, multidisciplinary approach to patient management that is consistent with the Hospital policies and procedures and

consistent (when appropriate) across each of the transplant programs and clinical units on which transplant patients are cared for.

- R10.1.6.18.3 Assure that the Hospital is in compliance with, and assumes a leadership role in devising and implementing the policies relating to national organ procurement agencies (OPTN), state regulations (DOH) and national accreditation bodies (DNV, CMS) as they relate to organ procurement and transplantation.
- R10.1.6.18.4 Ensure that internal and external communication and education of the Hospital's staff and the public supports the national OPTN goals of assuring maximal access for all patients to life saving organ transplants.
- R10.1.6.18.5 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.
- R10.1.6.18.6 Suggest the need for external program reviews to the Chief Medical Officer when indicated.
- R10.1.6.18.7 Evaluate the Hospital's utilization and outcome performance compared to other pediatric transplant centers.
- R10.1.6.18.8 Report annually in writing to the Quality Improvement Steering Committee on program data trends and results of efforts to improve transplant services.

R10.1.6.19 **Utilization Review Sub-committee (URC):** Utilization Review Committee provides oversight of the Hospital Utilization Management function. The Utilization Management function ensures procedures are in place to meet the Center for Medicare and Medicaid Services (CMS) Conditions of Participation.

The URC is Co-chaired by Associate Chief Medical Officer and the Director of Revenue Cycle Operations. Members of the URC represent senior physician leadership, House Staff, and Hospital representatives from care coordination, clinical effectiveness, and revenue cycle.

The physician Co-chair shall be appointed by the Chief Medical Officer and approved by the Board Credentials and Medical Staff Committee. The members of the Sub-committee shall be ap-

pointed by the Co chairs to two-year terms. Terms are extendable by the Co-Chairs. The URC shall meet quarterly or more often at the call of the Chairs, to perform the following duties. Some of the duties may be carried out by working committees such as Care Progression Rounds Committee or UR Virtual Referral Committee.

- R10.1.6.19.1 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.
- R10.1.6.19.2 Report review findings and recommendations to the QISC, Medical Executive Committee and/or other Medical Staff and Hospital entities as appropriate.
- R10.1.6.19.3 Review trend reports on third party payer denials, make recommendations relative to contracting language, take appropriate actions on findings as needed.
- R10.1.6.19.4 Collect and analyze data necessary to carry out these responsibilities. For example:
  - R10.1.6.19.4.1 Process data collected on every admission escalated to the Virtual UR Physician.
  - R10.1.6.19.4.2 Review root cause of medically unnecessary services, inappropriate place of service setting, extended stay and professional services.
  - R10.1.6.19.4.3 Outcome data on the resolution plans identified from the escalations.
  - R10.1.6.19.4.4 Trends data collected in the bi-monthly Care Progression Rounds Committee, working sub-committee of the Utilization Review committee.
  - R10.1.6.19.4.5 Outcome data on the extended stay review compliance rate.

- R10.1.6.19.5 Analyze issues, problems (system, or individual case) or individual cases identified through utilization review activities. For example:
  - R10.1.6.19.5.1 Determine an admission is not medically necessary and escalate for resolution.
  - R10.1.6.19.5.2 Require a patient care team to justify an individual patient admission.
  - R10.1.6.19.5.3 Notify an attending and a patient family or appropriate representative that an admission is not medically necessary.
  - R10.1.6.19.5.4 Initiate review of clinical practice Sponsor or advocate for improvement work related to system inefficiencies, staffing, clinical practice standards, Hospital policies, resource allocation or other barriers that lead to inappropriate or delayed hospitalizations, place of service issues, delayed or no care coordination or discharge planning, inappropriate professional services and avoidable readmission.
- R10.1.6.19.6 Evaluate all Hospital specific communications from internal and external entities related to utilization review activities.
- R10.1.6.19.7 Monitor compliance with utilization review policies and procedures. Update the applicable policies and procedures to assure an effective utilization review program. Approve the Hospital's Utilization Management Plan.
- R10.1.6.19.8 The Chief Medical Officer or other physician members of the URC may review and sign orders for appropriate level of care after review by the Utilization Review staff.



## **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 "Patients 21 Years Or Older" Policy, adults may be provided with 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 Credentials and Medical Staff Committee.

