TG-AH Medical Staff Rules and Regulations

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Rule 1
Categories of Medical Staff Membership

1.1 Categories

The Medical Staff shall consist of the following categories: Provisional; Active; Courtesy; Affiliate; Telemedicine; Honorary/Retiree.

Table 1

Prerogatives	**Provisional**	**Active**	**Courtesy**	**Affiliate**	**Telemedicine**	**Honorary Retired**
Eligible for Clinical Privileges	Yes	Yes	Yes	Limited to refer and follow only.	Yes	No
Vote	Yes	Yes	No	No	No	No
Hold Office	Yes	Yes	No	No	No	No
Serve as Committee Chair	No	Yes	No	No	No	No
Serve on Committees	Yes	Yes	Yes	No	Yes	Yes
Attend Meetings	Yes	Yes	Yes	No	Yes (virtually)	Yes
Serve as a Proctor	Yes	Yes	No	No	Yes	No
Responsibilities	**Provisional**	**Active**	**Courtesy**	**Affiliate**	**Telemedicine**	**Honorary Retired**
Pay Credentialing Fees/Dues	Initial fees $250, $100 dues at re-appointment	$100 dues at reap-pointment	$100 dues at reap-pointment	Initial fees $250, $100 dues at re-appointment	Initial fees $250, $100 dues at re-appointment	No
ED Call (Consistent with Service Rules)	Yes	Yes	Yes	No	No	No
Participate in Performance Improvement and Peer Review	Yes	Yes	Yes	Yes	Yes	Yes
Professional liability insurance registered in WA	$1,000,000 occurrence/ $3,000,000 aggregate	$1,000,000 occurrence/ $3,000,000 aggregate	$1,000,000 occurrence/ $3,000,000 aggregate	$1,000,000 occurrence/ $3,000,000 aggregate	$1,000,000 occurrence/ $3,000,000 aggregate	N/A
Qualifications	**Provisional**	**Active**	**Courtesy**	**Affiliate**	**Telemedicine**	**Honorary Retired**
Must First Complete Provisional Appointment	N/A	Yes	Yes	No	No	N/A
Patient Contacts* (admitting, attending, referring or consulting)	1st five cases reviewed	Minimum 12 patient contacts annually	Minimum of one and not to exceed 11 annually	None	Initial cases will be reviewed (number to be determined with initial privileges)	N/A

** A patient contact as defined by the Medical Staff Bylaws, meaning the admission of a patient to the Hospital, the admission of a patient to the Emergency Department, the admission of a patient to a hospital outpatient clinic, the performance of outpatient surgery at the hospital, assisting with surgery in the hospital, or a consultation for a patient in either the hospital or its Emergency Department or a hospital outpatient clinic.*

1.2 Provisional Medical Staff Member

The Provisional Staff shall consist of Members who:

a. Are initial appointees to the Medical Staff and plan to quality for and seek transfer to the Active or Courtesy Staff in 12 to 24 months.

b. Are subject to case review of the first five patient admissions and/or consults.

c. In the ordinary course of events, are transferred to Courtesy status after serving at least 12 but not more than 24 months on the Provisional Staff. Action shall be initiated by the Medical Executive Committee to terminate the privileges and membership of a Provisional Member who does not qualify for advancement within 24 months. The Member shall only be entitled to a hearing or appeal under Article 13 of the Bylaws if advancement is denied because of a failure to have a sufficient number of cases proctored or because of a failure to maintain satisfactory level of activity. The Member shall be entitled to the hearing and appeal rights under Article 13 if advancement is denied because the Member's clinical performance or professional conduct is unsatisfactory.

1.3 Active Medical Staff Member

The Active Staff shall consist of Members who:

a. Are regularly involved in caring for patients. Regular involvement in patient care shall mean admitting, attending, referring or consulting on at least twelve patients per year.

b. Have completed at least 12 months of satisfactory performance as a Provisional Staff Member.

1.4 Courtesy Medical Staff Member

The Courtesy Medical Staff shall consist of Members who:

a. Provide clinical services in the Hospital for at least one patient, but no more than 11 patients during each medical staff year. Courtesy Staff Members who provide clinical services to more than 11 patient contacts during a year shall be deemed to have requested transfer to the Active Staff and shall be automatically transferred to the Active Staff following Notice. Courtesy Staff Members who provide no clinical services during a year shall be deemed to have requested transfer to the Affiliate Staff and shall be automatically transferred to the Affiliate Staff following Notice.

b. Prior to reappointment, provide evidence of current clinical competence of performance such form as the Medical Executive Committee may require.

c. Have completed at least 12 months of satisfactory performance as a Provisional Staff Member.

1.5 Affiliate Medical Staff Member

The Affiliate Medical Staff shall consist of Members who:

a. Do not admit or provide professional services to patients in the Hospital but may order or provide professional services in any outpatient clinic operating under Hospital's license, e.g., ambulatory infusion services.

b. May document in the patient's medical records and make social visits to their patients while they are inpatients.

1.6 Telemedicine Medical Staff Member

The Telemedicine Staff shall consist of Members who provide diagnostic or treatment services to Hospital patients via telemedicine devices. (”Telemedicine device” means audio or video devices that allow for interactive, two-way transfer of medical information. Telemedicine devices do not include telephone or electronic mail.)

1.7 Honorary / Retired Medical Staff Member

The Honorary / Retired Medical Staff shall consist of Members who are deemed deserving of Membership by virtue of their outstanding reputations, noteworthy contributions to the health and medical sciences, or previous longstanding services to the Hospital, and Members who were in good standing upon retirement.

Rule 2
Appointment, Privileging and Reappointment Process

2.1 Overview of Process

The following chart summarizes the appointment, privileging and reappointment processes. Details of each step are described in Rules 2.2 through 2.9.

Table 2

Responsible Body	Initial Appointment	Temporary Appointment	Reappointment	Report to:
Medical Staff Office	Verify that the applicant meets Medical Staff membership requirements and initiate Primary Source Verification	Verify that the applicant meets Medical Staff membership requirements and initiate Primary Source Verification	Verify reappointment information	Medical Services Officer
Service Committee	Review applicant's qualifications vis-à-vis standards developed by Service; recommend appointment and privileges	Review applicant's qualifications vis-à-vis standards developed by Service; recommend temporary privileges	Review applicant's performance vis-à-vis standards developed by Service; recommend appointment and privileges	Medical Executive Committee
Medical Executive Committee	Review Service Committee's recommendation; review applicant's qualifications vis-à-vis Medical Staff bylaws general standards; recommend approval or denial of appointment and privileges	Review recommendations of Service Committee; recommend approval/denial of temporary privileges	Review Service Committee's recommendation; review applicant's qualifications vis-à-vis Medical Staff bylaws general standards; recommend approval/denial of appointment and privileges	*Governing Board*
Governing Body	Grants or denies appointment and/or privileges	Grants or denies appointment and/or privileges	Grants or denies appointment and/or privileges	Final Action

2.2 Application

2.2-1 Each Practitioner who requests Medical Staff membership and privileges shall complete an application form approved by the Medical Executive Committee and the Governing Body. The Practitioner shall return the completed application form, including all supporting documents, to the Medical Staff Office together with a nonrefundable initial application fee ($150 Physicians and $75 Allied Health Professionals).

2.2-2 The application shall

a. Require the applicant to abide by the Medical Staff Bylaws, Rules and Regulations, and TG-AH and MHS policies;

b. Elicit the applicant's qualifications, including, but not limited to education; training; professional affiliations; references; health status; malpractice history; professional licensure; certification or registration actions the voluntary relinquishment of such licensure, certification or registration voluntary or involuntary termination, limitation, reduction or loss of Medical Staff or Medical Group membership and/or clinical privileges at any other hospital or health facility or entity; any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and information detailing any prior or pending government agency or third party payor investigation, proceeding or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare or Medicaid fraud and abuse proceedings or convictions.

2.3 Physical and Mental Disabilities

2.3-1 Obtaining Information

a. The application shall request information pertaining to the condition of the applicant's physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental disabilities shall be removed and referred to the Physician Wellness Committee.

b. When the Medical Staff Office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant. This information will be referred to the Physician Wellness Committee.

c. The Physician Wellness Committee shall evaluate any practitioner who has or may have a physical or mental disability to determine whether such disability might affect the practitioner's ability to exercise his or her requested privileges in a manner that meets the Hospital's and Medical Staff's standards and to determine whether and what reasonable accommodations are necessary. The Physician Wellness Committee may interview the practitioner and may require the practitioner to undergo a physical, psychological or psychiatric examination

2.3-2 Review and Reasonable Accommodations

a. Any practitioner who discloses a qualified physical or mental disability will have his or her application processed in the usual manner without reference to the condition.

b. The Physician Wellness Committee shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Medical Executive Committee (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests) have determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the Physician

Wellness Committee may disclose information regarding any physical or mental disabilities and the effect of those on the Practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the Practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Committee to evaluate what, if any, accommodations may be necessary and feasible. The Physician Wellness Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

c. The Medical Staff and Hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of Medical Staff membership and privileges in a manner which meets the Hospital's and Medical Staff standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in Article 13 of the Bylaws.

2.4 Effect of Application

By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

2.4-1 Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.

2.4-2 Authorizes Medical Staff and Hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

2.4-3 Consents to the inspection and copying, by Hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

2.4-4 Certifies that he or she will report any subsequent changes in the information submitted on the application to the authorized Hospital representative or Medical Executive Committee and the Chief Executive Officer.

2.4-5 Releases from any and all liability the Medical Staff and the Hospital and its representatives for their acts performed in connection with evaluating the applicant.

2.4-6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to Hospital representatives.

2.4-7 Authorizes and consents to Hospital representatives providing other hospitals, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the Hospital may have concerning him or her, and releases the Hospital and Hospital representatives from liability for so doing.

2.4-8 Agrees that the Hospital and Medical Staff may share information with a representative or agent from any system member, including information obtained from other sources, and releases each person and each entity who received the information and each person and each entity who disclosed the information from any and all liability, including any claims of violations of any federal or state law, including the laws forbidding restraints of trade, that might arise from the sharing of the information and likewise agrees that the system and any and all system members may act upon such information.

2.4-9 Consents to undergo and to release the results of a medical, psychiatric or psychological examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

2.4-10 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the Bylaws and these Rules.

2.4-11 For purposes of this Rule 2.4, the term "Hospital representative" includes the Governing Body, its individual Directors and committee members; the Chief Executive Officer and other MHS employees, the Medical Staff, and section officers and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

2.5 Verification of Information

The Medical Staff Office personnel shall verify the information submitted. The application will be deemed complete when verification of the following has been obtained: current license; licensing board disciplinary records; specialty board certification status; National Practitioner Data Bank information; Drug Enforcement Administration certificate, if applicable; practice history from professional school through the present; current malpractice liability insurance certificate; and reference letters. The Medical Staff Office shall transmit the completed application and all supporting materials to the Chair of each Service in which the applicant seeks privileges.

2.6 Incomplete Application

2.6-1 If the Medical Staff Office is unable to verify the information, if necessary references have not been received, or if the application is otherwise incomplete, the Medical Staff Office may delay further processing of the application.

2.6-2 If processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the applicant shall be so informed. He or she shall be given written notice of the information missing and the date upon which such information must be received in the Medical Staff Office. If the applicant fails to respond or to provide the information on or before that date, the applicant shall be deemed to have voluntarily withdrawn his or her application. Applications fees shall not be refunded.

2.6-3 Any application deemed incomplete and withdrawn under this rule may, thereafter, be reconsidered only if all requested information is submitted and all other information updated.

2.7 Action on the Application

2.7-1 **Service Action** Upon receipt, the Service Chair or designee shall review the application and supporting documentation and shall transmit to the Medical Executive Committee on the prescribed form a written report and recommendation as to Medical Staff appointment and clinical privileges. In conducting such review, the Service Chair may interview the applicant and/or request such additional information, as the Chair deems necessary to evaluate the applicant's eligibility for medical staff appointment and/or privileges.

2.7-2 Medical Executive Committee Action

a. Preliminary Recommendation: The Medical Executive Committee shall review the application, the supporting documentation, the Service Chair or designee's report and recommendations, and shall consider all relevant information available to it. The Medical Executive Committee or a subcommittee thereof may personally interview the applicant and/or request such additional information the

Committee deems necessary to evaluate the applicant's eligibility for appointment and/or privileges. The Medical Executive Committee shall formulate a preliminary recommendation. If the preliminary recommendation is favorable, the Committee shall assess the applicant's health status (if the applicant has provided information about a disability), and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff.

b. Final Recommendation: Thereafter, the Medical Executive Committee shall formulate a final recommendation, which will be reflected in the written minutes of the Committee and which shall be provided to Governing Body as follows:

1) Favorable Recommendation: Favorable recommendations shall be promptly communicated to the Governing Body together with the completed application, accompanying information and the Service and Medical Executive Committee reports and recommendations.

2) Adverse Recommendation: If the recommendation is adverse in whole or in part, the President of the Medical Staff shall immediately inform the practitioner by Special Notice, and he or she shall be entitled to such procedural rights as may be provided in the Bylaws. The Governing Body representatives shall be informed of, but shall take no action on the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

3) Deferral: The Service or Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a recommendation regarding for appointment and privileges.

