MEDICAL STAFF BYLAWS
OF
VALLEY HOSPITAL
P R E A M B L E

WHEREAS, VALLEY HOSPITAL, hereinafter referred to as "Hospital", is operated by MultiCare Health System, a Washington not for profit corporation and is lawfully doing business in Washington and is not an agency or instrumentality of any state, county or federal government; and

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

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

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

WHEREAS, The Medical Staff is accountable to the Governing Body for the quality of medical care provided to patients. In matters of Medical Staff self-governance, the Governing Body's consent to, and affirmance of, Medical Staff actions shall not be unreasonably withheld. The Governing Body shall give great deference to the Medical Staff in medical matters and in those operational issues pertaining to physicians' competency, clinical standards and patient care.

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

NOW, THEREFORE, the practitioners practicing in VALLEY HOSPITAL hereby organize themselves into a Medical Staff conforming to these bylaws.

D E F I N I T I O N S

1. The term “Professional Staff” means physicians and osteopathic physicians holding appropriate licenses and duly licensed dentists, oral surgeons and podiatrists, who are members of the Professional Staff of this Hospital and licensed in the State of Washington.

2. The term “Advanced Practice Providers Staff” means Advanced Practice Providers Practitioners credentialed in their respective profession who are employed by the Hospital or by members(s) of the Professional Staff to perform specific functions for which they have been granted privileges through processes outlined in these Bylaws documents and are licensed in the State of Washington.

3. "Board" means the Board of Trustees of VALLEY HOSPITAL and DEACONESS HOSPITAL.

4. Board Certified means by the professional board approved by the Accreditation Council for Graduate Medical Education or recognized by the American Board of Medical Specialties, American Osteopathic Association, Royal College of Physicians and Surgeons of Canada, American Dental Association, or American Board of Podiatric Surgery for the specialty for which the applicant is requesting clinical privileges.

5. “President” means the individual appointed by the Corporation to provide for the overall management of the Hospital or his/her designee.

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

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

8. "Corporation" means MultiCare Health System.

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

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

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

12. "Fair Hearing Plan" means the procedure adopted by the Medical Staff with the approval of the Board to provide for an evidentiary hearing and appeals procedure when a physician’s or dentists clinical privileges are adversely affected by a determination based on the physician’s or dentist’s professional conduct or competence. The Fair Hearing Plan is incorporated into these Bylaws and is contained in Appendix “A” hereto.

13. “Hospital” means VALLEY HOSPITAL.

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

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

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

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

18. "Medical Staff Year" means calendar year.

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

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

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

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

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

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

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

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

27. “Interdisciplinary team” (IDT) A coordinated group of experts from several different fields who work together towards a common goal.

ARTICLE I
NAME

The name of this organization shall be the Medical Staff of VALLEY HOSPITAL.

ARTICLE II
PURPOSES & RESPONSIBILITIES

2.1 PURPOSE

The purposes of the Medical Staff are:

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

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

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

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

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

2.1(f) To support appropriate educational opportunities that will promote continuous advancement in professional knowledge and skill;

2.1(g) To enact maintain and enforce bylaws and rules and regulations for the proper functioning and self-governance of the Medical Staff;

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

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

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

2.1(k) To accomplish its goals through appropriate committees, interdisciplinary teams (IDT's) and IDT's.

2.2 RESPONSIBILITIES

The responsibilities of the Medical Staff include:

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

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

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

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

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

(4) Develop an organizational structure that provides monitoring of patient care practices and appropriate supervision of APPS;

(5) Initiate and pursue corrective action with respect to practitioners and APPs, when warranted;

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

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

(8) Promote and support a process to identify and manage matters of individual physician health that is separate from the Medical Staff disciplinary function in accordance with the Practitioner Wellness Policy, which is incorporated herein and attached as Appendix "B" hereto.

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

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

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

2.3 PARTICIPATION IN ORGANIZED HEALTH CARE ARRANGEMENT

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

ARTICLE III
MEDICAL STAFF MEMBERSHIP

3.1 NATURE OF MEDICAL STAFF MEMBERSHIP

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

3.2 BASIC QUALIFICATIONS/CONDITIONS OF STAFF MEMBERSHIP

3.2(a) Basic Qualifications

The only people who shall qualify for membership on the Medical Staff are those practitioners legally licensed in Washington who:

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

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

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

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

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

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

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

(8) Show evidence, of meeting Washington State license CME requirements in accordance with WAC Code 246-919-430 of which the majority of CME should be related to the physician's specialty and to the provision of quality patient care in the Hospital;

(9) Board Certification:

(a) Board Certification; or

(b) Adequate progress toward Board certification. The determination of adequacy shall be made by the MEC and must be approved by the Board of Trustees; or

(c) Demonstration to the satisfaction of the MEC and the Board of Trustees of competency and training equal or equivalent to that required for Board certification.

(d) It is the intention of the medical staff that all members be continuously board qualified or board certified.

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

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

3.2(b) Effects of Other Affiliations

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

3.2(c) Non-Discrimination

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

3.2(d) Ethics

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

3.3 BASIC RESPONSIBILITIES OF STAFF MEMBERSHIP

Each member of the Medical Staff shall:

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

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

3.3(c) Abide by the Medical Staff Bylaws and other lawful standards, policies (including Practitioner Wellness and Behavior that Undermines a Culture of Safety polices, Appendices "B" and "C" hereto), Rules and Regulations of the Medical Staff;

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

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

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

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

3.3(h) If, at any time, the Hospital does not have arrangements for the provision of Emergency Services, any physician on the Active or Affiliate staff clinically treating patients shall take emergency call on a reasonable rotating basis with the other Active and Affiliate Staff members. The Medical Executive Committee shall determine reasonableness with Board approval which will not be unreasonably withheld;

3.3(i) Attest that he/she suffers from no health problems which could affect ability to perform the functions of Medical Staff membership and exercise the privileges requested prior to initial exercise of privileges;

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

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

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

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

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

(3) He/She has been excluded from any federal or state health program, including Medicare and

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

(5) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her; and any guilty pleas or convictions entered that may impact the delivery of patient care in the hospital;

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

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

(8) Failure to provide any such notice, as required above (exception as to professional negligence actions that have not resulted in judgment tor settlement), may result in immediate loss of medical staff membership and clinical privileges, without right to fair hearing procedures.

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

3.3(o) At a minimum the H&P must contain an age specific assessment of the Patients include:

(1) The chief complaint;

(2) A history of the present illness as appropriate outlining the location, quality, severity, duration, timing, context and modifying factors of the complains.

(3) Medications, including both prescribed and over-the-counter remedies;

(4) Allergies and intolerances, including a description of the effects caused by each agent;

(5) Past medical and surgical history;

(6) Family history and social history, including socioeconomic factors, sexual and substances use/abuse issues, advance directives and potential discharge or disposition challenges;

(7) Comprehensive physical examination, including vital signs, general appearance, mental status and abnormal and pertinent normal findings from each body system;

(8) Diagnostic data that is either available or pending at the time of admission;

(9) Clinical impression outlining the provisional diagnoses and/or differential diagnoses for the patient's symptoms; and

(10) The plan outlining the evaluation and treatment strategy, any limitations including patient and/or family requests and discharge planning initiation.

If the history and physical is completed by a licensed independent practitioner who is not a physician or oral and maxillofacial surgeon, the findings, conclusions and assessment of risk must be endorsed by a qualified physician prior to surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia, or other major high risk procedures.

If the H&P is documented by a dependent practitioner, it must be countersigned by the admitting physician. For applicable dentists and podiatrists, the H&P is a shared responsibility with an independent practitioner.

A medical history and physical examination be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy.

An updated examination of the patient, including any changes in the patient's condition, be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination are completed within 30 days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oromaxillofacial surgeon, or other qualified licensed individual in accordance with State law and hospital policy

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

For Inpatient Admission of > 48 hours the H&P must be detailed and comprehensive.

(1) A problem focused (limited) H&P is required for patients who are admitted to the hospital for observation (e.g. bedded outpatients, LOS <48 hours); and for patients who are undergoing a procedure that must be

performed or directed by a physician, or requiring moderate sedation or anesthesia.

(2) For all other procedures that require physician supervision, a medical record will be developed by the hospital staff under the supervision of the admitting physician or according to hospital policy.

Forms and Other Documentation

The H&P must be dictated, transcribed, authenticated and a copy placed in the medical records, or legibly written in the progress notes, signed and dated.

A written note shall be entered at the time of admission, documenting the diagnosis and reason for admission.

For all outpatient admissions and procedures, practitioners may utilize the approved pre-printed Limited History and Physical Exam form to document the examination and update.

The practitioner must write legibly, sign and date the Limited History & Physical form. Other pre-printed forms, such as those from physician office records, electronic or otherwise may also be used to document the H&P as long as they meet content requirements and intent set form in this policy.

3.4 DURATION OF APPOINTMENT

3.4(a) Duration of Initial Appointments

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

3.4(b) Reappointments

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

3.4(c) Modification in Staff Category & Clinical Privileges

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

3.5 LEAVE OF ABSENCE

3.5(a) Leave Status

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

3.5(b) Termination of Leave

(1) At least sixty (60) days prior to the termination of leave, or at any earlier time, the staff member may request reinstatement of his/her privileges by submitting a written notice to that effect to the Medical Staff Office for transmittal to the MEC. The staff member shall submit a written summary of his/her relevant activities during the leave. The MEC shall make a recommendation to the Board concerning the reinstatement of the member's privileges. Failure to request reinstatement in a timely manner shall result in automatic termination of staff membership, privileges and prerogatives without right of hearing or appellate review. Termination of Medical Staff membership, privileges and prerogatives pursuant to this section shall not be considered an adverse action, and shall not be reported to the Data Bank. A request for staff membership subsequently received from a staff member so terminated shall be submitted and processed in the manner specified for application for initial appointments.

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

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

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

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

ARTICLE IV
CATEGORIES OF THE MEDICAL STAFF

4.1 CATEGORIES

The staff shall include Active, Affiliate, Community Associate and Honorary and Administrative categories.

4.2 ACTIVE STAFF

4.2(a) Qualifications

The Active Staff shall consist of practitioners who:

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

(2) Are sufficiently close to the Hospital as defined in the Rules & Regulations by each IDT and subject to approval by the MEC and Board, or maintain formal coverage arrangements to assure that any patient under the care and supervision of such practitioner will receive continuous care consistent with their expected needs, especially in the case of emergencies.

(3) Regularly admit to, or are otherwise regularly involved in the care of at least six (6) patients in the Hospital in a calendar year. For purposes of determining whether a practitioner is "regularly involved" in the care of the requisite number of patients, a patient encounter or contact shall be deemed to include any of the following: admission; consultation with active participation in the patient's care; provision of direct patient care or intervention in the hospital setting; performance of any outpatient or inpatient surgical or diagnostic procedure; or interpretation of any inpatient or outpatient diagnostic procedure or test. When a patient has more than one procedure or diagnostic test performed or interpreted by the same practitioner during a single hospital stay, the multiple tests for that patient shall count as one patient contact. Patient contacts exclude any evaluations, visits or surgeries done while covering Emergency call by an Active staff member.

4.2(b) Prerogatives

The prerogatives of an Active Staff member shall be:

(1) To admit patients without limitation, unless otherwise provided in the Medical Staff Bylaws and Rules & Regulations;

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

(3) To vote on all matters presented to them at general and special meetings of the Medical Staff, either in person or by mail-in ballot, when voting by proxy is used.

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

(5) To vote in all Medical Staff elections.

4.2(c) Responsibilities

Each member of the Active Staff shall:

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

(2) Within his/her area of professional competence, retain responsibility for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, or arrange a suitable alternative for such care and supervision; including an initial assessment by the admitting physician or his/her designee of all patients within twenty-four (24) hours of admission, and an initial assessment of all patients in the intensive care/critical care unit no later than two (2) hours after admission or sooner if warranted by the patient's condition;

(3) Actively participate:

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

(ii) in supervision of other appointees where appropriate;

(iii) in the emergency department on-call rotation, as more specifically described in the Medical Staff Rules & Regulations, and as recommended by the MEC and , approved by the Board including personal appearance to assess patients in the emergency department when deemed appropriate by the emergency department physician;

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

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

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

4.2(d) Failure

Failure to carry out the responsibilities or meet the qualifications as enumerated shall be grounds for corrective action, including, but not limited to, termination of staff membership.

4.3 AFFILIATE STAFF

4.3(a) Qualifications

The Affiliate Staff shall consist of practitioners, who:

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

(2) Are sufficiently close to the Hospital as defined in the Rules & Regulations or maintain formal coverage arrangements to assure that any patient under the care and supervision of such practitioner will receive continuous care consistent with their expected needs, especially in the case of emergencies.