## **SECTION R12 ASSIGNMENT OF PATIENTS**

- R12.1 Every patient admitted to the Hospital will have a responsible attending Physician/Dentist/Clinical Psychologist (the Attending) 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/Clinical Psychologist in charge. Attending Staff shall be notified in a timely fashion of any admissions 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 both the then-current attending and receiving Physicians. 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 Providers agree not to, except in life threatening emergencies where appropriate specialty assistance is not available, provide medical care or treatment at the Hospital to their immediate family members. "Immediate family member" is defined at the Hospital as the provider's children, stepchildren, foster children, grandchildren or nieces and nephews. Providers are not precluded from treating the children of colleagues, close friends or neighbors but the Medical Staff Member should consider his/her ability to provide objective care.
- R12.4 Providers shall not provide urgent medical care to any persons, staff or other Providers in the Hospital or at a Seattle Children's ambulatory or regional site unless the care is part of an approved Hospital program or in response to a life threatening event. Approved Hospital programs may include, but are not limited to, the following examples: Code response, Medical Evaluation Response or anyone registered for care (e.g., staff registered for care in the Emergency Department). Providers are specifically prohibited from performing any procedures, performing diagnos-

tic testing and dispensing or administering medications unless expressly permitted by this Section 12. This Section does not prohibit Providers from answering general medical questions,

- R12.5 All Providers must adhere to the policies of the Hospital as they apply to service rendered, including but not limited to the Hospital's Compliance Program and the policies applying to documentation of services and the reporting of clinical services.
- R12.6 Dentists and Clinical Psychologists who admit patients shall assume primary responsibility for the patients and are required to seek consultation for any medical problems, which may be present or arise during the hospitalization.

### **SECTION R13 AUTOPSIES**

- R13.1 Unless the Medical Examiner has assumed jurisdiction, no autopsy shall be performed without written or oral consent from the legally authorized representative.
- R13.2 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 encouraged in cases in which the patient is at high risk for mortality or morbidity (except in an emergency) when the diagnosis is obscure, or in keeping with other Hospital policies.
- R14.2 A record of consultation shall be documented in the medical record and shall be signed by the consultant.
- R14.3 The attending Medical Staff Member, 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.

### **SECTION R15 DISCHARGES**

Discharges shall follow the appropriate policies (e.g., Medical Record Documentation).

### **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, may be referred to outside laboratories per Laboratory policies. The Director of Laboratories 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 Providers, will be determined by the Director of Laboratories and as approved by the Medical Executive Committee.
- R16.3 All tissues and foreign bodies removed during operative or medical procedures in the Hospital shall be handled in accordance with the requirements as outlined in the Handling of Human Tissue Removed During Operative or Medical Procedures policy. 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 BloodWorks Northwest.

### **SECTION R17 MEDICAL CARE**

- R17.1 Medical Staff Members shall be responsible for all medical orders, including those for outpatient services, for patients in their care. This is true whether orders are written by house officers or by the attending Physicians themselves. All paper orders shall be dated, timed, and have legible name, signature and contact information 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 appropriate clinical information system training.
- R17.2 Naturopathic physicians may order Speech, Occupational and Physical Therapy and other services as allowed within the scope of their licensure and State law.
- R17.3 Registered Dietitian Nutritionists (RDNs) may perform the following according to approved Hospital policy: (1) modify diet orders and enteral formula orders to facilitate appropriate, safe and timely medical nutrition therapy and (2) diagnose nutrition status (including malnutrition). RDNs work in collaboration with the medical team to advance patient care goals and outcomes related to nutrition. Order changes and nutritional diagnoses will be communicated to the Provider.
- R17.6 A Medical Staff Member 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/she 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 Medical Staff Member.
- R17.7 Limitation of resuscitation orders should be documented according to hospital policy.

### **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 in accordance with the Hospital's 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.
- R18.4 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.
- R18.6 The Operative note must be documented immediately following the procedure. (Reference Section R23.4)
- R18.7 Discharge and expiration summaries should be documented and finalized according to the Hospital's 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.
- R18.8 In case of readmission of a patient, all previous records shall be available for the use of the Medical Staff.
- R18.9 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).
- R18.10 All medical student admission notes and orders require countersignature by a resident, fellow or staff physician.
- R18.11 All verbal orders should be co-signed within 48 hours.
- R18.12 Failure to follow the rules and regulations or the applicable documentation policies may be grounds for suspension of privileges according to the Delinquent Medical Record 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.

