HARRISON MEDICAL CENTER

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ST. MICHAEL MEDICAL CENTER

Medical Staff Policies

January 31, 2023

St. Michael Medical Center
Medical Staff
Chapters of the Medical Staff Policies

Chapter Number	Title	Page
1	Officers of the Medical Staff 1.1 General Provisions 1.2 Chief of Staff 1.3 Assistant Chief of Staff 1.4 Secretary – Treasurer 1.5 Immediate Past Chief of Staff 1.6 Department and Section Chiefs	6
2	Departments and Sections 2.1 General Provisions 2.2 List of Departments & Sections 2.3 Department Chiefs 2.4 Section Chiefs 2.5 Functions of Departments 2.6 Functions of Sections	13
3	Committees 3.1 General Provisions 3.2 Creation of a Short Term Committee	20
4	Appointment 4.1 Nature of Medical Staff Membership 4.2 Qualifications for Membership 4.3 Clinical Performance 4.4 Professional Conduct 4.5 Health Status 4.6 Professional Liability Insurance 4.7 Duration of Membership 4.8 Conditions of Membership 4.9 Request for Application 4.10 Complete Application 4.11 Processing the Application-Section Chief Review 4.12 Processing the Application-Credentials Committee Review 4.13 Processing the Application-Professional Performance Committee Review	23
5	Reappointment 5.1 Reappointment Schedule 5.2 Reappointment Packet 5.3 Complete Reappointment Package 5.4 Evaluation and Recommendation 5.5 Advancement from Provisional Status	43
6	Leave of Absence	50

7	Clinical Privileges 7.1 Initial Request for Clinical Privileges 7.2 Request at the Time of Reappointment 7.3 General Principles 7.4 Criteria for Determining Qualifications for Clinical Privileges 7.5 Procedure to Develop Criteria for New Privileges 7.6 Care of a Specific Patient 7.7 Disaster Credentialing	52
8	Investigations 8.1 Request for Formal Investigation 8.2 Professional Performance 8.3 Medical Executive Committee 8.4 Board of Directors	66
9	Precautionary Suspension	71
10	Automatic Suspension	73
11	Impaired Practitioners 11.1 General Provisions 11.2 Practitioner Wellness Committee 11.3 Action	75
12	Consent for Treatment	79
13	Conduct of Care 13.1 Medical Screening Examination 13.2 Admission of Patients 13.3 Non-Discrimination 13.4 Consultation 13.5 Daily Care of Patients 13.6 Coverage Arrangements 13.7 Autopsies 13.8 Patients Admitted by Dentists and Podiatrists 13.9 Discharge 13.10 Hospital Death 13.11 Continuity of Care	81
14	Health Information Management 14.1 General Provisions 14.2 History and Physical 14.3 Orders for Treatment 14.4 Progress Notes 14.5 Operative and Procedure Reports 14.6 Obstetrical Record - *pending* 14.8 Discharge Summary	95
15	Disruptive Behavior 15.1 Purpose 15.2 Definitions 15.3 Types of Conduct 15.4 Classification of Disruptive Behavior 15.5 Intervention 15.6 Procedure for Reporting Claim of Disruptive Behavior 15.7 Content of Complaint of Inappropriate or Disruptive Behavior	108

	15.8 Investigating and Assessing a Claim of Inappropriate or Disruptive Behavior 15.9 Consequences 15.10 Immediate Corrective Action 15.11 Documentation 15.12 Right to Counsel	
16	Fair Hearing 16.1 General Provisions 16.2 Grounds for Hearing 16.3 Effective Date of Action 16.4 Notice of Action or Proposed Action 16.5 Request for Hearing 16.6 Time and Place of Hearing 16.7 Notice of Hearing 16.8 Discovery of Additional Facts 16.9 Arbitration 16.10 Hearing Officer 16.11 Judicial Review Committee 16.12 Ex Parte Communication 16.13 Postponements and Extensions 16.14 Pre-Hearing Exchange of Information and Discovery – Rights to Inspection and Copying 16.15 Right to Evidence, Limits on Discovery, and Discovery Disputes 16.16 Witness Lists 16.17 Right to Summon Medical Staff Members 16.18 Failure of Affected Practitioner to Appear 16.19 Oath of Witnesses 16.20 Rights of Parties 16.21 Pre-Hearing Conference 16.22 Organization and Conduct of Hearing Process 16.23 Recess, Adjournment, and Conclusion 16.24 Deliberations and Basis for Recommendation 16.25 Basis for Decision 16.26 Decision and Report of Judicial Review Committee 16.27 Board Decision Giving Rights to a Hearing 16.28 Appeals 16.29 Hospital Board Action 16.30 Appellant Review Proceeding 16.31 Final Decision – Effective Date 16.32 Conclusion of Appellate Review 16.33 Challenges to Proceeding Participants 16.34 Reporting of Adverse Actions 16.35 Right to One Hearing 16.36 Informal Interviews 16.37 Confidentiality of Proceedings 16.38 Exceptions to Hearing and Appeal Rights 16.39 Hearing Rights Regarding Exclusive Contracts 16.40 Hearing Rights for Allied Health Practitioners	 126

	16.41 Disputing Report Language 16.42 Reapplication 16.43 Challenges to General Applicable Policies, Rule, or Regulation 16.44 Expunction of Disciplinary Action	
17	Mandatory Reporting	176
18	Medical Staff Quality Plan 18.1 Scope of Accountability 18.2 Confidentiality Protections 18.3 Definitions 18.4 Quality Improvement Goals 18.5 Information Management 18.6 Occurrence Screens and Indicators Selection 18.7 Chart Review Process 18.8 Peer Review Findings Types 18.9 External Review 18.10 Confidentiality of Quality Files 18.11 IRIS Reports 18.12 Medical Staff Quality Committee 18.13 Quality Improvement Activities 18.14 Quality Improvement Actions 18.15 Quality Improvement Reporting 18.16 Process to Appeal MPRC Scoring	177
19	Advanced Practice Clinicians 19.1 General Provisions 19.2 List of Practitioners Covered by this Policy 19.3 Non-Discrimination 19.4 Requesting Clinical Privileges 19.5 Prerogatives 19.6 Conditions and Duration of Clinical Privileges 19.7 Procedure for Renewal of Clinical Privileges 19.8 Peer Review 19.9 Fair Hearing	209
20	Allied Health Professionals 20.1 General Provisions 20.2 List of Practitioners Covered by this Policy	222
21	Department and Section Rules and Regulations	224
22	Students and Observerships 22.1 Pre-Med Student Observations 22.2 Physician Observerships – Foreign Medical Graduates	225
23	Emergency Department Call	229
Appendix A	Committee Charters	231
Appendix B	Section Rules & Regulations	259

Title	Officers of the Medical Staff – General Provisions	
Number	1.1	
Effective Date	August 27, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

1.1.1	The officers of the Medical Staff shall consist of the following:
	1.1.1.1 Chief of Staff
	1.1.1.2 Assistant Chief of Staff
	1.1.1.3 Secretary/Treasurer
	1.1.1.4 Immediate Past Chief of Staff
	1.1.1.5 Section Chiefs
	1.1.1.6 Department Chiefs
1.1.2	All matters dealing with the qualifications, conflict of interest disclosures, terms of office, nomination process, election of officers, removal of officers, and vacancies in an office are detailed in the Medical Staff Bylaws, Article V, Section 4.A-J.
1.1.3	Duties to be fulfilled by the Medical Staff Officers are specified in Medical Staff Bylaws, Article V, Section 4.L. as well as this Medical Staff Policy.

Approval Process:

Bylaws Committee	May 20, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	June 20, 2013
Published to the Medical Staff	September 24, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- August 10, 2017
- June 26, 2018
- March 25, 2019
- February 22, 2021

Title	Officers of the Medical Staff – Chief of Staff	
Number	1.2	
Effective Date	August 27, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

1.2	The Chief of Staff		
	1.2.1	Serves as chief administrative officer of the organized Medical Staff	
	1.2.2	Calls, determines the agenda, and presides at all general and special meetings of the Medical Staff	
	1.2.3	Serves as the Chair of the Medical Executive Committee, with tie-breaking vote prerogative only	
	1.2.4	Serves as a non-voting, ex-officio member of all other Medical Staff Committees	
	1.2.5	Serves as a member of the St. Michael Quality Improvement and Safety Committee	
	1.2.6	Serves as a full voting member of the Board of Directors, and, in that capacity	
		1.2.6.1	Represents the views, policies, procedures, concerns, needs, and grievances of the Medical Staff to the Board of Directors and Administration
		1.2.6.2	Advises the Board of Directors on the effectiveness of the quality assessment/improvement program and the overall quality of patient care provided by St. Michael
		1.2.6.3	Advises the Board of Directors on matters that impact the delivery of patient care and clinical services, including, but not limited to, new or modified programs or services, recruitment and training of professional and support staff personnel, staffing patterns, and performance
		1.2.6.4	Coordinates and cooperates with the Board of Directors, President, Administration, and St. Michael leadership staff in matters of mutual concern for the promotion of safe and effective quality of care in St. Michael facilities
		1.2.6.5	As a physician member of the Board of Directors, complies with the provisions of Medical Staff Bylaws, Article V, Section 4.K.
	1.2.7	Serves as spokesman for the Medical Staff in its external professional and public relations	
	1.2.8	Ensures enforcement of the Medical Staff Bylaws, Policies, Rules and Regulations, and St. Michael policies pertinent to the Medical Staff	
	1.2.9	Implements sanctions when indicated in accordance with provisions of the Medical Staff Bylaws	
	1.2.10	Ensures Medical Staff compliance with procedural safeguards in all instances in which corrective action has been requested or initiated against a member of the Medical Staff or Non-Physician Practitioner	
	1.2.11	Appointment Chairperson and members of all Medical Staff Committees in accordance with the Medical Staff Bylaws, Article VII.	

	1.2.12	Ensures development and implementation of methods and processes for credentialing, delineation of privileges, continuing education, utilization management, quality improvement, patient safety, and concurrent and focused monitoring of patient care quality(OPPE and FPPE)
	1.2.13	Designates other members of the Medical Staff to serve as liaisons and representatives to other health care entities on behalf of St. Michael and the organized Medical Staff
	1.2.14	Approves expenditures from the Medical Staff Treasury in accordance with Medical Staff Bylaws, Article V, Section 2.E.

Approval Process:

Bylaws Committee	May 20, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	June 20,2013
Published to the Medical Staff	September 30, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- March 25, 2019
- February 22, 2021

Title	Officers of the Medical Staff – Assistant Chief of Staff	
Number	1.3	
Effective Date	August 27, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

1.3	Assistant Chief of Staff	
	1.3.1	Serves as a member of the Medical Executive Committee
	1.3.2	Serves as a member of St. Michael Board Quality Improvement and Patient Safety Committee
	1.3.3	Serves as a member of the Medical Staff Quality Committee
	1.3.4	Assumes of the duties and has all authority of the Chief of Staff in the temporary absence of the Chief of Staff
	1.3.5	Performs such additional duties as may be assigned by the Chief of Staff or the Medical Executive Committee
	13.6	Serves as an ad hoc, ex-officio, without vote, participant in St. Michael Board of Directors' meetings, at the invitation of the Board Chair.

Approval Process:

Bylaws Committee	May 20, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	June 20, 2013
Published to the Medical Staff	September 30, 2013
Petition Yes/No	No
Results of Vote	n/a
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- October 18, 2017
- March 25, 2019
- February 22, 2021

Title	Officers of the Medical Staff – Secretary/Treasurer	
Number	1.4	
Effective Date	August 27, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

1.4	Secretary/Treasurer	
	1.4.1	Serves as a member of the Medical Executive Committee
	1.4.2	Ensures maintenance of accurate and complete minutes for all general Medical Staff meetings and Medical Executive Committee meetings, with the assistance of support staff
	1.4.3	Ensures proper notice is given for all Medical Staff meetings on the order of the Chief of Staff, with assistance of support staff
	1.4.4	Ensures that an answer is rendered to all official Medical Staff correspondence, with the assistance of support staff
	1.4.5	Prepares for submission to the Medical Executive Committee the annual Medical Staff budget, with the assistance of support staff
	1.4.6	Is responsible for collection and expenditure of Medical Staff Treasury funds and the proper maintenance of all Medical Staff accounts, with assistance from support staff
	1.4.7	Submits a financial report to the Medical Executive Committee at least quarterly and to the Medical Staff at least annually, with the assistance of support staff
	1.4.8	Performs such additional duties as may be assigned by the Chief of Staff or Medical Executive Committee

Approval Process:

Bylaws Committee	May 20, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	June 20, 2013
Published to the Medical Staff	September 30, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- September 27, 2017
- March 25, 2019
- February 22, 2021

Title	Officers of the Medical Staff – Immediate Past Chief of Staff	
Number	1.5	
Effective Date	August 27, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

1.5	Immediate Past Chief of Staff	
	1.5.1	Serves as a member of the Medical Executive Committee
	1.5.2	Chairs the Nominating Committee

Approval Process:

Bylaws Committee	May 20, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	June 20, 2013
Published to the Medical Staff	September 30, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- September 27, 2017
- March 25, 2019
- February 22, 2021

Title	Officers of the Medical Staff – Department and Section Chiefs	
Number	1.6	
Effective Date	August 27, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

1.6.1	Department and Section Chiefs are considered officers of the Medical Staff.
1.6.2	Department and Section Chiefs serve as members of the Medical Executive Committee.
1.6.3	Department and Section Chiefs may be assigned additional duties or tasks by the Chief of Staff or Medical Executive Committee.
1.6.4	Full descriptions of the duties of the Department and Section Chiefs are contained in the Medical Staff Policies, Chapter 2, Departments and Sections.

Approval Process:

Bylaws Committee	May 20, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	June 20, 2013
Published to the Medical Staff	September 30, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- September 27, 2017
- March 25, 2020
- February 22, 2021

<table>
<tr><td>Title</td><td colspan="2">Departments and Sections – General Provisions</td></tr>
<tr><td>Number</td><td colspan="2">2.1</td></tr>
<tr><td>Effective Date</td><td colspan="2">August 27, 2014</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Bylaws Committee
Medical Executive Committee</td><td>Associate Chief Medical Officer</td></tr>
<tr><td>Review Date</td><td colspan="2">February 22, 2022</td></tr>
</table>

2.1.1	Pursuant to the Bylaws, Article VI, the Medical Staff shall be organized into clinical sections.
2.1.2	Each member of the Medical Staff as well as nurse practitioners, nurse anesthetists, physician assistants and psychologists shall be assigned membership and clinical privileges in the Section most appropriate to his/her training, experience, and clinical privileges requested.
2.1.3	A Medical Staff member may be assigned clinical privileges in more than one Section, if appropriate. However, a practitioner may only have voting rights in one Section.
2.1.4	The functions of the Sections are outlined in Article VI, Section 2 of the Bylaws.

Approval Process:

Bylaws Committee	July 15, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	July 18, 2013
Published to the Medical Staff	July 23, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	August 21, 2014
Board of Directors	August 27, 2014

Reviewed:

- September 27, 2017
- May 20, 2019 – no changes needed
- February 22, 2021

Title	Departments and Sections – Departments & Sections	
Number	2.2	
Effective Date	February 26, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

2.2.1	The Sections of the Medical Staff shall be	
	2.2.1.1	Anesthesiology
	2.2.1.2	Cardiology
	2.2.1.3	Emergency Medicine
	2.2.1.4	General Surgery
	2.2.1.5	Inpatient Medicine
	2.2.1.6	Medical Specialties
	2.2.1.7	Obstetrics and Gynecology
	2.2.1.8	Ophthalmology
	2.2.1.9	Orthopedic Surgery
	2.2.1.10	Pediatrics
	2.2.1.11	Primary Care Ambulatory
	2.2.1.12	Radiology
	2.2.1.13	Surgical Specialties

Approval Process:

Bylaws Committee	July 23, 2018
This revision, newly organized Sections, was necessitated by a recent change of the Medical Staff Bylaws. That change was approved by vote of the Active Medical Staff and ratified by the Medical Executive Committee and Board of Directors. In the opinion of the Bylaws Committee this change in the policy did not warrant approval by the MEC to be distributed to the Medical Staff for a 60 day review with subsequent by the MEC and BQVC.	

Reviewed:

- May 20, 2019 – minor changes only, no content changes
- February 22, 2021

Title	Departments and Sections – Department Chiefs	
Number	2.3	
Effective Date	To be determined	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	One date from board approval date	

MSP 2.3 – Department Chiefs - Being drafted

Title	Departments and Sections – Section Chiefs	
Number	2.4	
Effective Date	November 30, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

2.4.1	The qualifications of the Section Chiefs are defined in the Bylaws, Article V, Section 4.B.	
2.4.2	The term of office of the Section Chiefs is defined in the Bylaws, Article V, Section 4.D.	
2.4.3	The nomination and election of the Section Chiefs are defined in the Bylaws, Article V, Section 4.G.	
2.4.4	The process for removal of a Section Chief from office is defined in the Bylaws, Article, VI, Section 3.D.	
2.4.5	The duties and responsibilities of the Section Chiefs are defined in the Bylaws, Article VI, Section 3.E.	
2.4.6	Other duties to include:	
	2.4.6.1	Ensure that Section meetings are scheduled at least quarterly, but more often if necessary, to carry out the functions of the Section.
	2.4.6.2	Appoint sub-committees, ad hoc or regular, within the Section to carry out regular functions or special assignments. Such sub-committees may include medical staff members of other specialties and hospital staff to promote patient safety and effective coordination of patient care.
	2.4.6.3	Attend Medical Executive Committee meetings and represent the interests of the Section. Regularly report to Section members actions taken by the MEC.
	2.4.6.4	Carry out administrative duties on behalf of the Section in a timely manner such that approvals, actions, and recommendations are not unduly delayed.

Approval Process:

Bylaws Committee	June 27, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	July 15, 2016
Published to the Medical Staff	August 12, 2016
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	October 20, 2016
Board of Directors	November 30, 2016

Reviewed:

- Bylaws Committee - June 27, 2018
- Bylaws Committee – May 20, 2019 – formatting changes only
- February 22, 2021

Title	Departments and Sections – Functions of Departments	
Number	2.5	
Effective Date	November 30, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

2.5.1	Two or more Sections with common interests may form a Department to promote the stated goals of the Medical Staff upon approval by the MEC and a vote of the affected Sections.	
	2.5.1.1	The Sections desiring to create a Department shall petition the MEC. Such petition must include the signatures of at least 51% of the Active Staff members of each affected Section.
	2.5.1.2	Upon on approval of the MEC, the matter will be referred to the Bylaws Committee to make recommendations for any revisions of Medical Staff governance documents to accommodate the creation of the Department.
	2.5.1.3	The Department shall be authorized to carry out its functions upon approval of any necessary amendments to Medical Staff Bylaws and Policies.
2.5.2	The primary responsibility of the Department is to facilitate communication and collegial activities within the Department to support quality, safety, and efficiency of patient care.	
2.5.3	Recommend and assist in the development of continuing education programs relevant to the work of the Department.	
2.5.4	Establish rules and regulations for the Department.	
2.5.5	Under the direction of the Department Chief, mediate any disputes among the Sections within the Department.	
2.5.6	Meet as often as necessary to carry out the business of the Department.	
2.5.7	Within the Department, establish such sub-committees, task forces, and other mechanisms, as necessary, to perform the assigned functions.	
2.5.8	Other duties as may be assigned by the Chief of Staff or the MEC.	

Approval Process:

Bylaws Committee	June 27, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	July 21, 2016
Published to the Medical Staff	August 12, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	October 20, 2016
Board of Directors	November 20, 2016

Reviewed:

- December 27, 2017
- May 20, 2019 – Bylaws Committee: minor changes only, no content changes
- February 22, 2022

Title	Departments and Sections – Functions of Sections	
Number	2.6	
Effective Date	November 30, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

2.6.1	The primary responsibility of the Section shall be to implement and conduct specific review and evaluation activities that contribute to the quality, safety, and efficiency of patient care provided by members of the Section, specifically, and of the Medical Staff in general.	
2.6.2	The number and extent of such reviews to be conducted during the year shall be determined by the individual Sections and approved by the MEC, in consultation with other appropriate Committees and in conjunction with the Medical Staff Quality Plan, as outlined in Medical Staff Policies, Chapter 18.	
2.6.3	Each Section shall routinely collect information about important aspects of patient care provided in the Section, periodically assess this information, and develop objective criteria for use in evaluating patient care.	
	2.6.3.1	The Quality Department shall provide the support to the Sections in carrying out the review and evaluation functions, including the gathering and analysis of data.
	2.6.3.2	This shall include periodic review of recommendations and findings of the Multispecialty Peer Review Committee and the Medical Staff Quality Committee.
	2.6.3.3	Patient care reviews shall include all clinical work performed under the jurisdiction of the Section, regardless of whether the member whose work is subject to such review is a member of the Section.
2.6.4	Recommend credentialing criteria for the granting of clinical privileges to members of the Section and/or members of another Section seeking privileges that is under the jurisdiction of the Section.	
2.6.5	Establish rules and regulations for the Section as provided in Article XIV of the Medical Staff Bylaws.	
2.6.6	Meet at least quarterly, but more often if necessary, to carry out the business of the Section.	
2.6.7	Within the Section, establish such sub-committees, task forces, and other mechanisms as necessary to perform the assigned functions.	
2.6.8	Recommend and assist in the development of continuing education programs relevant to the work of the Section	
2.6.9	Other duties as may be assigned from time to time by the Chief of Staff or the MEC	

Approval process:

Bylaws Committee	June 27, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	July 21, 2016
Published to the Medical Staff	August 12, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	October 20, 2016
Board of Directors	November 30, 2016

Reviewed:

- December 27, 2017
- May 20, 2019 – Bylaws Committee: numbering changes only, no effect on content
- February 22, 2021

Title	Committees of the Medical Staff – General Provisions	
Number	3.1	
Effective Date	February 26, 2014	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director of Medical Staff Services Associate Chief Medical Officer
Review Date	February 22, 2022	

3.1.1	Pursuant to the Medical Staff Bylaws, Article VII, Section 3, the Standing Committees of the Medical Staff are	
	3.1.1.a.	Credentials Committee
	3.1.1.b	Practitioner Wellness Committee
	3.1.1.c	Professional Performance Committee
	3.1.1.d	Medical Executive Committee
	3.1.1.e	Medical Staff Quality Committee
	3.1.1.f	Multispecialty Peer Review Committee
3.1.2	Pursuant to the Medical Staff Bylaws, Article VII, Section 4, additional special committees or ad hoc committees may be created by the Chief of Staff, with the advice and consent of the Medical Executive Committee, to perform tasks specified in the Committee Charters.	
3.1.3	A list of all special and ad hoc Medical Staff committees is appended to this policy.	
3.1.4	The charters of all standing, special, and ad hoc committees are appended to this policy.	

Approval Process:

Bylaws Committee	October 21, 2013
Medical Executive Committee Approval for distribution to the Medical Staff	November 21, 2013
Published to the Medical Staff	December 18, 2013
Medical Executive Committee Recommendation for Approval to Board of Directors	February 20, 2014
Board of Directors	February 26, 2014

Reviewed:

- June 27, 2016
- September 27, 2017
- January 22, 2018 – Appended updated list
- August 26, 2019 – Bylaws Committee – minor wording changes only; no effect on content
- February 22, 2021

St. Michael Medical Center

Medical Staff

Special and Ad Hoc Committees of the Medical Staff

- Blood Utilization Committee
- Bylaws Committee
- Cancer Committee
- Ethics Committee
- Health Information Management Committee
- Infection Prevention Committee
- Maternal – Fetal Health Committee
- Robotics Committee
- Utilization Management Committee

January 22, 2018
August 26, 2019
February 22, 2021

Title	Committees of the Medical Staff – Creation of a Short Term Committee	
Number	3.2	
Effective Date	January 25, 2107	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

3.2.1	From time to time it may be necessary to create a committee for a short term assignment for a specific purpose.
3.2.2	Pursuant to the Medical Staff Bylaws, Article VII, Section 4, additional special committees or ad hoc committees may be created by the Chief of Staff, with the advice and consent of the Medical Executive Committee to perform tasks specified in the Committee Charters.
3.2.3	The duration of such committee is expected to be less than one year. If at the end of the first year, the assignment is deemed incomplete, the MEC may extend the duration of the committee.
3.2.4	The short term committee will have a charter approved by the MEC which sets forth the assignment and other terms generally included in a committee charter, if applicable.
3.2.5	Such committees may include medical staff members, hospital staff, and external resources as needed.
3.2.6	Creation of a short-term committee may be requested by a Department or Section Chief, Chief of Staff, or MEC.
3.2.7	The committee will provide written reports to the entity (Section, Department, or MEC) who requested its creation.
3.2.8	Such committees are considered medico-administrative in nature and will not address matters subject to peer review protections.
3.2.9	This provision does not apply to investigative committees which are addressed in Medical Staff Policy, Chapter 8 and Disruptive Behavior Policy, 15.8. Peer review protections apply in these situations.