2.7-3 Governing Body Action

a. On Favorable Medical Executive Committee Recommendation: The Governing Body shall ratify, reverse or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Service and/or Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Committee shall respond. If the Governing Body's action is a ground for a hearing under the Bylaws, the Chief Executive Officer shall promptly inform the applicant by Special Notice, and he or she shall be entitled to the procedural rights as provided in the Bylaws.

b. Without Benefit of Medical Executive Committee Recommendation: If the Governing Body does not receive a Medical Executive Committee recommendation within the time specified in Rule 2.7-6 below, it may, after giving the Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is adverse and creates grounds for a hearing under the Bylaws, the Chief Executive Officer shall give the applicant Special Notice of the adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the procedural rights and appellate review set forth in the Bylaws before final adverse action is taken.

c. After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Rule 2.7-3 or an adverse Governing Body decision pursuant to Rule 2.7-4a. or 2.7-4b., the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her right to hearing and appellate review as set forth in the Bylaws. Action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Governing Body shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Governing Body shall make a final decision.

2.7-4 Time Frames for Processing Applications

All individuals and committees shall act on applications in a timely and good faith manner. Except when additional information must be secured, or for other good cause, each application should be processed within the following time guidelines:

REVIEWER	TIME FRAMES FOR COMPLETION OF REVIEW
Medical Staff Office	Within 10 days after primary source verification is received
Service Chair or designee	Within 10 days after receipt of completed file from Medical Staff Office
Medical Executive Committee/Governing Body	Within 180 days of Attestation and Release of Liability signature date and no later than the 24 month cycle of last reappointment.

These time periods are guidelines and are not directives that create any rights for a practitioner to have an application processed within these precise periods.

2.8 Duration of Appointment

2.8-1 Provisional Staff appointments may be for a period of 12 - 24 months. The period of appointment to all other Medical Staff categories shall be 2 years.

2.9 Reappointment Process

2.9-1 **Schedule for Reappointment** At least 120 days prior to expiration of each Medical Staff member's term of appointment, the Medical Staff Office shall provide the member with a reappointment application. Completed reappointment application shall be returned to the Medical Staff Office at least 90 days prior to the expiration date. Failure, without good cause, to return the form shall result in automatic suspension or resignation as described in section 4.3-4 of the Bylaws.

2.9-2 Verification and Collection of Information

The Medical Staff Office shall verify information submitted on the reappointment application, collect any other information requested by the Medical Executive Committee or Service Committee and submit such documentation to the Service to which the applicant is appointed and/or seeks or holds privileges. Information required for reappointment shall include, without limitation, the following:

a. Evidence of current competency to perform the privileges requested, including but not limited to consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

b. Participation in relevant continuing education activities, as evidenced by an active Washington State License.

c. Level/amount of clinical activity (patient care contacts) at the hospital.

d. Sanctions imposed or pending, including but not limited to previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

e. Health status including completion of a physical, psychological or psychiatric evaluation by a physician if requested.

f. Timely and accurate completion of medical records.

g. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel and patients.

h. Professional liability claim experience.

i. Compliance with applicable Medical Staff and Hospital Rules, and Policies.

j. Professional references from at least one practitioner familiar with the applicant's clinical skills.

k. Any other pertinent information including the Staff Member's activities at other hospitals and his or her medical practice outside the hospital.

l. Information concerning the member from the State Licensing Board and the federal National Practitioner Data Bank and all relevant sources.

2.9-4 Action of Reappointment Applications

Action on the applications for reappointment and privileges shall be conducted pursuant to the process set forth in Rule 2.7.

2.10 <u>Modifications of Privileges</u>

A Medical Staff member who wishes to relinquish or modify his/her current privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall send written notice to the President of the Medical Staff and the appropriate Service Chair identifying the particular privileges to be relinquished or modified. A copy of this notice shall be forwarded to the Medical Staff Office for inclusion in the member's file. Request to relinquish or limit privileges shall be effective upon receipt by the Medical Staff Office. Other modifications to privileges shall be effective upon final action by the Governing Body.

2.11 <u>Proctoring</u>

2.10-1 Proctor Requirements. A proctor shall be required when:

a. A Practitioner requests privileges to perform a service or procedure without evidence of training and/or clinical experience.

b. Any quality assurance or peer review committee determines the need for a proctoring plan as part of a Practitioner's improvement or corrective action plan.

c. A Practitioner requests assignment of a proctor.

2.11-2 Proctoring Assignment Process.

a. When a Practitioner requests additional privileges or the assignment of a proctor, the Practitioner shall propose a proctor. The appropriate oversight committee (Service, Medical Executive or Governing Body) will approve or reject assignment of such proctor. If the committee rejects recommended proctor, the committee shall provide a written reason and shall suggest an alternative proctor.

b. When a quality assurance or peer review committee determines the need for a proctor, the committee shall either direct the provider to find an acceptable proctor that is approved by the committee and/or assign a proctor.

c. The committee will determine the number of cases and/or time period for completion of the proctoring arrangement.

d. All related expenses for proctoring shall be assumed by the practitioner.

2.10-3 Eligibility to Serve as a Proctor. To serve as a proctor, the proctor must:

a. Be a Medical Staff member in good standing **or** a recognized expert who meets criteria for Medical Staff appointment and privileges in the procedures or practice to subject to the proctoring requirement.

b. If the proctor is to participate in the care of the patient they will hold current privileges at the facility. If the role of the proctor is to review/observe care, they will either hold privileges or be eligible for privileges to perform procedure(s) or practice, but are not required to hold the privilege at the facility.

c. Have documented evidence of clinical competence in the procedure or practice being proctored.

d. Agree to provide objective, written evaluation to the practitioner being proctored and the committee.

2.12 Participation in Organized Health Care Arrangement (OHCA)

2.12-1 Purpose: As set forth in Section 5.7 of the Bylaws, in order to provide quality patient care in a clinically integrated setting, MHS (including its employed professional staff) and independent Practitioners, AHPs and other health care professionals providing services at the Hospital (collectively, “OHCA Participants”) are required to share protected health information for treatment purposes, as well as for a broad range of activities that support and improve their healthcare operations, including without limitation, payment and billing functions, quality improvement initiatives and operations management and planning. The OHCA described herein has been declared and established, in accordance with the HIPAA "Standards for Privacy of Individually Identifiable Health Information" ("Privacy Rules), 45 C.F.R. Subtitle A, Subchapter C, Parts 160 and 164, and for the purpose of better serving MHS patients and facilitating the exchange of “protected health information” among MHS, Practitioners, AHPs and other health care professionals providing care at the Hospital.

2.12-2 Terms of OHCA Participation: In accordance with the obligations arising under the Bylaws and these Rules, the OHCA Participants shall participate in the OHCA described herein on the terms set forth in the Bylaws and as set forth below.

a. Pursuant to the Privacy Rules, MHS has developed a notice of privacy practices that will be distributed to or made available to the OHCA Participants in accordance with applicable MHS policies (“Privacy Notice”) that provides MHS patients with information about the uses and disclosures of patient “Protected Health Information” or “PHI” at MHS. The Privacy Notice indicates to patients that, among other things (i) MHS and the OHCA Participants participate in an OHCA in a clinically integrated setting at the Hospital, and (ii) MHS and the OHCA Participants will share PHI as necessary to carry out treatment, payment and operations relating to the OHCA in accordance with the Privacy Rules. The Privacy Notice, along with the OHCA described herein, shall become effective on the Privacy Rules compliance deadline of April 14, 2003.

b. The Privacy Notice includes a “joint notice” provision that generally describes the class of separate covered entities to which the Privacy Notice applies for health care delivered at MHS facilities, which class includes the OHCA Participants. MHS and OHCA Participants acknowledge and agree to abide by the terms of the Privacy Notice in connection with the use and disclosure of PHI related to care or other services provided at the Hospital. Through the execution of the appointment and reappointment application form, OHCA Participants agree with MHS to abide by the terms of the Privacy Notice, as it may be revised from time to time by MHS in accordance with these Rules, with respect to PHI created or received by either of them as part of their participation in the OHCA described herein.

c. MHS may from time to time (prior to and following the Privacy Rules compliance deadline) amend or revise the Privacy Notice. MHS will notify OHCA Participants of any revisions to the Privacy Notice in accordance with applicable MHS policies and such revisions shall be binding on OHCA Participants without further action by MHS or any OHCA Participant.

d. An OHCA Participant's participation in the OHCA described herein shall terminate automatically to the extent that an OHCA Participant's Privileges at the Hospital are terminated or suspended. Except as described below, no OHCA Participant shall be entitled to voluntarily withdraw from the OHCA described herein while maintaining Privileges at the Hospital. MHS, by amendment to the Bylaws and Rules, reserves the right in its sole discretion to withdraw from and terminate the OHCA described herein.

e. The OHCA described herein has been established for the sole and limited purpose of meeting the OHCA requirements set forth in the Privacy Rules. OHCA Participants shall exercise medical judgment free of any direction or control by MHS within the areas of such participant's professional competence and the limits established by the Bylaws, and the terms of any employment relationship between MHS and an OHCA Participant or other agreement between an OHCA Participant and MHS. The OHCA described herein shall not be construed to (i) constitute MHS or any independent OHCA Participant as partners, joint venturers, co-owners or otherwise as participants in a joint or common undertaking of any kind whatsoever, or (ii) allow either party to create or assume any obligation on behalf of the other party for any purpose whatsoever. To this end, OHCA Participants shall not be permitted to act on behalf of MHS with respect to MHS' compliance obligations under the Privacy Rules or any other similar law or regulation, including without limitation, the right to (i) agree to restrictions regarding the use PHI or agree to amend PHI or records about an individual maintained by MHS.

f. OHCA Participants shall be responsible for their respective compliance obligations under the Privacy Rules, the HIPAA "Administrative Simplification" regulations or any other applicable law or regulation, including without limitation the obligation to prepare and use, if applicable, separate notices of privacy practices for medical practices in offices or facilities separate from MHS. Other than as to the limited responsibilities as participants in the OHCA described herein, neither MHS nor any OHCA Participant is undertaking any responsibility whatsoever in relation to compliance obligations of any other covered entity or OHCA Participant under the Privacy Rules or other HIPAA Administrative Simplification regulations.

g. In accordance with the definition of "business associate" found in 45 C.F.R. § 103 of the Privacy Rules, no participant in the OHCA described herein shall become a "business associate" of any other OHCA participant solely through the performance of any function or activity described in such definition on behalf of the OHCA described herein.

h. MHS and OHCA Participants shall comply with all applicable laws, and regulations, including without limitation, state and federal laws and regulations related to health information privacy, security, confidentiality, consent, access and disclosure, including the Privacy Rules and Washington Uniform Health Information Act, RCW Chapter. 70.02.

Rule 3
Service/Committee Rules

3.1 Services

The Medical Staffs of Tacoma General-Allenmore and Mary Bridge Hospitals shall be comprised of the following Services and corresponding Service Committees:

a. Adult Medical Services
b. Diagnostic/Procedural Services
c. Pediatric Medical Services
d. Surgical Services
e. Women and Newborn Services

3.2 Service Committee Composition and Officers

3.2-1 Each Medical Staff Service shall have a standing committee. The composition of each Service Committee shall be as follows:

a. **Adult Medical Services.** The Committee shall be made up of physician representation from Family Practice, Emergency Medicine, Internal Medicine, Medical Specialties, (i.e. Cardiology, Gastroenterology, Pulmonology, Oncology), Hospitalist, Intensive Care, Pathology, Radiology, and Trauma. Additional membership includes MHS representation from nursing, laboratory, respiratory therapy, imaging, pharmacy, clinical informatics and administration.

b. **Diagnostic/Procedural Services.** The Committee shall be made up physician representation from Radiology, Pathology, Cardiology, Gastroenterology, Pulmonology, Primary Care (may be Family Practice or Internal Medicine), Emergency Medicine, Obstetrics and Trauma. Additional membership includes MHS representation from nursing, laboratory, imaging, pharmacy, clinical informatics and administration.

c. **Pediatric Medicine Services.** This Committee shall be comprised of: physician representation from Pediatric Medicine, Pediatric Specialties (i.e. Gastroenterology, Cardiology, Neurology, Pulmonology, Oncology), Pediatric Intensivist, Hospitalist, Family Practice, Emergency Medicine, Pathology, and Radiology. Additional members include MHS representation from nursing, laboratory, respiratory therapy, imaging, pharmacy, clinical informatics and administration.

d. **Surgical Services.** The Committee shall be made up of physician representation from Anesthesia, Adult and Pediatric Surgical Specialties (i.e. Cardiac, ENT, General, Gynecology, Neuro, Ophthalmology, Orthopedics, Urology, Vascular), Trauma, Hospitalist, Primary Care (may be Family Practice or Internal Medicine), Emergency Medicine, Pathology, and Radiology. Additional members include MHS representatives from nursing, laboratory, imaging, pharmacy, clinical informatics and administration.

e. **Women and Newborn Services.** The Committee shall be made up of physician representation from Anesthesia, Family Practice, Obstetrics, Pathology, Pediatrics, Perinatologist, Neonatology, and Radiology. Additional membership will include MHS representatives from nursing, laboratory, respiratory therapy, pharmacy, clinical informatics and administration.

3.2.2. Officers of the Committee shall include a Chair and Chair-elect. The term of office for the Chair and Chair-elect shall be one year. The term shall be the calendar year.