(3) Do not admit or regularly participate in the care of more than five (5) patients in a calendar year All Radiology, Pathology and Emergency Department physicians will be placed on Affiliate staff, with the following exceptions:

(i) Emergency – physicians working more than twelve (12) shifts in two years will be placed on Active staff;

(ii) Radiology – all Radiologists who either interpret or perform procedures within the facility more than twelve (12) times in two years will be placed on Active staff;

(iii) Pathology – all Pathologists who interpret studies in the facility more than twelve (12) times in two years will be placed on Active staff

(4) Admit patients for the purposes of covering call for a staff member who is required to take call but he/she does not do elective admissions or procedures when not covering call.

(5) Except for Residents, Affiliate staff members will be permitted to attend a maximum of 12 patients over two years in the Hospital. This includes admissions, consultations, surgeries, anesthetics, deliveries and care newborn infants, excluding emergency call contacts. Any Affiliate staff member who attends more than twelve patients over two years shall convert to Active staff and shall be required to meet the responsibilities of such membership.

(6) Those Affiliate staff members who have little or no clinical activity within the as identified through ongoing monitoring activities (OPPE) or focused performance monitoring activities (FPPE), will be required to verify their status and privileges in good standing at their hospital of primary practice or ambulatory surgery center (ASC) on an ongoing basis. If no clinical activity can be verified at any hospital or ASC, practitioner will be automatically moved to the Community Associate Staff. They will be subject to the requirements for reappointment as outlined in these Bylaws

4.3(b) Prerogatives

The prerogatives of an Affiliate Staff member shall be to:

(1) Admit patients to the Hospital within the limitations provided in Section 4.3(a);

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

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

(4) Affiliate Professional Staff shall consist of practitioners qualified for staff membership who have been granted initial Professional Staff membership but who only occasionally attend patients at the Hospital. Affiliate Professional Staff members shall not be eligible to vote or hold office. If, however, an Affiliate staff member has been asked by the Chief of Staff of the Medical Staff to participate in any Medical Staff Committee or IDT, they will be eligible to vote on that respective Committee and/or IDT only. It is the intent of these Bylaws that only Active staff members will be eligible to vote on issues or Bylaws changes that result in a mailing to the Active staff for a vote.

4.3(c) Responsibilities

Each member of the Affiliate Staff shall:

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

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

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

4.4 COMMUNITY ASSOCIATE STAFF

4.4(a) Qualifications

Community Associate Staff shall consist of physicians who meet the basic qualifications of Article III, 3.2. (a).

4.4(b) Prerogatives

The Community Associate staff shall consist of members who have no admission or clinical privileges at this Hospital but who refer patients to Medical Staff members with admitting privileges. Community Associate Staff members may visit their patients that they have referred and review the patient's medical record. They may consult on those patients with the Admitting physician at his/her request and with appropriate privileges, but may not write orders or direct inpatient care. They may also observe procedures with the consent of the patient and the practitioner performing the procedure. They may refer patients to Outpatient Services and are subject to all requirements for initial appointment and reappointment.

4.4(c) Responsibilities

(1) Community Associate staff members are encouraged to attend CME offerings and general Professional Staff meetings within the Hospital.

(2) Those Community Associate Staff members who utilize the Hospitalist service within the Hospital, only upon request by the IDT, IDT or Committee Chair or Chief of Staff of the Medical Staff, may sit as a member of a Medical Staff Committee or IDT and will be eligible to vote only on that respective Committee and/or IDT. It is the intent of these Bylaws that only Active staff members will be eligible to vote on those issues or Bylaws changes that result in a mailing to the Active staff for a vote or when a general staff meeting is held for the Active staff to vote on matters affecting the medical staff.

4.5 HONORARY AND ADMINISTRATIVE STAFF

The following staff positions shall be bestowed by the Board upon recommendation of the Professional Staff Executive Committee.

4.5(a) Qualifications

(1) Honorary Professional Staff - Shall consist of practitioners who are not practicing in the Hospital but who are honored by emeritus positions. Honorary staff members may be physicians, dentists, oral surgeons or podiatrists who have retired from Hospital practice.

(2) Administrative Staff - Shall consist of practitioners who hold medical administrative positions in VALLEY HOSPITAL. Individuals in administrative positions are subject to the same appointment/reappointment procedures as other applicant/staff members, except for the verification of current malpractice insurance as they are not providing direct patient care.

4.5(b) Prerogatives

(1) Honorary and Administrative staff members shall not be eligible to admit patients, examine or treat patients in any Hospital inpatient or outpatient facility. They may not vote, hold office or serve on standing Professional Staff IDT's or committees, but may attend IDT and Hospital Professional Staff meetings and educational programs:

4.6. RESIGNATIONS FROM STAFF

(1) Written notice of resignation is requested.

(2) Practitioners are responsible for completion of all medical records prior to the date of resignation.

(3) In order to provide adequate ED coverage, physicians are expected to provide a minimum of sixty (60) days' notice of either a change in staff status or resignation that would affect call responsibilities.

ARTICLE V
ADVANCED PRACTICE PROVIDERS PROFESSIONALS (APP)

5.1 CATEGORIES

Advanced Practice Providers Professionals ("APPs") shall be identified as any person(s) other than practitioners who are granted privileges to practice in the Hospital and are directly involved in patient care. They shall be credentialed in their respective profession to perform specific functions within the Hospital. They shall not be eligible to vote or hold office, but may serve on committees. They are required to pay dues.

This article shall pertain only to Advanced Practice Advanced Practice Providers Professionals ("APPs") that is, those who are credentialed pursuant to the Medical Staff process as outlined in the definition of "Advanced Practice Providers Professional" herein. Clinical Assistants who are not Advanced Practice Advanced Practice Providers Professionals and who are not credentialed pursuant to the Medical Staff process shall be governed by the applicable human resource policies of the Hospital.8

(a) INDEPENDENT – Psychologists who are authorized by state law and recognized by the Governing Body at the recommendation of the Executive Committee to provide care to patients.

Nurse Midwives who are authorized by the state law and recognized by the Governing Body at the recommendation of the Executive Committee to provide independent care to low-risk patients with a written coverage plan in place. Independent AHS will be afforded full fair hearing rights.

(b) DEPENDENT – Those practitioners who are required by state law and/or the Hospital to provide medical care to patients under the supervision of a physician, dentist or oral surgeon. These practitioners may be employed by the Hospital or employed by a practitioner physician, dentist or oral surgeon on the medical staff. This category would include all other members of the Advanced Practice Providers staff with the exception of the categories listed under the Independent category.

5.2 QUALIFICATIONS

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

5.2(a) APPs must:

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

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

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

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

(5) If the dependent Advanced Practice Providers practitioner no longer has an employing physician, dentist or oral surgeon on the medical staff in good standing, or, if applicable, is no longer an employee of the Hospital, they will automatically be removed from the Advanced Practice Providers staff and therefore are not subject to the corrective action and hearing and appellate review procedures as outlined in these Bylaws documents.

5.3 PREROGATIVES

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

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

5.3(b) To participate directly, including writing orders to the extent permitted by law, in the management of patients under the supervision of their sponsoring physician, dentist or oral surgeon who is a member of the Medical Staff;

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

5.4 CONDITIONS OF APPOINTMENT

5.4(a) APPs shall be credentialed in the same manner as outlined in Article VI of the Medical Staff Bylaws for credentialing of practitioners. Each APP shall be assigned to one (1) of the clinical IDT's based on the specialty of their employing physician, dentist or oral surgeon and shall be granted clinical privileges relevant to the care provided in that IDT. The Board in consultation with the MEC shall determine the scope of the activities which each APP may undertake. Such determinations shall be furnished in writing to the APP and shall be final and non-appealable, except as specifically and expressly provided in these bylaws.

5.4(b) Appointment of APPs must be approved by the Board. Adverse actions or recommendations affecting APP privileges shall not be covered by the provisions of the Fair Hearing Plan. However, the affected APP shall have the right to request to be heard before the Credentials Committee with an opportunity to rebut the basis for termination. Upon receipt of a written request, the Credentials Committee shall afford the APP an opportunity to be heard by the Committee concerning the APP's grievance. Before the appearance, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto. A record of the

appearance shall be made. The Credentials Committee shall, after conclusion of the investigation, submit a written decision simultaneously to the MEC and to the APP.

5.4(c) The APP shall have a right to appeal to the Board any decision rendered by the Credentials Committee. Any request for appeal shall be required to be made within fifteen (15) days after the date of the receipt of the Credentials Committee decision. The written request shall be delivered to the Chief of Staff and shall include a brief statement of the reasons for the appeal. If appellate review is not requested within such period, the APP shall be deemed to have accepted the action involved which shall thereupon become final and effective immediately upon affirmation by the MEC and the Board. If appellate review is requested the Board shall, within fifteen (15) days after the receipt of such an appeal notice, schedule and arrange for appellate review. The Board shall give the APP notice of the time, place and date of the appellate review which shall not be less than fifteen (15) days nor more than ninety (90) days from the date of the request for the appellate review. The appeal shall be in writing only, and the APP's written statement must be submitted at least five (5) days before the review. New evidence and oral testimony will not be permitted. The Board shall thereafter decide the matter by a majority vote of those Board members present during the appellate proceedings. A record of the appellate proceedings shall be maintained.

5.4(d) APP privileges shall automatically terminate upon revocation of the privileges of the APP's employing physician, dentist, or oral surgeon member of the staff, unless another qualified physician, dentist or oral surgeon within the same member's practice group indicates his/her willingness to supervise the APP and complies with all requirements hereunder for undertaking such supervision. In the event that an APP's employing physician, dentist, or oral surgeon member's privileges are significantly reduced or restricted, the APP's privileges shall be reviewed and modified by the Board upon recommendation of the MEC. Such actions shall not be covered by the provisions of the Fair Hearing Plan.

If the dependent Advanced Practice Providers practitioner no longer has an employing physician, dentist or oral surgeon or, if applicable, is no longer an employee of the Hospital, they will automatically be removed from the Advanced Practice Providers Staff and therefore are not subject to the corrective action and hearing and appellate review procedures outlined in Article III and Appendix "A" of these Bylaws.

5.5 RESPONSIBILITIES

Each APP shall:

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

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

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

5.5(d) Act professionally toward members of the Medical Staff, administration, the Board of Trustees and employees of the Hospital;

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

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

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

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

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

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

(3) He/She has been excluded from any federal or state health program, including Medicare and

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

(5) Any criminal charges, other than minor traffic violations, are brought/initiated against him/her; and any guilty pleas or convictions entered that may impact the delivery of patient care in the hospital;

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

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

(8) Failure to provide any such notice, as required above (exception as to professional negligence actions that have not resulted in judgment tor settlement), may result in immediate loss of medical staff membership and clinical privileges, without right to fair hearing procedures.

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

ARTICLE VI
PROCEDURES FOR APPOINTMENT & REAPPOINTMENT

6.1 GENERAL PROCEDURES

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

6.2 CONTENT OF APPLICATION FOR INITIAL APPOINTMENT

Each application for appointment to the Medical Staff shall be in writing, submitted on the prescribed form approved by the Board, and signed by the applicant. A copy of all active state licenses, current DEA registration/controlled substance certificate (for all practitioners except pathologists and non-prescribing diagnostic radiologists who voluntarily do not hold a DEA certificate), a signed Medicare physician acknowledgment and identification statement and a certificate of insurance must be submitted with the application. Applicants shall supply the Hospital with all information requested on the application.

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

(a) Acknowledgment & Agreement: A statement that the applicant has received and read the Bylaws, Rules & Regulations and Fair Hearing Plan of the Medical Staff and that he/she agrees:

(i) to be bound by the terms thereof if he/she is granted membership and/or clinical privileges; and

(ii) to be bound by the terms thereof in all matters relating to consideration of his/her application, without regard to whether or not he/she is granted membership and/or clinical privileges.