Approval Process:

Bylaws Committee	August 22, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	September 15, 2016
Published to the Medical Staff	September 23, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	January 19, 2017
Board of Directors	January 25, 2017

Reviewed:

- April 18, 2018
- August 26, 2019 – Bylaws Committee: minor wording changes only, no effect on content
- February 22, 2021

<table>
<tr><td>Title</td><td colspan="2">Appointment – Nature of Medical Staff Membership</td></tr>
<tr><td>Number</td><td colspan="2">4.1</td></tr>
<tr><td>Effective Date</td><td colspan="2">March 20, 2018</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Bylaws Committee
Credentials Committee
Medical Executive Committee</td><td>Associate - Chief Medical Officer</td></tr>
<tr><td>Review Date</td><td colspan="2">February 22, 2022</td></tr>
</table>

4.1.1	“Medical Staff Membership” refers to the organizational rights accorded practitioners pursuant to the Medical Staff Bylaws (i.e. how the member practitioners relate to the Medical Staff as an organization and to fellow practitioners on the Medical Staff; the right to vote, serve on committees, etc.)
4.1.2	By contrast, the term “Medical Staff Privileges” refers to rights recommended by the Medical Staff and granted by the Board pursuant to the Medical Staff Bylaws that delineate the clinical services that the practitioner can render to patients at St. Michael.
4.1.3	Membership confers associational rights; privileges confer clinical privileges.
4.1.4	Membership on the Medical Staff of St. Michael is available only to those Physicians (MD or DO), Dentists (DDS or DMD), or Podiatrists (DPM) who continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws, in this Medical Staff Policy on Appointment, and in other applicable Medical Staff Rules and Regulations, and CHI Franciscan Policies.
4.1.5	Pursuant to the Medical Staff Bylaws, Article III, Section 3, all matters relating to qualifications for appointment to the Medical Staff are contained in the Policy on Appointment.
4.1.6	See appended table 4.1.6.A

Approval Process:

Bylaws Committee	October 23, 2017
Medical Executive Committee approval for distribution to the Medical Staff	November 16, 2017
Published to the Medical Staff	January 5, 2018
Medical Executive Committee recommendation for Approval to Board of Directors	March 15, 2018
Board of Directors	March 20, 2018

Reviewed:

- August 26, 2019 – Bylaws Committee: minor wording changes, no effect on intent
- February 22, 2021

Table 4.1.6.A

St. Michael Medical Center
Medical Staff
Membership vs. Privileges

Category	Membership	Privileges
Active	x	x
Provisional Active	x (Limited - may vote in committees or sections only)	x
Affiliate	x (limited)	x
Provisional Affiliate	x (limited)	x
Courtesy		X (access to EMR, order outpatient diagnostic and therapeutic services; participate in CME)
Military		x
Locum Tenens		x
Residents		x
Advanced Practice Clinicians		x
Allied Health Practitioners		x

September 27, 2017
August 26, 2019
February 22, 2021

Title	Appointment: Qualifications for Membership	
Number	4.2	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.2.1	Medical Staff membership and/or clinical privileges shall not be granted or denied on the basis of any protected class as defined by federal, state, or municipal law or on the basis of any other criterion unrelated to the delivery of quality patient care at St. Michael, or to professional ability and judgment.		
4.2.2	Medical Staff membership and/or clinical privileges shall not be granted or denied based solely and primarily on economic criteria (other than statutory, regulatory, or judicial requirements or other exceptions, such as the maintenance of professional liability insurance as specifically described in the Medical Staff Bylaws and Policies) that do not relate to clinical qualifications, professional responsibility, or quality of care.		
4.2.3	Every practitioner seeking or holding Medical Staff appointment must, at the time of initial application and thereafter, demonstrate to the satisfaction of appropriate authorities of the Medical Staff, Administration, and the Board, subject to final review and decision by the Board, that he/she possesses the following qualifications and any additional qualifications and procedural requirements set forth elsewhere in the Medical Staff Policies and other pertinent St. Michael Medical Staff Bylaws and Rules and Regulations.		
	4.2.3.1	Possess a valid license issued by the State of Washington to practice in his/her profession. Practitioners in the Military Staff category are exempt from this provision as long as they carry a license issued by an official agency of a State, the District of Columbia, or a Commonwealth, territory, or possession of the United States to provide health care independently as a health-care professional.	
	4.2.3.2	Graduation from a professional school and an appropriately accredited US residency program or other training program that qualifies one for specialty board certification	
	4.2.3.3	Training and experience sufficient to support the request for clinical privileges for which the Practitioner is applying	
	4.2.3.4	Board certification or eligibility/admissibility in a specialty appropriate for the clinical privileges being requested by physicians, oral surgeons, and podiatrists.	
		4.2.3.4.1	Board certification or board eligibility/admissibility requirements for dentists will be considered on a case by case basis in relation to clinical privileges being requested.
		4.2.3.4.2	The Medical Staff membership and clinical privileges of all practitioners who were members of the Medical Staff prior to June 1, 1998 will be exempt from provision 4.2.3.4.

Approval Process:

Bylaws Committee	October 28, 2019
Medical Executive Committee approval for distribution to the Medical Staff	November 21, 2019
Published to the Medical Staff	January 20, 2020
Petition Yes/No	No
Medical Executive Committee recommendation for Approval to Board of Directors	March 19, 2020
Board of Directors	September 15, 2020

Reviewed: February 22, 2021

Title	Appointment: Clinical Performance	
Number	4.3	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.3.1	Every Practitioner seeking or holding Medical Staff Appointment must, at the time of application and thereafter, provide information sufficient for the Medical Staff, Administration, and CHI Franciscan Board of Directors to satisfactorily evaluate the Practitioner's		
	4.3.1.1	Current clinical competence	
	4.3.1.2	Ongoing continuing professional education	
	4.3.1.3	Utilization patterns documenting a continuing ability to provide patient care	
		4.3.1.3.1	At an acceptable level of quality and efficiency
		4.3.1.3.2	Consistent with available resources
		4.3.1.3.3	Consistent with CMS and other regulatory and accreditation standards

Approval Process:

Bylaws Committee	April 21, 2014
Medical Executive Committee approval for distribution to the Medical Staff	August 21, 2013
Published to the Medical Staff	January 16, 2015
Petition Yes/No	No
Medical Executive Committee recommendation for Approval to Board of Directors	March 18, 2016
Board of Directors	March 23, 2016

Reviewed:

- September 27, 2017
- August 26, 2019 – Bylaws Committee: formatting changes only, no effect on content
- February 22, 2021

Title	Appointment – Professional Conduct	
Number	4.4	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.4.1	Each Practitioner's behavior and interactions with patients, other Practitioners, St. Michael staff, and Administration shall be guided by, and subject to, the provisions of the Disruptive Behavior Policy, Chapter 15, found in these Medical Staff Policies.

Approval Process:

Bylaws Committee	April 21, 2014
Medical Executive Committee approval for distribution to the Medical Staff	August 21, 2014
Published to the Medical Staff	January 16, 2015
Petition Yes/No	No
Medical Executive Committee recommendation for Approval to Board of Directors	March 18, 2016
Board of Directors	March 23, 2016

Reviewed:

- September 27, 2018
- August 26, 2019 – Bylaws Committee: minor wording changes only; no effect on content
- February 22, 2021

Title	Appointment – Health Status	
Number	4.5	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.5.1	Each Practitioner shall attest to		
	4.5.1.1	Freedom from or having under adequate control any physical or mental health impairment which presents a reasonable probability of interfering with the Practitioner's ability to provide quality and safe patient care	
	4.5.1.2	Freedom from abuse of any type of substance or chemical which may affect cognitive, motor, or communication ability in a manner which interferes with, or which presents a reasonable probability of interfering with, the Practitioner's ability to provide quality and safe patient care.	
4.5.2	Testing and Evaluation		
	4.5.2.1	Each Practitioner consents to a psychiatric or other medical evaluation and a chemical test or test of blood, breath, urine, and other bodily substances for the purpose of determining his or her ability to render or participate in the care of patients, where such tests or evaluations are relevant to the applicant's ability to exercise the clinical privileges sought by the applicant and are requested at any time during the application process.	
	4.5.2.2	Such tests or evaluations are to be requested through and administered by the Practitioner Well Being Committee. The consent of the Practitioner shall be ongoing during the application process and after such time as Medical Staff membership, clinical privileges, or both are granted. Such testing may be requested at any time during the application process for membership on the Medical Staff or during the course of the Practitioner's Medical Staff Membership by any one of the following:	
		4.5.2.2.1	Chair of the Professional Performance Committee
		4.5.2.2.2	Chief of the Section in which the applicant is seeking clinical privileges
		4.5.2.2.3	Chief of the Medical Staff
		4.5.2.2.4	President
		4.5.2.2.5	Associate Chief Medical Officer

Approval Process:

Bylaws Committee	April 21, 2014
Medical Executive Committee approval for distribution to the Medical Staff	August 21, 2014
Published to the Medical Staff	January 16, 2015
Petition Yes/No	No
Medical Executive Committee recommendation for Approval to Board of Directors	March 18, 2016
Board of Directors	March 23, 2016

Review:

- September 27, 2017
- August 26, 2019 – Bylaws Committee: minor wording changes only, no effect on content
- February 22, 2021

Title	Appointment – Professional Liability Insurance	
Number	4.6	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.6.1	Each Practitioner applying for or holding Medical Staff membership must be able and willing to demonstrate proof of continuous professional liability insurance coverage meeting those requirements established by the Board of Directors.

Approval Process:

Bylaws Committee	April 21, 2014
Medical Executive Committee Approval for distribution to the Medical Staff	August 21, 2014
Published to the Medical Staff	January 23, 2015
Medical Executive Committee recommendation for Approval to Board of Directors	March 18, 2016
Board of Directors	March 23, 2016

Reviewed:

- June 27, 2018
- August 26, 2019 – Bylaws Committee: minor wording changes only, no effect on content
- February 22, 2021

Title	Appointment – Duration of Membership	
Number	4.7	
Effective Date	March 20,2018	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.7.1	Initial appointment to the Medical Staff shall be made by the Medical Staff.
4.7.2	Granting of clinical privileges shall be made solely at the discretion of the CHI Franciscan Health Board of Directors upon recommendation of the Medical Executive Committee.
4.7.3	The CHI Franciscan Board of Directors shall act upon appointments pursuant to the recommendations from the Medical Staff as described in the Bylaws and this policy.
4.7.4	All initial appointments will be to the Provisional staff, which is defined in Medical Staff Bylaws, Article IV, Section 4.
4.7.5	Provisional staff is a probationary period lasting for a minimum of 12 months.
4.7.6	The Provisional 12-month period begins on the date the practitioner has been granted Medical Staff membership and clinical privileges by the CHI Franciscan Board of Directors.
4.7.7	At the end of the initial Provisional period, the practitioner may be advanced to a higher level provided he/she meets the standards for advancement to Active or Affiliate staff category.
4.7.8	The Provisional period may be extended for an additional 12 months if, in the opinion of the Section Chief, PPC, MEC, and CHI Franciscan Board of Directors, the member does not meet the standards for advancement to a higher level.
4.7.9	At the end of the second year of the Provisional period, action must be taken to either advance the member to the next level of the Medical Staff or to deny membership. Provisional status may not exceed 24 months.
4.7.10	At the completion of the Provisional period and advancement to a higher staff category, membership continues in increments of a maximum of 2 years.
4.7.11	Thereafter, renewal, or reappointment, cycles are based upon the practitioner's birth date. The first reappointment cycle will be for a period that ends with the second year's birth date. That may be for a period of 13 months to 24 months depending upon when the birthdate falls relative to the initial date of appointment. Reappointment is discussed in more detail in Medical Staff Policies, Chapter 5.

Bylaws Committee	October 23, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	November 15, 2107
Published to the Medical Staff	January 5, 2018
Medical Executive Committee Recommendation for Approval to Board of Directors	March 15, 2018
Board of Quality and Values Committee	March 20, 2018

Reviewed:

- February 22, 20221 – Bylaws Committee: minor wording corrections, no effect on content.

Title	Appointment – Conditions of Membership	
Number	4.8	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.8.1	By accepting appointment to the Medical Staff or as an Advanced Practice Clinician, or a Non-Physician Practitioner, a practitioner acknowledges an obligation to abide by			
	4.8.1.1	Medical Staff Bylaws		
	4.8.1.2	Medical Staff Policies		
	4.8.1.3	Medical Staff Department and Section Rules and Regulations		
	4.8.1.4	Medical Staff Plans		
	4.8.1.5	St. Michael Policies and Procedures		
4.8.2	By accepting appointment to the Medical Staff or as an Advanced Practice Clinician or a Non-Physician Practitioner, a practitioner agrees:			
	4.8.2.1	To act in an ethical , professional, and courteous manner toward all patients and their families, St. Michael staff, Medical Staff, and Non-Physician Practitioners in a manner guided by, and subject to, the Disruptive Behavior Policy, Chapter 15		
	4.8.2.2	To provide continuous care for patients, either personally or by designation of an appropriately qualified covering Practitioner who has been granted comparable clinical privileges at St. Michael		
	4.8.2.3	To report in writing to the Associate Chief Medical Officer any of the following		
		4.8.2.3.1	Any professional disciplinary actions imposed by a State or Federal professional disciplinary board, including issuance of a formal statement of charges	
		4.8.2.3.2	Any professional disciplinary actions imposed by a Professional Review Organization	
		4.8.2.3.3	Any professional disciplinary actions imposed by a State or Federal agency	
		4.8.2.3.4	Any professional disciplinary actions imposed by any professional organization, including, but not limited to, the Medical Staff of any other hospital, surgery center or post-acute care facility.	
		4.8.2.3.5	Conviction of a felony in any State or federal jurisdiction	
		4.8.2.3.6	Any judgment of settlement in a professional liability action in which he/she is a defendant	
		4.8.2.3.7	Any voluntary or involuntary relinquishment of	
			4.8.2.3.7.1	Professional license in any state
			4.8.2.3.7.2	Professional Board Certification
			4.8.2.3.7.3	Medical Staff membership to avoid disciplinary action

			4.8.2.3.7.4	Clinical privileges to avoid disciplinary action, including possible loss of or reduction of clinical privileges
4.8.3	By accepting appointment to the Medical Staff or as a Non-Physician Practitioner, a practitioner acknowledges that any misrepresentation, misstatement, or omission of information from the application for appointment is cause for denial for appointment or revocation of appointment, without appeal, if it has already been conferred.			

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	9/20/2018
Published to the Medical Staff	10/12/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	1/17/2019
Board of Directors	

Reviewed:

- February 19, 2019
- February 22, 2021

Title	Appointment – Request for Application	
Number	4.9	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.9.1	Individual requesting to commence the application process for Medical Staff or Non-Physician Practitioner appointment shall a request in writing, via e-mail, or by telephone		
4.9.2	Upon receipt of such request, the Medical Staff Services Office shall send the practitioner a Request for Application form which outlines		
	4.9.2.1	The basic criteria for appointment which are	
		4.9.2.1.1	Valid, unrestricted license to practice professionally in the US
		4.9.2.1.2	Appropriate prescriptive authority for privileges requested
		4.9.2.1.3	Specialty Board Certification or evidence of admissibility/eligibility status.
4.9.3	Each person seeking an application for appointment must submit a completed Request for Application form prescribed by St. Michael.		
4.9.4	Each person seeing an application for appointment must submit the following documentation to assure he/she meets the minimum threshold criteria to qualify for an application:		
	4.9.4.1	Copy of current professional license to practice in the US	
	4.9.4.2	Current Drug Enforcement Administration certificate, if prescriptive authority is required for privileges expected	
	4.9.4.3	ECFMG Certificate, if foreign medical graduate	
	4.9.4.4	Evidence of current specialty Board Certification or admissibility/eligibility status. If not currently certified, a timeline for obtaining certification status	
	4.9.4.5	Current curriculum vitae	
	4.9.5.6	Application processing fee in an amount prescribed by the Board of Directors	
	4.8.5.7	Disclosure statement for the Washington State Patrol Background Check	
4.9.5	If the request for application is completed and returned with the requested documentation, it will be reviewed by the Medical Staff Services Office to ensure it meets basic criteria to apply for Medical Staff membership.		
4.9.6	If there is a question that the practitioner does not meet the basic criteria to receive an application, it will be forwarded to the CMO for review.		
4.9.7	If in the opinion of the CMO the practitioner does not meet basic criteria to receive an application, the practitioner will be notified by the CMO in writing.		
4.9.8	A practitioner not meeting basic criteria for appointment to the Medical Staff shall not have appeal rights as described in the Medical Staff Fair Hearing Policy, Chapter 16		
4.9.9	If the request for application is complete and the practitioner meets the basic criteria necessary to apply for appointment, he/she will be notified of acceptance as an applicant for appointment to the Medical Staff or as a Non-Physician Practitioner.		
4.9.10	The applicant will receive		
	4.9.10.1	The application form prescribed by the Board	

	4.9.10.2	Copy of the Medical Staff Bylaws and Policies	
	4.9.10.3	Medicare “Notice to Physicians”	
	4.9.10.4	Attestation	
	4.9.10.5	Non-discrimination statement	
	4.9.10.6	Other forms which are administrative in nature:	
		4.9.10.6.1	Signature card
		4.9.10.6.2	Parking permit request
		4.9.10.6.3	Contact information form

Approval Process:

Bylaws Committee	April 21, 2014
Medical Executive Committee Approval for distribution to the Medical Staff	August 21, 2014
Published to the Medical Staff	February 13, 2015
Medical Executive Committee Recommendation for Approval to Board of Directors	March 17, 2016
Board of Directors	March 23, 2017

Reviewed:

- February 22, 2021

Title	Appointment – Complete Application	
Number	4.10	
Effective Date	January 27, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	June 10, 2022	

4.10.1	Completed applications are returned to the Medical Staff Services Office in sufficient time prior to the anticipated start date to allow for completion of primary source verification and thorough review by persons and committees responsible for such review.		
4.10.2	Each application for Medical Staff membership shall be submitted in writing, signed by the applicant on a form prescribed by the Board of Directors. An application shall be considered completed in writing if it has been filled out via electronic means. Faxed, digital, electronic, or scanned signatures are acceptable. Signature stamps are not acceptable.		
4.10.3	Each application shall include information concerning the applicant's professional qualifications, including licensure, training, and documented experience in categories of treatment areas or procedures such that current clinical competence can be confirmed.		
4.10.4	Each application shall include the names of at least three peer references who can provide adequate information on the applicant's current professional competencies and ethical character.		
	4.10.4.1	A peer reference is, generally, someone with the same professional credential as the applicant.	
		4.10.4.1.1	Physician – MD or DO
		4.10.4.1.2	Dentist – DDS or DMD
		4.10.4.1.3	Podiatrist – DPM
		4.10.4.1.4	An ARNP or PA-C may be considered peer references for either discipline in those circumstances where a practitioner from the other discipline is in a better position to evaluate current clinical competence. However, at least one reference must hold the same professional credential as the applicant.
	4.10.4.2	Whenever possible one reference should be the Program Director of the applicant's training program.	
	4.10.4.3	Depending upon privileges requested, dentists and podiatrists may substitute a physician reference as one of the peer references. Or, in some instances, the Section Chief or Credentials Committee may request an additional physician reference for dentists and podiatrists if further information is needed relative to clinical privileges requested.	
	4.10.4.4	In addition to the two peer references, Advanced Practice Clinician applicants need to provide a physician reference.	
	4.10.4.5	Exceptions to the above will be handled on a case-by-case basis by the Credentials Committee upon request by the applicant	
	4.10.4.5	Exceptions to the above will be handled on a case-by-case basis by the Credentials Committee upon request by the applicant	

4.10.5	Each application shall include a request for the specific clinical privileges desired by the applicant on the form(s) prescribed by the MEC and the Board.			
4.10.6	Each application shall include a designation of which Medical Staff category the applicant will request following the end of the Provisional period.			
4.10.7	Each application shall include information regarding whether the applicant's			
	4.10.7.1	Medical Staff membership and/or clinical privileges have ever – on a voluntary or involuntary basis- been revoked, suspended, diminished, or not renewed at any other hospital or institution or employer		
	4.10.7.2	Drug Enforcement Administration or other controlled substance registration has ever – on a voluntary or involuntary basis – been revoked, suspended, or diminished		
	4.10.7.3	License to practice any healthcare profession in any jurisdiction has ever – on a voluntary or involuntary basis – been suspended, limited, restricted, or terminated		
4.10.8	The applicant shall include a signed attestation and release form which includes the following provisions			
	4.10.8.1	Acknowledgement of receipt of the Medical Staff Bylaws and Policies and applicable Section Rules and Regulations		
	4.10.8.2	Agreement to be bound by the terms of the Medical Staff Bylaws, Policies, and Rules and Regulations and all St. Michael policies during the time the applicant is under consideration and, if Medical Staff membership is granted, while a member of the Medical Staff		
	4.10.8.3	Statement of willingness to appear for interviews with regard to the application, if requested		
	4.10.8.4	Authorization for St. Michael representatives to consult with others who have been associated with the applicant or who may have information bearing on the competence and qualifications of the applicant		
	4.10.8.5	Consent to inspection by St. Michael representatives of all records and documents that may be material to an evaluation of the applicant's professional and personal qualifications for Medical Staff membership and the ability to carry out clinical privileges requested in a safe and effective manner		
	4.10.8.6	Releases from all liability all St. Michael representatives for their acts performed in substantial good faith in connection with the evaluation of the applicant's credentials and qualifications		
		4.10.8.6.1	For the purpose of this policy, the term "St. Michael representative" shall include the following which have responsibility for collecting or evaluating the applicant's credentials and current clinical competence and acting upon the applications:	
			4.10.8.6.1.1	Members of the Board of Directors and its committees
			4.10.8.6.1.2	President and designee(s), including the Chief Medical Officer
			4.10.8.6.1.3	All Medical Staff members of its various departments, sections, and committees
			4.10.8.6.1.4	Administrative staff supporting the credentialing and privileging process

	4.10.8.7	Releases from liability all individuals and organizations who provide information in substantial good faith, including otherwise privileged or confidential information, to St. Michael representatives concerning the applicant's	
		4.10.8.7.1	Professionalism
		4.10.8.7.2	Patient care and procedure skills
		4.10.8.7.3	Medical knowledge
		4.10.8.7.4	Practice-based learning and improvement
		4.10.8.7.4	Interpersonal and communication skills (including verbal, written, and documentation by electronic means)
		4.10.8.7.5	Systems based practice
		4.10.8.7.6	Physical and mental health, including emotional stability
		4.10.8.7.7	Other qualifications for Medical Staff appointment and clinical privileges requested
4.10.9	By submitting the application the applicant authorizes the Medical Staff and St. Michael to contact other hospitals, surgery centers, long term care facilities, other institutions and professional references with which the applicant has been associated and who may have information bearing on the applicant's licensure, competence, character, and ethical qualifications, including the National Practitioner Data Bank as established by the Heath Care Quality Improvement Act.		
4.10.10	The application must be complete before it will be processed. This includes		
	4.10.10.1	All blanks on the application are filled and all necessary additional explanations have been provided	
	4.10.10.2	Copies of the following documents:	
		4.10.10.2.1	Washington state professional license; practitioners applying for Military Category membership, a license issued by an official agency of a State, the District of Columbia, or a Commonwealth, territory, or possession of the United States to provide health care independently as a health-care professional
		4.10.10.2.2	DEA certificate applicable to practice in Washington state
		4.10.10.2.3	Professional liability insurance face sheet evidencing coverage effective from start date at St. Michael
		4.10.10.2.4	Copy of DD214 for any person who has served in the US military
		4.10.10.2.5	Any other documents requested by the Section Chief or Credentials Committee deemed necessary to complete the application
	4.10.10.3	Additional supplemental documents as required for membership and clinical privileges requested have been completed and signed	
	4.10.10.4	Verification that all information necessary to properly evaluate the applicant's qualifications has been received and is consistent with the information provided on the application form	
	4.10.10.5	Verification that all letters of reference and information from past hospitals and other affiliations, as required, have been received.	
	4.10.10.6	Any additional information requested by those with the responsibility for evaluation, recommendation, and approval of the application has been provided, including case logs	

4.10.11	The applicant bears the burden of proof that he/she meets all of the qualifications for Medical Staff membership and clinical privileges requested, which includes	
	4.10.11.1	Resolving any questions raised by any of the information or sources of information provided
	4.10.11.2	Assuring that all required documentation, including case logs, is made available in a timely fashion to the St. Michael representatives evaluating the applicant's credentials
	4.10.11.3	Responding to any information adverse to the applicant derived from other sources and relied upon by St. Michael, so long as it is disclosed to the applicant with sufficient specificity so the applicant is able to respond.
4.10.12	In that CHI Franciscan has an integrated Medical Staff Services Office which supports three separate medical staffs within the system, it is agreed that primary source verifications and other application related documents which might have been obtained in processing an application for one medical staff within the system, will be acceptable, provided that the date the information is received is consistent with Joint Commission standards for timeliness of primary source verified information.	
	4.10.12.1	The exception to the above is that the Attestation and the Authorization and Release need to be signed separately for each facility at the time of submission of the application.
	4.10.12.2	The Associate Chief Medical Officer, the Section Chief, or the Credentials Committee may elect not to accept the information obtained on behalf of the applicant to another system Medical Staff and direct the Medical Staff Services Office to obtain additional information.