3.2-3 If the Chair is unable to complete his/her term, the Chair-elect shall assume the role of Chair and the Committee shall elect a new Chair-elect who shall serve for the remainder of the term.

3.2-4 The Chair-elect shall assume the role of Chair after one year. The Committee shall select a new Chair-elect each calendar year.

3.3 Procedures for Selecting Service Committee Officers

3.3-1 Each Service Committee shall nominate at least one person meeting the qualifications for the Chair-elect for the next calendar year.

3.3-2 Each Service Committee shall elect a new Chair-elect by October of each calendar year. The approved slate shall go to the Governing Body for approval.

3.4 Responsibilities of Service Committees

3.4-1 Each Service Committee and its Officers shall be responsible for:

a. Oversight, assessment and improvement of the quality of clinical care provided by and professional performance of Members assigned to the Service.

b. Oversight of the administrative activities of the Service.

c. Integrating the activities of the Service with the other Services and committees to maintain and improve the quality of care of MHS patients.

d. Developing and implementing policies and procedures that guide and support the provision of care in the Service.

e. Recommending qualified and competent practitioners through the privileging process to provide care in the Service.

g. Delineating the privileges and the criteria for granting such privileges in the Service.

h. Participate in quality control and improvement programs, as appropriate and in coordination with the MHS Performance Improvement Plan.

i. Making recommendations regarding space and other resources needed by the Service.

j. Making recommendations to the relevant hospital authority with respect to off-site resources needed for patient care services not provided by the Service or MHS.

k. Providing representation on Service sub-committees and ad hoc committees.

l. Maintaining and distributing Service Committee minutes.

m. Providing representation by Chair (or in his/her absence, Chair-elect) on the Medical Executive Committee.

n. Performing such additional responsibilities as may be delegated by the Medical Executive Committee, Chief of Staff or the President of the Medical Staff.

o. Services Committees shall meet at least eight (8) times per year or as defined by the Committee.

3.5 Other Committees

In addition to the Service Committees identified in Section 3.7-1, the Medical Staff shall have the following committees. The rules applicable to each committee are set forth in the applicable appendices attached hereto and incorporated here.

Cancer Committee
Clinical Documentation Committee
Code 4 Committee
Medical Executive Committee
Ethics Committee
Graduate Medical Education Committee
Infection Control Committee
Medical Staff Operations
Peer Review Committee
Pharmacy & Therapeutics Committee
Radiation Safety & Imaging Committee
Transfusion Committee
Trauma (Adult and Pediatric) Committees

Ad Hoc Committees

Allied Health Committee
Bylaws Committee
New Technology
Physician Wellness
Sedation Committee

Appendix 3A:
Allied Health Committee

1. Purpose

The Allied Health Committee, comprised of Allied Health Professionals, will develop, implement and maintain an effective, integrated, system-wide approach to patient care and operational efficiency. This will be accomplished by providing a collaborative quality management and improvement program.

2. Composition

The Allied Health Committee shall be comprised of at least four Allied Health Professionals, one of who shall serve as the Committee Chair. Members shall include representatives of the various categories of Allied Health Professionals and will hold Allied Health privileges within an MHS facility. The Chair and Chair-Elect will be members of the Committee and will be elected by the membership yearly. Hospital and MHS representatives may be invited to attend meetings at the request of the membership, to conduct the business of the Committee.

3. Duties

The primary responsibilities of the Allied Health Committee shall be to conduct medical record and peer review and make recommendations related to patient care and operational efficiency. The Allied Health Committee reports to the Medical Executive Committee and minutes will be forwarded for review and approval.

4. Meetings

The MultiCare Allied Health Committee shall meet as needed (ad hoc).

Appendix 3B
Bylaws Committee

1. Purpose

The purpose of the Bylaws Committee is to review the Medical Staff Bylaws and TG-AH Rules and Regulations on a regular basis for currency and to advise the Medical Executive Committee and Administration with respect to revisions.

2. Composition

The Committee shall be comprised of at least one Medical Staff member from the Tacoma General campus, the Allenmore Campus and Mary Bridge Children's Hospital.

3. Duties

a. Review the Bylaws at least annually for currency, applicability and accuracy.
b. Review the Medical Staff Rules at least annually for currency, applicability and currency.
c. Recommend Bylaw and Rule revisions to the Medical Executive Committee and MHS administration.

4. Meetings

Meetings will be held at least once a year and more often if needed. Minutes of the meeting shall be recorded and provided to the Medical Executive Committee.

Appendix 3C
Cancer Committee

1. Purpose

The purpose of the Cancer Committee is to conduct the quality assurance, quality improvement, case review, peer review, and various organizational functions for Cancer Services within MultiCare Health System.

2. Composition

The Cancer Committee shall be composed of physicians who represent areas where Cancer services are provided or supported and may include medicine, family practice, surgery, pathology, radiology, and radiation oncology, as well as representatives from multiple disciplines within MHS such as administration, nursing services and Cancer Services. All members of the committee will be voting members.

3. Duties

The Committee shall conduct quality assurance, quality improvement, case review and/or peer review, and research review and recommendations. It shall set standards for cancer care, provide a forum for communications and education. The Cancer Committee reports to the Medical Executive Committee and minutes will be forwarded for review and approval.

4. Meetings

Committee meetings will be held at least quarterly.

Appendix 3D
Clinical Documentation Committee

1. Purpose

The purpose of the Clinical Documentation Committee is to review, improve and set standards for clinical documentation across MHS.

2. Composition

The Committee will be made of Medical Staff members, as well as non-physician representatives.

3. Duties

Review of information from chart review, clinical practice, clinical requirements and other sources related to clinical documentation for improvement efforts. Recommendations for improvement based on new requirements, clinical standards, evidence based practice, internal data, and chart review. The Clinical Documentation Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval.

4. Meetings

Minimum of quarterly and at the call of the Chair.

Appendix 3E
Code 4 Committee

1. Purpose

The purpose of the Code 4 Committee is to review all Codes called within the hospital for review of resuscitation care and outcomes.

2. Composition

The Committee shall be made up of physicians, nurses and other members of the health care team.

3. Duties

The team will analyze the collected data on codes assessing for trends or patterns and opportunities for improvement in patient safety and outcomes. The Code 4 Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval.

4. Meetings

The Committee will meet at least bi-monthly.

Appendix 3F
Ethics Committee

1. Purpose

Tacoma General-Allenmore Hospital and Mary Bridge Children's Hospital have a joint Medical Ethics Committee. The committee consists of a multi-disciplinary group of health professionals and community members established to address ethical dilemmas that occur in the course of patient care at MultiCare Health System.

2. Composition

The Ethics Committee is composed of the MHS Chaplain, at least one community member, and other representatives from the health care team.

3. Duties

a. Provides medical ethics consultation on request.
b. Provides a forum for education on ethics and ethical decision making for the staff and community.
c. Serve as a resource to MHS staff, Medical Staff, patients and family.
d. The Ethics Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval.

4. Meetings

Meetings are held every other month.

Appendix 3G
Graduate Medical Education Committee

1. Purpose

The purpose of the GMEC is to provide administrative oversight to the Graduate Medical Education programs sponsored at MultiCare Health System and to provide a forum for communication with Administration to assure ongoing regulatory compliance with applicable standards, support for the programs and ongoing reporting.

2. Composition

The GMEC is composed of the Program Directors for the following GMEC programs: Tacoma Family Medicine (TFM) and MultiCare Foot and Ankle Residency, and a minimum of two supervising physicians, a representative from the Hospital and MultiCare Medical Associates (MMA), and at least one resident representative from each program.

3. Duties

a. Oversight of the Graduate Medical Education Programs
b. Assure regulatory compliance (compliance with Residency Review Committee guidelines)
c. Communicate with leadership on the issues related to graduate medical education
d. The GMEC reports to both the Combined Medical Executive Committee and the Professional Activities Committee of the Board and minutes will be forwarded for review and approval.

4. Meetings

Meetings will be held quarterly.

Appendix 3H
Infection Control Committee

1. Purpose

The Infection Control Committee is responsible for oversight of infection surveillance, prevention and control activities throughout the health system.

2. Composition

Director, Infection Control; Infection Control Nurse; Infectious Disease Physician; and representatives from Microbiology; Safety; each Hospital Administration; OR; TFM; Quality Management; Hospice; MMA; Pharmacy; Institute for Learning and Development (ILD); Employee Health; Engineering and Construction Services; Tacoma Pierce County Health Dept., others as needed.

3. Duties

a. Approve annual goals of the infection control program
b. Review surveillance and other data, clusters and trends, problem areas
c. Share information with the appropriate areas
d. Recommend actions
e. Evaluate results
f. The Infection Control Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval.

4. Meetings

The committee will meet quarterly.

Appendix 3I
Medical Executive Committee

1. Purpose

The purpose of the Medical Executive Committee is to review and make recommendations on Medical Staff membership, credentialing, privileging and corrective actions to the Governing Body and to provide oversight of the Medical Staff Services and other standing and ah hoc committees.

2. Composition

The Committee shall be an integrated committee made up of the elected Tacoma General-Allenmore and Mary Bridge Medical Staff officers, the Service Committee Chairs, members-at-large from the TG-AH and MBCH Medical Staffs, physician PAC members, MHS Board members, and hospital staff and administrative representatives as specified in the Bylaws.

3. Duties

a. Provides oversight of the quality of care, treatment and services by:

(1) Reviewing, approving the minutes and acting on actions as appropriate of the Services and Committees from the reporting forums.

(a) Adult Medical Services
(b) Diagnostic/Procedural Services
(c) Pediatric Medical Services
(d) Surgical Services
(e) Women & Newborn Services
(f) Allied Health Committee
(g) Bylaws Committee (ad hoc)
(h) Cancer Committee
(i) Ethics Committee
(j) Graduate Medical Education Committee
(k) Medical Staff Operations Committee
(l) Peer Review Committee
(m) Physician Wellness Committee (ad hoc)
(n) Trauma, Adult Committee
(o) Trauma, Pediatric Committee

(2) Reviewing and recommending Medical Staff appointments, credentialing and privileging from the Services Committees which will be approved by the Governing Body members of the Committee.

(3) When indicated, initiating and/or pursuing disciplinary or corrective actions affecting individually privileged providers.

(4) Establishing as necessary ad hoc committees that will fulfill particular functions for a limited time.

(5) Establishing the date, place, time and program of any meetings of the entire Medical Staff.

(6) The Medical Executive Committee reports to the Professional Activities Committee of the Governing Body and minutes will be forwarded for review and approval.

4. Meetings

Minimum of 10 meetings per year.

Appendix 3J
Medical Staff Operations

1. Purpose

The purpose of the Medical Staff Operations Committee is to approve system policies that cross multiple Services and work processes that effect the Medical Staff in more than one Service. In addition, they provide oversight to other standing and ah hoc committees.

2. Composition

The Committee shall be an integrated committee made up of the elected Tacoma General-Allenmore and Mary Bridge Medical Staff officers, representatives from each Service Committee, hospital staff and administrative representatives as specified in the Bylaws.

3. Duties

a. Provides oversight of the quality of care, treatment and services by:

(1) Reviewing, approving the minutes and acting on actions as appropriate of the Committees from the reporting forums.

(a) Clinical Documentation
(b) Code 4
(c) Infection Control
(d) Sedation
(e) New Technology
(f) Pharmacy and Therapeutics
(g) Radiation Safety & Imaging Services
(h) Transfusion

(2) Reviewing and approving MHS policies with Medical Staff responsibilities.

(3) The Medical Staff Operations Committee reports to the Medical Executive and minutes will be forwarded for review and approval.

4. Meetings

Minimum of 10 meetings per year.

Appendix 3K
New Technology

1. Purpose

The New Technology Committee shall review and make recommendations as to the propriety and feasibility of introducing new technology, new procedures or new therapeutic regimes at MultiCare Health System. The committee shall advise the Services and Medical Executive Committees with respect to appropriate privileging criteria for new technologies, procedures or treatments.

2. Composition

The Committee shall be made up of physicians and administrative representatives as well as members of the health care team, including Materials Management.

3. Duties

a. As set forth in the MHS Policy: New Technology, Procedure and Therapeutics Credentialing Guidelines.

b. The New Technology Committee reports to the Medical Staff Operation Committee and minutes will be forwarded for review and approval.

4. Meetings

The committee will meet as needed (ad hoc).

Appendix 3L
Peer Review Committee

1. Purpose

The TG-AH Medical Staffs are responsible for ensuring that patients admitted or treated at Tacoma General-Allenmore Hospitals receive care at a level of quality and efficiency that is consistent with generally accepted standards attainable within the Hospitals' means and circumstances. It is the policy of the Hospital to support a fair, timely, and objective process performed by the medical staff to evaluate and measure the competence and professional conduct of practitioners holding privileges at TG-AH and where necessary, improve performance.

2. Composition

The Peer Review Committee shall be comprised of 10 members from the Active Staff categories of the Tacoma General-Allenmore and Mary Bridge Children's Hospital medical staffs. There shall be two members from each of the following medical staff Services: Pediatric Medical Services, Adult Medical Services, Diagnostic/Procedural Services, Women's Health Services, and Surgical Services.