(b) Administrative Remedies: A statement indicating that the practitioner agrees that he/she will exhaust the administrative remedies afforded by these bylaws before resorting to formal legal action, should an adverse ruling be made with respect to his/her staff membership, staff status, and/or clinical privileges;

(c) Criminal Charges: Any current criminal charges pending against the applicant and any past convictions or pleas. The practitioner shall notify the President or his/her designee and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(d) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any past allegations including their resolution and any investigations by any private, federal

or state agency concerning participation in any health insurance program, including Medicare or Medicaid;

(e) Health Status: Evidence of current physical and mental health status only to the extent necessary to demonstrate that the applicant is capable of performing the functions of staff membership and exercising the privileges requested. In instances where there is doubt about an applicants' ability to perform privileges requested, an evaluation by an external or internal source may be requested by the MEC or the Board;

(f) Program Participation: Information concerning the applicant's current and/or previous participation in any rehabilitation or impairment program, or termination of participation in such a program without successful completion. In addition, the practitioner shall have a continuing duty to notify the MEC through the Medical Staff Office and the President or his/her designee of the initiation of participation in any rehabilitation or impairment program. The President or his/her designee shall be responsible for notifying the MEC of all such actions;

(g) Information on Malpractice Experience: All information concerning malpractice cases against the applicant either filed, pending, settled, or pursued to final judgment. It shall be the continuing duty of the practitioner to notify the MEC of the initiation of any professional liability action against him/her. The practitioner shall have a continuing duty to notify the MEC through the Medical Staff Office and the President or his/her designee within thirty (30) days of receiving notice of the initiation of a professional liability action against him/her. The President or his/her designee shall be responsible for notifying the MEC of all such actions;

(h) Education: Detailed information concerning the applicant's education and training.

(i) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws. Each practitioner must, at all times, keep the Medical Staff Office and President informed of changes in his/her professional liability coverage;

(j) Notification of Release and Immunity Provisions: Statements notifying the applicant of the scope and extent of authorization, confidentiality, immunity and release provisions of Section 6.3(b) and (c);

(k) Professional Sanctions: Information as to previously successful or currently pending challenges to, or the voluntary relinquishment of, any of the following:

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

(ii) specialty board certifications;

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

(iv) Drug Enforcement Agency (DEA) number/controlled substance license (except pathologists);

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges;

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

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

If any such actions were taken, the particulars thereof shall be obtained before the application is considered complete. The practitioner shall have a continuing duty to notify the MEC through the Medical Staff Office and the President or his/her designee within seven (7) days of receiving notice of the initiation of any of the above actions against him/her.

The President or his/her designee shall be responsible for notifying the MEC of all such actions.

(l) Qualifications: Detailed information concerning the applicant's experience and qualifications for the requested staff category, including information in satisfaction of the basic qualifications specified in Section 3.2(a), and the applicant's current professional license and federal drug registration numbers;

(m) References: The names of at least three (3) practitioners, excluding employees or relatives, who have worked with the applicant within the past two (2) years and personally observed his/her professional performance and who are able to provide knowledgeable peer recommendations as to the applicant's education, relevant training, experience, clinical ability and current competence, ethical character and ability to exercise the privileges requested and to work with others;

(n) Request: Specific clinical privileges for which the applicant wishes to be considered;

(o) Practice Affiliations: The name and address of all other hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated;

(p) Photograph: A recent, wallet sized photograph of the applicant;

(q) Citizenship Status: Proof of United States citizenship or legal residency; and

(r) Professional Practice Review Data: For all new applicants and practitioners requesting new or additional privileges, evidence of the practitioner’s professional practice review, volumes and outcomes from organization(s) that currently privilege the applicant.

6.3 PROCESSING THE APPLICATION

6.3(a) Request for Application

A practitioner wishing to be considered for Medical Staff appointment or reappointment and clinical privileges may obtain an application form therefore by submitting his/her request for an application form to the Medical Staff Office.

6.3(b) Applicant's Burden

By submitting the application, the applicant:

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

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

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

(4) Represents and warrants that all information provided by him/her is true, correct and complete in all material respects, and agrees to notify the Hospital of any change in any of the information furnished in the application; and acknowledges that provision of false or misleading information, or omission of information, shall be grounds for immediate rejection of his/her application without fair hearing rights;

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

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

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

6.3(c) Statement of Release & Immunity from Liability

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

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

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

Information given in or attached to this application is accurate and complete to the best of my knowledge. I fully understand and agree that as a condition to making this application, any misrepresentations or misstatement in, or omission from it, whether intentional or not, shall constitute cause for automatic and immediate rejection of this application, resulting in denial of appointment and clinical privileges. I further acknowledge that if I am reasonably determined to have made a misstatement, misrepresentation, or omission in connection with an application that is discovered after appointment and/or the granting of clinical privileges, I shall be deemed to have immediately relinquished my appointment and clinical privileges.

If granted appointment, I accept the following conditions:

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

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

(ii) periodic reappraisals;

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

(iv) summary suspension;

(v) hearings and appellate reviews;

(vi) medical care evaluations;

(vii) utilization reviews;

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

(ix) inquiries concerning my professional qualifications, credentials, clinical competence, character, mental or emotional stability, physical condition, criminal history, ethics or behavior; and

(x) any other matter that might directly or indirectly impact or reflect on my competence, on patient care or on the orderly operation of this or Hospital.

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

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

I acknowledge that:

(1) Medical Staff appointments at this Hospital are not a right;

(2) my request will be evaluated in accordance with prescribed procedures defined in these Bylaws and Rules & Regulations;

(3) all Medical Staff recommendations relative to my application are subject to the ultimate action of the Board whose decision shall be final;

(4) I have the responsibility to keep this application current by informing the Hospital through the President and the Medical Staff Office, of any change in the areas of inquiry contained herein; and

(5) appointment and continued clinical privileges remain contingent upon my continued demonstration of professional competence, my general support of the acceptable performance of all responsibilities related thereto, as well as other

factors that are relevant to the effective and efficient operation of the Hospital. Appointment and continued clinical privileges shall be granted only on formal application, according to the Hospital and these Bylaws and Rules & Regulations, and upon final approval of the Board.

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

If appointed or granted clinical privileges, I specifically agree to:

(1) refrain from fee-splitting or other inducements relating to patient referral;

(2) refrain from delegating responsibility for diagnosis or care of hospitalized patient to any other practitioner who is not qualified to undertake this responsibility or who is not adequately supervised;

(3) refrain from deceiving patients as to the identity of any practitioner providing treatment or services;

(4) seek consultation whenever necessary;

(5) abide by generally recognized ethical principles applicable to my profession;

(6) provide continuous care and supervision as needed to all patients in the Hospital for whom I have responsibility; and

(7) accept committee assignment and such other duties and responsibilities as shall be assigned to me by the Board and Medical Staff.

6.3(d) Submission of Application & Verification of Information

Upon completion of the application form and attachment of all required information, the Applicant shall submit the form to the Medical Staff Office. The application shall be returned to the practitioner and shall not be processed further if one (1) or more of the following applies:

(1) Not Licensed. The practitioner is not able to be licensed in this state to practice in a field of health care eligible for appointment to the Medical Staff; or

(2) Privileges Denied or Terminated. Within one (1) year immediately preceding the request, the practitioner has had his/her application for Medical Staff appointment at this Hospital denied, has resigned his/her Medical Staff appointment at this Hospital during the pendency of an active investigation which could have led to revocation of his/her appointment, or has had his/her appointment revoked or terminated at this Hospital; or

(3) Exclusive Contract. The practitioner practices a specialty which is the subject of a current written exclusive contract for coverage with the Hospital; or

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

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

(6) No DEA number. The practitioner's DEA number/controlled substance license has been revoked or voluntarily relinquished (this section shall not apply to pathologists or diagnostic radiologists who do not voluntarily hold a current DEA); or

(7) Continuous Care Requirement. For applicants to Active, or Affiliate Staff, failure to maintain an office or residence sufficiently close to the Hospital or maintain formal coverage arrangements to assure that any patient under the care and supervision of such practitioner will receive continuous care consistent with their expected needs, especially in the case of emergencies; or

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

(9) Inadequate facilities, equipment or support . Request for application may be denied without right of appeal if the applicant's qualifications do not match the ability of the Hospital, as determined by the Board, to provide adequate facilities, equipment, number and type of qualified support personnel, and any necessary support for the applicant and his/her patients and/or the needs of the Hospital, for Medical or Staff members with the applicant's patient care skills and training; and,

(10) Board Certification. Certified/Admissible by the professional board approved by the Accreditation Council for Graduate Medical Education or recognized by the American Board of Medical Specialties, American Osteopathic Association, Royal College of Physicians and Surgeons of Canada, the Canadian College of Family Physicians, the American Dental Association, or American Board of Podiatric Surgery for the specialty for which the applicant is requesting clinical privileges; if Board Certification / recertification is not attained within the period of time required by the applicant's certifying board, the member will no longer meet the qualifications for Medical Staff membership and this will be considered a voluntary resignation from the Medical Staff. Physicians who are members in good standing of the Medical Staff who are not currently Board Certified or

Board Admissible as of 07/26/2006 will be exempted from the requirements of this paragraph.

The refusal to further process an application form for any of the above reasons or for failure to meet any objective, threshold requirement for appointment, reappointment and/or privileges shall not entitle the practitioner to any further procedural rights under these bylaws.

In the event that none of the above apply to the application, the Medical Staff Office and President or his/her designee shall promptly seek to collect or verify the references, licensure and other evidence submitted. The Medical Staff Office and President or his/her designee shall promptly notify the applicant, of any problems in obtaining the information required and it shall then be the applicant's obligation to ensure that the required information is provided within thirty (30) days of receipt of such notification. Verification shall be obtained from primary sources whenever feasible. Licensure shall be verified with the primary source at the time of appointment and initial granting of privileges, at reappointment or renewal or revision of clinical privileges, and at the time of expiration by a letter or computer printout obtained from the appropriate licensing board. Verification of current licensure through the primary source internet site or by telephone is also acceptable so long as verification is documented. When collection and verification are accomplished, the application and all supporting materials shall be transmitted to the Credentials Committee. An application shall not be deemed complete nor shall final action on the application be taken until verification of all information, including query of the Data Bank, is complete.

6.3(e) Description of Initial Clinical Privileges

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

6.3(f) Credentials Committee Action

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

also be in writing, supported by explanation, references and documents, and transmitted with the majority report.

6.3(g) Medical Executive Committee Action

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

6.3(h) Effect of Medical Executive Committee Action

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

In no event shall the MEC defer action on a completed and verified application for more than ninety (90) days beyond receipt of same.

(2) Favorable Recommendation: When the recommendation of the MEC is favorable to the applicant, the Chief of Staff of the Medical Staff shall promptly forward it, together with all supporting documentation, to the Board. For purposes of this section, "all supporting documentation" generally shall include the Credentials report and recommendation of the MEC as well as the completed application . The Board shall act upon the recommendation at its next scheduled meeting, or may defer action if additional information or clarification of existing information is needed, or if verification is not yet complete.

(3) Adverse Recommendation: When the recommendation of the MEC is adverse to the applicant, the Chief of Staff of the Medical Staff shall immediately inform the practitioner by special notice which shall specify the reason or reasons for denial and the practitioner then shall be entitled to the procedural rights as provided in the Fair Hearing Plan. The applicant shall have an opportunity to exercise his/her procedural rights prior to submission of the adverse recommendation to the Board. For the purpose of this section, an "adverse recommendation" by the MEC is defined as denial of appointment, or denial or restriction of requested

clinical privileges. Upon completion of the Fair Hearing process, the Board shall act in the matter as provided in the Fair Hearing Plan.

6.3(i) Board Action

(1) Decision; Deadline. The Board of Trustees may accept, reject or modify the MEC recommendation. The Board shall make specific findings as to the applicant's satisfaction of the requirements of experience, ability, and current competence as set forth in Section 6.3(o). The Secretary of the Board shall reduce the full Board's decision to writing and shall set forth therein the reasons for the decision. The written decision shall not disclose any information which is or may be protected from disclosure to the applicant under applicable laws. The Board of Trustees shall make every reasonable effort to render its decision within ninety (90) days following receipt of the MEC's recommendation.

(2) Favorable Action. In the event that the Board of Trustees' decision is favorable to the applicant, such decision shall constitute final action on the application. The President or his/her designee shall promptly inform the applicant that his/her application has been granted. The decision to grant Medical Staff appointment or reappointment, together with all requested clinical privileges, shall constitute a favorable action even if the exercise of clinical privileges is made contingent upon monitoring, proctoring, periodic drug testing, additional education concurrent with the exercise of clinical privileges, or any similar form of performance improvement that does not materially restrict the applicant's ability to exercise the requested clinical privileges.

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

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

6.3(j) Interview

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

6.3(k) Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be considered for appointment to the Medical Staff for a period of one (1) year after notice of such decision is sent, or until the defect constituting the grounds for the adverse decision is corrected, whichever is later. An applicant who has received a final adverse decision as a result of fraudulent conduct, misrepresentations in the application process, or other basis involving dishonesty shall not be permitted to reapply for a period of five

(5) years after notice of the final adverse decision is sent. Any reapplication shall be processed as an initial application and the applicant shall submit such additional information as the staff or the Board may require. For purposes of this section, "final adverse decision" shall include denial after exercise or waiver of fair hearing rights and/or rejection or refusal to further process an application (or relinquishment of privileges) due to the applicant's provision of false or misleading information on, or the omission of information from, the application materials.