Approval Process:

Bylaws Committee	1/25/2021
Medical Executive Committee Approval for distribution to the Medical Staff	2/18/2021
Published to the Medical Staff	3/16/2021
Medical Executive Committee Recommendation for Approval to Board of Directors	5/20/2021
Board of Directors	6/10/2021

Title	Appointment – Processing the Application – Section Chief Review	
Number	4.11	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.11.1	Upon completion of primary source verification and after all supporting information has been obtained and verified, the ACMO shall review the application for completion preparatory to submission of the application to the appropriate Section Chief of review.
4.11.2	If in the opinion of the CMO, additional information is needed to fully evaluate qualifications and/or current clinical competence, the ACMO may request the information from the applicant
4.11.3	The Section Chief may request additional information to assist his his/her evaluation of the applicant's qualifications for membership and/or request for clinical privileges.
4.11.4	Either the ACMO or Section Chief may request an interview of the applicant by phone or in person at their discretion. Whenever possible, this interview should include, at a minimum, the ACMO, Section Chief, and Credentials Committee Chair or designee.
4.11.5	The Section Chief shall review the application and supporting material and make a statement as to whether or not the applicant meets the established criteria for membership in that Section and to make recommendations regarding clinical privileges to be granted.
4.11.6	If the applicant meets the established criteria, the application and supporting materials shall be forwarded to the Credentials Committee.

Approval Process:

Bylaws Committee	April 21, 2014
Medical Executive Committee Approval for distribution to the Medical Staff	August 21, 2014
Published to the Medical Staff	March 6, 2015
Medical Executive Committee Recommendation for Approval to Board of Directors	March 18, 2016
Board of Directors	March 23, 2016

Reviewed:

- February 22, 2021

Title	Appointment – Processing the Application – Credentials Committee Review	
Number	4.12	
Effective Date	February 19, 2019	
Accountability	Medical Staff	Administration
	Credentials Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.12.1	Generally, the Chair of the Credentials Committee or a designee will review the application and supporting documentation following review by the Section Chief. However, nothing in this policy precludes the review by the Section Chief and the Credentials Chair being carried out concurrently.	
4.12.2	If the Credentials Chair or designee requests additional information prior to presentation of the applicant to the Credentials Committee, the application is considered incomplete until such time as the requested information is obtained.	
	4.12.2.1	The ACMO may assist in obtaining the information requested by the Credentials Chair or designee.
4.12.3	Once the application is deemed complete, it may be presented to the Credentials Committee.	
4.12.4	Any member of the Credentials Committee who may have a conflict of interest or bias toward the applicant should disclose such to the committee prior to deliberations. That disclosure, in and or itself, does not preclude the committee member in participating in deliberations or the voting. The member, however, could elect to recuse himself/herself from the vote or be asked to do so by the committee Chair if it is felt the conflict or bias will adversely affect the proceedings. In case the Chair has a bias, the Assistant Chair will make the determination.	
4.12.5	The Credentials Committee may take the following actions:	
	4.12.5.1	Recommend the applicant be approved for Medical Staff membership
	4.12.5.2	Based upon the recommendation of the Section Chief, recommend clinical privileges requested be approved or modified.
	4.12.5.3	Recommend that the applicant be denied Medical Staff membership and clinical privileges.
	4.12.5.4	Defer action and request additional information.
4.12.6	The recommendations of the Credentials Committee will be forwarded to the Professional Performance Committee and the Medical Executive Committee.	

Approval Process:

Credentials Committee	7/24/2018
Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	9/20/2018
Published to the Medical Staff	10/12/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	1/17/2019
Board of Quality and Value Committee	2/19/2019

Reviewed:

- February 22, 2021

Title	Appointment – Processing the Application – Professional Performance Committee	
Number	4.13	
Effective Date	May 21, 2019	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

4.13.1	The Professional Performance Committee receives the recommendations of the Credentials Committee, usually before the recommendations are submitted to the Medical Executive Committee.
4.13.2	Unlike practitioners seeking reappointment, the Professional Performance Committee generally does not have additional information about applicants for initial appointment to the Medical Staff; thus, it is not in position to modify the recommendations of the Credentials Committee for an applicant.
4.13.3	However, if deemed necessary, the Professional Performance Committee may submit any additional information they may have about an applicant and an alternate recommendation to the Medical Executive Committee for their consideration.

Approval Process:

Professional Performance Committee	8/14/2018
Bylaws Committee	10/22/2018
Medical Executive Committee approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Reviewed:

- February 22, 2021

Title	Reappointment – Reappointment Schedule	
Number	5.1	
Effective Date	September 23, 2015	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Director- Medical Staff Services Associate Chief Medical Officer
Review Date	February 22, 2022	

5.1.1	Renewals of Medical Staff Membership and clinical privileges shall be for a period not to exceed two years.	
5.1.2	In certain circumstances, based upon the recommendations of the Credentials Committee, Professional Performance Committee, and/or the Medical Executive Committee, a physician/provider who is under Focused Professional Performance Review may be reappointed for less than a two year period by the Board.	
5.1.3	Unless otherwise provided the expiration date of Medical Staff Membership and clinical privileges will coincide with the individual's birthday.	
5.1.4	Physicians actively practicing in a St. Michael facility, who have reached the age of 75, shall only be entitled to reappointment for one year at a time.	
	5.1.4.1	If there is doubt about the physician's physical or mental health status related to his/her ability to safely practice medicine and perform the privileges requested, the Chief of Staff or Associate Chief Medical Officer may request an evaluation by a provider or entity mutually agreeable to the physician and St. Michael.
	5.1.4.2	When a member of the Medical Staff is eligible for a reappointment term of one year under this provision, the reappointment fee will be pro-rated accordingly.

Approval Process:

Bylaws Committee	April 27, 2015+
Medical Executive Committee Approval for distribution to the Medical Staff	May 21, 2015
Published to the Medical Staff	June 5, 2015
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	September 17, 2015
Board of Directors	September 23, 2015

Reviewed:

- October 11, 2016
- October 9, 2017
- February 22, 2021

Title	Reappointment Packet	
Number	5.2	
Effective Date	December 21, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Director – Medical Staff Services Chief Medical Officer
Review Date	February 22, 2022	

5.2.1	At least 120 days prior to the expiration date of the current Medical Staff appointment, the Medical Staff Services Office shall send to the physician/provider the reappointment packet as prescribed by the Board.
5.2.2	The physician/provider desiring reappointment shall, at least 60 days prior to the expiration date, submit the completed reappointment packet to the Medical Staff Services Office.
5.2.3	Failure to submit the information requested shall result in suspension of Medical Staff membership and clinical privileges at the end of the member's current term, without entitlement to appeal.
5.2.4	Suspension for failure to submit a complete reappointment packet will remain in place until the reappointment is processed and approved by the Section Chief, the relevant Medical Staff Committees and the Board of Directors.
5.2.5	Failure to submit a complete reappointment packet for sixty days after the suspension is imposed shall be deemed voluntary resignation from the Medical Staff

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	9/20/2018
Published to the Medical Staff	10/12/2018
Medical Executive Committee Recommendation for Approval to Board of Quality and Value Committee	1/17/2019
Board of Directors	2/19/2019

Reviewed:

- February 22, 2021

Title	Reappointment – Complete Packet	
Number	5.3	
Effective Date	December 21, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

5.3.1	It is the responsibility of the applicant to ensure that the reappointment packet is complete.		
5.3.2	Complete means		
	5.3.2.1	All blanks on the reappointment form are filled in.	
	5.3.2.2	All requested supporting documentation is provided.	
	5.3.2.3	Verification of all information necessary to properly evaluate the applicant's qualifications have been received and information is consistent with the information provided in the reappointment packet.	
	5.3.2.4	Requested information from other hospitals or entities, as required, has been received.	
	5.3.2.5	Payment of reappointment fee in an amount set by the Board	
		5.3.2.5.1	If the physician/provider was placed on FPPE for a duration of less than two years and is applying for reappointment within the two year period for another two year period, the amount of reappointment fee charged will be prorated based upon the amount previously paid.
5.3.3	The applicant alone shall bear the burden of proof by clear and convincing evidence		
	5.3.3.1	That he/she meets all the qualifications for reappointment and renewal of clinical privileges.	
	5.3.3.2	That he/she has resolved any doubt raised by any of the information or sources of information provided	
	5.3.3.3	That all required documentation is made available, in a timely manner, to the Medical Staff and Hospital representatives responsible for evaluating the applicant and his/her credentials.	
5.3.4	Any information adverse to a reappointment applicant coming from other sources may be relied upon if it has been disclosed to the applicant with sufficient specificity so that the applicant may respond to it within the timeline for processing and submitting the reappointment packet for review.		

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	9/20/2018
Published to the Medical Staff	10/12/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	1/17/2019
Board of Directors	2/19/2019

Reviewed:

- February 22, 2021

Title	Reappointment – Evaluation and Recommendation	
Number	5.4	
Effective Date	December 21, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

5.4.1	Section Chief Review		
	5.4.1.1	After all supporting information has been obtained and verified, the Chief of the appropriate Section shall review the application for reappointment and all supporting material.	
	5.4.1.2	The Section Chief shall made a statement as to whether or not the applicant meets the established criteria for reappointment to that Section.	
	5.4.1.3	The Section Chief shall make recommendation for renewal of clinical privileges requested by the applicant.	
	5.4.1.4	The Section Chief shall make a recommendation as to which Category of the Medical Staff to which the applicant should be assigned.	
	5.4.1.5	If additional focus is felt to be needed for any clinical privilege or activity, including interpersonal professional conduct, the Section Chief may recommend a Focused Professional Performance Evaluation. Such recommendation should include at least the following:	
		5.4.1.5.1	Aspect(s) of performance to be evaluated
		5.4.1.5.2	Duration of Focused Professional Performance Evaluation
	5.4.1.6	If the period of Focused Professional Performance Evaluation is less than 2 years, the Section Chief may recommend that the duration of the reappointment period be consistent with the duration of the Focused Professional Performance Evaluation.	
	5.4.1.7	The reappointment application, supporting material and the Section Chief's recommendation will be forwarded to the Credentials Committee.	
	5.4.1.8	If the applicant is the Section Chief, the reappointment application and supporting material will be submitted to the Department Chief for review. It that Section is not a part of a Department, the reappointment application and supporting material will be presented to the Assistant Section Chief or, if there is not assistant, an alternate member of the Section designated by the Chief of Staff.	
5.4.2	Credentials Committee Review		
	5.4.2.1	At its next regularly scheduled meeting, the Credentials Committee shall review the application and supporting material and the recommendation of the Section Chief.	
	5.4.2.2	The Credentials Committee may take the following action:	
		5.4.2.2.1	Recommend to the Professional Performance Committee reappointment to the Medical Staff, renewal of clinical privileges, and assignment to a Category as recommended by the Section Chief, including any special conditions
		5.4.2.2.2	Amend the recommendation of the Section Chief

		5.4.2.2.3	Request additional information to assist in its deliberations, such request to not unduly delay action on the request for reappointment.
	5.4.2.3	The reappointment application, supporting material and recommendations of the Section Chief and the Credentials Committee's recommendation will be forwarded to the Professional Performance Committee.	
5.4.3	Professional Performance Committee Review		
	5.4.3.1	At its next regularly scheduled meeting, the Professional Performance Committee shall review the application and supporting material and the recommendation of the Credentials Committee.	
	5.4.3.2	The Professional Performance Committee may take the following actions	
		5.4.3.2.1	Recommend to the Medical Executive Committee reappointment to the Medical Staff, renewal of clinical privileges, and assignment to a Category as recommended by the Credentials Committee, including any special conditions
		5.4.3.2.2	Amend the recommendation of the Credentials Committee
		5.4.3.2.3	Request additional information to assist in its deliberations, such request to not unduly delay action on the request for reappointment.
		5.4.3.2.4	If a Focused Professional Performance Evaluation, provide specificity as to the elements thereof and frequency of reports to the Professional Performance Committee.
	5.4.3.3	The reappointment application, supporting material and recommendations of the Section Chief, Credentials Committee, and the Professional Performance Committee will be forwarded to the Medical Executive Committee.	
	5.4.3.4	In the event that the recommendation to the Medical Executive Committee is that the application for reappointment to the Medical Staff and request for clinical privileges not be approved as initially requested, and this had not otherwise been resolved with the applicant, the applicant will be notified in writing by the Associate Chief Medical Officer within 10 working days. This notification shall include	
		5.4.3.4.1	The details of the recommendation
		5.4.3.4.2	The reasons therefore
		5.4.3.4.3	Any supporting material used the by the Professional Performance Committee to reach its decision
	5.4.3.5	The applicant may, within 10 working days, present in writing, any additional information to the Professional Performance Committee regarding its recommendations and reasons therefore. Such information will be forwarded to the Medical Executive Committee for consideration.	
5.4.4	Medical Executive Committee Review		
	5.4.4.1	At its next regularly scheduled meeting, the Medical Executive Committee shall review the application and supporting material and the recommendation of the Professional Performance Committee.	
	5.4.4.2	The Medical Executive Committee may take the following actions:	
		5.4.4.2.1	Recommend to the Medical Executive Committee reappointment to the Medical Staff, renewal of clinical privileges, and assignment to a Category as recommended by the Professional Performance Committee, including any special conditions

		5.4.4.2.2	Amend the recommendation of the Professional Performance Committee
		5.4.4.2.3	Recommend further investigation and consideration by the Professional Performance Committee
	5.4.4.3	In the event that the recommendation of the Medical Executive Committee meets the criteria of an adverse decision as defined in the Fair Hearing Policy Chapter 16 the applicant will be notified by special notice from the Associate Chief Medical Officer within 10 working days , which shall include	
		5.4.4.3.1	The details of the adverse recommendation or decision
		5.4.4.3.2	The reasons therefore
		5.4.4.3.3	Any supporting information used by the Medical Executive Committee in reaching that recommendation or decision.
		5.4.4.3.4	A copy of the Medical Staff Fair Hearing Policy
	5.4.4.4	Only one such fair hearing may be requested for an request for reappointment or renewal of clinical privileges. If the applicant exercises the fair hearing right at this point in the process, he/she shall not be eligible for a fair hearing following the decision by the Board of Directors.	
5.4.5	Board Action		
	5.4.5.1	At its next regularly scheduled meeting, the Board of Directors shall consider the request for reappointment and renewal of clinical privileges and the recommendations of the Medical Executive Committee.	
	5.4.5.2	The Board of Directors may take the following actions	
		5.4.5.2.1	Renew Medical Staff Membership and clinical privileges as recommended by the Medical Executive Committee
		5.4.5.2.2	Decline to renew Medical Staff Membership and clinical privileges
	5.4.5.3	Written notice of the Board of Directors' decision shall be given by the President within 10 working days to the applicant and the Chief of Staff, and the Chief of each Department or Section concerned.	
	5.4.5.4	The Board of Directors may reconsider its decision in accordance with its own procedures.	
	5.4.5.5	If the decision of the Board of Directors meets the criteria for a Fair Hearing, and the applicant has not already exercised this right following the recommendations of the Medical Executive Committee, he/she may request a Fair Hearing in accordance with the Fair Hearing Policy (Chapter 16)	

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	9/20/2018
Published to the Medical Staff	10/12/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	1/17/2019
Board Quality and Values Committee	2/19/2019

Reviewed:

- February 22, 2021

<table>
<tr><td>Title</td><td colspan="2">Reappointment – Advancement from Provisional Status</td></tr>
<tr><td>Number</td><td colspan="2">5.5</td></tr>
<tr><td>Effective Date</td><td colspan="2">December 21, 2009</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Bylaws Committee
Credentials Committee
Medical Executive Committee</td><td>Associate Chief Medical Officer</td></tr>
<tr><td>Review Date</td><td colspan="2">February 22, 2022</td></tr>
</table>

5.5.1	The process for Advancement from Provisional Status is the same as for reappointment.
5.5.2	The expiration date for advancement will be determined based upon the physician/provider's birthday. The expiration date will be the second birthday following Board action. Therefore, the duration of the first reappointment following the Provisional period may be for 13 – 24 months.
5.5.3	Following the initial provisional period, the Board of Directors, acting upon the recommendation of the Medical Executive Committee, may extend the Provisional period for another year. However, the total period in Provisional status may not exceed 2 years.

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	9/20/2018
Published to the Medical Staff	10/12/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	1/17/2019
Board of Quality and Value Committee	2/19/2019

Reviewed:

- February 22, 2021

Title	Leave of Absence	
Number	6	
Effective Date	January 25, 2017	
Accountability	Medical Staff	Administration
	Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	February 22, 2022	

6.1	A voluntary leave of absence may be granted to a member of the Medical Staff or Advanced Practice Clinician by the Board of Directors.		
6.2	The request for a leave shall be in writing and submitted to the Chief of Staff and shall include the following:		
	6.2.1	Reason for request	
	6.2.2	Duration of the leave, shall not to exceed 12 months	
		6.2.2.1	An exception to the 12 month limit will be made in the case of military deployment. In this instance, the duration of the leave period will be the length of the deployment which precludes the practitioner practicing at St. Michael.
	6.2.3	Plan for continuity of care for patients from the practice of the practitioner, if applicable	
6.3	The submission of a request for voluntary leave of absence by a practitioner shall constitute an agreement that, if the leave is granted, the clinical privileges, rights, and responsibilities of the practitioner shall be suspended for the duration of the leave and until reinstated by the Board of Directors.		
6.4	A request for reinstatement, either at the end of the leave period or at an earlier date, shall be in writing and submitted to the Chief of Staff at least 90 days prior to the end of the leave period.		
	6.4.1	The request for reinstatement should include information about any clinical or other patient care activities in which the practitioner participated during the leave.	
	6.4.2	In the case of medical leave, the Chief of Staff may require that the practitioner provide documentation that he/she is capable of providing patient care in a safe and effective manner.	
6.5	A practitioner may request an extension of the leave of absence for subsequent periods up to 12 months for two additional leave periods. Such request must be submitted in writing to the Chief of Staff and include the same information required for an initial request at least 90 days prior to expiration of the leave of absence. It is the practitioner's responsibility to initiate such a request.		
6.6	Processing a request for leave of absence, extension of a leave of absence, or reinstatement following a leave of absence.		
	6.6.1	Upon receipt, the Chief of Staff will forward the request to the Medical Staff Services office to facilitate review by the Credentials Committee.	
		6.6.1.1	If the Chief of Staff determines that additional documentation is required to process the request, he/she will advise the CMO who will assist in obtaining the required documentation.
	6.6.2	The request and additional documentation, if applicable, will be submitted to the Credentials Committee for review and recommendation at its next regularly scheduled meeting. The Credentials Committee may recommend to approve or	

		deny the request. The recommendation will be forwarded in writing to the Professional Performance Committee.
	6.6.3	The recommendation will be considered by the Professional Performance Committee at its next regularly scheduled meeting. The recommendation of the Professional Performance Committee to approve or deny the request will be forwarded in writing to the MEC.
	6.6.4	The recommendation will be considered by the MEC at its next regularly scheduled meeting. The recommendation of the MEC to approve or deny the request will be forwarded in writing to the Board of Directors. If the recommendation of the MEC is unfavorable to the practitioner, the President shall notify the practitioner of the unfavorable recommendation. The practitioner may provide additional information to support the request to be submitted to the Board..
6.7	The Board of Directors will approve or deny the request at its next regularly scheduled meeting. The decision will be provided in writing to the practitioner. If the decision is unfavorable to the practitioner, he/she may exercise Fair Hearing rights as described in the Medical Staff Bylaws and Policies.	
6.8	A leave of absence shall have no effect on any corrective proceedings pending against the practitioner nor on any corrective proceedings initiated subsequent to the leave precipitated by actions of the practitioner prior to the leave.	
6.9	If a practitioner's current appointment expired during the leave of absence, he/she shall be required to complete the reappointment process prior to reinstatement of clinical privileges.	
6.10	Even if a practitioner has been granted a Leave of Absence by his/her employer, it is still necessary to separately request a leave of absence from the Medical Staff.	

Approval Process:

Bylaws Committee	July 25, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	September 15, 2016
Published to the Medical Staff	September 30, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	January 19, 2017
Board of Quality and Value Committee	January 25, 2017

Reviewed:

- July 17, 2018
- February 22, 2021

Title	Clinical Privileges – Initial Request for Clinical Privileges	
Number	7.1	
Effective Date	December 21, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.1.1	Every initial application for Medical Staff appointment must be accompanied by a request for specific clinical privileges as desired by the applicant.	
7.1.2	Request for clinical privileges will be made on the delineation of privilege forms specified by the Medical Staff and approved by the Board of Directors.	
7.1.3	It is the responsibility of the applicant to provide evidence of current clinical competence for privileges requested. This may be demonstrated by any or all of the following means:	
	7.1.3.1	Verification from references who are familiar with the work on the applicant and can attest that the applicant is competent to perform any or all of the clinical privileges requested
	7.1.3.2	Verification from training program directors wherein the applicant demonstrated current clinical competence to perform any or all of the clinical privileges requested
	7.1.3.3	Case logs or patient logs with procedure names and/or diagnoses which document experience
	7.1.3.4	Verification of clinical performance, including patient outcomes, from other health care facilities where the applicant exercised clinical privileges
	7.1.3.5	Any other means as requested by the Associate Chief Medical Officer, Section Chief, or Credentials Committee
7.1.4	Clinical privilege determination shall be based upon pertinent information concerning clinical performance, including patient outcomes, available at the time of review by the Section Chief and/or any subsequent Medical Staff committee responsible for recommending clinical privileges.	
7.1.5	Any information adverse to the applicant may be used in making the determination provided that it is disclosed to the applicant with sufficient specificity so that the applicant may respond and/or provide additional information.	
7.1.6	The applicant alone shall bear the burden of proving by clear and convincing evidence that he/she meets and the qualifications for the clinical privileges requested.	
7.1.7	The applicant alone shall bear the burden of assuring that all required and requested documentation is made available, in a timely fashion, to the Medical Staff and St. Michael representatives evaluating the application and the applicant's credentials and qualifications for clinical privileges requested.	
7.1.8	The final decision for the granting of clinical privileges rests with the Board of Directors.	

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019
Reviewed: • 5/23/2022 - Bylaws Committee – no changes needed	

Title	Clinical Privileges – Request at the Time of Reappointment	
Number	7.2	
Effective Date	January 22, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.2.1	At the time of a request for reappointment, the practitioner must complete a new request for clinical privileges on the delineation of privileges forms specified by the Medical Staff and approved by the Board.	
7.2.2	It is the responsibility of the practitioner requesting reappointment to provide evidence of current clinical competence for privileges requested. This may be demonstrated by any or all of the following means:	
	7.2.2.1	Verification of clinical performance, including patient outcomes, for all clinical activities at St. Michael during the period covered by this review
	7.2.2.2	Verification of clinical performance, including patient outcomes, for all clinical activities performed at other health care facilities during the period covered by this review
	7.2.2.3	Case logs or patient logs with procedure names and/or diagnoses which document experience, including procedures performed at other accredited facilities
	7.2.2.4	Documented observation of clinical performance by the Section Chief or other members of the Medical Staff
	7.2.2.5	Results of Ongoing Professional Performance Evaluation (OPPE) or Focused Professional Performance Evaluation (FPPE)
	7.2.2.6	Documentation of compliance with Medical Staff quality measures, including patient satisfaction
	7.2.2.7	Review of contents of the Practitioner's Quality File
	7.2.2.8	Any other means as requested by the Associate Chief Medical Officer, Section Chief, or Credentials Committee
7.2.3	Determination of renewal of clinical privileges shall be based upon pertinent information concerning clinical performance available at the time of review by the Section Chief or any subsequent Medical Staff committee responsible for recommending clinical privileges.	
7.2.4	Any information adverse to the practitioner's request for renewal of clinical privileges will be disclosed to him/her with sufficient specificity so that he/she may respond and/or provide additional information.	
7.2.5	The practitioner alone shall bear the burden of proving by clear and convincing evidence that he/she meets the qualifications for the clinical privileges requested.	
7.2.6	The practitioner alone shall bear the burden of assuring that all required and requested documentation is made available, in a timely fashion, to the Medical Staff and St. Michael representatives evaluating the request for renewal of clinical privileges.	
7.2.7	The final decision for the granting renewal of clinical privileges rests with the Board of Directors.	

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

Reviewed:

- 5/23/2022 - Bylaws Committee – minor wording changes only, no effect on content

Title	Clinical Privileges – General Principles	
Number	7.3	
Effective Date	January 22, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.3.1	Membership on the Medical Staff is granted by the Medical Staff; clinical privileges are granted solely by the CHI Franciscan Board of Directors.	
7.3.2	Medical Staff membership in and of itself does not confer clinical privileges.	
7.3.3	Each individual practitioner working in a St. Michael facility shall be entitled to exercise only those clinical privileges when providing patient care services as granted by the CHI Franciscan Board of Directors for a St. Michael facility, with the following exception:	
	7.3.3.1	Any restriction or limitation of clinical privileges based upon the delineated privileges granted is waived in an emergency situation. In such a situation actions are governed by Medical Staff Policies which state: In the case of an emergency, any practitioner shall be expected to do all in his/her power to save the life of the patient or to save the patient from serious harm. An emergency is described as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
7.3.4	Specialty Board Certification in and of itself does not entitle a practitioner to any clinical privilege. However, current specialty Board Certification may be designated as a pre-requisite for certain clinical privileges as determined by the Section, recommended by the Credentials Committee, Professional Performance Committee, and Medical Executive Committee and approved by the CHI Franciscan Board of Directors.	
7.3.5	Membership on the Medical Staff at any other CHI Franciscan facility does not in and of itself entitle a practitioner to any clinical privileges at St. Michael. Such practitioners will need to apply for clinical privileges he/she may find the need to exercise at St. Michael in accordance with St. Michael Medical Staff Bylaws and Policies.	
	7.3.5.1	In the event of a St. Michael declared or community declared disaster or in the event of a special patient care need that cannot be met with currently credentialed practitioners, assistance may be sought from colleagues who hold privileges at other CHI/Franciscan hospitals. In such situations, in accordance with existing Medical Staff Bylaws and Policies, the process for granting clinical privilege may be modified by the Chief of Staff, in collaboration with the appropriate Section Chief, to meet an immediate need.