3. Duties

The Peer Review Committee shall be responsible for assessing the clinical competency and professional conduct of Medical Staff members and practitioners holding hospital privileges. Such responsibilities shall include the following:

a. Conducting peer and case review by investigating the medical care rendered in order to determine whether accepted standards of care have been met and, where appropriate, making recommendations for corrective action to the appropriate Medical Staff Committee;
b. Reviewing practitioner performance data, incident reports, sentinel events, reports of disruptive conduct, patient and staff complaints related to Medical Staff Members regarding care and treatment, and recommending action to the appropriate Medical Staff Committee(s); Medical Staff Officer and/or Vice President of Medical Affairs;
c. Providing written documentation of the Committee's findings, conclusions (including the underlying rationale), and recommendations to the practitioner under review and to the appropriate Medical Staff Committee;
d. Reporting system problems impacting patient care to MHS Administration, the Vice President of Medical Affairs, and/or the appropriate Medical Staff Committee.
e. Reporting regularly to the Medical Executive Committee.

4. Meetings

Minimum of 10 meetings per year.

Appendix 3M
Pharmacy & Therapeutics Committee

1. Purpose

The purpose of P&T is to assure quality and improvement of processes relating to medication management and oversees the medication use evaluation process. P&T provides a forum for:

- **a.** Recommending the adoption of, or assists in the formulation of, policies regarding the evaluation, selection and therapeutic use of drugs, blood and blood products at MultiCare Health System.
- **b.** Communication among staff
- **c.** Education and problem solving of issues involving the entire system by recommending or assisting in the formulation of programs designed to meet the needs of the professional staff (Physicians, nurses, pharmacists, and other health care practitioners) for complete, current knowledge on matters related to drugs, drug use, blood products, and cost effective drug therapy.

The P&T Committee also participates with the Franciscan and Good Samaritan Health Systems to develop a community-wide formulary for medications.

2. Composition

The Committee shall be composed of physician representatives from each Service as well as members of the interdisciplinary health care team and administration.

3. Duties

The P&T Committee shall be responsible for the development and surveillance of all medication management policies and practices within MultiCare Health System order to assure optimum clinical results and minimal risk. The Committee shall formulate professional policies regarding the evaluation, selection, procurement, storage, use and safety related to drug usage. The Committee shall perform the following specific functions:

- **a.** Develop a formulary of drugs accepted for use in the system and provide for ongoing review and revision. The selection of items to have formulary status will be based on objective evaluation of the relative therapeutic merits, safety and cost. The Committee shall minimize duplication of the same basic drug type, drug entity or drug product.
- **b.** Establish programs and procedures that help ensure cost effective drug therapy.
- **c.** Establish or plan suitable educational programs for the professional staff on matters related to drug use.
- **d.** Participate in quality improvement activities related to medication management.
- **e.** Review adverse drug reactions.
- **f.** Initiate and direct medication use review programs, review the results of such activities and recommend practice changes as necessary.
- **g.** Evaluate clinical data concerning new drugs or preparations requested for use in the Health System.
- **h.** The P&T Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval.

4. Meetings

The P&T Committee meets eight (8) times a year.

Appendix 3N
Physician Wellness

1. Purpose

The purpose of the Physician Wellness Committee shall be to investigate issues regarding any practitioner (includes allied health providers who hold individual privileges) who has or may have a physical or mental disability that might affect the practitioner's ability to exercise his or her requested privileges in a manner that meets the hospital and Medical Staff's quality of care.

2. Composition

The Physician Wellness Committee shall be composed of no fewer than three Active Medical Staff Members appointed by the President, a majority of whom, including the Chair, shall be Physicians and one of whom should be a psychiatrist. Committee members shall serve a term of three years, and the terms shall be staggered to achieve continuity. Insofar as possible, members of this Committee shall not actively participate on other peer review committees/groups while serving on this Committee.

3. Duties

a. The Wellness Committee shall review the responses from applicants concerning physical or mental disabilities and recommend what, if any, reasonable accommodations are necessary to enable the Practitioner to provide services in accordance with the Hospitals' and Medical Staff's standard of care.

b. The Wellness Committee shall also strive to help improve the quality of care for patients by to identify and address matters relating to Medical Staff Members' physical and mental health and professional conduct that might jeopardize patient care.

c. The Wellness Committee may receive reports related to the health, well being, or impairment of Medical Staff Members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual Medical Staff Members, the Committee may, upon its own initiative, upon request of the involved Practitioner, or upon request of a Medical Staff or Service committee, Officer, Medical Services Officer or Chief Operating Officer provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, if the Committee receives information that demonstrates that the health or impairment of a Medical Staff Member may pose a risk of harm to hospital patients (or prospective patients), that information shall be referred to the President or Medical Services Officer, who will determine after consultation with the hospital's lawyer, whether corrective action is necessary to protect patients.

d. The Committee may also consider general matters related to the health and well being of Medical Staff Members and, with the approval of a Medical Executive Committee, develop educational programs or related activities.

e. The Physician Wellness Committee reports to the Medical Executive Committee. Meeting minutes will be recorded and provided to the MEC.

4. Meetings

The Committee shall meet as often as necessary. It shall maintain confidential records (names shall be protected) of its proceedings.

Appendix 3O
Radiation Safety & Imaging Committee

1. Purpose

The Radiation Safety & Imaging Committee is an organization wide committee that oversees radiation safety functions/services for MultiCare Health System. The Committee sets standards, conducts regulatory review, provides quality improvement, oversight, and various organizational functions for MultiCare Health System. It shall review compliance with standards and provide a forum for education and communication.

2. Composition

The Committee shall be Chaired by a member of the MHS Medical Staff, with Medical Staff representatives from Therapeutic Radiology, Nuclear Medicine, Radiology, Cardiac Cath Lab, and Administrative Management representatives from Imaging, Nursing, Oncology, and the Radiation Safety Officer of MultiCare Health System.

3. Duties

a. Set standards and review radiation safety functions, results and processes
b. Quality Improvement and oversight of system functions relating to radiation safety to include ALARA (As Low As Reasonably Achievable Audit Report)
c. Make recommendations and insure implementation of changes related to improvements
d. Serve as a resource to the system on radiation safety functions
e. Serve as the liaison with the National Regulatory Agency and any other regulatory agencies on radiation safety issues
f. The Radiation Safety and Imaging Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval

4. Meetings

Meetings will be held four (4) times per year.

Appendix 3P
Sedation Committee

1. Purpose

The purpose of the Sedation Committee is to set standards, determine policy and oversee the provision of sedation services at MultiCare Health System.

2. Composition

The Committee shall be made up of physicians, including Anesthesia, and administrative representatives as well as members of the health care team.

3. Duties

a. Quality improvement and oversight of system functions relating to sedation
b. Make recommendations and insure implementation of changes related to improvements
c. Case review, as appropriate or needed
d. Serve as a resource to the system on sedation issues
e. The Sedation Committee reports to the Medical Staff Operation Committee and minutes will be forwarded for review and approval

4. Meetings

The Sedation Committee shall meet as needed (ad hoc).

Appendix 3Q
Transfusion Committee

1. Purpose

The Transfusion Committee is a system wide Committee that oversees the transfusion functions/services for MultiCare Health System. The Committee conducts quality assurance, quality improvement, standard of care review relating to transfusion, and various organizational functions for MultiCare Health System.

2. Composition

The Committee shall be made up of Physician representatives from Pathology and other specialties with high use of blood and blood products and representatives from Transfusion Services, Nursing, Pharmacy, Oncology and other members of the healthcare team.

3. Duties

a. Set standards and review transfusion functions, results and processes
b. Quality Improvement and oversight of system functions relating to transfusion safety to include Food and Drug Administration (FDA) and American Blood Bank Association (ABBA) requirements
c. Make recommendations and insure implementation of changes related to improvements
d. Serve as a resource to the system on transfusion safety practices
e. Serve as the liaison with the FDA, ABBA and any other regulatory agencies on transfusion safety issues
f. The Transfusion Committee reports to the Medical Staff Operations Committee and minutes will be forwarded for review and approval

4. Meetings

Meetings will be held quarterly.

Appendix 3R
Trauma (Adult) Committee

1. Purpose

The development and maintenance of the adult trauma system to provide effective patient care requires cooperation, flexibility, adjustment, and dedication on the part of those disciplines most intimately involved in the system. The infrastructure of the Trauma Committee is hereby established to create a forum for the exchange of information and ideas and for the purpose of interdisciplinary consultation to ensure the highest quality adult trauma care services.

2. Composition

The Adult Trauma Committee shall be comprised of the Trauma Service Director who shall be the Committee Chairperson, a registered nurse with special competence in care of the injured, an Emergency Department physician, an Emergency Department registered nurse, a general surgeon with special competence in trauma care, a neurosurgeon, an orthopedic surgeon, an anesthesiologist, a critical care physician, a critical care registered nurse, and the trauma case manager and such other members as the Committee may from time to time appoint.

3. Duties

a. The Trauma Committee will establish standards, policy and procedure; provide quality assurance through case review and trend identification/analysis; implement changes as appropriate; and generally oversee all aspects of adult trauma services provided by the Tacoma Trauma Center.

b.

b. The Adult Trauma Committee reports to the Combined Medical Executive Committee and minutes will be forwarded for review and approval.

4. Meetings

a. The Trauma Committee will meet at least 10 times per year at a regular day and time in a location to be determined within each hospital. The Joint Trauma Committee will meet quarterly with meeting locations rotated between Tacoma General and St. Joseph.

b. Additional meetings can be scheduled for urgent issues at the request of the Committee Chair or when either at least 7 committee members or 20% of committee membership want to meet.

c. In each committee, decisions will be made by a simple majority vote by a quorum of committee members. A quorum to start a meeting is 50% of members. A quorum to continue the meeting is two-thirds of those present at the beginning of the meeting. Proxy votes by alternates are allowed, but those alternates must be present at the meeting in order to vote. Each person present for voting, regular member or alternate, is allowed only one vote.

Table 3
4.1 Types of Allied Health Professionals Eligible for Privileges

	Requirements						Prerogatives		
Allied Health Professional	Licensed Certified Registered	Proof of Malpractice Coverage	Employed or Sponsored	Apply for Reappoint-ment	Application Fees $150 at initial, $50 at renewal	Participate in PI and Peer Review	Serve on Committees	Attend Meetings	Delineated or Categorical Privileges
ARNP	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Delineated
Audiologist	Licensed	Yes	Employed Only	Yes	Yes	Yes	Yes	Yes	Categorical
Certified Nurse Midwife	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Delineated
Clinical Psychologist	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Categorical
Dental Assistant	None	Yes	Yes	Yes	Yes	Yes	No	No	Categorical
Dietician	Registered	Yes	Employed Only	Yes	Yes	Yes	Yes	Yes	Categorical
Evoke Potential Technologist	Certified	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Categorical
Nurse Educators	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Categorical
Occupational Therapist	Licensed	Yes	Employed	Yes	Yes	Yes	Yes	Yes	Categorical
Perfusionist	Certified	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Categorical
Physical Therapist	Licensed	Yes	Employed	Yes	Yes	Yes	Yes	Yes	Categorical
Physician Assistant	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Delineated
Procedural/ Surgical Assistant	None	Yes	Yes	Yes	Yes	Yes	No	No	Categorical
Radiology Assistant	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Delineated
RN First Assistant	Licensed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Delineated
Social Worker	Registered	Yes	Employed	Yes	Yes	Yes	Yes	Yes	Categorical
Speech Pathologist	Licensed	Yes	Employed	Yes	Yes	Yes	Yes	Yes	Categorical

4.2 Applications and Reapplications for AHP: for AHP privileges will be processed in accordance with Rule 2 unless otherwise specified.

4.3 Supervising Physician. All AHPs privileged at MHS shall have a designated supervisor who is titled "Sponsoring Physician" who is a current member of the Medical Staff who is responsible for the over sight of the AHP.

4.4 Mid –Level Practitioners Discharging Patients: In Adult Medicine Service, a Mid-level Practitioners may enter discharge orders in uncomplicated patients with a less than 48-hour length of stay. A reference to agreement by attending physician must be noted in order, progress note and discharge summary. All other patients shall be discharged only on an order of the attending practitioner.

Patients with less than forty-eight (48) hour length of stay (i.e. diagnostic coronary and peripheral angiography, cardiac and peripheral interventional procedures, GI procedures) may be seen by a Mid-Level Practitioner after the initial evaluation is performed by the physician within the first 24 hours, if the case is uncomplicated; in such case, the ARNP/PA must make reference in the order, progress notes, and discharge summary that the discharge was requested on the discharge day by the attending physician.

In Surgical Services, if the case is uncomplicated; in such case, the ARNP/PA must make reference in the order, progress notes, and discharge summary that the discharge was requested on the discharge day by the attending physician.

5.1 Admission

All patients admitted to the hospital will have clearly designated Admitting and Attending Physicians who hold such privileges for admission and care. The admitting and/or attending physician (or covering physician) must see admitted patients within 12 hours of admission and prior to invasive procedure/surgery. Patients admitted to the Intensive Care Units must be seen by the admitting or attending (or covering) physician within four hours of admission.