6.3(l) Time Periods for Processing

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

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

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

(1) The hospital lacks the facilities or supportive services to adequately provide the service or procedure requested.

(2) The applicant fails to meet the criteria previously specified for granting staff membership or the privilege requested.

(3) The hospital has an exclusive contractual arrangement with other members of the medical staff to provide the services or procedures requested.

6.3(n) Appointment Considerations

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

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

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

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

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

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

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

6.4 REAPPOINTMENT PROCESS

6.4(a) Information Form for Reappointment

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

6.4(b) Content of Reapplication Form

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

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

(2) License: Current licensure;

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

(4) Program Participation: Information concerning the applicant's current and /or previous participation in any rehabilitation or impairment program, or termination of participation in such program without successful completion. In addition, the practitioner shall have a continuing duty to notify the MEC through the President or his/her designee of the initiation of participation in any rehabilitation or impairment program. The President or his/her designee shall be responsible for notifying the MEC of all such actions;

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

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

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

(ii) specialty board certification; or

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

(iv) Drug Enforcement Agency (DEA) number/controlled substance license; or

(v) Medical Staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges; or

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

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

(7) Information on Malpractice Experience: Details about filed, pending, settled, or litigated malpractice claims and suits during the preceding appointment period;

(8) Criminal Charges: Any current criminal charges pending against the applicant and any convictions or pleas during the preceding appointment period. The practitioner shall notify the President and the Chief of Staff within seven (7) days of receiving notice of the initiation of any criminal charges, and shall acknowledge the Hospital's right to perform a background check at appointment, reappointment and any interim time when reasonable suspicion has been shown;

(9) Fraud: Any allegations of civil or criminal fraud pending against any applicant and any allegations resolved during the preceding appointment period, as well as any investigations during the preceding appointment period by any private, federal or state agency concerning participation in any health insurance program, including Medicare or Medicaid during the preceding appointment period;

(10) Insurance: Information as to whether the applicant has currently in force professional liability coverage meeting the requirements of these bylaws. Each practitioner must, at all times, keep the Medical Staff Office and the President informed of changes in his/her professional liability coverage;

(11) Current Competency: Objective evidence of the individual's clinical performance, competence, and judgment, based on the findings of medical staff IDT/Committee evaluations of care, Chairperson and by one (1) other Medical Staff member who is not an employee or relative of the practitioner but would be considered a peer, and results from the performance improvement process of the Medical Staff. Such evidence shall include as the results of the applicant's ongoing practice review, including data comparison to peers, core measures, outcomes, and focused review outcomes during the prior period of appointment. Practitioners who have not actively practiced in this Hospital during the prior appointment period will have the burden of providing evidence of the practitioner's professional practice review, volumes and outcomes from organizations that currently privilege the applicant and where the applicant has actively practiced during the prior period of appointment.

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

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

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

6.4(c) Verification of Information

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

6.4(d) Action on Application

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

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

6.4(e) Basis for Recommendations

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

6.5 REQUESTS FOR MODIFICATION OF APPOINTMENT

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

6.6 PRACTITIONERS PROVIDING CONTRACTUAL PROFESSIONAL SERVICES

6.6(a) Qualifications & Processing

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

6.6(b) Requirements for Service

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

6.6(c) Termination

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

The concurrent termination provision can be waived for individual practitioners by agreement between the new contracting entity and the hospital, as approved by the Board.

ARTICLE VII
DETERMINATION OF CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

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

7.2 DELINEATION OF PRIVILEGES IN GENERAL

7.2(a) Requests

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

7.2(b) Basis for Privileges Determination

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

7.2(c) Procedure

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

7.2(d) Limitations on Privileges

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

7.2(e) Initial and Additional Grants of Privileges

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

7.3 SPECIAL CONDITIONS FOR DENTAL PRIVILEGES

Requests for clinical privileges from dentists and oral surgeons shall be processed, evaluated and granted in the manner specified in Article VI. Surgical procedures performed by dentists and oral surgeons shall be under the overall supervision of the Chief of Surgery, however, other dentists and/or oral surgeons shall participate in the review of the practitioner through the performance improvement process. All dental patients shall receive the same basic medical appraisal as patients admitted for other surgical services. If a practitioner does not hold history and physical privileges, a physician member of the Medical Staff shall be responsible for admission evaluation, history and physical, and for the care of any medical problem that may be present at the time of admission or that may be discovered during hospitalization, and shall determine the risk and effect of the proposed surgical procedure on the total health status of the patient.

7.4 CLINICAL PRIVILEGES HELD BY NON-MEDICAL STAFF MEMBERS

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

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

In these cases only, the President or his/her designee, upon recommendation from the Chief of Staff may grant such privileges upon establishment of current competence for the privileges requested, completion of the appropriate application, consent, and release, proof of current licensure, DEA certificate, appropriate malpractice insurance, and completion of the required Data Bank query, and upon verification that there are no

current or prior successful challenges to licensure or registration, that the practitioner has not been subject to involuntary termination of Medical Staff membership at another facility, and likewise has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another facility. Such privileges may be granted for no more than one hundred and twenty (120) days of service.

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

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

Temporary privileges may be granted by the President upon recommendation of the Chief of Staff when there is an important patient care, treatment or service need that mandates an immediate authorization to practice, for a limited period of time, when no application for medical staff membership or clinical privileges is pending. An example would be situations in which a physician is involved in an accident or becomes suddenly ill, and a practitioner is needed to cover his/her practice immediately. Upon receipt of a written request, an appropriately licensed person who is serving as a substitute for a member of the Medical Staff during a period of absence for any reason, or a practitioner temporarily providing services to cover an important patient care, treatment or service need (which may include care of one (1) specific patient), may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for one (1) successive consecutive period not to exceed thirty (30) days (for no more than (60) consecutive days), but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in no event to exceed one hundred and twenty (120) days of service within a calendar year. All practitioners providing coverage for other practitioners much ensure that all legal requirements, including billing and reimbursement regulations, are met. The Data Bank query must be completed prior to any award of temporary privileges pursuant to this section. Further, prior to award of temporary privileges, due to important patient care needs, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by the bylaws, copies of the practitioner's and practitioner's primary hospital. The letter approving temporary privileges shall identify the specific privileges granted.

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

7.4(c) Proctoring Privileges

Upon receipt of a written request, an appropriately licensed person who is serving as a proctor for a member of the Medical Staff may, without applying for membership on the staff, be granted temporary privileges for an initial period not to exceed thirty (30) days. Such privileges may be renewed for successive periods not to exceed thirty (30 days, but only upon the practitioner establishing his/her qualifications to the satisfaction of the MEC and the Board and in event to exceed the period of proctorship, or a maximum of

one hundred twenty (120) days. The Data Bank query must be completed prior to any award of proctoring privileges pursuant to this section. Further, prior to award of proctoring privileges, the applicant must submit a written request for specific privileges and evidence of current competence to perform them, a photograph, proof of appropriate malpractice insurance, the consent and release required by the these bylaws, copies of the practitioner's license to practice medicine, DEA certificate and confirmation of privileges at the practitioner's primary hospital. The letter approving proctoring privileges shall identify the specific privileges granted. In these cases only, the President or his/her designee, upon recommendation of the Chief of Staff, Chairperson of the Credentials Committee and Chairperson of the applicable department, may grant such privileges upon receipt of the required information.

7.4(d) Resident Privileges

Resident privileges may be granted to qualifying practitioners not licensed in the State of Washington under limited circumstances:

(1) Whether a practitioner is a participant in a qualified and approved post graduate medical training program sponsored by a college or university in this state or by a Hospital accredited in this state and when the provision of care is pursuant to his/her duties as a trainee;

(2) Whether the practitioner is a commissioned medical officer serving in the Armed Forces of the United States or the Public Health Service or is a medical officer on duty with the Veterans' Administration and is engaged in the performance of duties prescribed for him/her by the laws and regulations of the United States;

(3) Where the practitioner is a participant in a qualified and approved post graduate medical training program in another state, provided that an exemption has been granted by the State Board of Medical Examiners.

Practitioners with resident privileges are required to work under the daily supervision of a sponsoring practitioner who assumes responsibility for the care of patients treated by the resident. The practitioner with resident privileges will be assigned to the IDT of the sponsoring physician with whom he/she is working while at Valley Hospital.

Practitioners with resident privileges may admit and discharge patients, write orders, and perform procedures under the direct supervision of a Professional Staff member possessing clinical privileges for that procedure. Practitioners with resident privileges may attend Professional Staff committees, but are not eligible to vote or to hold office in the Professional Staff organization.

When a Practitioner with resident privileges leaves a residency program, resident privileges will automatically terminate without prejudice and without entitlement to due process procedures. This action is not reportable to the National Practitioner's Data Bank.

7.4(d) Conditions

Temporary and Proctoring privileges shall be granted only when the information available reasonably supports a favorable determination regarding the requesting applicant' qualifications, ability and judgment to exercise the privileges granted. Special

requirements of consultation and reporting may be imposed by the Chief of Staff, including a requirement that the patients of such practitioner be admitted upon dual admission with a member of the Active Staff. Before temporary privileges are granted, the applicant must acknowledge in writing that he/she has received and read the Medical Staff Bylaws, Rules & Regulations, and that he/she agrees to be bound by the terms thereof in all matters relating to his/her privileges.

7.4(e) Termination

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

7.4(f) Rights of the Practitioner

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

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

7.5 EMERGENCY & DISASTER PRIVILEGES

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

Disaster privileges may be granted by the President or Chief of Staff when, and for so long as, the Hospital’s emergency management plan has been activated and the hospital is unable to handle the immediate patient needs. Prior to granting any disaster privileges the volunteer practitioner, or licensed independent practitioner, shall be required to present a valid photo ID issued by a state, federal or regulatory agency, and at least one of the following: a current hospital picture ID which clearly identifies professional designation; a current license, certification or registration; primary source verification of licensure, certification or registration (if required by law to practice a profession); ID indicating the individual is a member of a Disaster Medical Assistance Team

(DMAT), or the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP); ID indicating the individual has been granted authority to render patient care, treatment, and services in a disaster; or ID of a current medical staff member who possesses personal knowledge regarding the volunteer practitioner's qualifications. The President and/or Chief of Staff are not required to grant such privileges to any individual and shall make such decisions only on a case-by-case basis.

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

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

7.6 TELEMEDICINE

7.6(a) Scope of Privileges

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

7.6(b) Telemedicine Physicians

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

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

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

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

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

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

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

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

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

If the telemedicine physician's is also accredited by Joint Commission, and the telemedicine physician is privileged to perform the services and procedures for which privileges are being sought in the Hospital, then the telemedicine physician's credentialing information from that site may be relied upon to credential the telemedicine physician in the Hospital. However, this Hospital will remain responsible for primary

source verification of licensure, Medicare/Medicaid eligibility and for the query of the Data Bank. This Hospital shall also remain responsible for primary source verification for professional liability insurance unless the distant site entity has provide the Hospital with a current certificate of insurance meeting the requirements set forth in these Bylaws and a malpractice claims history consistent with the standard claims history required for memberships of the Medical Staff. This Hospital shall further conduct the verification procedures for all hospitals, health care organizations or practice settings with whom the applicant is or has previously been affiliated.

ARTICLE VIII
CORRECTIVE ACTION

8.1 ROUTINE CORRECTIVE ACTION

8.1(a) Criteria for Initiation

Whenever activities, omissions, or any professional conduct of a practitioner with clinical privileges are detrimental to patient safety, to the delivery of quality patient care, are disruptive to hospital operations as more specifically defined in the disruptive practitioner policy, or violate the provisions of these Bylaws, the Medical Staff Rules and Regulations, or duly adopted policies and procedures; corrective action against such practitioner may be initiated by any officer of the Medical Staff, by the Chairperson of the Department of which the practitioner is a member, by the President, or the Board. Procedural guidelines from the Health Care Quality Improvement Act shall be followed and all corrective action shall be taken in good faith in the interest of quality patient care.

8.1(b) Request & Notices

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

8.1 (c) Investigations by the Medical Executive Committee

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

8.1(d) Medical Executive Committee Action

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

(1) Rejecting the request for corrective action;

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

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

(4) Recommending terms of probation or required consultation;

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

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

(7) Recommending suspension or revocation of staff membership.