## SECTION R20 AMBULATORY SERVICE(S)

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. The appropriate Medical Screening Examination (MSE) required under the federal Emergency Treatment and Active Labor Act (EMTALA), for an individual who is not a Hospital patient and may have an Emergency Medical Condition as defined by EMTALA, will be performed by a Code Blue Team/Medical Evaluation Leader (i.e., an Intensive Care Unit (ICU) attending, ICU fellow or ICU Advanced Registered Nurse Practitioner (ARNP) or an Emergency Medicine (EM) provider (i.e., an EM attending, EM fellow, or EM ARNP) as appropriate depending on the circumstances. If the patient is exhibiting psychiatric symptoms, the medical record should indicate an assessment of suicide and / or homicide attempt risk, and / or assaultive behavior, and a determination of whether the patient likely poses a danger to self and / or others.

## SECTION R21 ORGANIZED HEALTH CARE ARRANGEMENT

**R21.1 Purpose.** The Medical Staff, Allied Health Professional Staff and the Hospital participate in a clinically integrated care setting where patients receive treatment from the Medical Staff and Allied Health Professional 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 Allied Health Professional Staff, and sets forth the obligations of Staff Providers in relation to their participation in the OHCA.

**R21.2 Requirements.** As participants in the OHCA, each Provider 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 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 HIPAA 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 and Allied Health Professional Staff,

or any independent Member of the Medical Staff or Allied Health Professional 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 Allied Health Professional Staff, or any independent Member of the Medical Staff or the Allied Professional Staff to create or assume any obligation or liability on behalf of each other.

## **SECTION R22 RESEARCH**

Research must follow the applicable policies and procedures of the Children's Institutional Review Board or external approved IRBs) including, but not limited to, the applicable access, privacy and record retention procedures.

## **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 patient may not be operated upon nor given an anesthetic for surgical or invasive procedures (e.g., endoscopy, interventional radiology, cardiac catheterization) unless a surgical informed consent has been signed by the competent patient, the legally authorized representative 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 Associated medical condition(s).
  - R23.1.3.5 Present medications (may be documented in electronic health record (EHR)).
  - R23.1.3.6 Medical, food, latex, or other allergies (may be documented in EHR).

- R23.1.3.7 Pertinent family history (e.g., malignant hyperthermia) and review of systems.
- R23.1.3.8 The procedure or surgery.
- R23.1.3.9 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, 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 any other Hospital approved form (electronic or paper) that includes the necessary elements itemized above.

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

- R23.1.3.10 The presence of the History and Physical Exam before the procedure begins.
- R23.1.3.11 Verifying the date and the format of the History and Physical Exam by documenting that on the Surgery Boarding Pass or any other form approved for this purpose.
- R23.1.3.12 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.
- R23.1.3.13 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 Providers. The proposed anesthetic plan should be part of this documentation.

The combination of the pre-operative History and Physical Exam, and the Pre-anesthetic Evaluation 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 in the EHR on an approved form (operative procedure note) or other method approved by the Medical Informatics Committee only if the comprehensive operative report is not available prior to moving to the next venue / level of care. 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, complications, implants, grafts, type of anesthesia administered, estimated blood loss and specimen removed (if applicable).
- R23.4.2 The operative note must be documented 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 the Privileges have been given.
- R23.6 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 Medicine and the Vice President of Surgical Services. Unresolved problems shall be referred to the Perioperative Steering Committee for discussion and recommendation. If the problem is still not resolved the problem should be submitted to the Chief Medical Officer for resolution or for presentation to the Medical Executive Committee.
- R23.7 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 Credentials and Medical Staff Committee. (Details of the general privileging process are found in Rules and Regulations Section R6.)
- R24.2 Anesthesia and sedation can only be administered in accordance with the applicable Hospital policies and procedures by an appropriately privileged Provider.



**SECTION R25  
AMENDMENTS OF THE RULES AND REGULATIONS**

These Rules and Regulations may be amended by the process described in Article 11 of the Medical Staff Bylaws.