Approval Process:

Credentials Committee	6/24/2018
Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

Reviewed: • 5/23/2022 - Bylaws Committee – no changes needed

Title	Clinical Privileges – Criteria for Determining Qualifications for Clinical Privileges	
Number	7.4	
Effective Date	January 22, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.4.1	Each Section of the Medical Staff shall delineate specific criteria to be used in determining the qualifications for clinical privileges that should be granted to Practitioners assigned to that Section.	
7.4.2	Factors to be considered in setting the criteria may include, but are not limited to	
	7.4.2.1	Education
	7.4.2.2	Training received during and following residency or fellowship
	7.4.2.3	Experience required for the initial granting of the clinical privilege and experience required for maintenance of the privilege from one reappointment cycle to the next
	7.4.2.4	Recommendations of specialty board; which may include current board certification
	7.4.2.5	Other criteria that is generally recognized as pertinent to the safe and effective exercise of the privilege
7.4.3	From time to time, separate Sections may include the same clinical privilege for their Section members. In such cases, the criteria for granting the clinical privilege must be consistent from one Section to the other(s). All Sections must approve any changes that affect their Section members.	
7.4.4	Sections shall review their criteria for granting clinical privileges at least every two years and recommend any revisions	
	7.4.4.1	Schedule for routine review of delineation of privileges documents:
	7.4.4.2	In odd numbered years, the following Sections will conduct routine review of delineation of privileges documents: ● Anesthesiology ● Cardiology ● Emergency Medicine ● Inpatient Medicine ● Medical Specialties ● Primary Care - Ambulatory ● Radiology
	7.4..4.3	In even numbered years, the following Sections will conduct routine review of delineation of privileges documents: ● General Surgery ● Pediatrics ● Obstetrics & Gynecology ● Ophthalmology ● Orthopedics

		● Surgical Specialties
7.4.5	Approval process for drafting new or revised criteria for granting or renewing clinical privileges:	
	7.4.5.1	Section publishes proposed changes to Section members, announcing when vote will be taken
	7.4.5.2	Vote is taken at the next regularly scheduled Section meeting.
	7.4.5.3	Credentials Committee votes on recommendation at its next regularly scheduled meeting following Section approval.
	7.4.5.4	Professional Performance Committee votes on recommendation at its next regularly scheduled meeting following the Credentials Committee recommendation.
	7.4.5.5	Medical Executive Committee votes on recommendation at its next regularly scheduled meeting following the Professional Performance Committee recommendation
	7.4.5.6	If the Medical Executive Committee approves the recommendation, the matter is forwarded to the Board of Directors for their review and approval.
	7.4.5.7	The Board of Directors takes the final action to approve or not approve the recommendation of the Medical Executive Committee.
7.4.6	At any step during the approval process, the reviewing body may request additional information to support the proposal. It is the responsibility of the Section, with the assistance of the Associate Chief Medical Officer, to provide the requested information.	
7.4.7	If any reviewing body modifies the request for revision from the Section, the Section Chief will be advised. The matter may be returned to the Section for review, discussion, and revote at the discretion of the Section Chief.	

Approval Process:

Credentials Committee	7/24/2018
Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

Reviewed: • 5/23/2022 - Bylaws Committee – no changes needed

Title	Clinical Privileges – Procedure to Develop Criteria for New Privileges	
Number	7.5	
Effective Date	June 24, 2015	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.5.1	When a Practitioner requests a privilege for which no criteria have been developed, the Section Chief, or his/her designee, in conjunction with the Chief Medical Officer, shall prepare a report which shall include the following:	
	7.5.1.1	Description of the privilege and how it will be used at St. Michael
	7.5.1.2	Availability and patient access to this service at another CHI/Franciscan facility in the Puget Sound area.
	7.5.1.3	Which Practitioners are likely to request the new privilege
	7.5.1.4	Recommendations of specialty boards regarding credentialing criteria, including maintenance of proficiency
	7.5.1.5	Training available in residency and fellowship programs in specialties likely to request this privilege
	7.5.1.6	Training available outside of residency or fellowship programs
	7.5.1.7	Criteria required by other hospitals/facilities
	7.5.1.8	Resources, supplies and equipment, needed to provide the new privilege
	7.5.1.9	Staffing needed to provide the new privilege. Training needed for St. Michael staff to provide the new privilege.
	7.5.1.10	Cost/benefit/reimbursement analysis
	7.5.1.11	Estimated date of implementation
	7.5.1.12	Estimated volume
	7.5.1.13	Sufficient volumes at St. Michael to maintain staff proficiency
	7.5.1.14	Other relevant information to support the request to add a new privilege
	7.5.1.15	Recommended privileging criteria for use at St. Michael
7.5.2	If the privilege is not FDA-approved, the request must be forwarded to the Institutional Review Board (IRB) for review and recommendation.	
7.5.3	The Section Chief and the Chief Medical Officer shall jointly provide the above outlined report, including recommendation of the IRB, if necessary, to the Medical Executive Committee at its next regularly scheduled meeting.	
7.5.4	The final decision for making the new privilege available at St. Michael is a joint decision of the Medical Staff and the Board of Directors.	
7.5.5	Once approval has been given that the requested privilege will be offered at St. Michael, the newly developed credentialing criteria must be approved by the following. Credentialing criteria must be consistent if the privilege is available in more than one section.	
	7.5.5.1	The Sections in which the privilege will be available to its members
	7.5.5.2	Credentials Committee
	7.5.5.3	Medical Executive Committee
	7.5.5.4	Board of Directors

7.5.6	Final approval, or the effective date, for granting the privilege to an individual physician may be dependent upon a number of factors such as, but not limited to, acquisition of supplies and equipment and availability of trained staff.

Approval Process:

Bylaws Committee	February 23. 2015
Medical Executive Committee Approval for distribution to the Medical Staff	March 19, 2015
Published to the Medical Staff	April 3, 2015
Petition to Vote (Yes/No)	No
Medical Executive Committee Recommendation for Approval to Board	June 18, 2015
Board of Directors	June 24, 2015

Reviewed:

- 6/26/2017
- 6/26/2018
- 5/23/2022 – Bylaws Committee – minor wording edit, no content change

Title	Clinical Privileges – Care of a Specific Patient	
Number	7.6	
Effective Date	January 22, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.6.1	In a special situation, a Practitioner, who is not a member of the Medical Staff, may be given permission to assist a member of the Medical Staff in the care of a specific patient in any St. Michael facility.	
7.6.2	Such assistance must be requested in writing by the requesting member of the Medical Staff which shall include name of the patient, privilege requested, duration of the need, and why this care cannot be provided by a St. Michael credentialed physician. This request shall be submitted to the Associate Chief Medical Officer, or in his/her absence, to the Chief of Staff.	
7.6.3	Prior to granting permission, acceptable verification of the following is required:	
	7.6.3.1	Current, unrestricted, Washington State professional license or for those members with a military category that may be in possession of a current unrestricted professional license from any of the 50 states, the District of Columbia, or the territories of Puerto Rico or Guam.
	7.6.3.2	Current, unrestricted prescribing authority, appropriate for the needs of the patient
	7.6.3.3	Professional liability insurance meeting St. Michael's requirements
	7.6.3.4	Documentation of current specialty Board eligibility or certification
	7.6.3.5	Privileges at another accredited hospital consistent with the clinical activities proposed
	7.6.3.6	Washington State Patrol Background check
	7.6.3.7	National Practitioner Data Bank
	7.6.3.8	Immunization status
7.6.4	If the Practitioner is credentialed at another CHI Franciscan facility and the acceptable verification elements listed are current, they may be obtained from the CHI Franciscan Medical Staff Services Office to expedite the process.	
7.6.5	Permission is granted by the President (or designee) after consultation with the appropriate Section Chief (or designee) and the Chief of Staff (or designee)	
7.6.6	Such permission shall not be granted to a Practitioner more than 5 times in one Medical Staff year	

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

Reviewed: 5/23/2022 Bylaws Committee – minor wording changes

Title	Clinical Privileges – Disaster Credentialing		
Number	7.7		
Effective Date	June 25, 2018		
Accountability	Medical Staff	Administration	
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer Emergency Management Coordinator	
Review Date	May 23, 2023		

7.7.1	When St. Michael activates its Emergency Operations Plan in response to a disaster and the immediate needs of its patients cannot be met, licensed personnel who are not members of the Medical Staff may present themselves with an offer to serve as adjunct staff.		
7.7.2	This policy deals only with those licensed practitioners whose credentialing and privileging fall under the purview of the Medical Staff by virtue of their licenses, scope of practice in the State of Washington, and the St. Michael Medical Staff Bylaws and Policies. Reference Human Resources policies for information regarding other licensed personnel.		
7.7.3	This policy deals only with disaster work sites in St. Michael facilities for which the St. Michael Medical Staff has the obligation to credential and grant privileges to licensed practitioners who care for patients.		
7.7.4	Under the circumstances necessitating activation of the Emergency Operations Plan, it may not be possible to follow the standard credentialing and privileging processes. A modified credentialing and privileging process may be used to grant privileges to practitioners to assist in meeting immediate patient care needs.		
7.7.5	The following documentation is required for any individual seeking privileges to serve as adjunct staff during the course of the disaster.		
	7.7.5.1	Government issued photo identification (state or federal)	
	7.7.5.2	At least one of the following:	
		7.7.5.2.1	Current picture hospital identification card that clearly identifies professional designation
		7.7.5.2.2	Current professional license to practice
		7.7.5.2.3	Primary source verification of licensure
		7.7.5.2.4	Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Core (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group
		7.7.5.2.5	Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances, such authority having been granted by a federal, state, or municipal entity
		7.7.5.2.6	Confirmation by a licensed independent practitioner with current privileges at St. Michael or by a St. Michael staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during the disaster.
7.7.6	The scope of privileges granted during the disaster shall be		
	7.7.6.1	Appropriate for that profession in the State of Washington	

	7.7.6.2	Appropriate for the specialty as practiced at St. Michael	
7.7.7	Each individual granted disaster privileges shall work under the oversight of a credentialed and privileged member of the St. Michael Medical Staff.		
	7.7.7.1	Practitioners who have been granted privileges at another CHI/Franciscan hospital may, at the discretion of the Chief of Staff or designee, care for patients without the requirement of direct oversight by a member of the St. Michael Medical Staff.	
7.7.8	Approval is required from representatives from both the Medical Staff and St. Michael.		
	7.7.8.1	Medical Staff chain of command for approving practitioners	
		7.7.8.1.1	Chief of Staff
		7.7.8.1.2	Assistant Chief of Staff
		7.7.8.1.3	Secretary - Treasurer
		7.7.8.1.4	Chairman – Professional Performance Committee
		7.7.8.1.5	Chairman – Credentials Committee
		7.7.8.1.6	Any Department or Section Chief
		7.7.8.1.7	Any Past Chief of Staff
		7.7.8.1.8	The site Disaster Medical Officer per the St. Michael Emergency Management Plan
	7.7.8.2	St. Michael administrative Chain of Command for approving practitioners	
		7.7.8.2.1	President
		7.7.8.2.2	Associate Chief Medical Officer
		7.7.8.2.3	Chief Operating Officer
		7.7.8.2.4	Chief Nursing Officer
		7.7.8.2.5	Any member of the CHI/Franciscan Board of Directors
		7.7.8.2.6	Site Disaster Coordinator per the Emergency Management Plan
7.7.9	The Medical Staff Services Office personnel are responsible for primary source verification.		
7.7.10	Primary source verification of licensure will occur as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents at St. Michael, whichever comes first.		
7.7.11	Whenever possible, paper or electronic copies of evidence of primary source verification shall be maintained by Medical Staff Services.		
7.7.12	Medical Staff Services shall document all phases of the disaster credentialing process.		
7.7.13	If primary source verification cannot be completed within 72 hours, Medical Staff Services will document the following:		
	7.7.13.1	Why the primary source verification could not be performed within 72 hours	
	7.7.13.2	Evidence of demonstrated ability of practitioner to continue to provide adequate care, treatment, and services based upon the observation of St. Michael Medical Staff member(s) providing oversight	
	7.7.13.3	Efforts to rectify the situation and obtain primary source verification	
7.7.14	Based upon the oversight of volunteer practitioners, St. Michael determines within 72 hours of the practitioners arrival if the granted disaster privileges shall continue. Decision will be made jointly by the Chief of Staff and President or their respective designees.		
7.7.15	Documentation will be maintained in the Medical Staff Services Office in accordance with St. Michael's Emergency Management Plan.		

7.7.16	Duration of disaster privileges will be for that period when adjunct services are required to meet patient care needs as determined by the Chief of Staff and/or President, or their respective designees.

Approvals:

Bylaws Committee	January 22, 2018
Medical Executive Committee approval for distribution to the Medical Staff	February 15, 2018
Published to the Medical Staff	March 2, 2018
Medical Executive Committee recommendation for approval to Board of Directors	May 17, 2018
Board of Directors	June 19, 2018

Reviewed:

- 6/15/2018 Bylaws Committee – minor wording changes only, no effect on content
- 10/18/2019 Bylaws Committee – minor wording changes only, no effect on content
- 5/23/2022 Bylaws Committee – no changes

Title	Clinical Privileges - Proctors	
Number	7.8	
Effective Date	April 17, 2018	
Accountability	Medical Staff	Administration
	Credentials Committee Medical Executive Committee Multispecialty Peer Review Committee Professional Performance Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

7.8.1	Proctoring may be required in certain circumstances to meet credentialing criteria or as a part of Focused Professional Performance Evaluation.	
7.8.2	A proctor is generally a practitioner within the same profession as the individual who is required to have care of patients and procedures proctored to meet the requirements of focused professional practice evaluation.	
7.8.3	Qualifications of a proctor	
	7.8.3.1	May or may not be a member of the St. Michael Medical Staff
	7.8.3.2	Current professional license in the US or Canada
	7.8.3.3	Board certified in the specialty for which he/she is proctoring or have appropriate board certification in a related specialty
	7.8.3.4	Privileged to provide patient care service(s) and/or procedures being proctored at another Joint Commission accredited hospital at which he/she is in good standing
	7.8.3.5	Current professional liability insurance coverage
7.8.4	Each Section will develop criteria to determine when proctoring will be required as well as specific criteria for the patient care services or procedures to be observed and evaluated by the proctor.	
7.8.5	It is the responsibility of the practitioner to be proctored to secure an appropriately trained and experienced proctor that meets the criteria established by the Section.	
	7.8.5.1	Any expenses associated with obtaining the services of the proctor are to be borne by the practitioner to be proctored unless other arrangements have been approved by the Associate Chief Medical Officer.
7.8.6	If the practitioner is not a member of the St. Michael Medical Staff will need to apply for temporary proctoring privileges and provide the following documentation to the Medical Staff Services Office:	
	7.8.6.1	Copy of current professional license
	7.8.6.2	Evidence of professional liability insurance coverage
	7.8.6.3	Documentation of clinical privileges at another Joint Commission accredited hospital consistent with patient care service(s) to be proctored and confirmation that the practitioner is in good standing at that facility
	7.8.6.4	Copy of CV
	7.8.6.5	Case lists, if required by criteria set by the Section
7.8.7	The Medical Staff Services Office will obtain	
	7.8.7.1	Current National Practitioner Data Bank Report
	7.8.7.2	Washington State Patrol criminal background check

7.8.8	If a St. Michael practitioner has been proctored at another CHI/Franciscan hospital and the proctoring reports are made available to St. Michael, at the discretion of the Section Chief, it will not be necessary for the proctoring to be repeated at St. Michael.
7.8.9	It is the responsibility of the practitioner being proctored to ensure the completed proctoring forms are submitted by the proctor to the Medical Staff Services Office.
7.8.10	Generally, the role of the proctor is to observe and evaluate the quality of care provided by the practitioner being proctored. The proctor does not provide direct patient care. The proctor does not serve as a surgical first assistant. However, in the case of an emergency, any practitioner, including the proctor, shall be expected to do all in his/her power to save the life of the patient or to save the patient from serious harm. An emergency is described as a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

Approval Process:

Bylaws Committee	September 25, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	October 19, 2017
Published to the Medical Staff	December 15, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	March 15, 2018
Board of Directors	April 17, 2018

Reviewed:

- 523/2022 Bylaws Committee – no changes

Title	Investigations – Request for Formal Investigation	
Number	8.1	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

8.1.1	A request for investigation may be submitted with regard to a member of the Medical Staff or Advanced Practice Clinician whenever			
	8.1.1.1.	The activity or professional conduct of a practitioner is believed to be		
		8.1.1.1.1	Detrimental to patient safety	
		8.1.1.1.2	Detrimental to the delivery of quality patient care	
		8.1.1.1.3	Disruptive to hospital operations	
		8.1.1.1.4	In violation of the Medical Staff Bylaws, Policies, Rules and Regulations or Plans	
		8.1.1.1.5	In violation of Hospital policies.	
	8.1.1.2	Sufficient concern exists regarding the conduct of a practitioner outside the hospital, including, but not limited to		
		8.1.1.2.1	An indictment by federal or state authorities for suspected Medicare or Medicaid fraud or abuse	
		8.1.1.2.2	An indictment for suspected drug or alcohol violations	
		8.1.1.2.3	An indictment for any crimes against person(s)	
		8.1.1.2.4	Disciplinary action against a practitioner by another hospital or entity	
		8.1.1.2.5	External litigation which may call into question the practitioner's qualifications	
8.1.2	For more detailed information regarding request for investigations covered by the Disruptive Behavior policy, refer to Chapter 15 of Medical Staff Policies.			
8.1.3	All requests for investigation will be submitted to the Professional Performance Committee.			
	8.1.3.1	The submission of a request for investigation by the Professional Performance Committee will be made by the Associate Chief Medical Officer or any member of the Medical Executive Committee.		
	8.1.3.2	The request for investigation shall		
		8.1.3.2.1	Be in writing	
		8.1.3.2.2	Be signed by the person making the request	
		8.1.3.2.3	State specifically the reason for the request	
		8.1.3.2.4	Be supported by reference to specific conduct or activities which constitute grounds for the request.	
			8.1.3.2.4.1	Allegations regarding patient care should include patient information with specificity to allow for review of the care.
			8.1.3.2.4.2	Allegations regarding care of specific patients may be referred to the Multispecialty Peer Review Committee for evaluation in a peer review protected setting.
8.1.4	All requests for investigation shall be forwarded to the Professional Performance Committee.			

8.1.5	The Professional Performance Committee will conduct the investigation in accordance with MSP 15.8 – Disruptive Behavior – Investigating and Assessing a Claim of Inappropriate or Disruptive Behavior.

Approval Process:

Professional Performance Committee	8/14/2018
Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Reviewed:

- 5/23/2022 Bylaws Committee – no changes

<table>
<tr><td>Title</td><td colspan="2">Investigations – Professional Performance Committee Role in Investigation</td></tr>
<tr><td>Number</td><td colspan="2">8.2</td></tr>
<tr><td>Effective Date</td><td colspan="2">December 31, 2009</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Professional Performance Committee
Bylaws Committee
Medical Executive Committee</td><td>Associate Chief Medical Officer</td></tr>
<tr><td>Review Date</td><td colspan="2">May 23, 2023</td></tr>
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8.2.1	The Professional Performance Committee will follow the investigation and reporting process outlined in MSP 15.8 – Disruptive Behavior – Investigating and Assessing a Claim of Inappropriate or Disruptive Behavior
8.2.2	The Professional Performance Committee shall have available to it the full resources of the Medical Staff and St. Michael to aid in its work.
8.2.3	The Professional Performance Committee shall prepare a written report to the Chief of Staff outlining its findings, conclusions, and recommendations
8.2.4	Prior to submission of the Professional Performance Committee recommendations to the Medical Executive Committee, the Chief of Staff will provide the practitioner the opportunity to submit additional information.
8.2.5	The practitioner shall have 10 working days to append additional information to the Professional Performance Committee report prior to its submission to the Medical Executive Committee by the Chief of Staff.

Approval Process:

Professional Performance Committee	10/13/2020
Bylaws Committee	10/26/2020
Medical Executive Committee Approval for distribution to the Medical Staff	1/21/2021
Published to the Medical Staff	7/21/2021
Medical Executive Committee Recommendation for Approval to Board of Directors	11/18/2021
Board of Directors	12/20/2021

Reviewed:

- 5/23/2022 Bylaws Committee – no changes

Title	Investigations – Medical Executive Committee Action	
Number	8.3	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

8.3.1	Generally, the Medical Executive Committee will take up the matter of the report of the Professional Performance Committee at its next regularly scheduled meeting.	
	8.3.1.1	However, the Chief of Staff, in collaboration with the Associate Chief Medical Officer may schedule a special meeting of the Medical Executive Committee to address the matter in a more timely fashion and to meet deadlines specified in the Medical Staff Bylaws and Policies as related to a Fair Hearing.
8.3.2	Upon receipt of the findings, conclusions, and recommendations from the Professional Performance Committee, the Medical Executive Committee may take one of the following actions:	
	8.3.2.1	Return the matter to the Professional Performance Committee for further investigation with specific questions the Medical Executive Committee would like to see addressed.
	8.3.2.2	Find no cause for action
	8.3.2.3	Issue a letter of warning, admonition, or reprimand
	8.3.2.4	Set terms for Focused Professional Performance Evaluation, which may include mandatory observation of certain clinical activities
	8.3.2.5	Recommend requirement for mandatory consultation*
	8.3.2.6	Recommend reduction, suspension, or revocation of clinical privileges*
	8.3.2.7	Recommend reduction of Medical Staff category or limitations of any Medical Staff prerogatives directly related to patient care*
	8.3.2.8	Recommend suspension or revocation of Medical Staff membership*
	Note: Items with asterisk * are reportable to the National Practitioner Data Bank and the State of Washington licensing board	
8.3.3	The Medical Executive Committee shall notify the following within 15 working days of its decision:	
	8.3.3.1	Practitioner
	8.3.3.2	President
	8.3.3.3	Associate Chief Medical Officer

Approval Process:

Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

Reviewed:

- 5/23/2022 Bylaws Committee – no changes

Title	Investigations – Board of Directors Action	
Number	8.4	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	May 23, 2023	

8.4.1	The Board of Directors, taking into account the results of the investigation and the recommendation of the Medical Executive Committee, may take any of the following actions	
	8.4.1.1	Elect to conduct its own investigation to obtain additional information
	8.4.1.2	Accept the recommendation of the Medical Executive Committee
	8.4.1.3	Find no cause for action
	8.4.1.4	Issue a letter of admonition, warning, or reprimand
	8.4.1.5	Impose terms of probation or mandatory observations of clinical activities*
	8.4.1.6	Impose requirements for consultation*
	8.4.1.7	Reduce, suspend, or revoke clinical privileges*
	8.4.1.8	Reduce Medical Staff category or limit Medical Staff prerogatives directly related to patient care*
	8.4.1.9	Suspend or revoke Medical Staff appointment*
	Note: Items with asterisk * are reportable to the National Practitioner Data Bank and the State of Washington licensing board	
8.4.2	Written notice of the Board of Directors' decision shall be given by the President within 10 working days to the	
	8.4.2.1	Practitioner
	8.4.2.2	Chief of Staff
	8.4.2.3	Applicable Section Chief
8.4.3	The Board of Directors may reconsider its decision in accordance with its own procedures.	