8.1(e) Procedural Rights

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

8.1(f) Other Action

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

8.1(g) Board Action

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

8.2 SUMMARY SUSPENSION

8.2(a) Criteria & Initiation

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

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

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

8.2(b) Medical Executive Committee Action

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

8.2(c) Procedural Rights

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

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

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

8.3 ADMINISTRATIVE CORRECTIVE ACTION RE: DISRUPTIVE BEHAVIOR

8.3(a) Criteria for Initiation

Whenever a practitioner violates Hospital policies, rules or regulations, exhibits behavior that undermines a culture of safety or acts in a manner disruptive to hospital operations as more specifically defined in the disruptive practitioner policy, or in such a manner as to endanger the assets of the hospital , administrative corrective action may be initiated by the Hospital President, by the Chairman of the Board of Trustees, or by the Board after appropriate consultation with the Chief of Staff of the Medical Staff that this should be initiated under Section 8.1. If the MEC and Chief of Staff of the Medical Staff decline to proceed under Section 8.1, the President and/or Board of Trustees will proceed under Section 8.3. Such action shall be taken pursuant to this section, rather than Section 8.1 or 8.2, only in those instances in which disruptive, as more specifically defined in the disruptive practitioner policy, or inappropriate conduct, rather than clinical competency is in question. Such instances may include, but are not limited to, abusive treatment of hospital employees, refusal to discharge Medical Staff duties unrelated to patient care, violation of policies, rules or regulations, or harassment.

If collegial intervention and progressive discipline pursuant to the Policy Regarding Behavior that Undermines a Culture of Safety is not successful in remediating the issue, the MEC and/or Board may take action as provided herein. If the MEC addresses the issue, the procedure in Section 8.1 shall apply. If the MEC elects to refer the matter

directly to the Board, or the Board takes action on its own initiative, the Board may commence an investigation.

The President shall be responsible for presenting the history of conduct to the Board. The Board shall be fully apprised of the previous meetings and warnings, if any, so that it may pursue whatever action is necessary to terminate the unacceptable conduct. Should the Board determine that further investigation is necessary; the Board Chairperson shall appoint an individual or an ad hoc committee to investigate and report back to the Board at its next regular meeting. Within thirty (30) days after the investigation begins, a written report of the investigation shall be completed.

8.3(b) Board Action

Within sixty (60) days following receipt of the report, the Board shall take action upon the request. Its action shall be reported in writing to include reporting to the Chief of Staff of the Medical Staff and will be placed in practitioner's quality file as well as a copy to the practitioner, and may include, but is not limited to:

(1) Rejecting the request for corrective action;

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

(3) Requiring terms of probation or required consultation;

(4) Reducing, suspending or revoking clinical privileges;

(5) Reducing staff category or limiting prerogatives; or

(6) Suspending or revoking staff membership.

8.3(c) Procedural Rights

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

8.3(d) Other Action

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

8.4 AUTOMATIC SUSPENSION

8.4(a) License

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

8.4(b) Drug Enforcement Administration (DEA) Registration Number

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

8.4(c) Medical Records

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

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

8.4(d) Peer Review

Failure to complete the peer review within the additional 21 days (as outlined in the Internal Peer Review Process) will result in the Chief of Staff and MEC being notified and the following actions taken:

(1) Automatic suspension of the practitioner’s privileges shall be imposed for failure to complete assigned peer review charts as outlined above. The suspension shall continue until peer review charts are completed unless the practitioner satisfies the Chief of Staff that he/she has a justifiable excuse for such omissions.

(2) Any medical staff member who accumulates forty-five (45) or more CONSECUTIVE days of automatic suspension as outlined above shall automatically be expelled from the Medical Staff. Such expulsion shall be effective as of the first day after the forty-fifth (45) consecutive day of such automatic suspension. (amended 06/2014)

8.4(e) Malpractice Insurance Coverage

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

8.4(f) Exclusions/Suspension from Medicare

Any practitioner who is excluded, debarred, suspended, or otherwise declared ineligible from any state or federal health care or procurement program or has been convicted of a crime that meets the criteria for mandatory exclusion (regardless of whether the provider

has yet been excluded, debarred, suspended or otherwise declared ineligible) will be automatically suspended.

8.4(g) Failure to Appear/Cooperate

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

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

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

8.4(i) Chief of Staff

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

8.5 CONFIDENTIALITY

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

8.6 SUMMARY SUPERVISION

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

8.7 PROTECTION FROM LIABILITY

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

8.8 REAPPLICATION AFTER ADVERSE ACTION

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

8.9 FALSE INFORMATION ON APPLICATION

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

ARTICLE IX
INTERVIEWS & HEARINGS

9.1 INTERVIEWS

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

9.2 HEARINGS

9.2(a) Procedure

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

9.2(b) Exceptions

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

9.3 ADVERSE ACTION AFFECTING APPS

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

ARTICLE X
OFFICERS

10.1 OFFICERS OF THE STAFF

10.1(a) Identification

The officers of the staff shall be:

(1) Chief of Staff

(2) Chief of Staff Elect

(3) Immediate Past Chief of Staff

10.1(b) Qualifications

Officers must be members of the Active Staff at the time of nomination and election and must remain members in good standing during their term of office. They cannot serve as a staff officer at another Hospital during their term of appointment. Officers must be Board Certified in their specialty and/or possess experience that would qualify them to be considered for Professional Staff Office

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

10.1(c) Nominations and Elections of Officers

a. The Nominating Committee (a sub-committee of the Executive Committee) shall consist of the current officers of the Professional Staff who are willing and able to serve. The most recent Past Chief of Staff will serve as chair. The Nominating Committee shall develop a slate of at least one nominee for Chief of Staff-elect and nominees to fill 'at large' Executive Committees positions to be presented to the Professional Staff membership.

b. Further nomination may be made by petition signed by at least 30 members of the Active Professional Staff and filed with the Professional Staff office. If no additional names are submitted in nomination, the nominating committee’s slate of candidates shall be deemed elected.

c. No member can be nominated by the committee or by petition without his/her consent.

d. If additional nominations are made pursuant to (10.01(c) b) officers shall be elected by ballots mailed to the Active Professional Staff membership. To be counted, the ballots must be returned to the Professional Staff Services office. The Professional Staff Chief of Staff shall be responsible for tabulation of the vote. Election is by simple majority of the votes cast. The results of the balloting shall be conveyed to all Active Professional Staff members.

e. Following election, all officers of the Professional Staff must be approved by the Board. Should approval not be granted, the process described in Article X, Section 10.1(c) will be repeated.

10.1(d) Removal and Vacancies in Office

Failure to maintain Active Professional Staff status or to meet any other objective criteria for holding the office shall result in automatic removal from office. In addition whenever the activities, professional conduct or leadership abilities of a Medical Staff officer are believed to be below the standards established by the Medical Staff or to be disruptive to hospital operations as more specifically defined in the disruptive practitioner policy, the officer may be removed by vote of a two-thirds majority of the Active Medical Staff, upon petition of the Medical Executive Committee, Board, or 10% of the voting members of the staff. Reasons for removal may include, but shall not be limited to violation of these bylaws, breaches of confidentiality or unethical behavior. Such removal shall not affect the officer's Medical Staff membership or clinical privileges and shall not be considered an adverse action.

10.1(e) Term of Elected Officers

Each officer shall serve a two (2) year term, commencing on the first day of the Medical Staff year following his/her election. Each officer shall serve until the end of his/her term and until a successor is elected, unless he/she shall sooner resign or be removed from office.

10.1(f) Vacancies in Elected Office

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

10.1(g) Duties of Elected Officers

i. Chief of Staff. The Chief of Staff shall serve as the Chief of Staff and principal official of the staff. As such he/she will:

ii. call, preside at and be responsible for the agenda of all general meetings of the Professional Staff;

iii. serve as chair of the Executive Committee of the Professional Staff with vote;

iv. serve as ex-officio member of all other Professional Staff Committees/IDT's with vote;

v. serve on the Nominating Committee;

vi. Select and replace all Chairpersons of all standing, special and interdisciplinary Professional Staff Committees

vii. Select and replace, in coordination with the IDT Chair, participation (assign physicians) to Interdisciplinary Teams/Medical Staff Committees.

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

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

x. select and replace chairpersons of all standing, special and interdisciplinary Professional Staff committees;

xi. report to the Board and the President concerning the opinions, policies, needs and grievances of the Medical Staff and act in coordination with the President of the Hospital or his/her designee in all matters of medical concern with regards to the Professional Staff as well as act in coordination with the President of the Hospital or his/her designee in all matters of mutual concern within the Hospital;

xii. be responsible for and have the authority to ensure compliance of the Professional Staff with the Bylaws, Policies and Rules & Regulations of the Professional Staff and the Hospital, to include enforcement and clarification of Medical Staff Bylaws and Rules & Regulations, for the implementation of sanctions where indicated, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;

xiii. assist in coordinating the educational activities of the Medical Staff;

xiv. serve as liaison for the Medical Staff in its external professional and public relations;

xv. receive and communicate the policies of the Board to the Professional Staff and report to the Board on the performance and maintenance of quality with respect to the Professional Staff’s responsibility to provide medical care;

xvi. serve in capacities as requested by the Board;

xvii. serve on the Spokane County Medical Society Nominating Committee.

xviii. confer with the President, CFO, Chief Nursing Executive and Standing Committee Chairs, IDT Chairs and Department Medical as to whether there exists sufficient space, equipment, staffing, and financial resources or that the same will be available within a reasonable time to support each privilege requested by applicants to the Medical Staff; and report on the same to the MEC and to the Board; and

xix. assist the Standing Committee Chairs, IDT Chairs and Department Medical Directors as to the types and amounts of data to be collected and compared in

determining and informing the Medical Staff of the professional practice of its members.

Chief of Staff-Elect:

i. The Chief of Staff-Elect shall be a member of the MEC with a vote. In the absence of the Chief of Staff of the Staff, he/she shall assume all the duties and have the authority of the Chief of Staff of the Staff. He/She shall perform such additional duties as may be assigned to him/her by the Chief of Staff of the Staff, the MEC or the Board.

ii. serve on the Nominating Committee.

iii. serve as Chair of the Credentials Committee.

Immediate Past Chief of Staff shall:

i. be a member of the MEC with a vote and perform such additional duties as may be assigned to him/her by the Chief of Staff of the Staff, the MEC or the Board

ii. Serve as chairperson of the Nominating Committee for Professional Staff officers.

iii. Serve as chairperson of the Bylaws Committee.

10.1(h) Conflict of Interest of Medical Staff Members

The best interests of the community, Medical Staff and the Hospital are served by Medical Staff leaders (defined as any member of the Medical Executive Committee, Chair or Vice-Chair of any department, officer of the Medical Staff, and/or members of the Medical Staff who are also members of the Hospital's Board of Trustees) who are objective in the pursuit of their duties, and who exhibit that objectivity at all times. The decision making process of the Medical Staff may be altered by interests or relationships which might in any instance, either intentionally or coincidentally bear on that member's opinions or decision. Therefore, it is considered to be in the best interest of the Hospital and the Medical Staff for relationships of any Medical Staff leader member which may influence the decisions related to the Hospital to be disclosed on a regular and contemporaneous basis.

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

Upon being granted appointment to the Medical Staff and/or clinical privileges, and upon any grant of reappointment and/or renewal of clinical privileges, each Medical Staff member shall file with the MEC a written statement describing each actual or proposed relationship of that member, whether economic or otherwise, other than the member's status as a Medical Staff leader member, and/or a member of the community, which in

any way and to any degree may impact on the finances or operations of the Hospital or its staff, or the Hospital's relationship to the community, including but not limited to each of the following:

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

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

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

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

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

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

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

ARTICLE XI
CLINICAL IDT'S, SERVICES & IDT'S

11.1 CLINICAL IDT

To facilitate credentials and privilege process for practitioners of similar training and specialty.

11.1(a) Each IDT will be composed of members of the Professional Staff who are of similar training and specialty. Advanced Practice Providers professionals will be assigned to the IDT of their employing/supervising physician or the IDT most closely related to their specialty.

11.1(b) Each IDT shall have an IDT Chair responsible for overall supervision of all activities within the IDT.

11.1(c) The list of IDT's and specialties within each IDT is provided on Attachment 1.

11.1(d) Information from meetings of IDT's, IDT's, Standing Committees and other groups will be disseminated to the Professional Staff via open meetings, newsletters, voice mail and individual/IDT/general Professional Staff mailings.