Adopted: April 1940  
 Revised: 1979  
 Revised: August 1981  
 Revised: April 1984  
 Revised: April 1989  
 Revised: May 1993  
 Revised: November 1995  
 Revised: November 1997  
 Revised: April 1999  
 Revised: April 2003  
 Revised: June 2005  
 Revised: September 2005

Revised: May 2006  
 Revised: July 2006  
 Revised: February 2007  
 Revised: March 2008  
 Revised: September 2010  
 Revised: January 2011  
 Revised: February 2011  
 Revised: June 2011  
 Revised: September 2011  
 Revised: February 2012  
 Revised: October 2012  
 Revised: March 2013

Revised: March 2015  
 Revised: December 2015  
 Revised: February 2020

## ADDENDUM A – SUMMARY OF CHANGES FOR 2020 REVISION

Terminology / Punctuation	Throughout documents	<ul style="list-style-type: none"> <li>• Changed “Board of Trustees” to “Joint Conference Committee” to reflect Board of Trustees delegation of final approval for credentialing/privileging, medical staff policies, By-laws/Rules/Regulations to Joint Conference Committee</li> <li>• Changed “Joint Conference Committee: to reflect new “Board Credentialing and Medical Staff Committee”</li> <li>• Standardized references to “Seattle Children’s” or “Children’s” to “Hospital”</li> <li>• Standardized definitions and titles used throughout the document (e.g., “CMO” for “Chief Medical Officer”</li> <li>• Changed “letters of recommendation” to “peer references”</li> <li>• Changed Allied Health Professional “Scope of Practice” to “Privileges”</li> <li>• Scanned document to assure appropriate punctuation</li> <li>• Consistent use of “he/she” or “him/her” as preferred reference</li> <li>• Clarified chair and member appointment process and terms for Medical Staff Standing Committees and Quality Sub-committees (e.g., Section R10.1 and R10.1.6)</li> </ul>
Compliance and Professional Behavior	Throughout documents	<ul style="list-style-type: none"> <li>• Standardized language in several areas to clarify expectations to adhere to Medical Staff Bylaws/ Rules/Regulations, Hospital policies/procedures, Corporate Compliance Program (e.g., Article 3.1.5) and regulatory compliance regarding patient care and hospital accreditation (e.g., Article 8.1.10; Section R5.1.2.)</li> <li>• Realignment to assure consistency between Medical Staff and Hospital Bylaws (e.g., Article 3.3.7)</li> <li>• Updated diversity language in several areas (e.g., Article 8.2.1.4; Section R2) including additional of sections on “gender identity” and “sexual stereotyping”.</li> <li>• Clarified that primary source verification during the credentialing / privileging processes will be conducted using industry resources as reflected in Medical Staff Services operational policies (e.g., Article 3.1 and Section R3.1)</li> <li>• Standardized Board Certification timeline (Sections R1 and R6.2.2)</li> <li>• Added language to clarify that providers shall not provide urgent care to any persons, staff or other providers unless care is part of an approved hospital program or in response to life-threatening event. Section R12.4)</li> </ul>
Clarification or to reflect current policy / procedure / responsibilities	Throughout documents	<ul style="list-style-type: none"> <li>• Clarified that performance plans not considered corrective action plans are part of the quality or performance improvements activities (e.g., Article 3.9.4.1)</li> <li>• Clarified that Risk Management and Credentialing and Professional Standards Committee review may be required prior to review by departments/divisions for concerns identified during the credentialing/privileging processes (e.g., Article 4.1.4; Section R5.4)</li> <li>• Clarified expectations for Affiliate Staff (Section R4.5)</li> <li>• Added Mental Health Therapists and Licensed Behavioral Analysts as a credentialed/privileged type of Allied Health Profes-</li> </ul>