Approval Process:

Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

Reviewed:

- 5/23/2022 Bylaws Committee – no changes

Title	Precautionary Suspension	
Number	9	
Effective Date	March 23, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date:	June 27, 2023	

9.1	Those with authority to suspend all or any portion of the clinical privileges of a Medical Staff Member, advanced practice clinician, or any other individual credentialed by the Medical Staff are:	
	9.1.1	Chief of Staff
	9.1.2	Assistant Chief of Staff
	9.1.3	Chief Medical Officer
	9.1.4	President
	9.1.5	Chairperson of the Board of Directors
9.2	A precautionary suspension may be imposed whenever it is believed that failure to take such action might reasonably be expected to result in an imminent danger to the health and/or safety of any individual or to adversely affect the operation of St. Michael. The physician/provider will be notified by the Chief Medical Officer or their designee the imposition of the suspension	
9.3	The precautionary suspension is an interim precautionary step in a professional review action that may be taken with respect to the suspended individual; but, it is not a complete professional review action in and of itself.	
9.4	A precautionary suspension shall not imply any final finding or responsibility for the situation that caused the suspension.	
9.5	A precautionary suspension shall become effective immediately upon imposition and shall remain in effect until notified by the President.	
9.6	The individual receiving the precautionary suspension shall be notified in writing, including an explanation as to why the precautionary suspension is being imposed.	
9.7	A precautionary suspension shall immediately be reported in writing by the Chief Medical Officer to the President, Chief of Staff, and the Professional Performance Committee Chairperson.	
9.8	Immediately upon the imposition of a precautionary suspension, the Chief Medical Officer will ask the appropriate Section Chief, or if he/she is unavailable, the Chief of Staff, to assign another physician/provider with appropriate privileges the responsibility to care for the suspended physician/provider's patients who are still in the Hospital or are being cared for at another St. Michael facility.	
	9.8.1	Such assignment of the care of the suspended physician/provider's patients shall remain in effect until such time that the patient is discharged from the hospital or, in the case of a Franciscan Medical Group clinic, definitive alternate care is arranged.
	9.8.2	The wishes of each patient will be considered in the selection of the assigned physician/provider.
9.9	The Professional Performance Committee shall consider notification of its Chairperson as a request for investigation and shall immediately proceed as outlined in Medical Staff Policies, Chapter 16.9,	

Approval Process:

Bylaws Committee	January 26, 2015
Medical Executive Committee Approval for distribution to the Medical Staff	February 19, 2015
Published to the Medical Staff	March 16, 2015
Medical Executive Committee Recommendation for Approval to Board of Directors	March 18, 2016
Board of Directors	March 23, 2016

Reviewed:

- 7/23/2018
- 9/23/2019 Bylaws Committee
- 5/23/2022 Bylaws Committee – no changes

Title	Automatic Suspension	
Number	10	
Effective Date	November 30, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	June 27, 2023	

10.1	A physician/provider will be automatically suspended from the Medical Staff and all clinical privileges will be automatically suspended in the following circumstances:		
	10.1.1	Professional license in the State of Washington is revoked, suspended, voluntarily relinquished, or not renewed	
	10.1.2	Professional liability insurance is revoked, suspended, voluntarily relinquished, not renewed, or the coverage amount is reduced below the minimum amount required by the CHI/Franciscan Health Board	
	10.1.3	Failure to submit request for reappointment in accordance with the process outlined in Medical Staff Policies, Chapter 5, such suspension to be effective at the end of the physician/provider's current term of appointment.	
		10.1.3.1	The physician/provider bears sole responsibility for submission of the request for reappointment and supporting documentation in sufficient time to allow for the processing to the request for reappointment as outlined in Chapter 5.
	10.1.4	Upon conviction in any court in the United States, either federal or state, of a felony	
		10.1.4.1	Appeals from the conviction shall not affect the suspension unless the physician/provider is subsequently acquitted or the prosecution is dropped.
		10.1.4.2	Suspension pursuant to this provision does not preclude the physician/provider from subsequently re-applying for Medical Staff appointment.
	10.1.5	Exclusion from Medicare or Medicaid	
10.2	If a physician/provider's Drug Enforcement Administration (DEA) Certificate is revoked, suspended, voluntarily relinquished, amended, or not renewed, he/she shall be immediately and automatically divested of the right to prescribe medications covered by the certificate.		
	10.2.1	If prescription authority is deemed by the Chief of Staff or designee to be an essential requirement to exercise the physician/provider's clinical privileges safely and effectively, clinical privileges may be suspended as well.	
	10.2.2	Any action listed above with regard to the physician/provider's DEA certificate shall be referred to the Professional Performance Committee by the Associate Chief Medical Officer as a request for investigation.	
10.3	The physician/provider bears the responsibility of providing the Medical Staff Services Office with proof of licensure, professional liability insurance coverage, and DEA prescribing authority prior to the expiration.		
10.4	Automatic suspension is not subject to appeal under the Medical Staff Fair Hearing Plan (Chapter 16).		

10.5	Immediately upon the imposition of an automatic suspension, the Associate Chief Medical Officer will ask the appropriate Section Chief, or if he/she is unavailable, the Chief of Staff, to assign another physician/provider with appropriate privileges the responsibility to care for the suspended physician/provider's patients who are still in the Hospital or are being cared for at another St. Michael facility.	
	10.5.1	Such assignment of the care of the suspended physician/provider's patients shall remain in effect until such time that the patient is discharged from the hospital or, in the case of a St. Michael clinic, definitive alternate care is arranged.
	10.5.2	The wishes of each patient will be considered in the selection of the assigned physician/provider.

Approval Process:

Bylaws Committee	January 22, 2018
Medical Executive Committee Approval for distribution to the Medical Staff	February 15, 2018
Published to the Medical Staff	March 30, 2018
Medical Executive Committee Recommendation for Approval to Board of Directors	June 21, 2018
Board of Directors	July 17, 2018

Review:

- 6/27/2022 – no changes to content but replaced all references to the Quality & Value Committee with the term Board of Directors

Title	Impaired Practitioners – General Principles	
Number	11.1	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Professional Performance Committee Physician Wellness Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	March 19, 2020	

11.1.1	This policy applies to physicians, dentists, podiatrists, advanced practice clinicians, and allied health professional credentialed via the Medical Staff process.	
11.1.2	Practitioner impairment is frequently an unrecognized situation.	
11.1.3	The problem is intensified because there may be a high degree of denial on the part of the affected practitioners and their peers.	
11.1.4	The patient's best interests come first.	
11.1.5	Practitioners whose ability to care for patients in a safe, competent manner is impaired because of substance abuse, mental or personality disorder, illness, physical disability, or disruptive behavior present a potential hazard for patients.	
11.1.6	St. Michael and its organized Medical Staff have an obligation to provide safe, effective care to patients. This obligation includes protecting them from potential adverse effects arising out of the impairment of a practitioner, regardless of cause.	
11.1.7	There should be early recognition of impairment problems, with appropriate intervention, and the opportunity for early refutation of inaccurate or false impressions or accusations.	
11.1.8	As a result, St. Michael and its organized Medical Staff have an obligation to promptly detect impaired practitioners and to intervene in appropriate ways.	
11.1.9	There should be respect for all persons involved.	
11.1.10	Primary action should emphasize assistance and support.	
11.1.11	Disciplinary action should be used only when necessary, to protect patients or after all other attempts to correct the situation have failed.	
11.1.12	Response to impairment should ordinarily be graduated, with formal action taken typically after the informal action has failed. However, if there is any concern about patient safety or the safety of others, such that immediate action is needed, provisions in Medical Staff Policy, Chapter 9 – Precautionary Suspension for such action should be followed.	
11.1.13	The goals of intervention are	
	11.1.13.1	Protection of patients
	11.1.13.2	Initiation of treatment to encourage the practitioner to return to safe professional practice and personal capability through a plan of action and rehabilitation
11.1.14	The goals of the policy are	
	11.1.14.1	To identify any factors which may be contributing to instances of suboptimal care due to impairment.
	11.1.14.2	To strive for early recognition of impairment from any cause
	11.1.14.3	To limit clinical privileges only as identified impairment requires
	11.1.14.4	To offer support for practitioners seeking help to overcome the impairment.
11.1.14	For the purposes of this policy, impairment is defined as a personal condition or situation which significantly interferes with professional effectiveness in providing safe patient care	
11.1.16	Forms of impairment might include, but is not limited to	

	11.1.16.1	Abuse of any substance(s) that results in impairment
	11.1.16.2	Mental illness or disability
	11.1.16.3	Physical incapacity due to illness or injury
	11.1.16.4	Age-related conditions which may affect cognition, coordination, or technical skills
	11.1.16.5	Personality disorders
	11.1.16.6	Personal problems
	11.1.16.7	Work related stress
	11.1.16.8	Fatigue
	11.1.16.9	Abusive or disruptive behavior

Approval Process:

Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	11/11/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	2/21/2019
Board of Directors	3/19/2019

NOTE: The 2019 revision aggregates existing policies 11.1-5 into one policy. Scope of this policy was extended beyond physicians.

Title	Impaired Practitioner – Practitioner Wellness Committee	
Number	11.2	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Physician Wellness Committee Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	November 19, 2020	

11.2.1	To carry out this policy, the Medical Staff shall establish a Practitioner Wellness Committee to be composed of at least three members of the Active Medical Staff.		
11.2.2	Members shall be appointed by the Chief of Staff and shall serve at his/her pleasure.		
11.2.3	The Associate Chief Medical Officer shall provide the administrative support.		
11.2.4	This committee is a “quality assurance committee” as specified in RCW 70.41.200, as it is a component of the Medical Staff quality review system.		
11.2.5	All information coming to the attention of the committee shall be considered confidential, to be released only to		
	11.2.5.1	Washington Physician Health Plan, if referral is made or equivalent regulatory body	
	11.2.5.2	Washington State Medical Disciplinary Board	
	11.2.5.3	Other legal authorities, if required by law	
11.2.6	The committee’s charge shall be		
	11.2.6.1	To be the identified point within the hospital where information and concern about the health of an individual physician can be referred for consideration	
	11.2.6.2	To receive and consider information	
	11.2.6.3	To provide advice, recommendations, and assistance to the physician in question	
	11.2.6.4	To respond appropriately to the person or group who reported the concern	
	11.2.6.5	To educate its members and the members of the Medical Staff about	
		11.2.6.5.1	Physician health and well-being
		11.2.6.5.2	Physician impairment
		11.2.6.5.3	Appropriate responses to different levels and kinds of distress and impairment
		11.2.6.5.4	Appropriate resources for prevention, treatment, and rehabilitation
	11.2.6.6	To be a resource for voluntary consultation by a physician who feels the need for such consultation	
11.2.7	Advanced Practice Clinicians and Allied Health Professionals credentialed by this Medical Staff are included under this policy as per Medical Staff Policy 11.1.		

Approval Process:

Bylaws Committee	7/8/ 2019
Professional Performance Committee	7/9/2019
Medical Executive Committee Approval for distribution to the Medical Staff	7/18/2019
Published to the Medical Staff	8/7/2019
Medical Executive Committee Recommendation for Approval to Board of Directors	10/17/2019
Board of Directors	11/19/2019

Title	Impaired Physicians - Action	
Number	11.3	
Effective Date	December 9, 2009	
Accountability	Medical Staff	Administration
	Physician Wellness Committee Bylaws Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	November 19, 2020	

11.3.1	Any person having concern about the possibility of impairment affecting a staff physician shall report that concern to the Chief of Staff, Associate Chief Medical Officer, or any member of the Practitioner Wellness Committee.	
11.3.2	If it appears that immediate intervention is necessary for patient safety, the Chief of Staff or Associate Chief Medical Officer shall be requested to intervene and to have precautionary suspension of clinical privileges imposed if appropriate. The Practitioner Wellness Committee and the Professional Performance Committee shall be promptly informed of such action.	
11.3.3	The Chief of Staff, Associate Chief Medical Officer, or Chair of the Professional Performance Committee shall, within 24 hours, investigate the possibility of impairment, using all available resources of information, and decide whether or not the concern is justified.	
11.3.4	If the concern is justified, the Professional Performance Committee shall decide what it feels would be the best plan of action to address the impairment condition.	
11.3.5	The plan should include the following considerations:	
	11.3.5.1	Intervention – by whom, where, and when
	11.3.5.2	Determination of need to refer the case to WPHP and/or the appropriate Quality Assurance Commission or medical disciplinary board
	11.3.5.3	Development of a specific corrective action plan. This will likely be the task of the WPHP if the committee determines that formal intervention is necessary
	11.3.5.4	Consideration of whether or not clinical privileges should be summarily modified or suspended, an action justified solely by concern for patient safety.
	11.3.5.5	Follow up to monitor the success or failure of the plan
	11.3.5.6	Advising the President, Chief of Staff, and Associate Chief Medical Officer as appropriate
	11.3.5.7	Preparing a backup course of action if intervention efforts are rebuffed or if they fail.
11.3.6	The PPC should refer the situation for consideration of disciplinary action by submitting their results of a formal investigation as outlined in Chapter 8 of the Medical Staff Policies.	

Approval Process:

Bylaws Committee	7/8/ 2019
Professional Performance Committee	7/9/2019
Medical Executive Committee Approval for distribution to the Medical Staff	7/18/2019
Published to the Medical Staff	8/7/2019
Medical Executive Committee Recommendation for Approval to Board of Directors	10/17/2019
Board of Directors	11/19/2019

Title	Consent for Treatment	
Number	12	
Effective Date	April 16, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	June 27, 2023	

12.1	The St. Michael Medical Staff will adhere to the CHI Franciscan St. Michael policies and procedures as it relates to consent for admission and treatment to a St. Michael facility.	
12.2	The practitioner performing any of the following invasive, high risk, or surgical procedures will ensure the patient has been informed of the risks and benefits and has consented to the procedure prior to commencement of the procedure. This list is provided as a guideline and is not comprehensive.	
	12.2.1	Any procedure involving general or regional anesthesia, monitored anesthesia, or conscious sedation
	12.2.2	Any procedure involving skin incision
	12.2.3	Biopsy (e.g. bone marrow, breast, liver, muscle, kidney, genitourinary, prostate, bladder, skin)
	12.2.4	Cardiac procedures (e.g. cardiac catheterization, cardiac pacemaker, angioplasty, stent implantation, intra-aortic balloon catheter insertion, elective cardioversion)
	12.2.5	Central line placement
	12.2.6	Colposcopy and/or endometrial biopsy
	12.2.7	Debridement of skin or wound performed in an operating or a procedure room
	12.2.8	Dermatology procedures (e.g. biopsy, excision and deep cryotherapy for malignant lesions)
	12.2.9	Endoscopy (e.g. colonoscopy, bronchoscopy, esophagogastric, cystoscopy, percutaneous endoscopic gastrostomy, J-tube placement, nephrostomy tube placement)
	12.2.10	Injection of any substance into a joint space or body cavity
	12.2.11	Invasive ophthalmic procedures, including miscellaneous procedures involving implants
	12.2.12	Invasive radiographical procedures (e.g. angiography, angioplasty, percutaneous biopsy)
	12.2.13	Kidney stone lithotripsy
	12.2.14	Laparoscopic procedures (e.g. cholecystectomy, nephrectomy, hysterectomy)
	12.2.15	Oral procedures including tooth extraction and gingival biopsy
	12.2.16	Percutaneous aspiration of body fluids or air through the skin (e.g. arthrocentesis, bone marrow aspiration, lumbar puncture, paracentesis, thoracentesis, suprapubic catheterization, chest tube insertion)
	12.2.17	Manipulation and reduction
	12.2.18	Radiation oncology procedures
	12.2.19	Robotic assisted surgical procedures
12.3	The following procedures are not considered invasive, high risk, or surgical procedures and special consent is not required. This is covered under the basic consent to treat. This list is provided as a guideline and not comprehensive.	
	12.3.1	Ongoing chemotherapy/oncology procedure after initial consent

	12.3.2	Electrocautery for lesion
	12.3.3	Flexible sigmoidoscopy
	12.3.4	Foley catheter insertion
	12.3.5	Intravenous therapy
	12.3.6	Nasogastric tube insertion
	12.3.7	Vaginal examination/Pap smear
	12.3.8	Venipuncture
12.4	Nothing in this policy shall preclude a practitioner to obtain additional consent for a complex, high risk, or new procedure, outlining detailed risks and benefits of the procedure. Inclusion of such special consents must be approved by the appropriate Section.	

Approval Process:

Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	3/21/2019
Board of Directors	4/16/2019

Review:

- 6/27/2022 – no content changes needed but replaced all references to the Quality & Value Committee with the term Board of Directors.

Title	Conduct of Care – Medical Screening Examination	
Number	13.1	
Effective Date	March 28, 2013	
Accountability	Medical Staff	Administration
	Emergency Medicine Section OB/GYN Section Bylaws Committee Medical Executive Committee	Director - Emergency Department Director – Women & Children's Services Chief Nursing Officer Associate Chief Medical Officer
Review Date	December 19, 2023	

13.1.1	Any individual arriving at St. Michael Medical Center requesting examination or treatment of an emergency medical condition will be directed to the Emergency Department. Patients requiring obstetrical evaluation may be directed to the Obstetric Emergency Department in accordance with St. Michael policy.		
13.1.2	A qualified medical practitioner shall perform the Medical Screening Examination appropriate for the patient's clinical condition. A qualified medical practitioner is defined as follows:		
	13.1.2.1	Emergency Department	
		13.1.2.1.1	Physician
		13.1.2.1.2	Physician Assistant-Certified
		13.1.2.1.3	Advanced Registered Nurse Practitioner
		13.1.2.1.4	Sexual Assault Nurse Examiner
	13.1.2.2.	Obstetrical Emergency Department	
		13.1.2.2.1	Physician with obstetrical privileges
		13.1.2.2.2	OB ED Registered Nurse, as defined by St. Michael policy

References:

1. St. Michael Medical Center Policy Emergency Treatment and Active Labor Patient Access to Emergency Services revised March 31, 2012
2. St. Michael Medical Center Policy OB ED; Patient Assessment and Treatment

Approval

Bylaws Committee	January 21, 2013
Medical Executive Committee (Urgent Action Required to meet regulatory standard)	January 17, 2013
Published to the Medical Staff	January 22, 2013
Medical Executive Committee Recommendation to Board of Directors for Approval	January 17, 2013
Board of Directors	March 28, 2013

Reviewed:

- 3/26/2018 Bylaws Committee
- 12/19/2022 Bylaws Committee – no changes

Title	Conduct of Care – Admission of Patients	
Number	13.2	
Effective Date	February 20, 2018	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director Medical Staff Services Chief Medical Officer
Review Date	December 19, 2023	

13.2.1	A patient may be admitted to a bedded nursing unit of for a scheduled procedure only by a practitioner, in good standing, who has been granted clinical privileges to admit.	
13.2.2	Every patient admitted to a bedded nursing unit shall have a physician, dentist, or podiatrist designated in the medical record as having primary responsibility for the patient's care	
13.2.3	The admitting practitioner is responsible for	
	13.2.3.1	The medical care and treatment of the patient until such time that care is transferred to another qualified practitioner (i.e. attending physician, dentist, or podiatrist)
	13.2.3.2	Documenting patient admission status (inpatient, outpatient, or observation)
	13.2.3.3	Providing timely admission orders appropriate for the patient's clinical condition with instructions allowing nursing and other care givers to initiate care
	13.2.3.4	Accurate, complete, and timely ongoing documentation in the medical record
	13.2.3.5	Transmitting reports of the condition of the patient to the other involved practitioners, nurses, technicians, and other care givers.
	13.2.3.6	Giving such information to appropriate hospital staff as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient may be a source of danger.
	13.2.3.7	Communication with the patient and his/her family (if applicable)
13.2.4	When responsibility for the patient is transferred to another physician, dentists, or podiatrist, the admitting practitioner shall	
	13.2.4.1	Personally confirm with the accepting physician, dentist, or podiatrist that he/she is taking over primary direction of the care of the patient
	13.2.4.2	Communicate with the patient and his/her family (if applicable)
	13.2.4.3	Document transfer of care in the electronic medical records
	13.2.4.4	Enter a final progress note
	13.2.4.5	The above requirements listed in 13.2.4 do not apply in the event of temporary call coverage or shift to shift hand offs.
	13.2.4.6	In the event that a patient discharges a physician and no longer wishes to be under his/her care, the physician is responsible to provide continuing care to the patient until such time that another physician of record has assumed care.
13.2.5	Except in an emergency, no patient may be admitted or scheduled for a procedure until a provisional diagnosis has been made.	
	13.2.5.1	In case of an emergency, the provisional diagnosis shall be made as soon after the admission as possible.

Approval Process:

Bylaws Committee	July 24, 2017
Medical Executive Committee approval for distribution to the Medical Staff	September 21, 2017
Published to the Medical Staff	November 3, 2017

Medical Executive Committee Recommendation for Approval to Board of Directors	January 18, 2018
Board of Directors	February 21, 2018

Reviewed:

- 12/19/2022 Bylaws Committee – correction to bullets only

Title	Conduct of Care – Non-Discrimination	
Number	13.3	
Effective Date	March 4, 2013	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Human Resources Corporate Compliance
Review Date	December 19, 2023	

13.3.1	As a provider of medical care, St. Michael Medical Center follows the CHI Franciscan systemwide non-discrimination policy.
13.3.2	When faced with a health care provider's conscience protection, St. Michael will transfer the appropriate patient care responsibilities to an equally qualified health care provider.

Approval Process:

Bylaws Committee	October 15, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	October 18, 2012
Published to the Medical Staff	October 23, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	February 21, 2013
Board of Directors	March 4, 2013

Reviewed:

- 7/25/2018 Bylaws Committee
- 12/19/2022 Bylaws Committee – minor wording changes, no effect on content

Title	Conduct of Care - Consultations	
Number	13.4	
Effective Date	May 21, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 19, 2023	

13.4.1	Consultations will be requested via practitioner to practitioner conversation in person, via telephone or HIPAA compliant messaging platform. An order will be placed in the electronic medical record by the requesting physician.	
13.4.2	It is the responsibility of the requesting physician to provide the consultant with the following information	
	13.4.2.1	Patient identification information and location of the patient
	13.4.2.2	The urgency of the need for consultation
	13.4.2.3	The reason for the consultation
	13.4.2.4	The expectation for the consultant's involvement in the management of the patient
13.4.3	Based upon the information provided by the requesting physician, the consultant will see the patient in a mutually agreeable time frame, appropriate for the patient's current clinical condition.	
13.4.4	The consultant will document the findings and recommendations of the consultation in the electronic medical record as soon as possible after the consultation so the information is available to all care givers within a time frame that is appropriate for the patient's current clinical condition.	
13.4.5	In a circumstance of grave urgency, the Associate Chief Medical Officer, after consultation with the Chief of Staff, shall have the right to call in a consultant or consultants to meet the needs of the patient.	

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Review:

- 12/19/2022 Bylaws Committee – no changes

Title	Conduct of Care – Daily Care of Patients	
Number	13.5	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 19, 2023	

13.5.1	A patient admitted to a bedded nursing unit must be seen by the attending practitioner (or covering or consulting practitioner) at least daily or more frequently as required by the patient's clinical condition and other circumstances.		
13.5.2	An adequate progress note shall be documented at least daily and more often if there have been additional patient encounters to assess or address changes in the patient's clinical condition.		
	13.5.2.1	The progress note shall be of sufficient detail to allow other healthcare providers, including hospital utilization review staff, to formulate a reasonable picture of the patient's clinical course at the time of the observation, including, but not limited to	
		13.5.2.1.1	Response of the patient to treatment instituted
		13.5.2.1.2	Any new problems identified or complications of disease or treatment arising during the hospitalization
		13.5.2.1.3	Plans for further diagnostic evaluation
		13.5.2.1.4	Plans for further treatment
		13.5.2.1.5	Reason for continued hospitalization
		13.5.2.1.6	Expectations for length of continued stay in the hospital
		13.5.2.1.7	Plans for post-hospital care
13.5.3	Upon request of the utilization management staff, the attending practitioner must provide written justification of the necessity for continued hospitalization.		
13.5.4	While in post-anesthesia recovery, the patient's care is the responsibility of the anesthesiologist, the surgeon, or attending practitioner for medical concerns unrelated to the surgical procedure.		
13.5.5	Post-operative treatments, dietary limitations, medications, and supplies, directly related to the patient's surgery, are ordered and supervised by the attending surgeon.		
13.5.6	Post-operative treatments, medications, and supplies directly related to the patient's anesthesia are ordered and supervised by an anesthesiologist.		
13.5.7	When there is a potential or actual conflict among practitioners regarding orders and treatment plan, the practitioners involved shall discuss the issue promptly, in consideration of the patient's current clinical condition, and resolve the conflict.		
	13.5.7.1	The assistance of the Associate Chief Medical Officer may be sought to reach resolution.	
	13.5.7.2	If deemed necessary by the Associate Chief Medical Officer, he/she may follow the Medical Staff chain of command and involve the Department Chief and/or the Chief of Staff.	
13.5.8	If an admitted patient is scheduled for a procedure or surgery, it is the responsibility of the physician who orders the procedure to place an NPO order and/or ensure any medication adjustments are completed no later than the evening prior to the procedure.		

Approval Process:

Bylaws Committee	2/22/2022
Medical Executive Committee Approval for distribution to the Medical Staff	3/17/2022
Published to the Medical Staff	3/18/2022
Medical Executive Committee Recommendation for Approval to Board of Directors	6/16/2022
Board of Directors	7/19/2022

Review:

- 4/16/2020 Bylaws Committee
- 10/21/2021 Bylaws Committee

Title	Conduct of Care – Coverage Arrangements	
Number	13.6	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	January 23, 2024	

13.6.1	Each practitioner granted clinical privileges to work in the hospital shall arrange appropriate coverage of his/her hospitalized patients whenever he/she is absent or otherwise unavailable to care for the patient in the hospital.	
13.6.2	Appropriate coverage means	
	13.6.2.1	The covering practitioner has clinical privileges appropriate for the level of care required by the patient(s) being covered.
	13.6.2.2	The covering practitioner is available in a timely fashion to provide care, in person if needed, to the patient required by their current clinical condition or circumstances.
	13.6.2.3	If coverage includes the participation of an advanced practice clinician, there must also be available a designated covering physician available to provide care to the patient(s) required by their current clinical condition or circumstances that are beyond the scope of practice of the advanced practice clinician.
13.6.3	When handing off responsibility for coverage of a patient to another practitioner, it is expected that there be practitioner to practitioner communication to ensure the covering physician is aware of what is needed. This does not apply to hand off from coverage from shift to shift, although review of acute situations may necessitate a conversation.	
13.6.4	In the case of a practitioner to fail to provide adequate coverage, the Associate Chief Medical Officer will consult with the Chief of Staff to designate an appropriate member of the Medical Staff to attend to the patient.	
13.6.5	In the event of a failure to provide coverage, an IRIS report will be filed by the Associate Chief Medical Officer or designee.	