11.2 QUALIFICATIONS AND TENURE OF IDT CHAIRS

11.2(a) Each IDT Chair shall be a member of the Active Staff qualified by training, experience and demonstrated ability for the position. IDT Chairs must be Board Certified in their specialty and/or possess experience that would qualify them to be considered for a Professional Staff Executive position. IDT Chairs shall be appointed by the Professional Staff Chief of Staff.

11.2(b) Term of office - The IDT Chair shall serve a term of two (2) years and may be re-appointed providing that he/she maintains the qualifications of that office.

11.2(c) Removal of the IDT Chair during his/her term may be recommended by a vote of at least 50% of all Active Staff members of the IDT but shall become effective only after ratification by the Executive Committee. A new IDT Chair shall be appointed by the Professional Staff Chief of Staff.

11.3 FUNCTION OF IDT CHAIRS

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

Each IDT Chair shall:

11.3(a) Serve as a voting member of the Executive Committee and serve as a liaison between the IDT, Interdisciplinary Teams, Hospital Departments and the Executive Committee and be accountable to the MEC for all professional and Medical Staff administrative activities within the IDT;.

11.3(b) Assure that the quality and appropriateness of patient care provided within the IDT are monitored and evaluated and that appointees exercising privileges within the IDT be reviewed on an ongoing basis.

11.3(c) Appoint or serve as a chair for all functioning Interdisciplinary Teams and committees of that IDT . If continuity is advisable, reappointment may be made.

11.3(d) Coordinate with the Chief of Staff of the Medical Staff participation (assign physicians) to Interdisciplinary Teams/Medical Staff Committees.

11.3(e) Be responsible for the ongoing review of the professional performance of practitioners within that IDT and assist in orientation and the provision of continuing educational opportunities for members of that IDT pertinent to changes in current professional practices and standards.

11.3(f) Be responsible for enforcement of the Professional Staff Bylaws, Rules and Regulations within his/her IDT and monitoring of compliance with these bylaws and the rules and regulations, policies, procedures and other standards of the Hospital as well as other applicable professional standards.

11.3(g) Transmit to the Executive Committee his/her recommendations concerning Professional Staff and Advanced Practice Providers Staff membership, the appointment/reappointment and the delineation of clinical privileges for all practitioners in his/her IDT. Recommend the criteria for clinical privileges within the IDT to the Credentials Committee.

11.3(h) Participate in every phase of administration of his/her IDT and Interdisciplinary Team through cooperation with Patient Care Services and the Hospital administration in matters affecting patient care, including personnel, supplies, space, special regulations, standing orders and techniques and input regarding off-site sources for patient care services not provided by the Hospital. Participate in establishing the type and scope of services required to meet the needs of patients and the Hospital. Be responsible for the calling of IDT meetings, if and when needed, in accordance with the Professional Staff Bylaws, Article XII, 13.1, 13.2, 12.3.

11.3(i) Submit reports and/or minutes of IDT meetings on a regular basis to the Quality Council, the Executive Committee and the Governing Body regarding patient care services within the IDT and/or Interdisciplinary team as appropriate, including. :

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

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

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

11.3(j) Foster an atmosphere of professional decorum within the IDT.

11.3(k) Review all deaths occurring in the IDT and all unexpected patient care events and report findings to the appropriate committees of the medical staff;

11.3(l) Make recommendations to the MEC subject to Board approval of the kinds, types and amounts of data to be collected and evaluated to allow the medical staff to conduct an evidence-based analysis of the quality of professional practice of its members; and receive regular reports from IDT subcommittees regarding all pertinent recommendations and actions by the subcommittees.

11.3(m) Assuring that required performance improvement and quality control functions including, if applicable, surgical case review, blood usage review, drug usage evaluation, medical record review, pharmacy and therapeutics, risk management, safety, infection control, and utilization review are performed within the IDT and that findings from such activities are properly integrated with the primary functions of the department level.

11.3(n) Implementing within the IDT any actions or programs designated by the MEC;

11.3(o) Assisting in the preparation of reports as may be required by the MEC, the President or the Board;

11.3(p) Developing, implementing and enforcing the Medical Staff Bylaws, Rules & Regulations and policies and procedures that guide and support the provision of services;

11.3(q) Participating in every phase of administration with other IDT's or services in cooperation with nursing, hospital administration and the Board;

11.3(r) Assessing and recommending to the President any off-site sources for needed patient care services not provided by the IDT or organization;

11.3(s) Making recommendations for a sufficient number of qualified and competent persons to provide care or services within the IDT;

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

11.3(u) Determine the qualifications and competence of IDT personnel who are not licensed independent practitioners and who provide patient care, treatment or services.

11.4 SERVICE LINE INTERDISCIPLINARY TEAMS

To achieve quality, cost effective care and services for our patients and community in collaboration with others.

11.4(a) Chair of Meeting: Each interdisciplinary team (IDT) shall have a Professional Staff chair who shall be either a IDT Chair or appointed by a IDT Chair.

11.4(b) Meeting Schedule: Each IDT shall meet regularly as determined by the IDT Chair and shall report to the Executive Committee of the Professional Staff through a IDT or IDT Chair.

11.4(c) Voting Members: All IDT members are voting members, per the IDT Voting Policy (Attachment 3). Those present at scheduled meetings are considered a quorum.

11.4(d) Composition:

Chair - Active Professional Staff member (IDT Chair or appointee): Voting
Active Professional Staff members representing the specialties involved in that service line: Voting
Nursing Director: Voting
Other Nursing Representation: Voting
Ancillary/Support Staff Representation: Voting
Ambulatory Services Representation as appropriate: Voting
Chief Nursing Officer: Ex-Officio
President or senior leadership designee: Ex-Officio
Ad Hoc member as determined by the Chair: Voting

11.4(e) Duties: Develop as much as possible uniform care and service strategies including, but not limited to:

(1) Clinical pathways/decision algorithms/physician pre-printed orders;
(2) Outcome/performance indicators;
(3) Protocols/policies/procedures; and
(4) Education (department members and/or patients)
(5) Analyze and improve care and services through:
    a. Performance improvement indicators trend review; focused reviews etc.
    b. Performance patterns and trends; and
    c. Outcomes (financial and clinical)
(6) Evaluate equipment/facility strategy.
(7) Form ad hoc care delivery improvement teams as prioritized.
(8) Review and act on ad hoc team work or empower ad hoc teams to implement care delivery strategies.
(9) Define scope of privileges for medical staff IDT's/specialties.
(10) Provide a structure to ensure patient safety and satisfaction.
(11) Provide focused review of patient care provided by the Medical Staff.

11.4(f) Teams:

(1) Primary Care IDT – in addition to the functions outlined under 11.4 (e) above, this IDT also participates in the review of ongoing peer review monitoring activities for the Urgent/First Care physicians who are credentialed in accordance with these Bylaws Credentials Policies. This IDT will also provide oversight of the Hospitalist Service at the hospital.

1. Allergy / Immunology
2. Endocrinology
3. Hematology / Oncology
4. Internal Medicine
5. Neurology
6. Oncology
7. Psychology
8. Rheumatology
9. Dermatology
10. Family Practice
11. Infectious Disease
12. Nephrology
13. Occupational Medicine
14. Physical Medicine & Rehabilitation

15. Psychiatry

(2) Operative & Invasive Procedures IDT - in addition to the functions outlined under 11.4 (e) above above, this IDT also participates in Pathology, Radiology, Transfusion, and Anesthesia QA review, this IDT also participates in the review of ongoing peer review monitoring activities

1. Anesthesiology
2. Colo-Rectal Surgery
3. General Surgery
4. Ophthalmology
5. Otolaryngology
6. Plastic Surgery
7. Radiology
8. Urology
9. Cardiovascular / Thoracic Surgery
10. Gastroenterology
11. Neurosurgery
12. Oral Surgery
13. Pathology
14. Podiatry
15. Surgical Oncology
16. Vascular Surgery

(3) Emergency Department IDT. In addition to the functions outlined under 11.4 (e) above, this IDT also hears results of Trauma review, this IDT also participates in the review of ongoing peer review monitoring activities

1. Emergency Medicine

(4) Trauma - Composition includes trauma surgeon(s), surgical and sub-specialists who participate in the care of trauma patients, and physicians and staff of the ER, Anesthesia, Radiology as well as other surgical and medical specialties as deemed necessary by the IDT Chair. The duties related to Trauma for this IDT include but are not limited to the following:

1. To review and discuss all trauma patient care issues referred to the committee;
2. To provide a forum for discussion of trauma issues brought to the committee;
3. To provide coordination of the Trauma Service with subspecialty trauma support groups;
4. To present and review performance improvement results
5. To develop policies and procedures related to the medical/surgical management of trauma patients;
6. To communicate trauma-related administrative information;
7. To develop proposals regarding the Trauma Service for policy changes and other requests.
8. Trauma

(5) OB/Peds IDT – All functions outlined under 11.4 (e) above, this IDT also participates in the review of ongoing peer review monitoring activities

1. Gynecology
2. Pediatrics
3. Obstetrics

(6) Critical Care IDT - In addition to the functions outlined under 11.4 (e) above, this department also participates in the direction of the special care units and Code 55 Review, this IDT also participates in the review of ongoing peer review monitoring activities

1. Critical Care
2. Pulmonary Care
3. Cardiology

ARTICLE XII
STANDING COMMITTEES & FUNCTIONS

12.1 GENERAL INFORMATION

12.1(a) Performance improvement information will flow from the individual standing committee to the appropriate Professional Staff IDT's/ Committees/Interdisciplinary Teams, the EHS Quality Council and to the Professional Staff Executive Committee and Board.

12.1.(b) All chairs of standing committees of the Professional Staff shall be appointed by the Chief of Staff of the Professional Staff for a two-year term.

12.2 MEDICAL EXECUTIVE COMMITTEE

12.2(a) The Executive Committee shall be a standing committee, which is empowered to act on behalf of the Professional Staff and shall report on a timely basis to the Board. The Committee shall be responsible for governance of the Medical Staff, shall serve as a liaison mechanism between the Medical Staff, Hospital administration and the Board. All Active Medical Staff members shall be eligible to serve on the MEC as well as Community Associate Staff members at the request of the Chair.

12.2(b) Composition: The Executive Committee shall consist of the following: (all have a vote unless otherwise noted)

(1) officers of the Professional Staff;

(2) chair of each Professional Staff IDT, Standing Committee, IDT;

(3) Medical Directors of Radiology, Pathology, Anesthesia and Lead Hospitalist;

(4) four members at large (10.01(c));

(5) Hospital Chief Executive Officer, who shall be ex officio member without vote;

(6) Hospital Chief Medical Officer, who shall be an ex-officio member without vote;

(7) Hospital Chief Nursing Officer, who shall be an ex-officio member without vote.

Additional active staff members may be asked to attend meetings of the Executive Committee (without vote) at the discretion of the Chief of Staff of the Professional Staff. All members of the Active Professional Staff are eligible to be asked to serve on the Executive Committee.

12.2(c) Duties: The authority of the MEC is outlined in Section 12.2 and additional functions may be delegated or removed through amendments of this section 12(c). The duties of the Executive Committee shall be:

(1) To provide representation and participation in any deliberation affecting the discharge of Medical Staff responsibilities;

(2) to adopt and implement approved policies of the Professional Staff;

(3) to provide liaison between the Professional Staff and the Hospital's Chief Executive Officer and the Board;

(4) to recommend action to the Hospital's Chief Executive Officer on matters of a medico-administrative nature;

(5) to make recommendations on Hospital management matters (for example, long-range planning) to the Board through the Hospital's Chief Executive Officer;

(6) to fulfill the Professional Staff's accountability to the Board for the medical care rendered to patients in the Hospital;

(7) to keep the Professional Staff abreast of the accreditation program and informed of the accreditation status of the Hospital;

(8) to keep the Professional Staff abreast of actions and discussions of the Professional Staff Executive Committee related to standing committees of the Professional Staff such as Credentials and Pharmacy & Therapeutics Committees.

(9) to review the recommendations of the Clinical IDT chairs and Credentials Committee regarding Professional Staff applicants and to make recommenda¬tions to the Board for membership (staff category), assignments to IDT's and delineation of clinical privileges and corrective action;

(10) to review periodically all information available regarding the performance and clinical competence of staff members and other practitioners with clinical privileges; and, as a result of such reviews, to make recommendations for reappointment and renewal or changes in clinical privileges;

(11) to take all reasonable steps to assure professional ethical conduct, as described and defined by the physician's or dentist's professional organization, and competent clinical performance on the part of all members of the Professional Staff, including the initiation of and/or participa-tion in Professional Staff corrective or review measures when warranted;

(12) to review quality of medical care provided at the Hospital and its outpatient clinics through the reports of the Interdisciplinary Teams, the Quality Council and other Clinical IDT and Standing committees;

(13) with the advice of the Pharmacy & Therapeutics Committee to establish a Formulary of drugs used in the Hospital; and

(14) to establish, maintain and enforce the Bylaws and attendant documents and Rules & Regulations of the Professional Staff and to recommend any necessary revisions to these documents, including the structure of the Professional Staff and mechanisms to review credentials and delineate clinical privileges;

(15) to provide a structure to support patient safety and satisfaction.