5.2 How Often Patients Must Be Seen During Hospitalization

Patients must be seen by the Attending Physician (or covering physician) at least daily, and as frequently as required based on the criticality of the patient. Physician Assistant visits cannot be in lieu of the Physician's visit. Exceptions to this are:

(1) The Attending, admitting or covering Physician must evaluate a healthy newborn within 24 hours after birth. Thereafter, the newborn may be seen by an AHP

(2) Low risk obstetric patients may be admitted and seen daily by Certified Nurse Midwives (CNM) provided the CNM's sponsoring Obstetrician reviews and co-signs the antepartum record, the labor and delivery record, any procedure notes and the discharge summary prior to the patient's discharge from the Hospital.

(3) Daily visits to medical patients with less than forty–eight (48) hour length of stays (e.g. diagnostic coronary and peripheral angiography, cardiac and peripheral interventional procedures, GI procedures) may be provided by a Physicians Assistant or Advance Registered Nurse Practitioner provided the Attending (or covering Physician) has performed an initial examination within the first 24 hours after admission.

(4) Uncomplicated surgical patients need not be seen by a Physician on the day of discharge if discharged by an ARNP or PA, the discharge was requested by the attending Physician on the date of discharge and the ARNP/PA enters the attending physician's discharge request in the order, progress note and discharge summary.

5.3 Definitions and Responsibilities

5.3-1 The **Attending Physician** (Physician-in-Charge) is the physician with primary responsibility for providing and coordinating the patient's care for the duration of the hospitalization. The Attending Physician may use a Covering Physician from time to time. The Attending responsibilities may be transferred with the consent of the patient and the physician to whom the patient's care is transferred provided the transferring physician enters the transfer of care in the patient's medical record. Urgent and emergent consult requests must be communicated physician to physician at the time of the request.

5.3-2 The **Admitting Physician** is a physician responsible for the decision to admit. The admitting physician shall be responsible for initial orders and for providing hospital staff such information as may be necessary to ensure the protection of the patient and others. The Admitting Physician will identify, in the patient's medical record, the Attending, Primary Care and Consulting Physicians

5.3-3 A **Covering Physician** is a qualified physician with appropriate clinical privileges who agrees to substitute for the Attending Physician in the Attending Physician's absence.

5.3-4 The **Consulting Physician** is the physician who assists the Attending Physician in the evaluation and/or management of the patient upon request of the Attending Physician. The Attending Physician shall enter the reason for consultation in the medical record at the time of request.

5.3-5 The **Primary Care Physician** is the physician who routinely provides or arranges the provision of the patient's medical care.

5.3-6 Resident Physician is a Physician in training. Residents may assist the Attending Physician in providing patient care but may not serve as the Attending Physician.

5.3-7 Emergency Physician is an Active Medical Staff Member who works in the hospital Emergency Department. Emergency Physicians may enter orders for the Admitting or Attending Physician.

5.4 Call Coverage

Every Medical Staff Member shall arrange for another appropriately privileged Medical Staff Member, to provide necessary services to his/her patients during any period in which the member is unavailable (defined as > 30 minutes from the hospital). In case of failure to arrange such coverage, the Chair of the Service, the Chief Operating Officer (COO) or his designee, the CEO or President of the Medical Staff shall have the authority to request assistance of another Medical Staff Member in caring for the patient.

5.5 Disasters

All medical staff members and allied health professionals have a responsibility to the community in the event of a disaster and are expected to report to the nearest healthcare facility. Guidance on Emergency Procedures are available in the Emergency Quick Reference Guide under Emergency Management.

6.1 Clinical Documentation

The medical record is the source document for care, the communication tool for the health care team and the tool for coding, billing and defense of care, should it be needed. All medical record documentation shall comport with MHS documentation policies and the following:

Table 4: Documentation Requirements

Documentation Requirement	Time Frame	Responsible Party	Contents
Admission Orders	Must be completed no later than 12 hours after admission	Admitting Physician or ED Physician on behalf of Admitting Physician	Should include: Admission status (inpatient, ambulatory procedure, observation for:) Admitting location Vital signs Allergies/reactions Admitting Diagnosis Procedure (if applies) Diet Activity Lab / Diagnostic studies IV and Medication Orders Procedure / Treatments Other Orders (ex: Code status, consults, discharge needs, etc)
Admission Note	Must be completed no later than 12 hours after admission	Admitting Physician or ED Physician on behalf of Admitting Physician	Reason for admission Condition of patient Attending Physician (if not the admitting Physician) Plan of care **Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated and recorded. In the case of an emergency such statement shall be recorded as soon as possible.**
H & P	Completed within 30 days prior to admission **AND** prior to procedure **OR** within 24 hours after admission *If H&P completed prior to procedure /admission, must be accompanied by an update to the physical exam documenting any changes or statement “no change”.	Privileged Practitioner	If done by a PA or ARNP, must be co-signed by the Attending Physician Historical data may be gathered by Registered Nurses during the admission assessment for review and authentication by the practitioner as part of a pre-procedure history and physical Podiatrists may do the H & Ps for patients with ASA scores 1 & 2, scores 3+ must have a H & P performed by a privileged practitioner Dentists may do H & Ps for their day surgery patients

Documentation Requirements	Time Frame	Responsible Party	Contents
Physician Orders	As needed to safely manage patient care and assure continuity	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	All orders must be complete, legible, dated, timed and authenticated Only approved abbreviations may be used in orders There should be an order for every episode of treatment or care Clinical indications for each order should be entered in the patient's medical record (diagnosis, signs/ symptoms, indication)
Restraint Order	Timing determined by type of restraint (Med-Surg vs. Behavioral and if pediatric, timing of orders is more frequent - see Restraint Policy) Med-Surg and Adult Behavioral restraint orders must be renewed at least every 24 hours for continued use	Admitting, Attending, Consulting, Specialty, Primary Care, Supervising Physicians	**Physician order always required for use of Restraint** Order set available and encouraged for use to ensure compliance with all regulatory requirements
Code Order	At time of admission if known or whenever patient or family wishes expressed	Admitting, Attending, Consulting, Specialty, Primary Care, Supervising Physicians	Required for "no code". Physician may issue for full code if any question of patient wishes.
Medication Orders	As needed to safely manage patient care and assure continuity	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Medication dose and format: Drug name (generic preferred), dose, route, frequency of administration, directions (include reason "why") Medication names may not be abbreviated (except as spelled out in approved Abbreviation Manual) Use only approved abbreviations in directions (spell out Units - no not use "U") Do **not** use trailing zeros (write 2 mg, not 2.0)

Documentation Requirements	Time Frame	Responsible Party	Contents
Medication Orders – cont.			**Always** use leading zeros (0.25 mg) PRN medications must include indications for use Use Metric system only <u>Suggest</u> including no more than two choices for the following categories: Analgesics, Antiemetics, Sleep **Range orders only acceptable with descriptor of how to apply the range** Ex: first use lowest dose and if no relief, may use upper dose
Advance Directive	At time of admission if known or whenever patient or family wishes expressed	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Physician responsibility to reflect patient wishes for care based on content of Advance Directive or conversation of content
Consent	Completed prior to procedure	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Consent Form (supplied by MHS) Must be dated and timed, complete and in laymen's terms, signed by the patient/guardian, witnessed (witnessing signature only) The consent **process** should cover (per WA state law): the nature and character of the proposed treatment and/or procedure to be performed; the anticipated results of the proposed treatment and/or procedure; recognized possible alternative forms of treatment; recognized serious possible risks, complications and anticipated benefits; possible alternative forms of treatment, including non-treatment.
Plan of Care	On admission and updated as changes	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Noted in progress notes Needs to support continued stay based on severity of illness and intensity of service needs for the patient Incorporates input from all disciplines including consult information and diagnostic testing results

Documentation Requirements	Time Frame	Responsible Party	Contents
Daily Progress Note	Minimum of daily note - more often based on patient condition	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Includes: Patient complaint and current condition Plan of care In-hospital progress Interpretation of test results Response to treatment / therapy Changes in clinical impressions, diagnosis or differential diagnosis Complications including: Hospital-acquired infections Unfavorable reactions to drugs / Anesthesia If residents - document continuous supervision **Do not use progress notes to criticize the care of others, express concerns of risk management or quality issues**
Consult	As soon as possible after requested and within 72 hours	Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Consult results dictated or entered in progress notes
Immediate Post-Procedure Note	Completed immediate post-procedure	Consulting, Specialty Attending, House Staff and Supervising Physicians	Includes name of Surgeon/Physician Name of assistant(s) Surgery / Procedure description Pre-Op Diagnosis Post-Op Diagnosis Findings Complications (if any) Specimens (list) (if any) Anesthesia technique Estimated blood loss Blood replacement Fluid replacement Drains placed Condition of patient
Dictated Procedure Note	Dictated immediately upon completion of procedure	Consulting Specialty Attending House Staff and Supervising Physicians	This is a more detailed note that includes all elements of the immediate post-op note plus details of positioning and the surgical procedure / technique from beginning to end.

Documentation Requirements	Time Frame	Responsible Party	Contents
Transfer Orders (Intra facility)	Prior to transfer (ideally) but not to exceed 24 hours	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Transfer of patient between units or levels of care within the system. Completion of transfer orders is a patient safety issue.
Transfer Orders (Inter facility)	Prior to transfer	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Completed prior to patient movement between facilities (from an MHS facility to an outside facility). See MHS Patient Transfer and Transport Policy
Organ / Eye / Tissue Transplant	Prior to transplant	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Required by Federal and State law. See MHS Policy on *Organ/Tissue/Eye Donation*
Autopsy Request	Prior to autopsy	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Physician responsibility should be considered at all deaths.
Death Packet	At the time of death	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	
Discharge / Narrative Summary	Within 4 days of discharge	Admitting, Attending, Consulting, Specialty, Primary Care, House Staff and Supervising Physicians	Recommend completion within 96 hours must include: Admitting diagnosis Discharge diagnosis(s) Condition at discharge Pending studies and reports Review of hospital course Significant lab, X-ray, consult, etc. findings Disposition (home, SNF, Transfer, etc.) Discharge mode (ambulatory, ambulance, etc.) Any consultations, referrals, or communications Discharge instructions (diet, activity, treatments, dressings, medication, follow-up, etc.) Discharge medications Follow-up plan and providers

6.2 Admissions to Adult Intensive Care Units (CVICU, Med/Surg ICU, AH ICU)
Admissions to the Intensive Care Unit must meet admission criteria. Issues concerning the appropriateness of an admission to, or discharge from, the ICU are to be resolved through consultation with the ICU Intensivist on duty ICU and in accordance with criteria for ICU admission.

a. The Physician who transfers the patient to the ICU shall be the Admitting Physician until there is a telephone or completed order transferring care to another physician and a subsequent order from that physician accepting care.

b. Any patient admitted or transferred to the ICU must be seen by the Admitting Physician or the receiving physician within 4 hours (Exception: Patients admitted to the ICU following surgery by the anesthesiologist).

c. All imaging studies ordered "Stat" or "Dr. ASAP" on ICU patients shall be read and reported by the Ordering Physician or the Consulting Radiologist within 4 hours or immediately upon request of the Ordering Physician. The on-call Radiologist must be prepared to come in and read or read by teleradiology such studies, if requested. Any "STAT" lab or "STAT" EKG ordered on a ICU patient will be similarly handled and reported.

d. All patients in the ICU must have a designated "Physician-in-Charge" who shall be responsible at all times for providing or arranging the provision of care to the patient and is the one to be called when urgent help is needed.

e. All Primary Care Physicians must, at a minimum, have consultation from a Hospitalist, an Intensivist, or an appropriate sub-specialist within 12 hours of all patient admissions or transfers to the ICU.

f. Critical Care/Intensivist consultation will be obtained on:

1. All patients requiring ventilator support for more than 24 hours, except uncomplicated cardiac surgery patients expected to be extubated within 48 hours of surgery.

2. All patients requiring pressor support for Sepsis Syndrome.

3. Critical status patients in the ICU greater than 48 hours unless determined unnecessary by the Intensivist of the week.

6.3 H & P Prior to Procedure / Surgery
The H & P shall be present prior to procedure and will be used in patient identification and site/side verification. If the H & P is not available pre-procedure, the procedure will be canceled unless the Practitioner completes an H & P or the delay would be detrimental to patient care (emergency cases such as trauma). All such cases shall be reported to the Chairman of the appropriate Service for corrective action.

6.4 Obstetrical Records
The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the Attending Practitioner's office record transferred to the Hospital before admission, but an interval admission note must be completed that includes pertinent additions to the history and any subsequent changes in the physical findings.

6.5 Discharge
Patients shall be discharged only on an order of the Attending Practitioner or designee. The following AHPs have been granted privileges to enter discharge orders under the following circumstances, provided there is an entry in the patients medical record that the Attending Physician has approved the discharge prior to the discharge (this could be a note from the AHP stating "discussed with Dr. ____ who approves patient discharge). The conditions for ARNP and PA discharge privileges vary by Service; see Surgical and Adult Medicine Service Rules for specific privileges.

6.6 Pre-printed Orders

Pre-printed orders may be formulated by a Clinical Service, Committee or group in accordance with the MHS Policy *Order Sets (Pre-Printed)* using the *MHS Order Set Template* and shall be reviewed per MHS policy, with revision as necessary. All pre-printed orders require approval of the appropriate Medical Staff prior to printing. The orders, when used by a responsible Medical Staff Member for a given patient, shall be dated, timed and authenticated by the Medical Staff Member and available in the patient's medical record.

6.7 Co-Signing of Orders

The responsible Medical Staff member shall authenticate orders entered by individuals who are not Medical Staff members or otherwise authorized to issue orders.