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Review:

- 1/23/2023 Bylaws Committee

Title	Conduct of Care - Autopsies	
Number	13.7	
Effective Date	December 20, 2021	
Accountability	Medical Staff	**Accountability**
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 20, 2022	

13.7.1	It shall be the duty of all practitioners with clinical privileges to request meaningful autopsies.	
13.7.2	The following circumstances should trigger a request for autopsy:	
	13.7.2.1	Diagnosis uncertain or unknown
	13.7.2.2	Intra-operative or post-operative death
	13.7.2.3	Desirability of establishing firm evidence of cause of death
	13.7.2.4	Situations in which establishment of pathological findings might contribute to the advancement of medical knowledge
13.7.3	An autopsy may be performed only after obtaining written consent signed in accordance with State of Washington law.	
13.7.4	Autopsies shall be performed by a pathologist or under the supervision of a pathologist.	

Approval Process:

Bylaws Committee	4/26/2021
Medical Executive Committee Approval for distribution to the Medical Staff	5/20/2021
Published to the Medical Staff	7/21/2021
Medical Executive Committee Recommendation for Approval to Board of Directors	11/18/2021
Board of Directors	12/20/2021

Title	Conduct of Care – Patients Admitted by Dentists and Podiatrists	
Number	13.8	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	January 23, 2024	

13.8.1	A Dentist or Podiatrist may admit patients to a bedded nursing unit provided they have been granted privileges to do so.	
13.8.2	Qualified oral and maxillofacial surgeons, pediatric dentists, and podiatrists, if granted privileges to do so, may perform the medical history and physician examination in order to assess the medical, surgical, and anesthesia risks for the proposed operative or other procedure(s).	
	13.8.2.1	If the history and physical has been or will be performed by someone other than the dentist, the dentist is responsible for that part of the patient's history and physical that relates to dentistry.
	13.8.2.2	If the history and physical has been or will be performed by someone other than the podiatrist, the podiatrist is responsible for that part of the patient's history and physical that relates to podiatry.
	13.8.2.3	All patients of Dentists and Podiatrists shall receive the same basic medical appraisal as other patients, regardless of which specialty is providing the appraisal.
13.8.3	Patients, who have documented medical problems that may pose additional risks for the patient such as that they would fall into ASA Category III or IV, should be seen in consultation by an appropriate physician member of the Medical Staff.	
13.8.4	If the dentist or podiatrist has sought the services of a physician to assist in the care of the patient by managing underlying medical issues, the name of the collaborating physician must be clearly identified in the patient's record.	
13.8.5	A Dentist or Podiatrist may write orders that are within the scope of his/her license.	
13.8.6	A Dentist or Podiatrist may provide the discharge summary provided	
	13.8.6.1	The Dentist or Podiatrist gives the discharge order.
	13.8.6.2	The Dentist or Podiatrist has been sufficiently involved in the care of the patient throughout the hospital course to provide all the required elements of a discharge summary, address all medical and surgical aspects of care, and can articulate a follow up plan beyond dental or podiatric needs, if applicable.

Approval Process:

Bylaws Committee	1/28/2019
Medical Executive Committee Approval for distribution to the Medical Staff	2/21/2019
Published to the Medical Staff	3/17/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Review:

- 1/23/2023 Bylaws Committee

Title	Conduct of Care – Discharge of Patient	
Number	13.9	
Effective Date	April 16, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 19, 2023	

13.9.1	Patients shall be discharged only by order of the attending physician, dentist, or podiatrist or a designated alternate.
13.9.2	In the event that a patient leaves the hospital against medical advice of the attending practitioner or without completing the discharge process, the attending practitioner will document the circumstances in the medical record.
13.9.3	The attending practitioner (or designated alternate) will complete the discharge summary as described in MSP 14.8.
13.9.4	As much as is practical, the attending practitioner should complete the discharge summary. However, in those situations when another practitioner has more knowledge of the patient's course and status at discharge, completion of the discharge summary may be delegated to an alternate by mutual agreement following practitioner to practitioner communication.

Approval Process:

Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	3/21/2019
Board of Directors	4/16/2019

Review:

- 12/19/2022 Bylaws Committee

Title	Conduct of Care – Hospital Death	
Number	13.10	
Effective Date	December 31, 2009	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 19, 2023	

13.10.1	In the event of the death of a patient in the hospital, regardless of location, the Practitioner managing the resuscitation effort shall be responsible for the pronouncement of death.	
13.10.2	If there is a valid “Do Not Resuscitate” order in the patient’s medical record, a Registered Nurse may assume responsibility for determining and pronouncement of death in the absence of a physician.	
13.10.3	The body shall not be released until an entry has been made and authenticated in the medical record of the deceased by the Practitioner, or when allowable, the Registered Nurse pronouncing the patient dead.	
13.10.4	The death certificate should be completed by the physician most familiar with the patient’s course during this hospitalization, inpatient or outpatient.	
	13.10.4.1	If there is a dispute about which physician is responsible for completion of the death certificate, the decision of the Associate Chief Medical Officer will be final.
	13.10.4.2	It is expected that each physician is registered and proficient in the use of the State of Washington Electronic Death Registry, as this is the only acceptable means for submitting a death certificate.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2020

Review:

- 12/19/2022 Bylaws Committee

Title	Conduct of Care – Continuity of Care for Patients Who Require Follow Up on Medical Studies After Acute Hospitalization	
Number	13.11	
Effective Date	April 16, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 19, 2023	

13.11.1	In order to ensure continuity of care for patients who require follow up on medical studies or evaluations to occur after acute hospitalization, the following guidelines are provided for two clinical situations:		
13.11.2	Patients who have not required any other specialty consults during the hospital stay and who have had ancillary studies (i.e. medical imaging or pathology) that demonstrates a result that requires follow up care after hospitalization.		
	13.11.2.1	The primary attending physician of record at discharge is required to ensure that	
		13.11.2.1.1	All follow up recommendations are documented in the After Visit Summary during the time of hospitalization
		13.11.2.1.2	The Problem List is updated to include the suspected condition (if applicable)
		13.11.2.1.3	Follow up care recommendations are included in the discharge summary
13.11.3	Patients who have one or more clinical consultant visits during their hospital stay and who have had ancillary studies (i.e. medical imaging or pathology) or consultant recommendations that demonstrate a result or recommendation which requires follow up care after hospitalization:		
	13.11.3.1	The primary attending physician of record at discharge is required to ensure that	
		13.11.3.1.1	All follow up recommendations are documented in the After Visit Summary during the time of hospitalization
		13.11.3.1.2	The Problem List is updated to include the suspected condition (if applicable)
		13.11.3.1.3	Follow up care recommendations are included in the discharge summary
	13.11.3.2	If a consultant specialist recommends aftercare or follow up care, the consultant is equally responsible to ensure that	
		13.11.3.2.1	All follow up recommendations related to the consultation are documented in the After Visit Summary during the time of hospitalization
		13.11.3.2.2	The Problem List is updated to include the suspected condition (if applicable)
		13.11.3.2.3	Follow up care recommendations are listed in the sign-off note (if applicable)

Approval Process:

Bylaws Committee	9/24/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	03/21/2019
Board of Directors	4/16/2019

Review:

- 12/19/2022 Bylaws Committee

Title	Conduct of Care – Pre-Anesthesia Assessment	
Number	13.12	
Effective Date	March 17, 2020	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	March 17, 2021	

13.12.1	A pre-anesthesia evaluation must be completed and documented in the patient chart, by an individual qualified and privileged to administer anesthesia, within 48 hours prior to surgery or a procedure requiring anesthesia services.
13.12.2	This requirement applies to moderate sedation, deep sedation and anesthesia.

References:

- CMS Guidelines: Title 42, 482.52(b) Condition of participation: Anesthesia Services
- The Joint Commission Standard PC.03.01.03

Approval Process:

Bylaws Committee	8/26/2019
Medical Executive Committee Approval for distribution to the Medical Staff	10/17/2019
Published to the Medical Staff	10/28/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	2/20/2020
Board of Directors	3/17/2020

Title	Health Information Management – General Provisions	
Number	14.1	
Effective Date	September 25, 2013	
Accountability	Medical Staff	Administration
	Health Information Management Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Director Health Information Management
Review Date	May 21, 2020	

14.1.1	Accurate and timely documentation of the care rendered to a patient and the information and data utilized in the decision making process are an integral part of quality medical care.	
14.1.2	Accurate and timely documentation of care rendered to a patient available to all caregivers is essential to assuring continuity of patient care.	
14.1.3	All caregivers who participated in the care of the patient are responsible for completion of that portion of the medical record related to the care provided, including dictations and signatures.	
14.1.4	The content shall be pertinent to the patient's clinical condition.	
14.1.5	This records shall include	
	14.1.5.1	Patient identification data
	14.1.5.2	Allergies to food or medications
	14.1.5.3	Documentation of consents for treatment
	14.1.5.4	Complete history and physical examination report
	14.1.5.5	Consultation reports
	14.1.5.6	Clinical laboratory, medical imaging, and other diagnostic reports or findings
	14.1.5.7	Provisional diagnosis
	14.1.5.8	Medical and/or surgical treatments
	14.1.5.9	Operative or procedure reports
	14.1.5.10	Anesthesiology records
	14.1.5.11	Documentation of therapeutic care and treatments provided by nursing and ancillary staff
	14.1.5.12	Progress notes
	14.1.5.13	Final diagnosis
	14.1.5.14	Instructions for post hospital and post-operative care
	14.1.5.15	Transfer summary (when applicable)
	14.1.5.16	Discharge summary
	14.1.5.17	Autopsy report (when applicable)
	14.1.5.18	Other pertinent information, such as patient directives, including POLST form
14.1.6	Symbols and abbreviations may be used only when they have been approved by the Health Information Management Committee in accordance with the policy *Abbreviations and Symbols List and Potentially Dangerous Abbreviations and Symbols.*	
14.1.7	A record is complete when all practitioners caring for the patient have entered and authenticated all required documentation pertinent to the patient's clinical condition when receiving care at a St. Michael facility for that episode of care and as required by regulatory and accreditation standards.	
14.1.8	The Health Information Management Committee may authorize closure of an incomplete medical record.	
14.1.9	It is the expectation of the organized Medical Staff that each practitioner granted clinical privileges which require documentation in the electronic medical record shall obtain the necessary training to be proficient in the use of those applications relevant to his/her clinical activities.	

	14.1.9.1	It is expected that each practitioner shall remain proficient in the use of the electronic medical record, including applicable upgrades or changed, relevant to his/her clinical activities.
	14.1.9.2	CHI Franciscan/St. Michael will provide resources to support initial training and ongoing training, as needed, for practitioners who need to document in or access information contained in the electronic medical record.
	14.1.9.3	Each practitioner is expected to obtain and maintain proficiency in other clinical applications which augment or support the basic electronic medical record applicable to his/her clinical activities.
	14.1.9.4	If a practitioner does not have sufficient proficiency to use the electronic medical record and other clinical applications, the Associate Chief Medical Officer will provide the opportunity for additional training.
	14.1.9.5	If, in the opinion of the Section Chief or the Professional Performance Committee, the practitioner lacks sufficient proficiency in use of the electronic medical record and remedial training has not resulted in the desired improvement, the Professional Performance Committee will recommend that he/she be placed on a Focused Professional Practice Evaluation until satisfactory proficiency is obtained and sustained.

Approval:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for Distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Title	Health Information Management – History and Physical	
Number	14.2	
Effective Date	November 19, 2019	
		Administration
	Health Information Management Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Director - Health Information Management Manager - Quality
Review Date	November 20, 2020	

14.2.1	Every patient must have a history and physical (H&P) examination performed and documented
14.2.2	The H&P shall be appropriate for the patient's current clinical condition and proposed plan for evaluation and treatment. Table (#TBD) attached to this policy defines the content requirements for a comprehensive H&P, an intermediate H&P, and an H&P note.
14.2.3	For patients admitted as an inpatient, the H&P must be recorded within 24 hours of inpatient admission.
14.2.4	For patients admitted as a bedded outpatient, the H&P must be recorded within 24 hours of the order to admit.
14.2.5	For patients having surgery or a procedure requiring anesthesia services, the H&P must be completed prior to the surgery or procedure except when this is not feasible because of patient's clinical condition.
14.2.6	The admitting practitioner is responsible for the availability and content of the H&P.
14.2.7	The H&P examination may be performed within 30 days prior to admission or a scheduled procedure; however, the patient must be examined within 24 hours of admission and the previous H&P documentation updated to reflect the patient's current clinical condition, including signature, date, and time of the updated entry.
14.2.8	If the patient is being admitted for a procedure and the H&P examination was performed within 30 days prior to the procedure, the practitioner performing the procedure, or their designee who is actively credentialed at St. Michael Medical Center to perform H&Ps, will document in the patient's record that there have been no changes in the patient's condition. Or, if changes have been identified, the practitioner, or designee, will document the changes. In addition, if a designee will update the H&P and the designee identifies a change in the patient's condition, the designee is required to document changes into the electronic health record and verbally notify the practitioner who is performing the procedure as soon as possible and prior to the initiation of the procedure. If there are clinically relevant changes in the patient's condition detected by the designee, the practitioner must co-sign the updated H&P prior to the procedure.
14.2.9	A legible copy of recorded history and/or appropriate physical examination performed greater than 30 days prior to the hospital admission or procedure may be included in the medical record and used as supplemental information, but may not be used in lieu of current H&P documentation.
14.2.10	The H&P documentation for all patients scheduled for an elective surgical or interventional procedure or a potentially hazardous diagnostic procedure shall be in the record prior to commencement of the scheduled procedure. Availability and content of the H&P shall be the responsibility of the operating surgeon, interventionalist, or practitioner performing the procedure.
14.2.11	If the H&P is not in the record and is not available to the persons caring for the patient, the procedure will be delayed and potentially cancelled. All such cancelled cases shall be reported to the CMO by clinical hospital department leadership via the OARS system.
14.2.12	Only those members of the Medical Staff on Non-Physician Practitioner Staff may perform an H&P examination, document an H&P, or update an H&P.

14.2.13	If any other practitioner, other than a member of the Medical Staff or Non-Physician Practitioner Staff with privileges to perform an H&P, has recorded supplemental documentation as described above, the admitting practitioner shall countersign, date and time the information to acknowledge that he/she is aware of the supplemental information.

Approval Process:

Bylaws Committee	7/8/2019
Medical Executive Committee	7/18/2019
Published to the Medical Staff	7/22/2019
Medical Executive Committee recommendation for approval to Board of Directors	10/17/2019
Board of Directors	11/19/2019

Table 14.2.A

Comprehensive	Intermediate	H&P Note
When used: 1. Inpatients 2. Outpatients going to a bedded nursing unit 3. Surgery patients 4. Patients scheduled for an elective, potentially hazardous diagnostic procedure	When used: Outpatients admitted for elective therapeutic or diagnostic procedure with moderate risk	When used: Outpatients admitted for diagnostic testing, with minimal risk
Content: 1. Chief complaint 2. Reasonably detailed account of present illness 3. Assessment of contributing emotional, behavioral, and/or social factors 4. Relevant past medical, surgical, social, and family histories 5. Prior to Admission (PTA) medications 6. Allergies 7. Reasonably detailed review of body systems 8. Physical examination assessing the patient's general condition and specific details related to the condition(s) for which the patient is being treated or for which the procedure is being performed 9. Proposed initial plan of evaluation and treatment 10. For pediatric and adolescent patients, developmental age, educational and activity needs, immunization status, family's or guardian's expectations and involvement in the assessment, treatment, and plans for care	Content: 1. Chief complaint 2. Clinically relevant medical history 3. Pertinent physical findings 4. PTA medications 5. Allergies 6. Proposed plan of treatment	Content: 1. Chief complaint and important history 2. PTA medications 3. Allergies
When due: 1. Within 24 hours of admission 2. If completed within 30 days prior to admission, scheduled elective surgical procedure or hazardous diagnostic procedure, it must be updated within 24 hours of surgery 3. In the event of life-threatening (extreme emergency) situation, the operation or procedure may be done immediately and the examination recorded within 24 hours.	When due: Prior to commencement of procedure	When due: Prior to commencement of diagnostic test

Approvals:

Bylaws Committee	7/8/2019
Medical Executive Committee	7/16/2019
Published to the Medical Staff	7/18/2019
MEC Recommendation to BQVC	10/17/2019
Board of Directors	11/19/2019

Title	Health Information Management – Orders for Treatment	
Number	14.3	
Effective Date	November 30, 2016	
Accountability	Medical Staff	Administration
	Health Information Management Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Director – Health Information Management Director – Nursing Services
Review Date	October 28, 2020	

14.3.1	All orders for treatment shall be documented by electronic order entry or by handwritten order when the electronic option is not available.	
14.3.2	All handwritten orders for test or treatments shall be clear, legible, and complete, including signature, date, and time the order is written.	
14.3.3	Orders which are unclear, illegible, or otherwise improperly documented or cannot be understood will not be carried out until clarified, re-entered or rewritten.	
14.3.4	All orders for tests and treatments will be dated, timed, and signed. The day and time reflect when the order was signed manually or authenticated electronically.	
14.3.5	Texting of orders for diagnostic tests or therapeutic care is prohibited.	
14.3.6	Verbal Orders	
	14.3.6.1	A verbal order shall be considered to be in writing if dictated (personally or by telephone) to a duly authorized person functioning within his/her sphere of competence and manually signed or electronically authenticated by the ordering practitioner or a designated alternate within 48 hours.
	14.3.6.2	A “ duly authorized person” may include, but is not necessarily limited to the following acting within the person’s scope of practice: a. Registered nurse b. Licensed practical nurse c. Advanced Registered Nurse Practitioner d. Physician Assistant – Certified e. Respiratory Therapist f. Registered dietitian g. Registered medical imaging technologist h. Registered pharmacist
	14.3.6.3	The person receiving the order must read back to the practitioner the order to ensure accuracy.
	14.3.6.4	A verbal order must be signed by the person to whom the order was dictated, including the date and time the order was received and the name of the practitioner giving the order.
	14.3.6.5	The ordering practitioner, or approved surrogate, shall authenticate the verbal order within 48 hours by signature, including date and time or by electronic means.
	14.3.6.6	The use of verbal orders, including telephone orders, is discouraged. It is the expectation that when electronic means for order entry and authentication are available, the ordering practitioner is expected to enter or authenticate orders electronically. It is recognized that there are some

		instances in which the practitioner may not able to enter orders electronically (i.e., during a surgery or other procedure; when the practitioner is not in the hospital and does not have access to a computer). Authorized hospital staff will make every effort to accommodate the documentation of the order in the patient record in the interest of patient care. Practitioners are expected to maintain ongoing competence in the use of the electronic medical record systems used at St. Michael.
14.3.7	Practitioners may designate surrogates to authenticate orders or dictation by submitting a letter to the Health Information Management Department indicating all practitioners approved to authenticate chart entries for each other.	
14.3.8	Order Sets for Computerized Physician Order Entry	
	14.3.8.1	Order sets pertaining to procedures and to nursing or ancillary care may be developed by a system wide process to ensure consistency.
	14.3.8.2	There will be instances in which participants in the development and approval of the order sets may or may not be members of the St. Michael Medical Staff. However, the system process includes an opportunity for a designated St. Michael Medical Staff member to sign off on each order set applicable to services provided at St. Michael.
	14.3.8.3	Order sets will be implemented at St. Michael upon approval of the Medical Executive Committee.
	14.3.8.4	Order set development will not be considered complete until signed off by a St. Michael representative.
14.3.9	Orders by Advanced Practice Clinicians (APCs)	
	14.3.9.1	Orders by independent APCs with clinical privileges to provide orders do not require authentication by signature of a physician.
	14.3.9.2	Orders by supervised APCs with clinical privileges may require authentication by the supervising physician based upon the privileges granted.

Approval:

Bylaws Committee	June 27, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	July 21, 2016
Published to the Medical Staff	July 22, 2016
Medical Executive Committee recommendation for approval to Board of Directors	October 20, 2016
Board of Directors	November 30, 2016

Reviewed:

- Bylaws Committee - January 20, 2018
- Bylaws Committee – October 28, 2019; minor wording changes only, no effect on content

<table>
<tr><td>Title</td><td colspan="2">Health Information Management – Progress Notes</td></tr>
<tr><td>Number</td><td colspan="2">14.4</td></tr>
<tr><td>Effective Date</td><td colspan="2">September 25, 2013</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Health Information Management Committee
Bylaws Committee
Medical Executive Committee</td><td>Associate Chief Medical Officer
Director Health Information Management</td></tr>
<tr><td>Review Date</td><td colspan="2">August 20, 2020</td></tr>
</table>

14.4.1	Pertinent progress notes shall be recorded at the time of observation.
14.4.2	Progress notes may be handwritten, provided they are legible, or entered into the record electronically (provided that such technology is available). Handwritten notes shall be dated, timed, and signed.
14.4.3	Progress notes shall be of sufficient detail to allow other health care practitioners and persons performing administrative and clinical review functions to formulate a reasonable picture of the patient's clinical condition at the time of observation.
14.4.4	Progress notes shall be recorded using the SOAP format. a. Subjective b. Objective c. Assessment d. Plan
14.4.5	Progress notes shall include, but are not limited to a. What is the current clinical situation at the time of the assessment b. Response of the patient to treatment initiated c. Results of tests d. Any new problems or complications of disease or treatment during hospitalization e. Plans for future diagnostic evaluation and treatment f. Reason for continued hospitalization g. Expected length of stay in the hospital h. Plans for post hospital care
14.4.6	Whenever possible, each of the patient's active clinical problems should be clearly identified in the progress notes and correlated with specific orders
14.4.7	Progress notes shall be entered no less often than daily and whenever there is a change in the management of the clinical condition of the patient by any healthcare practitioner involved in the patient's care. For areas of the hospital that are designated transitional care units, which are care units that are occupied by long term stay patients who have minimal acute medical care needs, weekly progress notes are acceptable if there are no changes in the clinical condition of the patient.
14.4.8	Following a surgical or interventional procedure or an invasive diagnostic procedure, a post-operative/procedure note shall be entered immediately and shall include: a. Date and time of the procedure b. Primary surgeon or proceduralist c. Assistant (if applicable) d. Name of the procedure e. Description of the intra-operative or procedural findings f. Any difficulty encountered

	g. Estimated blood loss h. Specimens removed (if any) i. Post-operative or procedure diagnosis j. Condition of the patient at the conclusion of the procedure k. Physician or practitioner signature
14.4.9	In the event of a procedure, the operative note or procedure note provided immediately following the case can suffice as the final progress note for any patient discharged home from the recovery area, provided in includes the elements listed in 14.4.8. Additionally it should include instructions for use of medications post-operatively and follow up care.

Approval:

Bylaws Committee	3/25/2019
Medical Executive Committee Approval for distribution to the Medical Staff	4/18/2019
Published to the Medical Staff	5/1/2019
Medical Executive Committee Recommendation for Approval to Board of Directors	7/18/2019
Board of Directors	8/20/2019

Title	Health Information Management – Operative and Procedure Reports	
Number	14.5	
Effective Date	September 25, 2013	
Accountability	Medical Staff	Administration
	Health Information Management Committee Bylaws Committee Medical Executive Committee	Chief Medical Officer Director Health Information Management
Review Date	October 28, 2020	

14.5.1	An operative and procedure report shall include a. Date and time of the procedure b. Primary surgeon or proceduralist c. Assistant (if applicable) d. Name of the procedure e. Description of the intra-operative or procedural findings f. Any difficulty encountered g. Estimated blood loss h. Specimens removed (if any) i. Post-operative or procedure diagnosis j. Condition of the patient at the conclusion of the procedure k. Physician or practitioner signature or electronic authentication
14.5.2	The proceduralist shall enter a post procedure note immediately following the procedure which shall include the same information as listed above.
14.5.3	Operative and procedure reports shall be written or dictated within 24 hours following the procedure.
14.5.4	The dictated report shall be promptly authenticated as soon as possible, but within 24 hours of transcription.

Approval:

Bylaws Committee	February 27, 2017
Medical Executive Committee approval for distribution to the Medical Staff	March 16, 2017
Published to the Medical Staff	March 24, 2017
Petition Yes/No	No
Medical Executive Committee recommendation for approval to Board of Directors	September 21, 2017
Board of Directors	October 17, 2017

Reviewed:

- Bylaws Committee – October 28, 2019; minor wording changes only, no effect on content

Title	Health Information Management – Obstetrical Record	
Number	14.6	
Effective Date	June 27, 2013	
Accountability	Medical Staff	Administration
	OB/GYN Section Health Information Management Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Director Health Information Management Director Family Birth Center
Review Date	October 28, 2020	

14.6.1	A legible copy of the practitioner's office record may be included in the medical record as a supplement to the current obstetrical record. That portion of the office record submitted as supplemental information shall be scanned and retained in the patient's electronic medical record.
14.6.2	The admitting physician needs to include an interval admission note upon completion of the OB triage and decision to admit.
14.6.3	The interval admission note must include a. Pertinent additions to the patient's history b. Subsequent changes in the patient's physical condition

Approval Process:

Obstetrics & Gynecology Section	February 1, 2013
Bylaws Committee	February 18, 2013
Medical Executive Committee approval for distribution to the Medical Staff	February 21, 2013
Published to the Medical Staff	February 25, 2013
Petition Yes/No	No
Medical Executive Committee recommendation for Approval to Board of Directors	June 20, 2013
Board of Directors	June 27, 2013

Reviewed:

- Bylaws Committee – October 28, 2019; minor wording changes only, no effect on content

Title	Health Information Management – Consultation Reports	
Number	14.7	
Effective Date	September 25, 2013	
Accountability	Medical Staff	Administration
	Health Information Management Committee Bylaws Committee	Director – Medical Staff Services Chief Medical Officer Director – Health Information Management
Review Date	October 28, 2020	

14.7.1	Consultation reports shall show evidence of a. Date and time of the evaluation b. Review of the patient's record by the consultant c. Pertinent findings on examination of the patient d. Consultant's opinion and recommendations
14.7.2	The consultation report shall be written or dictated and shall be made a part of the current medical record.
14.7.3	Consultation reports must be authenticated by signature (including date and time) or by electronic means within 24 hours of completion of the evaluation by the consultant or an approved designated alternate.
14.7.4	When operative or invasive procedures are involved, the consultation report, except in emergency situations, must be recorded prior to the procedure.