(16) to receive and act upon IDT and committee reports.

(17) Develop and implement programs for continuing medical education for the Medical Staff;

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

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

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

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

(22) Informing the Medical Staff of JC and other accreditation programs and the accreditation status of the Hospital;

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

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

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

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

12.2(d) Meetings: The Executive Committee shall meet regularly, at least 10 times a year, maintain a permanent record of its proceedings and actions and forward said record to the Board.

(1) Special meetings of the Executive Committee may be called by the Chief of Staff of the Professional Staff or, in his/her absence, by the Chief of Staff-¬elect, or Immediate Past Chief of Staff in succession as listed in 10.f and 12.14 of the Bylaws, or by a quorum of its voting members

12.2(e) To take action a minimum of 10 Executive Committee Members must be present, then a simple majority of voting members of the Executive Committee shall constitute a

quorum. A simple majority is defined as the number greater than 50% of the total number of Executive Committee members present and eligible to vote

12.2(f) The removal process (including the reasons for removal) for those members at large of the MEC who are elected by the Medical Staff shall be the same as described in Section 10.1(d) with respect to Medical Staff Officers.

All other members of the MEC shall be removed in accordance with the provisions governing removal from their respective Medical Staff Leadership provisions. Officers and Committee Chairs of the Medical Staff who are ex officio members of the MEC shall be removed in accordance with the procedure described in Section 10.1(d). Division Chiefs who are ex officio members of the MEC shall be removed in accordance with the procedures described in Section 11.2(c).

12.3 BYLAWS COMMITTEE

12.3(a) The Professional Staff Bylaws Committee as a subcommittee of the Executive Committee shall be convened at least every two years for the purpose of reviewing and, as thought to be appropriate by the committee, recommending amendments to the Bylaws or any of the supporting documents defined above.

12.3(b) The Bylaws Committee shall be the Professional Staff Chief of Staff, Chief of Staff Elect and Immediate Past Chief of Staff.

12.3(c) The Immediate Past Chief of Staff shall chair.

12.3(d) The committee may request consultative support from other Professional Staff members, the Hospital staff, or outside sources, including legal advice, as it deems necessary. Such consultants will serve without vote.

12.3(e) A recording secretary and technical support will be provided by the Hospital.

12.4 CREDENTIALS COMMITTEE

12.4(a) Composition: This committee shall be a standing committee and shall consist of:

(1) a chair, which shall be the Chief of Staff-Elect of the Professional Staff during his two year term;

(2) members of the Active Professional Staff will be appointed by the Credentials Committee Chair in sufficient numbers to assure representation of the major clinical specialties as determined by the Executive Committee;

(3) other members of the Active Professional Staff who may be used for consulta¬tive support to the Credentials Committee, without voting privileg¬es, at the discretion of the Committee.

12.4(b) Term: members serve a two year term.

12.4(c) Functions and Responsibilities:

(1) The function of the Credentials Committee of the Professional Staff is to develop and define common professional criteria for Professional Staff membership and for clinical privileges and to apply these criteria to the review of applicant's credentials. The criteria shall pertain to, at the least:

i. evidence of current Washington State licensure;

ii. relevant experience and/or training;

iii. current competence;

iv. health status which would not impair the performance of the essential functions necessary to provide the services for which privileges are requested, with reasonable accommodations; and

v. board certification or admissible status for the IDT and/or specialty for which the applicant desires privileges.

Further, the criteria shall be specific to this Hospital, based on consideration of the types of procedures and types of care and services that can be performed or provided within this Hospital.

(2) The Credentials Committee of the Professional Staff receives recommendations from IDT chairs related to criteria for privileges within that IDT.

(3) The Credentials Committee shall regularly review the Credentials Policies, at least every three years, and make recommendations to the Professional Staff Executive Committee when any policy modification is proposed.

(4) All committee deliberations, reviews, records, and recommendations shall be treated in a confidential manner.

(5) Meetings: The Credentials Committee shall meet regularly as determined by the Committee Chair, shall maintain a permanent record of its proceedings and actions, and forward this report to the Executive Committee.

12.5 SPECIAL COMMITTEES OR AD HOC COMMITTEES:

The Professional Staff Executive Committee may create other committees to direct, review and analyze other aspects of Hospital services as indicated. Special or Ad Hoc Committees shall be appointed by the Chief of Staff of the Professional Staff as required. Such Committees shall be disbanded upon order of the Chief of Staff or upon completion of the work assigned.

12.6 ETHICS COMMITTEE

12.6(a) Composition: The Ethics Committee shall be composed of at least two members of the Active Professional Staff and representation from nursing service, administration, social services, pastoral care, legal counsel, risk management, and other membership as determined by the Committee.

12.6(b) Duties:

(1) To develop and recommend to the Executive Committee of the Professional Staff and Hospital Administration policies pertaining to ethical concerns within the Hospital

(2) To develop, recommend and coordinate presentation of educational programs pertaining to ethical aspects of health care

(3) To provide for a process of consultation and advice on selected decisions at the Hospital involving ethical issues

(4) To provide a forum for interdisciplinary discussion of ethical concerns at the Hospital

(5) To review and assist in clarifying and resolving ethical dilemmas occurring in patient care

(6) To monitor legislative, judicial and regulatory actions concerning ethical issues in healthcare

12.6(c) Meetings: The Ethics Committee will meet as determined by the Committee Chair and will report to the Executive Committee of the Professional Staff.

12.7 PHARMACY & THERAPEUTICS COMMITTEE

12.7(a) Composition: This committee shall be a standing committee and shall consist of:

(1) a chairperson, appointed by the Chief of Staff of the Medical Staff, who shall serve a four-year term;

(2) members of the Active Medical Staff from both Deaconess and Valley Hospitals appointed by the chairperson to the Pharmacy & Therapeutics Committee. They shall serve a four year term with approximately half the members completing their term every two years. The appointment to vacated committee positions shall be made by the current committee chair;

(3) the manager of the pharmacy services, who shall vote only on matters related to the Hospital formulary;

(4) the Vice Chief of Staff of Patient Care Services or designee; and

(5) the manager of dietary services or his/her designee, who shall vote only on matters pertaining to the nutrition program.

12.7(b) Duties: With the ultimate goal of patient safety, the primary purposes of the P&T Committee are policy development and education. Much of this is done on a city-wide level, with integration into the specifics of the Hospital's needs. The Hospital delegates this responsibility to the City-Wide P&T Committee with policies subject to the review of the hospital's P&T Committee and the Board of Directors. They shall also:

(1) be responsible for the development and surveillance of all drug utilization policy and practices within the Hospitals;

(2) be responsible for regulatory compliance for Pharmacy Services;

12.7(c) assist Pharmacy Services in the formulation of broad professional policies regarding the, procurement, storage, distribution, administration and, safety procedures, relating to drugs in the Hospitals, including investigational drugs;

1) be responsible for developing and periodically revising the formulary used in the Hospitals, taking into consideration:

(i) available Hospitals' specific clinical data and recommendations from Hospitals' interdisciplinary teams,

(ii) costs,

(iii) be responsible for the definition and review of all significant untoward drug reactions reported.

12.7(d) Meetings: This committee shall meet regularly as determined by the Committee Chair, alternating between Deaconess and Valley Hospitals and shall maintain a permanent record of the proceedings and activities and shall report to the Medical Staff Executive Committee.

12.8 TRANSFUSION SUB-COMMITTEE

12.8(a) Composition: The Committee shall be composed of representatives from appropriate Medical Staff Departments, the Inland Northwest Blood Center, the IV Therapy Department and the Pharmacy Department.

12.8(b) Duties:

(1) Ordering of appropriate blood or blood components

(2) Distribution, handling and dispensing of blood and blood components

(3) Administration of blood and blood components

(4) Monitoring of the effects of blood and blood components on patients so that appropriate modifications may be undertaken in a timely manner

12.8(c) Meetings: The Transfusion Sub-Committee will meet on a regular basis and will report to the Pharmacy & Therapeutics Committee.

12.9 CITY-WIDE/SPECIAL COMMITTEES

Authority is granted to the Chairs of Standing Committees to represent the Hospital on any City-Wide Committees

12.9(a) Institutional Review Board

(1) Composition: Valley Hospital and Hospital will be part of a combined IRB which is called IRB-Spokane. This Board will be composed as defined by Federal Regulations and include physicians and staff representatives from each of the five Spokane hospitals.

(2) Meetings: The IRB meets as necessary at the call of the Chair and keeps a permanent record of its activities.

12.10 QUALITY IMPROVEMENT AND PATIENT SAFETY COUNCIL

12.10(a)Organization and composition: The Board of Trustees has final authority and responsibility for ensuring that quality patient care is provided to all patients at VALLEY HOSPITAL. To accomplish this obligation the Board of Trustees works in conjunction with the Quality Improvement and Patient Safety Council and Medical Executive Committee (MEC).

12.10(b)Composition: The members of the Quality Improvement and Patient Safety Council shall include:

(1) Physician Chairperson

(2) Medical Staff Members

(3) Chief Nursing Office

(4) Director of Medical Staff Services (on an as needed basis)

(5) Quality Improvement Regulatory Compliance Director

(6) Assistant Administrator/Risk Manager

(7) Lab and Radiology Directors

(8) A Nursing Director

(9) Chief Executive Officer

12.10(c)Reports of quality improvement activities are directed to the Quality Improvement and Patient Safety Council through the approved organizational structure of the Quality Improvement and Patient Safety Plan and reported to the MEC and Board of Trustees.

12.10(d)Duties: The Quality Improvement and Patient Safety Council will:

(1) Implement a systematic, continuous improvement process.

(2) Receive recommendations from various sources regarding quality improvement efforts.

(3) Integrate findings and outcomes of reviews conducted by Medical Staff Committees.

(4) Evaluate and prioritize problems and identified opportunities to improve.

(5) Facilitate communication of the team progress and improvements throughout the organization.

(6) Establish guidelines for hospital-wide monitoring and evaluation of patient care and services.

(7) Coordinate assignment of team leaders and members when identified problems or opportunities to improve involve more than one function.

(8) Maintain communication with all teams, committees, departments and services.

12.10(e)Meetings: The Quality Improvement and Patient Safety Council will hold meetings at least quarterly and keep a written record of all proceedings.

12.11 UTILIZATION REVIEW COMMITTEE

12.11(a)Authority and Purpose: The Board of Trustees has the ultimate responsibility for review of the quality, appropriateness and medical necessity of admissions, continued stays and supportive services. It delegates specific functions to the Medical Staff to develop and implement a comprehensive plan. The Utilization / Case Management Plan is under the direction of the Utilization Review Committee.

12.11(b)Composition: The members of the Utilization Review Committee shall include:

(1) Chairperson – Physician

(2) Medical staff of 2 or more

(3) Physician Advisor

(4) Chief Nursing Office

(5) Chief Financial Office

(6) Director of Case Management

(7) Health Information Manager

(8) Chargemaster

(9) Director of Pharmacy

12.11(c) Responsibilities

(1) Maintain and execute an effective Utilization/Case Management Plan.

(2) Provide efficient utilization of beds and professional services through concurrent and retrospective reviews.

(3) Ensure patients receive quality care delivered in a cost effective manner.

(4) Refer all quality issues to Quality Council.

(5) Maintain and develop the functional elements of the Quality Improvement Organization Program (QIO).Review patterns and profiles generated by the QIO and hospital to identify opportunities to improve provision of care and to initiate appropriation actions.

(6) Collaborate in monitoring and analyzing the review activities of non-physician reviewers, and the Hospital appointed Physician Advisors.

(7) To Collaborate and establish criteria, standards and norms for pre-admission / admission review, continued stay review and professional services furnished including drugs and biological.

12.11(d)Meetings: Utilization Committee will meet at least six times per year. Will keep written documentation of minutes and reports to Quality Council at least semi-Annually. Report to Medical Staff any findings from QIO.