6.8 Authentication

Dictation of History and Physical examinations, consultations, operative reports, admission and discharge summaries are authenticated through the use of a digit dictation system which requires the author to enter a unique identification number. Legible initials may be used for authentication on dictated progress notes, orders, or groups of orders. All entries will be authenticated legibly with at least the first initial, last name and professional designation (example: J. Smith, M.D.).

6.9 Signature Stamp

The use of a signature stamp is acceptable under the following conditions: The Practitioner whose signature the stamp represents is the only one who has possession of the stamp and is the only one who uses it. The Practitioner places in the Health Information Management Office an authenticated statement to the effect that the Practitioner is the only one who has the stamp and is the only one who will use it and the Practitioner initials each stamp.

6.10 Consent Forms

The Medical Record must include evidence of informed consent for any invasive diagnostic or therapeutic procedure. The Physician cannot delegate their duty to obtain such informed consent, which consent shall include informing the patient of the risks, benefits, and alternatives to the procedure as well as the probability of success. Informed consent requires that the patient (or legal representative in the case of an incompetent patient) understands the nature of the proposed treatment/procedure; the expected outcome; the recognized alternative treatments/procedures, including non-treatment; the recognized risks, complications, and anticipated benefits and the probability of success. The practitioner should enter the substance of his/her discussion in the patient's medical record. The practitioner may delegate the task of having the patient or representative sign the consent form. In such cases, an MHS employee may sign as a witness to the patient/representative's signature only. The signed consent is valid up to 30 days prior to the procedure.

6.11 Plan of Care

The plan of care is initiated on admission and updated as changes occur. It is entered in the progress notes and needs to support continued stay based on severity of illness and intensity of service needs for the patient. It should incorporate input from all disciplines including consult information and diagnostic testing results.

6.12 Continued Care Documentation

Continued care documentation is utilized to support compliance with Medicare Conditions of Participation, payor authorization and patient care needs by assuring that all care provided is entered and all diagnoses are identified. Ongoing utilization review is done to support Physician documentation on a real time basis to maximize continued care documentation.

6.13 Progress Notes

Every patient shall have at a minimum, a daily progress note, or more often based on patient condition. The note shall include: patient complaint and current condition, plan of care, in-hospital progress, interpretation of test results, response to treatment / therapy, changes in clinical impressions, diagnosis(s) or differential diagnosis(s), complications, hospital-acquired infections, unfavorable reactions to drugs / Anesthesia, if residents – record of continuous supervision. All of the patient's clinical problems should be addressed or a note entered as to why they are not being addressed during this hospitalization. **Do not use progress notes to criticize the care of others, express concerns of risk management or quality issues.**

6.14 Consultation Notes

Consultations shall show evidence of a review of the patient's record by the Consultant, pertinent findings on examination of the patient, and the Consultant's opinion and recommendations. When operative procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to the procedure.

6.15 Surgical Care

6.15-1 Orders

All previous orders are canceled when the patient undergoes a procedure requiring Anesthesia/deep sedation. The Surgeon will enter post-operative orders after surgery is completed. "Resume pre-op orders" or "resume home meds" are not appropriate orders.

6.15-2 Role of Anesthesia

An Anesthesiologist will identify the needs of the patient through pre-Anesthesia assessment, discuss options and risks with patient and family, provide immediate re-assessment prior to the procedure, monitor patient's physiological status during Anesthesia, assess patient's post-procedure status, and ensure appropriate assessment prior to discharge from the post-Anesthesia recovery area. A full record of the assessment, informed consent, continued monitoring, medications and any other treatments and/or finding/complications will be completed concurrently with care.

6.15-3 Scheduling

The Operating Surgeon/Proceduralist is responsible for the accurate scheduling of a patient to include assistant surgeon or other assistants as may be indicated and to request the availability of special supplies, equipment, x-ray, and Pathology Services. Where possible, he/she should state the expected time or length of the operative procedure. This applies to procedures both inside and outside of the operating room (special procedures). The Surgeon/Proceduralist is expected to be on time for scheduled cases.

6.15-4 Site Verification / Time Out Procedure

Prior to the start of any invasive procedure, The MHS Policy, *Verification of Correct Patient, Procedure and/or Site/Side Pre-Procedure* will be followed. The Surgeon/Proceduralist will provide the H & P, Orders, films (as appropriate), etc. and will mark the site, with the patient and team's involvement, if possible. Just prior to the start of the procedure, a time out involving the entire team will occur to ensure correct patient, procedure, films, documents, etc.

6.15-5 Surgical Specimens

Surgical specimens will be submitted to Pathology in accordance with MHS Policy *Pathology Specimen Management*.

6.16 Operative/Procedure Reports

A post-operative note must be entered immediately following surgery that gives the post-operative diagnosis, procedure(s) performed, significant findings, post-operative condition of patient, the name of the surgeon and assistants. In addition, a dictated or entered operative report shall include a description of the findings, technical procedures used, specimens removed, post-operative diagnosis, and name of primary proceduralist and any assistants. Operative reports shall be completed (or dictated) immediately following the procedure for all patients and the report promptly authenticated by the author and made a part of the patient's current Medical Record. Any practitioner with unrecorded operative reports five (5) workdays following the day of the operation may automatically have administrative action taken in limiting exercising of operative privileges except for any inpatients that have already been scheduled for surgery.

6.17 Transfer Orders (Intra facility)

Patients may be transferred between units for different levels of care or between campuses for services not available (such as from Allenmore to TG for Cardiac Cath). Transfers from Allenmore to TG are NOT considered a discharge and readmission as TG-AH are licensed as one facility. Transfers from one unit to another (changes from one level of care to either a higher or lower level of care) require a change in orders. Orders should be completed as soon as possible for patient safety, but not to exceed 24 hours. See MHS Policy, *Orders:, Faxed, Emailed, Verbal, Telephoned - MHS*.

6.18 Transfer Orders (Inter facility)

It is the responsibility of the attending Physician to assure that every patient being transferred from an MHS to another facility has an assessment, orders and a completed transfer form. To determine which set applies, see the MHS Policy, *Patient Transfer & Transport*. Orders will be completed prior to disposition. The assessment exam ensures readiness for transfer and that patient is a match for the method of transport selected. Full compliance with the MHS *EMTALA* policy is required.

6.19 Transfer of Care

If an attending Physician will be unavailable to care for their patients, they must transfer care to another Physician prior to their unavailability. PAs and ARNPs may not care for patients in the absence of their sponsor as all patient's must have an attending Physician at all times - see Rules 6.2, 6.3, 6.4 above. This does not apply to "team coverage". Whenever responsibilities are transferred to another staff member, the responsible Physician will personally contact the Physician and the patient and if they concur a note indicating the transfer of responsibility shall be entered on the order sheet of the Medical Record. When a Physician takes over the Primary Care of another Physician's patient, he/she shall assume full responsibility for care and completion of the Medical Record of the patient.

6.20 Stays < 24 Hours

In the case of a patient treated in an ambulatory care setting, a non-emergent setting where the patient stay is not expected to exceed 24 hours, the following must appear in the Medical Record: a) Patient identification b) Relevant History of the illness or injury and Physical findings c) Diagnostic and therapeutic orders d) Clinical observations, including the results of treatment e) Reports of procedures and tests, including their results f) Diagnosis or impression g) Patient disposition and any instructions given to the patient or family for care h) Immunization status of children and adolescents i) Allergies j) Referrals to practitioners inside and outside the organization and k) Any communications to or from external practitioners.

6.21 Final Diagnosis

Final diagnoses shall be recorded in full, dated and authenticated by the discharging practitioner at the time of discharge of all patients. There shall be no abbreviations in the final diagnoses.

6.22 Discharge Summaries

A discharge summary shall be entered or dictated on patients hospitalized over forty-eight (48) hours except: uncomplicated obstetrical deliveries with a hospitalization of four (4) days or less; newborn infants who remain in the hospital five (5) days or less; or where a longer infant stay results from a maternal problem (this should be entered in the infant's record). Discharge summaries must be completed on every patient who dies during their hospitalization irrespective of the length of the hospitalization. Discharge summary shall include: the admitting diagnosis; discharge diagnosis(s); condition at discharge; pending studies and reports; review of hospital course; significant lab, x-ray, consult, etc. findings; disposition (home, SNF, transfer and to where, ambulance, etc.), any consultations, referrals, or communications; discharge instructions (diet, activity, treatments, dressings, medications, follow-up, etc.); discharge medications, follow-up plan and providers. The Attending Physician shall authenticate all discharge summaries. Discharge summaries shall be completed within 96 hours of discharge, but required within seven (7) days.

6.23 Removal of Medical Records

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of MHS and shall not otherwise be taken away without permission of the Chief Executive Officer or designee. In case of readmission of a patient, all previous records shall be available for the use of the Attending Physician. This shall apply whether the same Practitioner or another attends the patient. Unauthorized removal of records from the Hospital is grounds for corrective action to be determined by the Executive Committee of the Medical Staff.

6.24 Access to Medical Records

Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

6.25 Completion of Medical Records

Medical Records, including discharge summaries, should be completed within seven days after discharge. Discharging Practitioners shall receive written notification of delinquent records and shall have five (5) working days after receipt of such notice to complete the record(s). If the records are not completed within that period, the Physician will receive written notice from the President requesting Physician's appearance at the at the next scheduled Medical Executive Committee meeting to explain the reasons for failure to complete the record(s). If the Physician fails to appear and the records have not been completed by the time of the Medical Executive Committee meeting, the Physician's privileges will be automatically suspended in accordance with the bylaws.

7.1 Emergency Department Call Obligations

7.1-1 In accordance with the Medical Staff Bylaws, members of the Medical Staff are required to serve on Emergency Department ("ED") Call Panels (referred to as "Call" or "Call Panel") in the staff member's specialty and assigned service.

7.1-2 Each Medical Staff member required to serve on the Call Panel will be familiar and comply with the requirements of the Emergency Medical Treatment and Active Labor Act ("EMTALA") that pertain to on call responsibility as set forth in the MultiCare Health System ("MHS") Policy on Compliance with EMTALA.

7.2 Panel Assignment/Rotation

7.2-1 All specialty services represented on a Medical Staff are offered through the Call Panel. Each Medical Staff specialty will provide specialty and sub-specialty Call Schedules.

7.2-2 Specialty sections of a Medical Staff service or division shall develop specialty-specific schedules for Call Panels with approval of the service chair.

7.3 Call Period/Call Panel Changes

7.3-1 Specialty Call Panel provides coverage 24-hours per day, 7 days per week.

7.3-2 Call schedules shall be submitted in writing by the 15th day of each month to the Medical Staff Office.

7.4-3 Call rosters must list the individual physician responsible for call for each 24-hour period.

7.3-4 Call responsibility may be transferred to another eligible member of the Call Panel if both members agree. The medical staff member listed on the call roster is responsible for notifying the ED, and the Medical Staff office of the schedule change. The physician listed on the schedule remains responsible for call coverage until such notification is received. Any practitioner designated as a substitute must have appropriate clinical privileges **and** attend patients at the campus to which the call roster applies.

7.4 Responding to Emergency Department

7.4-1 The emergency department physician is responsible for determining the most appropriate on call specialist needed to examine or treat a patient's emergency medical condition.

7.4-2 If called or paged by the Emergency Department, the on-call physician must respond by telephone within 15 minutes. . The emergency department physician, following discussion of the patient's condition with the on-call physician will determine if the on-call physician's presence in the Emergency Department is necessary to examine or treat the patient's condition and how quickly the on-call physician must present to the hospital.

7.4-3 If the on-call physician determines that the patient requires care beyond the capability of the hospital or the on-call physician, then the on-call physician will come to the Emergency Department to confirm the patient's condition and to arrange for an appropriate transfer. No unstable patient will be transferred without evaluation by the on-call physician, unless it is in the patient's best interest.

7.4-4 If the patient requests transfer to another facility, the emergency physician will arrange appropriate transfer and will determine whether the presence of the on-call physician is required to stabilize the patient or to assist in arranging transfer.

7.4-5 If the emergency physician determines that an Emergency Medical Condition ("EMC") does not exist and the patient is stable for discharge if appropriate outpatient follow up care is provided, the patient shall be referred to:

(1) The patient's primary care provider or specialist of record who has a relationship with the patient; or

(2) The physician on-call for specialty necessary to treat the patient's condition, if the patient does not have a physician.

7.4-6 If a patient presents to the Emergency Department and requests a particular (private) physician because of a previous patient-physician relationship, and if the patient's medical condition will not be adversely effected by the delay in providing the medical screening examination or in providing necessary stabilizing treatment for an EMC, the ED staff will contact the requested physician and he/she will be given the option of seeing the patient. If the private physician declines or is not available within a reasonable time, the Call protocol will be followed.

7.5 Inpatient Consultations

7.5-1 While on-call for the Emergency Department, Medical Staff members shall be responsible for providing consultations on hospitalized patients requested during the Member's scheduled on-call period.

7.5-2 Medical Staff Members shall respond to calls or pages from inpatient units within a timely manner and shall complete requested consults within such reasonable time as appropriate based on the patient's condition. Questions concerning the necessity of and/or time frame for completing the consult should be resolved through discussions between the on-call consultant and the requesting physician. Deference as to the need for and timeliness of the consult shall be given to the requesting physician.