Approval:

Bylaws Committee	September 16, 2013
Medical Executive Committee	September 19, 2013
Urgent Action required to comply with accreditation standard	Yes. Per Joint Commission citation August 9, 2013
Board of Directors	September 25, 2013
Published to the Medical Staff	October 29, 2013

Reviewed:

- Bylaws Committee – October 28, 2019; minor wording changes only, no effect on content

Title	Health Information Management – Discharge Summary	
Number	14.8	
Effective Date	September 25, 2013	
Accountability	Medical Staff	Administration
	Health Information Management Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Director – Health Information Management
Review Date	October 28, 2020	

14.8.1	A discharge summary is required for the following patients:		
	14.8.1.1	All inpatients, regardless of length of stay	
	14.8.1.2	All bedded outpatients	
	14.8.1.3	All observation patients admitted to a nursing unit	
14.8.2	A discharge summary is required for all patient deaths, regardless of length of stay or admission status. This document shall be called a death summary.		
14.8.3	The discharge summary shall be sufficient to justify the diagnosis, to warrant the treatment, and to document the end result.		
14.8.4	The discharge summary shall contain the following elements:		
	14.8.4.1	Admitting or provisional diagnosis (the reason for the admission)	
	14.8.4.2	Pertinent test results	
	14.8.4.3	Summary of hospital course, including procedures, surgeries, consultations, and medical treatments	
	14.8.4.4	Status of patient at discharge	
	14.8.4.5	Plans for follow-up with regard to	
		14.8.4.5.1	Physical activity
		14.8.4.5.2	Limitations
		14.8.4.5.3	Medications
		14.8.4.5.4	Diet
		14.8.4.5.5	Home health follow-up, if applicable
		14.8.4.5.6	Physician follow-up
14.8.5	The discharge summary shall be dictated or documented in the Medical Record within 24 hours of discharge.		
14.8.6	The discharge summary shall be authenticated by electronic signature by the dictating practitioner, or approved designated alternate, within 24 hours of transcription.		
14.8.7	The death summary shall be completed within 7 calendar days of the death and authenticated by electronic signature by the dictating practitioner, or approved designated alternate, within 24 hours of transcription.		
14.8.8	A transfer summary for a patient going to another facility is acceptable as a discharge summary, provided it contains the elements listed above (13.8.4). Whenever possible, based upon the patient's clinical condition and to enhance continuity of care, a transfer summary should be dictated or otherwise documented in the medical record prior to the patient's departure from the facility.		

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Board of Quality and Value Committee	June 20, 2017

Reviewed: Bylaws Committee – July 25, 2018, October 28, 2019

Title	Disruptive Behavior - Purpose	
Number	15.1	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.1.1	The purpose of this policy is to promote improvement in the quality of patient care and safety by defining and prohibiting disruptive behavior by members of the Medical Staff and advanced practice clinicians, identifying the mechanism by which complaints of such behavior are received, investigated and assessed, and providing appropriate responses to disruptive behavior.	
15.1.2	The Medical Staff Bylaws, of which this Disruptive Behavior Policy is a part by reference, shall be the exclusive means for review and disciplining Medical Staff members and advanced practice clinicians for inappropriate or disruptive behavior, except as otherwise set forth in this policy or the Medical Staff Bylaws.	
15.1.3	It is the policy of St. Michael that all individuals within its facilities be treated with courtesy, respect, and dignity. To that end, the Board requires that all individuals, employees, Medical Staff members, and advanced practice clinicians conduct themselves in a professional and cooperative manner at St. Michael, to include	
	15.1.3.1	Complying with all applicable practice standards
	15.1.3.2	Using conflict resolution skills in managing disagreements
	15.1.3.3	Addressing concerns about clinical judgments with associates directly and privately
	15.1.3.4	Using appropriate grievance channels as outlined in the Medical Staff Bylaws as a means to address dissatisfaction with policies
	15.1.3.5	Communicating with others clearly and directly, displaying respect for their dignity
	15.1.3.6	Participating in regular behavior feedback
	15.1.3.7	Complying with existing policies
	15.1.3.8	Promoting cooperation and teamwork
15.1.4	The objectives of this policy are to	
	15.1.4.1	Ensure optimum patient care by promoting a safe, cooperative, and professional health care environment
	15.1.4.2	Prevent or eliminate, to the extent possible, conduct that is disruptive
	15.1.4.3	Attempt to provide a work environment where all Medical Staff members, advanced practice clinicians, employees, and staff can work together comfortably and productively, free from harassment
	15.1.4.4	Provide guidelines for identification, review, intervention, and action regarding disruptive conduct

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Board of Directors	July 27, 2016

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- Bylaws Committee - July 27, 2020 – minor wording changes only, no content changes

Title	Disruptive Behavior - Definitions	
Number	15.2	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.2.1	Appropriate behavior is any reasonable conduct to ● Advocate for patients ● Recommend improvements in patient care ● Participate in operations, leadership, or activities ● Engage in professional practice, including practice that may be in competition with St. Michael, unless prohibited by contract	
	15.2.1.1	Appropriate behavior is not subject to discipline under this Policy.
15.2.2	Disruptive behavior includes	
	15.2.2.1	Any improper conduct, including sexual or other forms of harassment, or other forms of verbal and non-verbal conduct that harms or intimidates others to the extent that quality of care or patient safety could be compromised.
	15.2.2.2	Any improper behavior that disrupts the operation of St. Michael to the extent that it affects the ability of others to do their jobs through creation of a “hostile work environment” for St. Michael employees, Medical Staff, or advance practice clinicians.
	15.2.2.3	Any improper behavior that interferes with the ability of an individual to practice competently
	15.2.2.4	Any improper behavior that adversely affects or impacts the community’s confidence in St. Michael’s ability to provide quality patient care
	15.2.2.5	Any other behavior on the part of Medical Staff members or advanced practice clinicians which, as determined by the Medical Staff or the Board, has the potential to have a negative impact on patient care, is disruptive to St. Michael or the Medical Staff operations, and is inconsistent with the norms of professional behavior.
15.2.3	Harassment is any conduct towards others which has the purpose or direct effect of unreasonably interfering with a person’s work performance or which creates an offensive, intimidating, or otherwise hostile work environment based upon their ● Race ● Religion ● Gender or gender identity ● Sexual orientation ● Nationality ● Ethnicity ● Any other protected classification or group as defined by current or future federal, state, or municipal laws or regulations	
	15.2.3.1	Harassment may include

		15.2.3.1.1	Derogatory comments or jokes
		15.2.3.1.2	Intimidation
		15.2.3.1.3	Negative stereotyping
		15.2.3.1.4	Threats
		15.2.3.1.5	Assaults
		15.2.3.1.6	Any physical interference with normal work
		15.2.3.1.7	Any threatening or abusive movement directed to an individual patient, their relatives, friends, or associates, St. Michael employees, volunteers, individual Medical Staff member or advanced practice clinicians
		15.2.3.1.8	Written or graphic material placed on walls, bulletin boards, or elsewhere in St. Michael's premises, or circulated in the workplace by electronic means that denigrates or shows hostility or aversion toward an individual or group because of the characteristics defined above
	15.2.3.2	Sexual Harassment	
		15.2.3.2.1	Based upon federal, state, or municipal laws prohibiting sexual harassment
		15.2.3.2.2	Unwelcome sexual advances
		15.2.3.2.3	Requests for sexual favors
		15.2.3.2.4	Verbal or physical activities through which submission to sexual advances is made explicit or implicit conditions of employment or future employment related decisions
		15.2.3.2.5	Unwelcome conduct of a sexual nature which has the purpose or effect of unreasonably interfering with a person's work performance or which creates an offensive, intimidating, or otherwise hostile work environment
		15.2.3.2.6	Sexual harassment is illegal. Any claim regarding sexual harassment must and will be treated as a disciplinary matter and addressed in the manner described in Chapter 9, Precautionary Suspension and other chapters which outline the investigative (Chapter 6) and hearing process (Chapter 15)
15.2.4	Retaliation		
	15.2.4.1	An action taken by an accused practitioner against the complainant or a person closely related to or associated with the complainant in return for the complaint	
	15.2.4.2	Retaliation may include threats, harassment, or other similar actions.	
	15.2.4.3	Retaliation does not include petty slights or trivial annoyances.	

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- Bylaws Committee – July 27, 2020

Title	Disruptive Behavior – Types of Conduct	
Number	15.3	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.3.1	This policy provides examples of appropriate, inappropriate, and disruptive behavior. The behaviors cited are not intended to be an exhaustive list, but are to be used as a guideline for categorizing the practitioner's action.		
15.3.2	Disciplinary action may be brought only for behaviors that fall under the categories of inappropriate or disruptive.		
15.3.3	Appropriate behavior		
	15.3.3.1	Practitioners cannot be subject to discipline for appropriate behavior.	
	15.3.3.2	Examples of appropriate behavior include, but are not limited to the following:	
		15.3.3.2.1	Criticism communicated in a reasonable manner and offered in good faith with the aim of improving patient care
		15.3.3.2.2	Encouraging clear communication
		15.3.3.2.3	Expressions of concern about patient care and safety
		15.3.3.2.4	Expressions of dissatisfaction with policies through appropriate grievance channels (Medical Staff Bylaws, Article X – Practitioner Rights) and other civil means of communication
		15.3.3.2.5	Use of cooperative approach to problem resolution
		15.3.3.2.6	Constructive criticism conveyed in a respectful and professional manner without blame, shame, or adverse outcomes
		15.3.3.2.7	Professional comments to any professional, managerial, supervisory, administrative staff or members of the Board about patient care or safety provided by others
		15.3.3.2.8	Active, good faith, participation in Medical Staff and hospital meetings. Good faith comments made during or resulting from such meetings cannot be used as the basis for a complaint under this policy. Neither can referral to the Physician Well-Being Committee, economic sanctions, or the filing of an action before any state or federal agency.
		15.3.3.2.9	Membership on other medical staffs
		15.3.3.2.10	Seeking legal advice or the initiation of legal action for cause
15.3.4	Inappropriate behavior		
	15.3.4.1	Inappropriate behavior by practitioners is discouraged.	
	15.3.4.2	Continuing inappropriate behavior can become a form of harassment and thereby become disruptive; and, thus, is subject to treatment as disruptive behavior.	
	15.3.4.3	Examples of inappropriate behavior include, but are not limited to the following:	
		15.3.4.3.1	Belittling or berating statements
		15.3.4.3.2	Name calling
		15.3.4.3.3	Use of profanity or disrespectful language
		15.3.4.3.4	Inappropriate comments entered into the patient's medical record

		15.3.4.3.5	Blatant failure to respond to patient care needs or appropriate staff requests
		15.3.4.3.6	Sarcasm or cynicism directed toward another person
		15.3.4.3.7	Deliberate lack of cooperation without good cause
		15.3.4.3.8	Deliberate refusal to return phone calls, pages, and other messages concerning patient care or safety
		15.3.4.3.9	Deliberate refusal to fulfill responsibilities as a member of the Medical Staff or advanced practice clinician
		15.3.4.3.10	Intentional condescending language
		15.3.4.3.11	Intentional degrading or demeaning comments regarding patients and their families, nurses, members of the Medical Staff, St. Michael personnel, advanced practice clinicians and/or St. Michael Medical Center.
15.3.5	Disruptive behavior		
	15.3.5.1	Disruptive behavior by practitioners is prohibited.	
	15.3.5.2	Examples of disruptive behavior include, but are not limited to the following:	
		15.3.5.2.1	Physically threatening language directed to anyone in a St. Michael facility, including patients and their families, members of the Medical Staff, nurses, advanced practice clinicians, or any St. Michael employee, administrator, or Board member
		15.3.5.2.2	Physical contact with another individual that is threatening or intimidating
		15.3.5.2.3	Throwing instruments or other objects
		15.3.5.2.4	Threats of violence or retribution
		15.3.5.2.5	Sexual harassment
		15.3.5.2.6	Other forms of harassment including, but not limited to, persistent inappropriate behavior

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Title	Disruptive Behavior – Classification of Disruptive Behavior	
Number	15.4	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.4.1	Disruptive behavior occurs in varying degrees, which are classified into three levels of severity, with Level I being the most severe violations of this policy.		
15.4.2	Any corrective action will be commensurate with the nature and severity of the disruptive behavior.		
15.4.3	Repeated instances of disruptive behavior will be considered cumulatively and actions shall be taken accordingly.		
15.4.4	Classification of severity will follow these guidelines:		
	15.4.4.1	Level I	
		15.4.4.1.1	Physical violence or other physical abuse which is directed to a person
		15.4.4.1.2	Sexual harassment or harassment involving physical contact
		15.4.4.1.3	Possession of weapons on St. Michael property
		15.4.4.1.4	Intentional acts with potential for patient harm, including misrepresentation in documentation of patient care
	15.4.4.2	Level II	
		15.4.4.2.1	Verbal abuse, such as yelling, swearing, cursing, threatening, or humiliating
		15.4.4.2.2	Sexual or otherwise inappropriate comments directed to a person or persons
		15.4.4.2.3	Physical violence or abuse directed in anger at an inanimate object
	15.4.4.3	Level III	
		15.4.4.3.1	Verbal abuse which is directed at large, but has been reasonably perceived by a witness to be disruptive behavior as defined above

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Title	Disruptive Behavior - Intervention	
Number	15.5	
Effective Date	July 27, 2106	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.5.1	Interventions should initially be non-adversarial in nature, if possible, with the focus on restoring trust, placing accountability on, and rehabilitating the offending practitioner.
15.5.2	Intervention should be focused on protecting patient care and safety.
15.5.3	The organized Medical Staff supports tiered, non-confrontational intervention strategies, starting with informal discussion of the matter with the appropriate Section Chief.
15.5.4	Further interventions can include an apology directly addressing the problems, a letter of admonition, a letter of warning, a letter of reprimand or corrective action pursuant to the Medical Staff Bylaws, if the behavior is or becomes disruptive.
15.5.5	The use of precautionary suspension should be considered only where the practitioner's disruptive behavior presents imminent danger to the health and well- being of any person or persons.
15.5.6	Rehabilitation may be recommended at any time.
15.5.7	If there is a reason to believe inappropriate behavior is due to illness or impairment, the matter should be evaluated and managed confidentially according to Medical Staff Policy 11 (Impaired Practitioners) and the established procedures of the Medical Staff Physician Well-Being Committee.
15.5.8	The Physician Well-Being Committee, after evaluation, may choose to refer the affected Medical Staff member or advanced practice clinician to the Washington Physician Health Program (WPHP) for further evaluation, counseling, and treatment. Those practitioners not under the auspices of WPHP would be referred to the program appropriate for their licensure.

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Title	Disruptive Behavior – Procedure for Reporting Claim of Inappropriate or Disruptive Behavior	
Number	15.6	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.6.1	A member of the Medical Staff or an advanced practice clinician shall report complaints about another practitioner to the Chief of Staff.
15.6.2	A St. Michael employee or volunteer shall report complaints about a member of the Medical Staff or advanced practice clinician regarding allegedly inappropriate or disruptive behavior to his/her direct supervisor who will forward the complaint to the ACMO. The ACMO will advise the Chief of Staff of the complaint.
15.6.3	A patient or family member, guardian, or caregiver with complaints about a member of the Medical Staff or advanced practice clinician regarding allegedly inappropriate or disruptive behavior shall be reported to the patient advocate who will forward the complaint to the ACMO. The ACMO will advise the Chief of Staff of the complaint.
15.6.4	In the above described scenarios, if the complaint is about the behavior of the Chief of Staff, the matter will be reported to or forwarded to the Assistant Chief of Staff. This arrangement remains in effect throughout the course of the investigation, assessment, and conclusion of the matter, as outlined in this policy.

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Title	Disruptive Behavior – Content of Complaint of Inappropriate or Disruptive Behavior	
Number	15.7	
Effective Date	July 27. 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.7.1	Any complaint about the behavior of a Medical Staff member or advanced practice clinician must be in writing, signed by the person reporting the inappropriate or disruptive behavior, or the person otherwise initiating the review under this policy.	
15.7.2	To the extent feasible, the report must include the following:	
	15.7.2.1	The date(s), time(s), and location(s) of the inappropriate or disruptive behavior
	15.7.2.2	A factual description of the inappropriate or disruptive behavior
	15.7.2.3	The circumstances which precipitated the incident
	15.7.2.4	The name and medical record number of any patient involved and name of any member of the patient's family, or other associate who was involved in or witnessed the incident
	15.7.2.5	The names of other witnesses of the incident
	15.7.2.6	The consequences, if any, of the inappropriate or disruptive behavior as it relates to patient care or safety, or St. Michael personnel or operations, and any action taken to intervene in or remedy the incident, including the names of those intervening.

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Title	Disruptive Behavior – Investigating and Assessing a Claim of Inappropriate or Disruptive Behavior	
Number	15.8	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.8.1	At the discretion of the Chief of Staff, the duties herein assigned to the Chief of Staff can, from time to time, be delegated to another elected member of the Medical Staff (i.e. a member of the MEC) who shall be the designee. Furthermore, at the discretion of the Chief of Staff, the ACMO and other St. Michael staff may provide technical and administrative support for the process.	
15.8.2	If, in the opinion of the MEC, the Chief of Staff has a conflict, the Assistant Chief of Staff will fill that role.	
15.8.3	The Chief of Staff or designee will review the complaint and will refer any disruptive behavior complaint to the Professional Performance Committee (hereinafter PPC).	
15.8.4	The Chief of Staff, at his/her discretion, may also refer any inappropriate behavior complaint to the PPC.	
15.8.5	The complainant will be provided with a written acknowledgement of receipt of the complaint.	
15.8.6	In all cases, the Chief of Staff will notify in writing the member of the Medical Staff or advanced practice clinician who is the subject of the complain that the complaint has been received.	
	15.8.6.1	Such notification shall occur in a timely manner, but no more than 30 days of receipt of the complaint.
	15.8.6.2	The notification shall include a copy of the Disruptive Behavior Policy and a copy of the complaint.
	15.8.6.3	The affected practitioner will be notified that attempts to confront, intimidate, or otherwise retaliate against the complainant is a violation of the Disruptive Behavior Policy and such acts may result in additional corrective action against the affected practitioner.
15.8.7	The PPC shall make such inquiry as appropriate of the circumstances, which should include interviewing the complainant, any witnesses, and the subject of the complaint.	
15.8.8	No member of the PPC who is a direct economic competitor, business partner, relative, or who otherwise might be perceived to have a conflict may participate in the investigation and decision without making full disclosure of the conflict of interest and recusing himself/herself from the vote.	
15.8.9	The timing of the interviews depends upon the severity of the complaint and should generally occur within the following timelines, depending upon the availability of witnesses.	
	15.8.9.1	Level I (most severe) – within 24 hours of receipt of the complaint
	15.8.9.2	Level II (intermediate severity) within 5 working days of receipt of the complaint
	15.8.9.3	Level III (least severe) within 10 working days of receipt of the complaint

<table>
<tr><td></td><td>15.8.9.4</td><td colspan="2">The failure of an interview to occur within the specified time frames shall not be the basis to invalidate the complaint or any action taken under this policy of the Medical Staff Bylaws.</td></tr>
<tr><td>15.8.10</td><td colspan="3">The affected practitioner shall be provided an opportunity to respond in writing to the complaint.</td></tr>
<tr><td>15.8.11</td><td colspan="3">The PPC will make a determination of the authenticity and severity of the complaint and shall make a written report to the Chief of Staff for review and action so long as the report clearly documents the basis of the PPC recommendation.</td></tr>
<tr><td>15.8.12</td><td colspan="3">The PPC may find no cause for action for any unsubstantiated complaint if it is not possible to confirm its authenticity or severity or if the conduct does not fall within the definition of disruptive conduct.</td></tr>
<tr><td></td><td>15.8.12.1</td><td colspan="2">The PPC will notify both the complainant and the practitioner who is the subject of the complaint if this is the decision reached.</td></tr>
<tr><td>15.8.13</td><td colspan="3">If the PPC suspects that the subject of the complaint may be suffering from a medical, psychiatric, or psychological illness, including substance abuse, the complaint will be handled in a confidential matter as outlined in Medical Staff Policy 11 (Impaired Practitioners).</td></tr>
<tr><td>15.8.14</td><td colspan="3">If the PPC determines the concern was substantiated, the complainant and practitioner who is the subject of the complaint will be informed of the decision. The recommendations of the PPC may include, but not be limited to, the following:</td></tr>
<tr><td></td><td>15.8.14.1</td><td colspan="2">That an interview or interviews be conducted to gather more information</td></tr>
<tr><td></td><td>15.8.14.2</td><td colspan="2">That an investigation with potential for corrective action be initiated or continued</td></tr>
<tr><td></td><td>15.8.14.3</td><td colspan="2">That a discussion be conducted with the affected practitioner to advise him/her of the problems identified, what conduct is expected going forward, and what action, if any is recommended.</td></tr>
<tr><td></td><td>15.8.14.4</td><td colspan="2">That a letter of admonition, warning, or reprimand be sent to the affected practitioner.</td></tr>
<tr><td></td><td>15.8.14.5</td><td colspan="2">That conditions and/or limitations be placed on the affected practitioner’s appointment or clinical privileges</td></tr>
<tr><td></td><td>15.8.14.6</td><td colspan="2">That other actions or recommendations as deemed appropriate by the PPC be implemented</td></tr>
<tr><td>15.8.15</td><td colspan="3">The Chief of Staff shall review the report of the PPC and may</td></tr>
<tr><td></td><td>15.8.15.1</td><td colspan="2">Request additional information</td></tr>
<tr><td></td><td>15.8.15.2</td><td colspan="2">Defer action and refer the matter back to the PPC with direction for specific reviews and report</td></tr>
<tr><td></td><td>15.8.15.3</td><td colspan="2">Accept the report</td></tr>
<tr><td>15.8.16</td><td colspan="3">After the Chief of Staff completes his/her review, and in consultation with the President, the Chief of Staff may take action which shall include, but not be limited to</td></tr>
<tr><td></td><td>15.8.16.1</td><td colspan="2">Terminate the review and dismiss the matter</td></tr>
<tr><td></td><td></td><td>15.8.16.1.1</td><td>If the PPC disagrees with the termination of the review or dismissal, the matter can be forwarded to the MEC for determination.</td></tr>
<tr><td></td><td>15.8.16.2</td><td colspan="2">Issuance of a formal letter of admonition, warning, or reprimand</td></tr>
<tr><td></td><td>15.8.16.3</td><td colspan="2">Propose terms of training, education, consultation (other than concurring consultation), supervision, intensified review (including concurrent and retrospective review), or observation</td></tr>
<tr><td></td><td>15.8.16.4</td><td colspan="2">Propose terms for physical examination or psychological evaluation</td></tr>
</table>

	15.8.16.5	Refer the matter to the MEC for corrective action
	15.8.16.6	Such other action(s) deemed appropriate by the Chief of Staff, provided that such other action(s) would not constitute corrective action under the Medical Staff Bylaws (Article X, Section 5 – Fair Hearing Plan)
15.8.17	The Chief of Staff and/or other individuals, as deemed appropriate by the Chief of Staff, shall meet with the affected practitioner to present the Chief of Staff's action. If the practitioner fails or refuses to agree to comply with the Chief of Staff's proposed action, the Chief of Staff shall refer the matter to the MEC with a request for the initiation of an investigation for potential corrective action and/or other such action as the MEC deems appropriate.	
15.8.18	Only actions which constitute Corrective Action as defined in the Medical Staff Bylaws (Article X, Section 5 – Fair Hearing plan) shall entitle the affected practitioner to procedural rights outlined in the Medical Staff Bylaws and/or other policies, procedures, rules, regulations, manuals, guidelines, and/or requirements of the Medical Staff.	