		<p>sional (e.g., Article 4.7 and Section R7.2.5 and Section R7.2.6)</p> <ul style="list-style-type: none"> <li>• Post Graduate Trainees (Residents and Fellows) clarified credentialing requirements for ACGME and non-ACGME accredited fellowships, and for moonlighting (e.g., Article 4.9)</li> <li>• Updated Chief Medical Officer (CMO) responsibilities and delegation of authority (e.g., Article 6.1)</li> <li>• Updated Medical Staff elected officers responsibilities (e.g., Article 6.4 – 6.5)</li> <li>• Updated titles and voting status for Medical Executive Committee (e.g., Article 8.2)</li> <li>• Updated percentage of community based members of Medical Executive Committee (Article 8.2)</li> <li>• Clarified membership and responsibilities for Board Credentials and Medical Staff Committee (formerly Joint Conference Committee) (e.g., Article 8.2.2)</li> <li>• Updated and clarified the situations giving cause to suspension; added “Administrative Suspension” authority of the CMO for action for situations that would significantly disrupt hospital operations (but criteria for “Summary Suspension” not met. (e.g., Article 9.7)</li> <li>• Added additional cause in Grounds for Hearing (e.g., Article 10.1) and written request to be submitted to CMO (e.g., Article 10.3)</li> <li>• Added expectations for availability while on-call (e.g., Section R1.1.1)</li> <li>• Included “interpersonal concerns” to identified red flag situations (e.g., Section R5.3)</li> <li>• Added “national / international” background checks if time permits for temporary privileges (e.g., Section R6.4.2)</li> <li>• Clarified hearing rights do not apply to temporary privileges (e.g., Section 6.4.2.5)</li> <li>• Clarified Leave of Absence request follow the Medical Staff Leave of Absence policy (Section R6.6)</li> <li>• Added “Clinical Nurse Specialist holding ARNP license” to included type of credentialed providers (Section R7.2.1)</li> <li>• Deleted Allied Health Professional “Procedure for Granting Service Authorization” (e.g., Section R7.3), “Prerogative” (e.g., Section R7.4) and “Responsibilities” (e.g., Section R7.5)</li> <li>• Clarified expectations for provider who is required to have a sponsor when current sponsor leaves the Hospital or is no longer wishes or unable to remain sponsor (e.g., Section R7.4.2)</li> <li>• Changed Medical Staff Department names - “Anesthesiology and Pain Management” to “Anesthesiology and Pain Medicine”; “Medicine” to “Pediatrics” (e.g., Section R8.1)</li> <li>• Added Medical Staff Department – “Neurology” (e.g., Section R8.1)</li> <li>• Clarified process for replacing a Medical Staff Department Director (Section R8.1.2)</li> <li>• Updated Medical Staff Department Director Responsibilities (e.g., Section R8.1.3)</li> <li>• Updated responsibilities / quorum for Medical Staff Meetings</li> </ul>
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		<p>(e.g., Section R9)</p> <ul style="list-style-type: none"> <li>• Clarified Bylaws Committee will complete comprehensive review every 3 years rather than 2. (e.g., Section R10.1.1)</li> <li>• Updated Credentialing and Professional Standards Committee description to align with Committee’s charter (e.g., Section R10.1.2)</li> <li>• Updated Honored Medical Staff Nominating Committee selection criteria; eliminating separate policy (e.g., Section R10.1.3.3.1)</li> <li>• Deleted full description of Institutional Review Board (IRB) duties, institutional officer, etc. and replaced with reference to governance by the Seattle Children’s Research Institute and applicable standards and regulations for research (e.g., Section R10.1.5). Deleted Article 2.1.4 that lists one of the purposes of the Medical Staff regarding medical research and re-numbered.</li> <li>• Updated Quality Improvements Steering Committee – QISC – to align with Committee’s charter (e.g., Section R10.1.6); VP Quality and Safety will chair the committee.</li> <li>• Deleted Practitioner Well-Being Committee as it hasn’t been active for several years; responsibilities have been included in other programs / committees (e.g., Section R10.1.1.17)</li> <li>• Updated responsibilities / expectations for Assignment of Patients (e.g., Section R12); Autopsies (e.g., Section R13); Consultation (e.g., Section R14); Discharges (e.g., Section 15); Laboratory (e.g., Section 16); Medical Care (Section R17); Medicines (e.g., Section R19); Ambulatory Services (e.g., Section R20); Research (e.g., Section R22); Provision of Anesthesia Services (Section R24)</li> <li>• Deleted Code Status / Do No Resuscitate (e.g., Section R17,6)</li> <li>• Section R18 – Medical Records</li> <li>• Section R21 - Organized Health Care Arrangement</li> <li>• Section R 23 – Operative and Invasive Procedures</li> </ul>