12.12 CANCER COMMITTEE:

12.12(a)Composition: The Cancer Committee shall be a standing committee and must consist of:

(1) at least one board certified physician representative from Surgery, Medical Oncology, Diagnostic Radiology, Family Practice and Pathology, and must include the cancer liaison physician. Other physician representatives should be included based on the cancer experience of VH. The physician members of the committee are appointed by the Chief of Staff of the Professional Staff.

(2) representatives from Administration, Nursing, Social Services, Cancer Registry, and Performance Improvement as well as other representatives based on the cancer experience of VH.

12.12(b)Duties: This committee is responsible for goal setting, planning, initiating, implementing, evaluating and improving all cancer related activities in the program. They shall:

(1) develop and evaluate annual goals and objectives for the clinical, community outreach, quality improvement and programmatic endeavors related to cancer care.

(2) assure that patients have access to consultation services in all disciplines and have access to clinical trials.

(3) assure that educational programs, conferences and other clinical activities cover the entire spectrum of cancer;

(4) Supervise the cancer data base for quality control of abstracting, staging and case findings, follow-up and reporting of data.

(5) analyze patient outcomes and disseminate results of analysis annually.

12.12(c)Meetings: This committee shall meet at least quarterly, shall maintain a permanent record of the proceedings and activities and shall report to the Professional Staff Executive Committee.

12.13 INFECTION CONTROL COMMITTEE

12.13(a)Authority Statement: The Chair of the Infection Control Committee, his/her designee, other physician members and/or infection control practitioners, pursuant to WAC 246-320-265, shall be delegated the authority by the administration of VALLEY HOSPITAL to institute surveillance, prevention and control measures when there is reason to believe any patient, personnel or staff may be at risk of infection.
12.13(b)The VALLEY HOSPITAL Infection Control committee is a standing committee of the Medical Staff. The activities of the Infection Control Committee are an extension of the Quality Assurance/Performance Improvement function of the Professional Staff. The Infection Control Committee Chair will report quarterly to the Medical Executive Committee. The committee will meet no less than quarterly and be comprised of no less than three Active staff members of the medical staff and hospital staff as assigned.

12.14 PROFESSIONAL STAFF MEETINGS

12.14(a) Meetings: There shall be General Staff meetings of the Professional Staff.

12.14(b) General/Special Professional Staff Meetings
General Staff Meetings shall be held as follows:

(1) The Chief of Staff of the Professional Staff or a majority of the Executive Committee may call a general or special meeting of the Professional Staff at any time. In addition, the Chief of Staff of the Professional Staff shall call a meeting within 14 days after receipt by him/her of a written request signed by not less than one fourth of the Active Professional Staff and stating the purpose of such meeting. The Executive Committee shall designate the time and place of any general or special meeting.

(2) Written or printed notice stating the place, day, and hour of any general or special meeting of the Professional Staff shall be delivered, either personally or by mail, to each member of the Active Professional Staff not less than five business days before the date of such meeting, by or at the direction of the Chief of Staff of the Professional Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the Hospital. The attendance of a member of the Professional Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any general or special meeting except that stated in the notice calling the meeting.

(3) A Professional Staff quorum shall consist of those who attend out of those who have been notified per 12.14.

(4) Professional Staff members are strongly encouraged to attend as many meetings as possible.

12.14(d) Quorum: A quorum for transaction of business at any regular or special meeting of the Professional Staff shall be as outlined in section 13.3

12.14(e) Ex-Officio Members: Persons serving under these Bylaws as ex-officio members of a committee shall have all rights and privileges of regular members except that they shall not be counted in determining the existence of a quorum and shall not be entitled to vote unless otherwise specified.

12.14(f) Minutes: Minutes of each regular and special meeting of a Committee, IDT or Interdisciplinary Team, shall be prepared and shall include a record of attendees and voting outcomes. The minutes shall be signed by the chair. Each Committee shall maintain a permanent file of minutes of each meeting.

12.14(g) Meeting Attendance: Attendance at committee, IDT/IDT and general professional staff meetings are optional, but encouraged. Lack of attendance will not be tracked or considered at the time of reappointment. Attendance at meetings of the Executive Committee is required at least a majority of the time. Failure to attend the required number of Executive Committee meetings may result in replacement of the member.

12.15 MEDICAL STAFF FUNCTIONS

12.15(a) Composition of Committees

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

12.15(b) Functions: The functions of the staff are to:

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

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

(3) Conduct or coordinate utilization review activities;

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

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

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

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

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

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

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

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

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

(i) medical assessment and treatment of patients;

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

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

(iv) efficiency of clinical practice patterns; and

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

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

(i) education of patients and families;

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

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

(iv) Patient satisfaction;

(v) Sentinel events; and

(vi) Patient safety.

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

(15) Recommend to the Board policies and procedures which define the circumstances, trends, indications, deviated expectations or outcomes, or concerns that trigger a focused review of a physician's or dentist's performance and evaluation of a physician's or dentist's performance by peers. The process and procedure for focused professional review shall be substantially in accord with the Hospital's Peer Review Policy, Appendix "D" to these Bylwas. The information relied upon to investigate a physician's or dentist's professional conduct and practice may include (among other items or information): internal or external chart reviews, prospective, concurrent and/or retrospective monitoring of actual practice, monitoring of clinical practice patterns, proctoring, and consultations with other physicians, assistants, nursing or Administrative personnel involved in the care of patients;

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

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

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

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

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

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

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

12.15(b) Meetings: These functions shall be performed as required by state and federal regulatory requirements, accrediting agencies and as deemed appropriate by the MEC and the Board.

12.16 CONFLICT RESOLUTION COMMITTEE

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

12.17 SPECIAL APPEARANCE: COOPERATION WITH MEC

Any committee or department of the Medical Staff may request the appearance of a Medical Staff member at a committee meeting when the committee or department is questioning the physician's or dentist's clinical course of treatment. Such special appearance requirement shall not be considered an adverse action and shall not constitute a hearing under these bylaws. Whenever apparent suspected deviation from standard clinical practice is involved, seven (7) days advance notice of the time and place of the meeting shall be given to the practitioner. When such special notice is given, it shall include a statement of the issue involved and that the physician's or dentist's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he/she was given such special notice and/or failure to comply with any reasonable directive of the MEC shall, unless excused by the MEC upon a showing of good cause, result in an automatic suspension of all or such portion of the physician's or dentist's clinical privileges as the MEC may direct. Such suspensions shall remain in effect until the matter is resolved by the MEC or the Board, or through corrective action, if necessary.

ARTICLE XIII
GENERAL PROVISIONS

13.1 STAFF RULES & REGULATIONS

Subject to approval by the Board and except as provided below, the Professional Staff delegates to the Medical Executive Committee the authority to adopt rules and regulations and policies necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of Professional Staff organizational activities as well as embody the level of practice that is required of each staff member or affiliate in the hospital. The rules and regulations may be amended by the Executive Committee as outlined below, unless the Professional Staff seeks to propose an amendment directly to the Board as outlined below. In either event, changes shall become effective when approved by the Board. The rules and regulations shall be reviewed at least every two (2) years, and shall be revised as necessary to reflect changes in regulatory requirements, corporate and hospital policies, and current practices with respect to Professional Staff organization and functions.

Notice of Proposed Adoption or Amendment: Where the MEC proposes to adopt a rule or regulation, or an amendment thereto; it must first communicate the proposal to the Professional Staff. The proposed amendments shall be communicated to all voting members of the Professional Staff in writing, at least 14 days prior the MEC forwarding such proposals to the Board. If five or more members of the Professional Staff object to the adoption of the amendment in writing within the notice period, the proposed amendment may only be adopted by a majority of the voting members of the Professional Staff. The MEC is not required to communicate adoption of a policy or an amendment thereto prior to adoption. When a policy or amendment thereto is adopted by the MEC, the MEC must promptly thereafter communicate such action to the Professional Staff. The voting members of the Professional Staff may also propose amendments to the Rules and Regulations directly to the Board. Where the voting members of the Medical Staff propose to adopt a rule, regulation or policy, or an amendment thereto, they must first communicate the proposal to the MEC.

Provisional Adoption by MEC: In cases of a documented need for urgent amendment to rules and regulations necessary to comply with law or regulation, the MEC may provisionally adopt, and the Board may provisionally approve, an urgent amendment without prior notification of the Professional Staff. In such cases, the Professional Staff shall be immediately notified by the MEC. The Professional Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If there is no conflict between the Professional Staff and the MEC, the provisional amendment shall stand. If there is conflict over the provisional amendment, the process described in Section 14.1(c) of this Article shall be implemented.

Management of Medical Staff/MEC Conflicts Related to Rule, Regulation or Policy Amendments: When conflict arises between the Professional Staff and MEC on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto, this process shall serve as a means by which these groups can recognize and manage such conflict early and with minimal impact on quality of care and patient safety. Upon notification to the Board Chair of the existence of a conflict, an ad hoc committee selected by the Board Chair shall meet as needed with leaders of the Professional Staff and MEC as early as possible to work with the parties to manage and, when possible, resolve the conflict. Nothing in the foregoing is intended to prevent Professional Staff members from communicating with the Board on a rule,

regulation, or policy adopted by the Professional Staff or the MEC or to limit the Board's final authority as to such issues.

13.2 PROFESSIONAL LIABILITY INSURANCE

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

13.3 PROFESSIONAL STAFF DUES

Professional staff dues shall be used in accordance with stated purposes in Article I of the Bylaws. In accordance with those purposes, dues may be used on occasions to promote and further the framework of practicing within the hospital, which may include, but are not limited to, educational opportunities, developmental materials and social events. In the event the hospital and medical staff cease to exist, the professional staff assets will be donated to an IRS designated, tax exempt, and not-for-profit organization to be determined at the time of dissolution. Dues will be assessed annually to all members of the medical staff in an amount established by the MEC. Dues will be assessed annually (within the first quarter of the year) to all members of the medical staff in an amount established by the MEC.

13.4. FORMS

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

13.5 CONSTRUCTION OF TERMS & HEADINGS

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

13.6 TRANSMITTAL OF REPORTS

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

13.7 CONFIDENTIALITY & IMMUNITY STIPULATIONS & RELEASES

13.7(a) Reports to be Confidential

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

13.7(b) Release from Liability

No representative of the hospital, including its Board, President, administrative employees, Medical Staff or third party shall be liable to a practitioner for damages or other relief by reason of providing information, including otherwise privileged and confidential information, to a representative of the hospital including its Board, President or his/her designee, or Medical Staff or to any other health care facility or organization, concerning a practitioner who is or has been an applicant to or member of the staff, or who has exercised clinical privileges or provided specific services for the hospital, provided such disclosure or representation is in good faith and without malice.

13.7(c) Action in Good Faith

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

ARTICLE XIV
ADOPTION & AMENDMENT OF BYLAWS

14.1 DEVELOPMENT

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

14.2 ADOPTION, AMENDMENT & REVIEWS

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

An amendment of these Bylaws may be initiated by a member of the Executive Committee, by the Board, or by petition of thirty members of the Active Professional Staff and may be proposed at any regular or special meeting of the Executive Committee but may not be voted upon until a subsequent meeting of the Executive Committee at least two weeks after the amendment has been proposed. If approved by a majority vote of the Executive Committee, a proposed amendment shall be circulated to the Active Professional Staff within two weeks of the date of the Executive Committee approval. If fewer than 5% of the Active Professional Staff object to the proposed amendment (objections must be returned to Professional Staff Services within 30 days of the date of circulation), the Executive Committee shall forward it to the Board with their recommendation. If greater than 5% of Active Staff object to the proposed amendment, a meeting of the Professional Staff will be convened. A re-vote on such an amendment proposal may be cast by a signed, written ballot (for those members unable to attend the special meeting) submitted to Professional Staff Services. To be approved, such amendment will require two-thirds affirmative vote of the votes cast at the special meeting including the signed, written ballots received prior to the meeting. The Executive Committee may, by majority vote, make changes in the Bylaws specifically required by law, state regulation or JC standards. Any such change shall be communicated in writing to the Professional Staff and Allied Staff. Any amendments enacted by the Executive Committee or by the Active Professional Staff shall be effective only when approved by the Board. Neither the Professional Staff nor Governing Body can unilaterally amend the Professional Staff Bylaws. The Medical Staff Bylaws and the Board Bylaws should not conflict.

Request for changes to the Rules & Regulations can be made by any member of the Professional Staff. A proposed change to the Rules & Regulations will first be evaluated by the relevant IDT prior to being referred to the Bylaws Committee for review. Any recommended changes will be made by the Bylaws Committee and then forwarded to the Medical Executive Committee and will be subject to the approval of the Board.

14.3 DOCUMENTATION & DISTRIBUTION OF AMENDMENTS

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

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

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

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