7.5-3 Medical Staff Members receiving requests for consults during their scheduled on-call period may arrange for the provision of such consult by another Medical Staff Member of the same specialty or subspecialty (such as a call partner) provided such arrangement does not result in an unreasonable delay or pose a risk to the patient.

7.6 Dispute Resolution Disputes arising with regard to the interpretation of any of the requirements of this Rule 7 shall be referred to the appropriate Medical Staff Service Chair. As authorized by the Medical Staff Bylaws, the Medical Staff Service Chair initiates an immediate corrective action investigation if an on-call physician fails to comply with the on-call requirements outlined above and included in the MHS "Policy On Compliance with Emergency Medical Treatment and Active Labor (EMTALA)".

7.7 Corrective Action for Physicians who Fail to meet On-Call Obligation

The following steps will take place upon validation:

a. 1st offense – letter to provider inviting provider to attend Medical Executive Committee to explain reasons for not being able to fulfill call obligations

b. 2nd offense - automatic suspension, up to 14 days, and a letter inviting the provider to attend the next Medical Executive Committee meeting.

c. 3rd offense – automatic 31 day suspension

d. 4th offense – revocation of medical staff privileges.

A provider subject to automatic suspension as outlined above is not entitled to procedural rights or a formal hearing.

8.1 Supervision All Resident /House Staff work under 100% supervision. The Resident staff work under increasing levels of responsibility outlined by their Residency program. The Attending or Supervising Physician is responsible for providing information to the Hospital regarding Resident Physicians assigned to the case.

8.2 Assignment
Fellows, Residents, and Medical Students may be assigned to the Hospital and its Staff for training and they may attend patients pursuant to the provisions of approved affiliation agreements. The precise definition of such educational programs shall be set forth in written form by each affected service and each service shall be responsible for participants in its approved program. Only ACGME-accredited training institution Resident Physicians will be selected for rotation. Residents will be licensed Physicians in good standing or identified as unlicensed. A letter of assignment will be provided to the organization. This letter will identify the resident, assigned preceptor and dates of rotation.

8.3 Notification to Patients of Residents Involvement in Care
Patients will be notified at admission that this is a teaching hospital and that trainees under the supervision of a Staff Preceptor/Attending Physician may render portions of their care. If they decline same, this must be discussed between patient and Attending Physician with resolution prior to Resident and Medical Student care.

8.4 Privileges
Residents from UW Affiliated Residency or another ACGME institution shall require no specific privileging if their practice is to remain within the scope of Family Practice and their Fellowship area of specialty and if the Fellowship is for one year or less. If practice is anticipated outside the scope of the Fellowship, the full credentialing/ privileging process will be accomplished. All Residents shall have a written description of each rotation experience, goals and objectives.

8.5 Preceptors
Medical Staff Members must notify the organization of all students they are supervising. Trainees will be under the supervision of a Preceptor and/or Attending Physician at all times. Preceptor is defined as the Physician who has undertaken to supervise the trainee. Attending is defined as the Physician primarily responsible for the patient from the beginning of the hospital episode. The same Physician may be both the Preceptor and the Attending Physician. The Attending Physician shall be ultimately responsible for all aspects of patient care. All patient care administered by the Resident shall be coordinated with the Preceptor and/or Attending Physician. The Resident performs within the scope of training. The Preceptor and/or Attending Physician supervise within their delineated clinical privileges. When a Resident contacts a Preceptor and/or Attending Physician and requests his or her presence to help manage a patient, the Faculty Member will respond to this request in an appropriate fashion.

8.6 Care of Patients and Entry in the Medical Record
All patients must be seen at least on a daily basis and that visit recorded in the Medical Record. If the Preceptor and/or Attending Physician are the Primary Physician, then entry of that daily visit by the Preceptor is expected. If the Preceptor and/or Attending Physician are a consultant only on the case, then each visit, daily or not, shall be entered. The only exception to this shall be by Service policy. Authorizations for admission, History and Physical, discharge orders, operative reports, and cover sheets will either be completed or co-signed by the Staff Preceptor and/or Attending Physician. Progress notes and orders completed by licensed or registered trainees do not need to be countersigned.

8.7 Ability to Perform Procedures
The Preceptor and/or Attending Physician shall determine the competency of the Resident in specific procedures, within the scope of training of the Resident. Each Service should specify those procedures that require another Surgeon to act as First Assistant, in which case the Resident may act as Second Assistant. The competency of the Resident to first assist on any surgical procedure shall be determined by the Preceptor and/or Attending Physician and be within the scope of training of the Resident. Trainees may participate in deliveries and cesarean sections at the discretion and under the supervision of the Preceptor and/or Attending Physician. Participation of Trainees (with any level of training) in surgery or performing invasive procedures (including first

assistant in surgery) will be at the discretion of the Surgeon. Induction of Anesthesia for surgical or obstetrical procedures should not, in general, be initiated prior to the arrival of the Preceptor and/or Attending Physician. Exceptions to this general policy may be made via direct contact between the Attending Physician and the Anesthesiologist.

8.8 Evaluation

At the conclusion of the Resident's rotation, the Preceptor/Attending Physician or the Director, Tacoma Family Medicine, whichever is more appropriate, will complete a written evaluation of the Resident's activities. Additionally, the Resident should be provided with an evaluation sheet for assessing activity of the Preceptor and/or Attending Physician. The author should forward the evaluation of the Preceptor/Attending Physician to the Family Practice Residency Program office or the Medical Staff Services Office, which ever is appropriate.

8.9 Authority

Patients may be admitted or transferred to an ICU or telemetry unit by a Resident under the supervision of the Preceptor and/or Attending Physician if the Preceptor is appropriately privileged to provide services in the critical care units. Alternately, an Attending Physician with clinical privileges adequate to provide intensive care services who has agreed to attend the patient may either assume full care or assume responsibilities as Preceptor for the Resident. Medical care within critical care units may only be provided by Residents in conjunction with an appropriately privileged Preceptor and/or Attending Physician. Specifics of care of individual patients will be closely coordinated with the appropriately privileged Preceptor and/or Attending Physician in all circumstances. Nursing staff will carry out Resident and Fellow patient orders. If there is a question on appropriateness of any order or procedure to be performed on the unit, Hospital personnel will verify the order with the Resident/Fellow then, if indicated, directly contact the Preceptor and/or Attending Physician to verify the treatment plan.

8.10 Medical Records

When Residents and Trainees are actively involved in the care of patients and are making entries in the Medical Record, the Attending Physician should be actively recording evidence of active participation in supervision of the Residents, Trainees and patient care in the Medical Record. With the consent of the Attending Physician, Residents may dictate histories and Physicals, discharge summaries, and operative reports, but the Preceptor and/or Attending Physician must countersign such dictations. Progress notes and orders entered by licensed Trainees do not need to be countersigned. The Preceptor and/or Attending Physician shall co-sign all orders and progress notes of non-licensed Trainees. Completion of the Medical Record is ultimately the responsibility of the Attending Physician. The Residency Director will act as an intermediary to resolve any issues of records delinquency by a Resident.

9.1 Anesthesia: Anesthesia services will provide twenty-four hour Anesthesia service (facility specific to scope of service) in the Operating Rooms and Labor and Delivery Suites, inpatient and post-operative pain management, unit sedative and resuscitative assistance as situations indicate (at the request of attending Physicians) and pre-operative consultation.

9.1.1 Operating Room: The operating rooms will be staffed with Anesthesiologists to match nursing personnel adequate to meet the daily schedule and to cover after hour emergencies. Anesthesiologists on call will be available within thirty minutes of notification. Delay of cases should be no longer than two hours in semi-emergent situations, and additional help will be called in accordingly.

9.1.2 Labor and Delivery: An Anesthesiologist will be assigned to the obstetrical unit to administer analgesia and anesthesia for patients in labor or requiring cesarean delivery.

9.1.3 Diagnostic and Therapeutic Nerve Blocks: After consultation with the attending physician, provide inpatient diagnostic and therapeutic nerve blocks and assistance with post-operative pain control.

9.1.4 Preoperative Anesthesia Consultation: All patients who are to receive anesthesia services will first undergo a specific pre-anesthetic evaluation to ascertain whether that patient is a suitable candidate for anesthesia or sedative procedures.

9.1.5 Anesthesia and Sedation outside the OR: Anesthesia will provide, after consultation with the attending Physician, anesthesia or sedation as needed within the hospital.

9.1.6 Codes/Resuscitation: Anesthesia will be principally responsible to respond for resuscitation within the Operating Room Suites, and will respond as able to the Cardiac Catheterization laboratory, the Post Anesthesia Care Unit, and the Obstetrical Unit. It will not respond elsewhere unless consulted.

9.1.7 Documentation: Documentation for all patients receiving anesthetic care will include pre-procedure assessment, suitability for anesthesia, intraoperative physiologic status, drugs and/or blood and blood products administered, anesthetic techniques used, and documentation of the patient's status on admission to and discharge (may use Anesthesia approved discharge criteria) from the Post-Anesthesia Care Unit.

9.2 Emergency Medicine The Emergency Department will provide twenty-four (24) hour emergency services for critically ill patients, as well as non-emergent medical services for ambulatory patients. The Emergency Department will be staffed twenty-four (24) hours a day, 365 days a year, by qualified physicians.

9.2.1 Documentation: Appropriate medical records will be kept for every patient receiving medical care in the emergency room at each visit to include disposition and condition at discharge.

9.2.2 If an attending Physician plans to meet their patient in the Emergency Department, they should call the Emergency Department prior to the patient's arrival with (1) patient's name; (2) nature of complaint; (3) orders; (4) how best to inform the physician that the patient has arrived and has been triaged. The Emergency Department Physician may evaluate the patient if the attending Physician is unavailable for a time period of over 20 minutes. The Emergency Department physician maintains the responsibility to evaluate and initiate therapy for any and all patients deemed unstable or urgent.

9.2.3 An attempt will be made at all times to honor the physician's stated preferences for consultation, but there will be times where expediency, urgency and availability may make it necessary to use the on-call roster.

9.2.4 The list of on-call physicians in all available specialties shall be maintained on the MHS Intranet, posted by Medical Staff Services. The Attending Physician or the Emergency Department physician will make referrals to specialists or backup physicians.

9.2.5 A licensed physician must see all persons presenting themselves for care in the Emergency Department,

when requested by the patient. If a patient indicates his desire to be seen by the Emergency Department Physician, his/her request will be honored. If, in the opinion of the Emergency Department R.N. or the Emergency Department physician, the patient's condition should have clinical evaluation by a physician and if the patient elects to leave the Emergency Department without such evaluation, the patient shall be requested to sign a waiver of responsibility for a physician not attending him.

9.2.6 Privileged Allied Health Providers, including Physician Assistants and Advanced Registered Nurse Practitioners, may perform medical screening examinations within their scope of practice and within the Emergency Department Practice Protocols and Procedures.

9.2.7 Following treatment by the Emergency Department provider, the patient will be referred for appropriate follow-up care, or if hospitalized, will be admitted to the service of the personal physician. In the event that another physician (alternate) is covering for the patient's personal physician, then that physician will be notified of admission. In the event neither the personal physician nor his alternate can be contacted, or the patient does not have a personal physician, the patient will be assigned to the backup physician for the day.

9.2.8 The Emergency Medicine Physician may admit patients to Tacoma General-Allenmore Hospital for the patient's personal physician or alternate for the backup physician for that day or for a specialist to whom the patient was referred. The Emergency Department Physician may issue transition orders as are deemed necessary for the patient until the patient is seen by his own attending physician. Once the attending physician has been notified of the admission of a patient to his/her service, they will then assume full responsibility for the patient's care.

9.2.9 Surgical procedures requiring local anesthesia or sedation may be done in the Emergency Department. Cases requiring general anesthesia must be done in the surgical suite.

9.2.10 Emergency Department physicians will be available for all hospital patients in the event of a potential life-threatening situation and will respond to all Code 4's within the hospital unless confined with a life-threatening case in the Emergency Room. Primary responsibility for response to TG campus Code 4's resides with the Tacoma Family Medicine residents.

9.3 Family Practice

9.3.1 All Active and Courtesy staff members of Family Practice shall participate on the "no-doc" call list and will be available for the care of unassigned patients as scheduled, either through the Tacoma General or Allenmore Emergency Departments for Medicine "no-doc". Family Physicians who participate in the newborn nursery no-doc list are not relieved of their obligation to participate in the Emergency Department “no-doc” list.

a. Family Physicians over 60 years old will be relieved of participation in the mandatory “no-doc” call roster.

b. Family Physicians may be relieved of participation in the mandatory no-doc call roster by reason of medical illness or maternity.

c. Family Physicians without any inpatient activity for the previous calendar year will be excused from the mandatory “no doc” call roster until such time as they have inpatient activity. Inpatient activity includes patient admissions, rounding on patients, writing orders on inpatient charts and discharging patients from the hospital.

9.4 Medicine

9.4.1 Internal Medicine sub-specialists in the fields of Hematology, Cardiovascular Disease, Infectious Disease, Endocrinology and Metabolism, Nephrology, Pulmonary Disease, Gastroenterology, Medical Oncology and Rheumatology shall likewise be qualified for admission by the sub-specialty's certifying examination administered by the American Board of Medicine. Internal Medicine providers practicing General Internal Medicine shall participate in the “no-doc” call schedule for Emergency Department backup coverage.

a. Physician practicing General Internal Medicine (without a sub-specialty) who has attained the age of 60 years old will be relieved of participation in the mandatory “no-doc” call roster.

9.4.2 Specialists in Allergy and Immunology shall be eligible by the certifying examination of the American Board of Allergy and Immunology.

9.4.3 Specialists in Dermatology shall be eligible by the certifying examination of the American Board of Dermatology.

9.4.4 Specialists in Psychiatry, Neurology, Child Psychiatry and Neurology shall be eligible by the appropriate certifying examination administered by the American Board of Psychiatry and Neurology.

9.4.5 Certification by the respective American Specialty Boards shall be required within five years from the time of Board eligibility of all specialists with the exception of certification by the American Board of Internal Medicine Subspecialties (four years), and American Board of Allergy and Immunology (four years), and the American Board of Neurology and Psychiatry (four years).

9.5 OB-GYN

9.5.1 OB-GYN Physicians may restrict their practice in any of the following ways:

a. **Obstetrics only**: those physicians limiting themselves to Obstetrical care, such as Perinatologists. Physicians who limit their practice to Obstetrics will not be required to take Gynecology no-doc patients.

b. **Gynecology only**: those physicians who have discontinued their Obstetrical practice, or who have restricted practices such as an Oncologist or Endocrinologist. Physicians who limit their practice to Gynecology will not be required to take Obstetric no-doc patients.

9.5.2 No-Doc coverage:

a. All physicians having Active or Provisional status in OB/GYN will be required to participate in the backup call roster.

b. All physicians having Courtesy status may be asked by the Medical Director to participate in no-doc patient care in the circumstance where an Active staff member cannot cover the schedule. **No-doc patients will not be counted toward the limit of 12 patients.**

c. A Physician may request that he/she not be placed on the backup list for any given month. At the end of each year the number of days each physician covers will be equitable. Skipping a month may result in additional coverage days during the months prior to or after the requested month off.

9.5.2-1 No Doc OB coverage:

a. Supervision of care is the responsibility of the high risk, on-call Obstetrician/Perinatologist. In the event that the in-house obstetrician cannot fulfill his/her supervision requirements, then he/she can call on the backup physician on call for that 24-hour period. It is expected that the backup physician can be physically present at the hospital within 40 minutes of being called.

b. No-doc patient care coverage will begin promptly at 8:00 am each day and continue for 24 hours.

b. All no-doc patients will be assigned to the MOGA (Multicare OB/GYN Associates) Service.

9.5.2-2 No Doc GYN Coverage:

a. No Doc GYN Coverage will be covered in the manner determined by the members of the Women and Newborn Services Committee.

9.5.3 Healthcare Affiliates: A Nurse-Midwife must have graduated from an accredited Midwifery program and have met the requirements for certification by the American College of Nurse-Midwives. The midwife shall be licensed as a Registered Nurse (RN) and an Advanced Registered Nurse Practitioner (ARNP) in the State of Washington.

9.5.4 Qualified Birth Center RNs may perform medical screening examinations of Obstetrical patients who are admitted for initial assessment in consultation with the patient's physician and pursuant to Birth Center practice protocols.

9.6 Pediatric/Newborn

9.6.1 All active providers with Pediatric Newborn Privileges shall participate on the call list to provide care for unassigned patients as scheduled, for those infants admitted to the Newborn Nursery.

9.7 Radiology

9.7.1 The Diagnostic/Procedural Service will assure the hospital patient has access to 24-hour/365 day diagnostic radiology services.

9.7.2 Because of exclusive contract arrangements between MultiCare and Tacoma Radiology Associates (TRA) on the Tacoma General Campus, Medical Imaging Northwest on the Allenmore Campus and at Covington, only those physicians employed by these groups will be privileged in Radiology.

9.8 Surgery

9.8.1 Members of the Surgery Service will be expected to provide Emergency Room backup, including emergency and acute care of patients without physicians, in their respective specialties.

a. Surgery will ultimately assure proper coverage for those patients seen at Tacoma General-Allenmore Hospital who require surgical evaluation and care. Being comprised of multiple surgical sub-specialties, Surgery has designated that the members of each sub-specialty shall provide the mechanism and the support for daily surgical coverage in their respective fields. This coverage shall be available to referring physicians, as well as to Emergency Room physicians caring for patients at Tacoma General-Allenmore Hospital.

b. In the event that a particular sub-specialty fails to provide such coverage, and that this appears to be a continuing problem, the Surgery Service will assume the responsibility of defining coverage for the sub-specialty in a manner felt to be fair to all.

c. Each sub-specialty will provide the identity of the individual responsible for completion of their call schedule to the Medical Staff Services Office (MSO) for the calendar year.

d. Call schedules are due to the MSO by the 15th of the month, prior to call.

9.8.2 A staff member with minor surgical privileges may perform the following procedures:

a. Incision and drainage, biopsy or excision of superficial lesion
b. Repair of minor laceration
c. Debridement and cleansing of minor burns
d. Closed reduction of minor fracture
e. Vasectomy
f. Circumcision

9.8.3 All operations shall be scheduled under the direction of a physician with the appropriate privileges. If, in the opinion of such physician, another physician without such privileges is capable of performing the operation, the other physician may be allowed to proceed with the operation under the primary physician's supervision. Both physicians must sign the operative report and the major surgeon must assume the responsibility for the management of the case.

9.8.4 The physician shall be on hand, scrubbed, and ready to operate at the time scheduled for a procedure. If the physician is not ready by 20 minutes past the scheduled time, the Surgery Supervisor is justified in using discretion in rescheduling the operation. The Surgery Supervisor will report to the Surgery Service Committee for appropriate action physicians who repeatedly delay the surgical schedule by their tardiness.

9.8.5 All major surgical procedures shall be performed with a qualified first surgical assistant present unless, in the opinion of the operating physician, the surgery can be performed without one present.

9.8.6 Anesthetics, other than local anesthesia and minor peripheral nerve blocks, must be administered by, or under the supervision of, a privileged Anesthesiologist.

9.8.7 Clinical judgment of the attending physician and/or his designee prevails in the decision to obtain an electrocardiogram (ECG) on any individual patient.

9.8.8 General Hospital Admission

a. EKG is not routinely indicated solely because of general hospital admission.

b. EKG may be indicated upon general hospital admission in patients who by history, physical examination, or on the basis of past medical history are at increased risk for occult heart disease. Included in this category are patients where arrhythmias of the heart are detected on physical examination (though the history of cardiac abnormalities may be silent); patients in whom systemic diseases or other conditions may be associated with clinically important, but previously unrecognized, cardiac abnormalities; and in patients who are currently taking prescribed non-cardiac medications with potential cardiac toxicity or ECG alterations. An ECG may also be indicated in patients with cardiac signs or symptoms on history or physical examination.

9.8.9 Preoperative

a. A preoperative ECG is not routinely indicated for non-cardiac surgery.

b. Preoperative ECG may be indicated in patients having intrathoracic, intraperitoneal, or aortic surgery, or emergency operations under general or regional anesthesia that are at risk for cardiac complications. In addition, patients undergoing major neurological operations may be at increased risk of ECG alterations. In these patients, an electrocardiogram preoperatively may also be useful.

c. In the case of preoperative ECG, where ordered and obtained, physician interpretation must be completed prior to the induction of general or regional anesthesia and the onset of the surgical procedure.

9.9 Ambulatory Surgery

9.9.1 For day surgery patients the admitting physician shall be responsible for an appropriate history and physical which shall include:

a. The rationale for the operation or diagnostic procedure;

b. The relevant history regarding other disease, medication, previous anesthetic experience, and drug sensitivity;

c. A description of the general condition of the patient, examination of the heart and lungs, findings pertinent to the anticipated procedure; and

d. Reports of all pertinent diagnostic procedures performed outside the hospital.

9.9-2 As is the case with other elective procedures, this information should be at the hospital at the time of the patient's admission as provided in the Rules and Regulations pertaining to medical records.

9.9-3 Patients who will require either general anesthesia or major conduction anesthesia and who have symptomatic impairment of one or more major organ systems should be scheduled for a preoperative evaluation by an Anesthesiologist in the Surgical Pre-admission Clinic.

9.9-4 Guidelines pertaining to preoperative and general hospital admission electrocardiograms, shall apply.

9.9-5 Day surgery patients must have an identified person who will provide transportation at the time of discharge.

9.10 Dentistry and Oral Surgery

9.10.1 Oral Surgeons must be certified by the American Board of Oral Surgery. Applicants who have completed all requirements for Board Certification but who have not been certified may be granted privileges until so certified. In the event certification is not obtained within the time provided by the appropriate certifying body, and in any case, within five years, all surgical privileges will be automatically terminated. The Surgical Service Committee may, at that time, recommend the granting of surgical privileges, which they feel are appropriate.

9.10-2 Patients admitted for Dental Services shall be admitted on the General Surgery Service. Before the start of any oral surgery, an adequate medical history and physical examination by a qualified oral surgeon on patients without other significant medical problems must be on the patient's chart. Patients with medical problems admitted to the hospital by qualified oral surgeons and all patients admitted by other dentists shall have an admission history and physical examination and an evaluation of the overall medical risk, which has been performed by a physician member of the Medical Staff, recorded on the chart.

9.10-3 The dentist or oral surgeon shall be responsible for preparation of the dental history and physical and operative report.

9.10-4 Medical consultation shall be obtained for management of non-dental complications.

9.10-5 Anesthesia, other than local anesthesia on dental surgery patients, must be administered by, or under the supervision of, a privileged Anesthesiologist.

9.11 Podiatric Privileges

9.11-1 A Podiatrist with clinical privileges may, with the documented concurrence of an appropriate member of the Medical Staff, initiate the procedure for admitting a patient. The concurring Medical Staff member shall assume responsibility for the overall aspects of the patient's care throughout the hospital stay, including the medical history and physical examination. Patients admitted to the hospital for podiatric care must be given the same basic medical appraisal as patients admitted for other services.

9.11-2 The Podiatrist may enter orders for local and topical treatment, for analgesics and narcotics. Orders for other systemic medications shall be the responsibility of the Attending Physician.

9.11-3 Podiatrists shall be granted surgical privileges on the basis of their training and experience but shall be limited to procedures below the ankle joint.

9.11-4 Pre-surgical histories and physicals are in the scope of practice of podiatric physicians. Podiatrists will be permitted to perform pre-operative histories and physicals in their office prior to surgery. If, in the opinion of the Podiatrist, the patient falls into ASA Category I or II, the Podiatrist may schedule the patient for surgery. The Podiatrist also has the option of scheduling the patient for the pre-op screening clinic.

9.11-5 If, after performing a pre-surgical history and physical, the Podiatrist feels the patient falls into ASA Category III or IV, the Podiatrist will not schedule surgery. Instead, the Podiatrist will schedule the patient with a primary care physician for a pre-op history and physical examination. If the primary care physician clears the patient for surgery, it will be the obligation of the Podiatrist to schedule this patient for a pre-op screening clinic appointment prior to any future surgery.

9.11-6 Prior to surgery, a privileged Anesthesiologist will complete the Pre-Operative Assessment Form. If the Anesthesiologist determines that the patient is a Category I or II, the surgery may proceed. If the Anesthesiologist determines that the patient is a Category III, then a consultation will take place with the Anesthesiologist. If, in the opinion of the Anesthesiologist, it is safe to proceed with the surgical procedure on an ambulatory basis, the surgery may be performed. If however, it is the opinion of the Anesthesiologist that this patient should not have surgery in an ambulatory setting, the procedure may not be performed.

9.11-7 It will be the obligation of the Podiatrist to (a) cancel the surgery, (b) inform the patient and the family of the need for the cancellation, (c) refer the patient to a primary care physician for a complete history and physical and (d) schedule the patient at the pre-op screening clinic prior to any future surgery.

9.11-8 All ASA Category IV patients and any ASA Category III patients determined by the Anesthesiologist to not be good candidates for an ambulatory setting, will have their surgeries performed in an inpatient setting. Therefore, these patients will need a primary care physician to admit the patient and to do a complete history and physical prior to any surgery performed by the Podiatrists. These patients will also require a primary care physician during the entire hospitalization.

10.1 Adoption and Amendment

These Rules may be amended or repealed upon a recommendation and approval of the Medical Executive Committee and approval of the Governing Body. Further, in recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Staff unreasonably fails to exercise its responsibility and after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, the Governing Body in its actions shall carefully consider Medical Staff recommendations and views.

10.2 Technical and Editorial Amendments

The Medical Executive Committee shall have the power to adopt such amendments to the Rules as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Rules, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross-references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Staff or the Governing Body within 90 days after adoption by the Medical Executive Committee. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee.

10.3 Approval

These Rules of the Medical Staff of Tacoma General/Allenmore Hospitals were approved by the Governing Body on February 19, 2008 pursuant to Medical Staff recommendations based on affirmative vote of the Medical Executive Committee, to be effective February 19, 2008, in full substitution and replacement for any and all previous Rules of Tacoma General Hospital-Allenmore Hospital Medical Staff.

PAC Revised 01172006
PAC Revised 09192006
PAC Revised 02192008
PAC Revised 05202008
QC Revised 10212008
QC Revised 03172009
QC Revised 04202010
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