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Title	Disruptive Behavior - Consequences	
Number	15.9	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.9.1	If this is the first incident of inappropriate behavior, the appropriate Section Chief shall discuss the matter with the offending practitioner, emphasizing that the behavior is inappropriate and must cease. The approach during this initial intervention should be collegial and helpful.	
	15.9.1.1	The offending practitioner may be asked to apologize to the complainant.
	15.9.1.2	This intervention will be documented by the Section Chief and placed in the practitioners Quality Improvement file.
15.9.2	Further isolated incidents that do not constitute continued, repeated inappropriate behavior will be handled by providing the offending practitioner with written notification of each incident and a reminder of the expectation of the practitioner to comply with the Disruptive Behavior Policy.	
15.9.3	If the PPC determines that the offending practitioner had demonstrated a pattern of repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, a letter of admonishment will be sent to the offending practitioner and, as appropriate, the letter will include a rehabilitation plan developed by the PPC, with the advice and consent of the Section Chief.	
	15.9.3.1	This will be reported to the MEC in executive session.
15.9.4	If, in spite of the admonition and intervention, the disruptive behavior recurs, the PPC shall meet with and advise the practitioner that such behavior must immediately cease or corrective action will be initiated.	
	15.9.4.1	This “final warning” shall be provided to the practitioner in writing, either in person, by certified mail, or by courier with documentation of receipt of the final warning.
15.9.5	At any point in the process, the PPC may elect to refer the practitioner to the Washington Physician Health Program (WPHP) for further evaluation and counseling. Other practitioners may receive a similar referral to a program for their discipline, if available.	
15.9.6	If after the “final warning’, the disruptive behavior recurs, corrective action (including suspension or termination of privileges), shall be initiated pursuant to the Medical Staff Bylaws, of which this Disruptive Behavior Policy is a part.	
	15.9.6.1	The practitioner shall have all the due process rights as set forth in the Medical Staff Bylaws, Article X, Section 5 – Fair Hearing and Medical Staff Policy, Chapter 16 – Fair Hearing.
15.9.7	If a single incident constitutes an imminent danger to a person or persons, the offending practitioner may be summarily suspended as provided in the Medical Staff Bylaws (Article X, Section 7 – Summary and Precautionary Suspension) and Medical Staff Policies (Chapter 9 – Precautionary Suspension)	
	15.9.7.1	The offending practitioner shall have all of the due process rights set forth in the Medical Staff Bylaws (Article X, Section 5 – Fair Hearing) and Medical Staff Policies (Chapter 16 – Fair Hearing)

15.9.8	The following shall not constitute corrective action and are not subject to appeal:	
	15.9.8.1	Informal rehabilitation plan
	15.9.8.2	Requirement for a written letter of apology to the complainant or others affected by the behavior
	15.9.8.3	Issuance of a letter of admonition or warning, including final warning
	15.9.8.4	Requirement for training
	15.9.8.5	Referral to the PPC or WPHP

Approval Process:

Bylaws Committee	April 25, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	May 19, 2016
Published to the Medical Staff	May 20, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	July 21, 2016
Board of Directors	July 27, 2016

Reviewed:

- Bylaws Committee - December 27, 2017
- Bylaws Committee – July 27, 2020

Title	Disruptive Behavior – Immediate Corrective Action	
Number	15.10	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 27, 2018	

15.10.1	Any person authorized to take immediate corrective action may also take immediate precautionary corrective action as outlined in the Medical Staff Bylaws (Article X, Section 7 – Summary and Precautionary Suspension) and Medical Staff Policies (Chapter 9 – Precautionary Suspension) pending completion of the review, investigation, or action under this Policy.
15.10.2	The MEC, at its discretion, based up the information available) may take precautionary corrective action pending outcome of the review or investigation.

Approval Process:

Bylaws Committee	April 25, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	May 19, 2016
Published to the Medical Staff	May 20, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	July 21, 2016
Board of Directors	July 27, 2016

Reviewed:

- Bylaws Committee - December 27, 2017
- Bylaws Committee – July 27, 2020

Title	Disruptive Behavior - Documentation	
Number	15.11	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.11.1	If no formal corrective action is taken pursuant to the Medical Staff Bylaws and Policies, a confidential memorandum summarizing the disposition of the complaint, along with copies of any written warnings, letter(s) of apology, and written responses from the practitioner shall be retained in the practitioner's Quality file.
15.11.2	If no related action is taken or pending at the completion of a rolling five year period, the documentation will be expunged from the Quality file.

Approval Process:

Bylaws Committee	April 25, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	May 19, 2016
Published to the Medical Staff	May 20, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	July 21, 2016
Board of Directors	July 27, 2016

Reviewed:

- Bylaws Committee - December 27, 2017
- Bylaws Committee – July 27, 2020

Title	Disruptive Behavior – Right to Counsel	
Number	15.12	
Effective Date	July 27, 2016	
Accountability	Medical Staff	Administration
	Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

15.12.1	At any time during the process the practitioner has a right to personally retain and consult with legal counsel.
15.12.2	St. Michael, on behalf of the organized Medical Staff, may also consult with legal counsel.
15.12.3	The legal counsel of the practitioner and of St. Michael are not permitted to participate in any committee meetings or to interview witnesses.

Approval Process:

Bylaws Committee	April 25, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	May 19, 2016
Published to the Medical Staff	May 20, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	July 21, 2016
Board of Directors	July 27, 2016

Reviewed:

- Bylaws Committee - July 25, 2018
- Bylaws Committee – July 27, 2020

Title	Fair Hearing – General Provisions	
Number	16.1	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2020	

16.1.1	Each applicant and Medical Staff member agrees to follow and complete the procedures set forth in this Section, including appellate procedures, before attempting to obtain judicial relief related to any issue or decision, procedural or substantive, which may be related to or the subject of the hearing or appeal process set forth in the Fair Hearing Policy. The individual has a duty to exhaust every remedy before requesting a fair hearing.		
16.1.2	Technical, non-prejudicial or insubstantial deviations from the procedures set for in the Fair Hearing Policy shall not be grounds for invalidating the action taken provided there was substantial compliance with the policy.		
16.1.3	The hearing and appeal process shall be completed within a reasonable time.		
16.1.4	Except in the case of a precautionary suspension, recommended adverse corrective actions shall become final only after hearing and appellate rights set forth in the Medical Staff Bylaws and Policies have either been exhausted or waived and final action has been taken by the Board of Directors.		
16.1.5	Notices		
	16.1.5.1	Notices shall be addressed to the party at his/her last known address on record in the Medical Staff Services Office	
	16.1.5.2	Each notice given in connection with the provisions of the Fair Hearing Policy shall be in writing and shall be deemed to have been given	
		16.1.5.2.1	On the date when it is delivered personally
		16.1.5.2.2	Two days after it is sent by overnight mail for delivery with confirmed receipt, whichever comes first
		16.1.5.2.3	Five days after it is deposited in the United States mail (postage prepaid) certified with return receipt requested
	16.1.5.3	Each such notice shall be given to each of the parties.	
	16.1.5.4	Copies of notices shall be as effective as the original for the purpose of giving notice.	
	16.1.5.5	The President, or designee, shall cooperate and assist in the giving of all notices on behalf of the Board of Directors.	
	16.1.5.6	The Medical Staff Secretary, or another member of the Medical Staff designated by the Chief of Staff, shall be responsible for sending notices on behalf of or in conjunction with the Medical Executive Committee, the Judicial Review Committee, or any other Medical Staff entity whose decision prompted the hearing.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee - April 23, 2018
- Bylaws Committee – July 27, 2020

St. Michael Medical Center
Medical Staff Policies

Title	Fair Hearing – Grounds for Hearing	
Number	16.2	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.2.1	Except as otherwise specified in the Medical Staff Bylaws and Polices, any one or more of the following actions or recommended actions concerning a physician, dentist, or podiatrist member of the Medical Staff or an applicant if based upon the professional competence or conduct which adversely or could adversely affect a patient or patients, shall be deemed actual or potential adverse action and constitute grounds for a hearing	
	16.2.1.1	Denial of Medical Staff membership
	16.2.1.2	Denial of requested advancement in Medical Staff membership status or category
	16.2.1.3	Denial of renewal of Medical Staff membership
	16.2.1.4	Demotion to lower Medical Staff membership status or category
	16.2.1.5	Suspension of Medical Staff membership or clinical privileges for more than fourteen calendar days
	16.2.1.6	Revocation of Medical Staff membership
	16.2.1.7	Denial of requested clinical privileges
	16.2.1.8	Involuntary reduction of current clinical privileges
	16.2.1.9	Termination of all clinical privileges
	16.2.1.10	Involuntary imposition of mandatory concurrent consultation

Approval Process:

Bylaws Committee	4/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	5/17/2018
Published to the Medical Staff	6/1/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	10/18/2018
Board of Directors	11/20/2018

Reviewed: Bylaws Committee July 27, 2020

Title	Fair Hearing – Effective Date of Action	
Number	16.3	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.3	Except in the case of a precautionary suspension, recommended adverse corrective actions described in MSP 16.2 shall become final only after the hearing and appellate rights set forth in the Medical Staff Bylaws and Polices have either been exhausted or waived and final action taken by the Board of Directors.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee - April 23, 2018
- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Notice of Action or Proposed Action	
Number	16.4	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.4.1	In all cases in which action has been taken or a recommendation made as set forth Medical Staff Bylaws, Article X, Section 5, The Chief of the Medical Staff or designee on behalf of the Medical Executive Committee shall give the affected practitioner prompt written notice of	
	16.4.1.1	The reasons for the proposed action, including acts or omissions with which the practitioner is charged
	16.4.1.2	The right to request a hearing and that such hearing must be requested within thirty days
	16.4.1.3	The summary of the rights granted in the haring pursuant to Medical Staff Bylaws and Policies

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: April 4, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Request for Hearing	
Number	16.5	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Medical Executive Committee
Review Date	July 27, 2021	

16.5.1	The practitioner shall have thirty calendar days following receipt of notice of such action or recommendation to request a hearing.
16.5.2	The request shall be in writing addressed to the Medical Executive Committee, delivered to the Medical Staff Services Office, with a copy to the Board of Directors, delivered to the President's Office.
16.5.3	In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and to have accepted the recommendation or action involved.

Approval Process:

Bylaws Committee	4/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	5/17/2018
Published to the Medical Staff	6/1/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	10/18/2018
Board of Directors	11/20/2018

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Time and Place of Hearing	
Number	16.6	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.6.1	Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and within 10 calendar days of scheduling the hearing give notice to the practitioner of the date, time, and place of the hearing.
16.6.2	Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall not be less than thirty days from the date of notice, nor more than sixty days from the date of receipt of the request by the Medical Executive Committee for a hearing.
16.6.3	When the request is received from a Medical Staff member who is under precautionary suspension, the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least thirty days from the date of the notice to prepare for the hearing or waives the right to thirty days' notice.

Approval Process:

Bylaws Committee	4/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	5/17/2018
Published to the Medical Staff	6/1/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	10/18/2018
Board of Directors	11/20/2018

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Notice of Hearing	
Number	16.7	
Effective Date	September 27, 2013	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Medical Executive Committee
Review Date	July 27, 2021	

16.7.1	Together with the notice stating the date, time, and place of the hearing.	
	16.7.1.1	The date shall not be less than 30 days after the date of the notice unless waived by the member under precautionary suspension.
	16.7.1.2	The notice shall be provided by the Chief of Staff or designee on behalf of the Medical Executive Committee
16.7.2	In addition to the meeting logistics, the notice shall provide the following:	
	16.7.2.1	The reasons for the recommended action, including the acts or omissions with which the practitioner is charged
	16.7.2.2	Whether the proposed action would be reportable to state or federal agencies
	16.7.2.3	A list of the patient records, if applicable
	16.7.2.4	A list of witnesses, if any, expected to testify at the hearing on behalf of the Medical Executive Committee.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: April 4, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Discovery of Additional Facts	
Number	16.8	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.8.1	If the discovery of additional facts or additional occurrences warrant the addition or deletion of charges, upon a showing of good cause and good faith, amendments to the statement of charges and list of witnesses may be made, but no later than the close of the case by the Medical Staff representative at the hearing.	
	16.8.1.1	Such amendments may delete, modify, or add to the acts, omissions, or reasons stated in the original notice.
	16.8.1.2	May delete or add patient records to be considered
16.8.2	Notice of each amendment shall be given to the affected practitioner, the Hearing Officer, and each party.	
16.8.3	If the affected practitioner promptly makes written request to the Hearing Officer, he/she shall be entitled to a reasonable postponement of the hearing to prepare a response or defense to any such amendments that adds acts, omissions, patient records, and reasons to the original notice.	
16.8.4	The Hearing Officer shall give prompt notice to the parties of each such postponement.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 20, 2012

Reviewed: April 4, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing - Arbitration	
Number	16.9	
Effective Date	September 12, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.9.1	The Chief of Staff has the authority vested by the Board, without further approval, to enter into an agreement with the affected practitioner to hold the hearing before a mutually acceptable arbitrator or arbitrators and agree to make the arbitrator's determination binding on the parties, provided that	
	16.9.1.1	The President agrees with the decision to arbitrate and the process for arbitration
	16.9.1.2	The affected practitioner agrees to waive all rights to the hearing and appeals process under the Medical Staff Bylaws and Policies and to waive any right to pursue further legal or equitable remedies arising out of the peer review process.
16.9.2	The cost for such arbitration shall be shared equally by the affected practitioner and the Medical Staff.	
16.9.3	Failure or refusal to exercise this option shall not constitute a breach of the Medical Executive Committee's responsibility to provide a fair hearing.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Hearing Officer	
Number	16.10	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Department – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.10.1	Within three days of receipt of the request for hearing, the Chief of Staff and affected practitioner shall nominate three candidates to serve as a Hearing Officer to preside at the hearing.	
16.10.2	The candidates for Hearing Officer shall be a retired judge, a mediator, an attorney at law, or an individual otherwise qualified to preside over a quasi-judicial hearing.	
16.10.3	The Hearing Officer shall not be biased against the affected practitioner, St. Michael, or CHI Franciscan Health.	
16.10.4	The Hearing Officer shall gain no financial benefit from the outcome.	
16.10.5	The Hearing Officer must not act as a prosecuting officer or as an advocate for any party.	
16.10.6	The prior use or anticipated use of the Hearing Officer in a quasi-judicial role shall not be grounds for disqualification.	
16.10.7	Both parties have the right to voir dire (question to determine qualifications and suitability to serve) Hearing Officer candidates telephonically and to record the voir dire electronically. Should the Hearing Officer's bias become an issue.	
16.10.8	If the parties fail to agree on a Hearing Officer within seven days of the request for fair hearing, the selection of the Hearing Officer shall be turned over to the American Arbitration Association (AAA) Seattle office for expedited appointment of a qualified neutral person.	
	16.10.8.1	The Medical Staff shall pay the fees for such assistance from the AAA.
16.10.9	The Hearing Officer shall endeavor to assure all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner and that proper decorum is maintained.	
16.10.10	The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure, or admissibility of evidence.	
16.10.11	If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances.	
16.10.12	If requested by the Judicial Review Committee, the Hearing Officer may participate in the deliberations and be a legal advisor to it; but, the Hearing Officer shall not be entitled to vote.	
16.10.13	Initially, the parties shall split the cost of the Hearing Officer or arbitrator (if the parties failed to agree on a Hearing Officer). But, the party who prevails in the Judicial Review (regardless of any subsequent action by the Board) shall be entitled to reimbursement of any such costs advanced for the Hearing Officer or arbitrator.	

Approval Process:

Bylaws Committee	4/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	5/17/2018
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Medical Executive Committee Recommendation for Approval to Board of Directors	10/18/2018
Board of Directors	11/20/2018

Reviewed: Bylaws Committee – July 27, 2020

Title	Fair Hearing – Judicial Review Committee	
Number	16.11	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.11.1	Within ten days of receipt of the request for hearing, the Medical Executive Committee shall propose a Judicial Review Committee to the Board Quality and Values Committee and the affected practitioner.		
16.11.2	The members of the Judicial Review Committee must not be in direct economic competition with the affected practitioner.		
16.11.3	The Judicial Review Committee shall be composed of no less than three members of the Active Medical Staff.		
	16.11.3.1	Membership on the Judicial Review Committee shall include one member who shall have the same healing arts licensure as the affected practitioner.	
	16.11.3.2	The Judicial Review Committee members shall gain no direct financial benefit from the outcome.	
	16.11.3.3	The Judicial Review Committee members shall not have acted as accusers, investigators, fact finders, initial decision makers, or otherwise shall not have actively participated in the consideration of the matter leading up to the recommendation or action nor may they be partners, business associates, or relatives of the affected practitioner.	
	16.11.3.4	Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee.	
	16.11.3.5	The Judicial Review Committee shall elect its chair.	
	16.11.3.6	In the event that it is not feasible to appoint a Judicial Review Committee from the Active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff.	
		16.11.3.6.1	If necessary, appointees to the Judicial Review Committee may be made temporary medical staff members.
16.11.4	The Judicial Review Committee shall comprise the hearing panel.		
16.11.5	The Board of Directors shall be deemed to approve the selection of the Judicial Review Committee members unless within five days either party files or provides written request with the Hearing Officer for voir dire (question to determine qualifications and suitability to serve).		
	16.11.5.1	Within five days of receipt of the request for voir dire the Hearing Officer shall convene the parties and the proposed Judicial Review Committee in person or by telephone, or electronically to permit voir dire of the proposed panel.	
	16.11.5.2	Either party may challenge a proposed Judicial Review Committee member on the basis of bias or prejudice.	
16.11.6	If the parties fail to agree within ten days on who shall serve on the Judicial Review Committee, the selection process shall be turned over to the American Arbitration		

	Association (AAA) for appointment of any unfilled seats on the Judicial Review Committee within 5 days.	
	16.11.6.1	Said selection shall fulfill the criteria set forth herein.
	16.11.6.2	The Medical Staff shall pay the fees for such assistance from the AAA.

Approval Process:

Bylaws Committee	4/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	5/17/2018
Published to the Medical Staff	6/1/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	10/18/2018
Board of Directors	11/20/2018

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Ex Parte Communication	
Number	16.12	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.12.1	Once nominated to serve on the Judicial Review Committee and continuing thereafter through the course of the hearing and deliberation, the Hearing Officer and members of the Judicial Review Committee shall not engage in any discussions regarding the merits of the proceedings with any party to the proceeding or a representative of a party, unless all parties have been notified and given the opportunity to be present or to participate in the discussion.
16.12.2	The Hearing Officer and members of the Judicial Review Committee shall treat the matter as jurors in a court of law and may not discuss the matter with anyone other than themselves while the case is pending (i.e. until the Board takes final action on the matter).
16.12.3	Violation of this provision shall be grounds for disqualification of the Hearing Office or Judicial Review Committee member.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee – July 27, 2020

St. Michael Medical Center
Medical Staff Policies

Title	Fair Hearing – Postponements and Extensions	
Number	16.13	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.13.1	After the appointment of the Judicial Review Committee and before the commencement of the hearing, postponements beyond the times required by the Medical Staff Bylaws and Policies may be requested by any of the parties for good cause, and shall be granted on agreement of the parties or by the Hearing Officer.
16.13.2	The Judicial Review Committee shall promptly give notice to the parties of each such postponement.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Pre-Hearing Exchange of Information and Discovery – Rights to Inspection and Copying	
Number	16.14	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.14.1	At all times in the peer review process, the affected practitioner shall have access to a copy of all medical records of his/her patients.	
	16.14.1.1	The practitioner shall have the right to copy said records at his/her own expense.
	16.14.1.2	St. Michael shall cooperate by providing such copies promptly upon request.
16.14.2	Each party must provide access to any other documents relevant to the charges in its possession and control for purposes of inspection and copying at least fifteen working days prior to the commencement of the hearing.	
	16.14.2.1	The failure by either party to provide access to this information at least fifteen days before the hearing shall constitute good cause to grant a continuance or to limit introduction of any documents not provided to the other party in a timely manner.
16.14.3	If the Medical Staff or the practitioner fails to fulfill its obligation to disclose its evidence in advance of the hearing, the Judicial Review Committee can determine that the failure of the party constitutes a default.	
	16.14.1	If the practitioner is in default, it will be considered a waiver of the hearing and appeal procedures.
	16.14.2	If the Medical Staff is found in default, the notice of charges will be dismissed and not renewed.
16.14.4	The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners other than the practitioner requesting the fair hearing.	

Approval Process:

Bylaws Committee	4/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	5/17/2018
Published to the Medical Staff	6/1/2018
Medical Executive Committee Recommendation for Approval to Board of Directors	10/18/2018
Board of Directors	11/20/2018

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Right to Evidence, Limits on Discovery, and Discovery Disputes	
Number	16.15	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director Medical Staff Services Associate Chief Medical Officer
Review Date	July 27, 2021	

16.15.1	The Hearing Officer shall consider and rule upon any dispute or controversy concerning a request to information.	
16.15.2	The Hearing Officer may impose any safeguards required to protect the peer review process and preserve fairness and equity.	
16.15.3	When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall consider, among other factors, the following:	
	16.15.3.1	Whether the information sought may be introduced to support or defend the charges
	16.15.3.2	The exculpatory or inculpatory nature of the information sought, if any, i.e. whether there is a reasonable possibility that the result of the hearing would be influenced significantly by the information if received into evidence.
	16.15.3.3	The burden imposed on the party in possession of the information sought if access is granted
	16.15.3.4	Any previous requests for access to information submitted or resisted by the parties to the same proceeding.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 17, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Witness Lists	
Number	16.16	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.16.1	Not less than 15 working days prior to the hearing, each party shall furnish the other a written list of the names of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence to support that party at the hearing.	
16.16.2	Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated.	
	16.6.2.1	The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses.
16.16.3	The failure to have provided the name of any witness at least 10 working days prior to the hearing date at which the witness is to appear, without a showing of good cause as to why the witness could not have been identified earlier, shall constitute cause for a continuance.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27,2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Right to Summon Medical Staff Members	
Number	16.17	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.17.1	The Medical Staff and the Affected Practitioner may seek and elicit the sworn testimony of up to 3 witnesses and may compel their attendance at the hearing.	
16.17.2	The Medical Staff and the Affected Practitioner may call and compel more than 3 witnesses only when one of the following exists	
	16.17.2.1	Circumstances necessitate additional witnesses.
	16.17.2.2	The need for additional witnesses has been submitted to the Hearing Officer 15 working days prior to the hearing in accordance with MSP 16.16.
	16.17.2.3	The need for additional witnesses is mutually agreed by both parties
16.17.3	The decision of the Hearing Officer on this matter shall be final.	
16.17.4	The Medical Staff member called as a witness shall, as a condition of maintaining Medical Staff membership, cooperate with the Judicial Review Committee in scheduling the presentation of his or her testimony.	
16.17.5	Failing to cooperate with the peer review process by refusing to provide testimony without good cause may be grounds for corrective action against the proposed witness.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Failure of Affected Practitioner to Appear	
Number	16.18	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.18.1	The personal presence of the affected practitioner is required.
16.18.2	Failure, without good cause, of the member to personally attend and participate at a pre-hearing conference or the hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and waiver of Fair Hearing rights related to this matter.
16.18.3	The question of good cause shall be within the sole discretion of the Judicial Review Committee.

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	3/21/2019
Board of Directors	4/16/2019

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Oath of Witnesses	
Number	16.19	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.19	The Hearing Officer may, but shall not be required to, order that oral evidence be taken only on oath or affirmation administered by any person so designated to and entitled to notarize documents.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Rights of the Parties	
Number	16.20	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.20.1	Both the affected Medical Staff member and the Medical Executive Committee have the following rights			
	16.20.1.1	To be represented at any phase of the hearing or preliminary procedures by an attorney at law or by any other person of that party's choice.		
		16.20.1.1.1	If a party to the hearing will be represented by legal counsel or another person, the party shall identify such person to the Hearing Officer at least 15 working days prior to the scheduled date of the hearing.	
	16.20.2	To have an accurate record of the hearing kept		
		16.20.2.1	The means of maintaining an accurate record shall be established by the Hearing Officer and may include	
			16.20.2.1.1	The use of a court reporter
			16.20.2.1.2	The use of an electronic recording unit
			16.20.2.1.3	Detailed transcription
			16.20.2.1.4	The taking of adequate minutes
		16.20.2.2	The cost of attendance of the court reporter and transcription, if used, shall be borne by the Medical Staff.	
		16.20.2.3	The cost of any transcript shall be borne by the party requesting it.	
		16.20.2.4	Pre-hearing proceedings may be electronically recorded, if requested, by either party with the tape or CD retained by the Hearing Officer and transcribed if, and only if, it becomes relevant to the proceedings at a later date.	
	16.20.3	To call, examine, cross-examine, and impeach witnesses.		
		16.20.3.1	The Medical Executive Committee may call the affected member as if under cross-examination.	
	16.20.4	To present evidence determined to be relevant by the Hearing Officer, regardless of its admissibility in a court of law		
	16.20.5	To submit a written statement at the close of the hearing		

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: June 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Pre Hearing Conference	
Number	16.21	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.21.1	The Hearing Officer may require the attorneys or representatives of the parties to attend a pre-hearing conference to resolve all procedural matters prior to the hearing. Such matters may include, but are not limited to, the following:	
	16.21.1.1	Both parties may be required to present all of the documents they plan to submit at the hearing
	16.21.1.2	A list of witnesses to be called will be presented by both parties
	16.21.1.3	Time limits can be set for witnesses, testimony, and cross-examination
	16.21.1.4	Objections to witnesses, documents, or the plan set forth for the conduct of the proceedings will be dealt with at this time.
16.21.2	Any witnesses or document not identified and agreed upon at the pre-hearing conference will be excluded from the hearing, absent a showing of good cause.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Organization and Conduct of Hearing Process	
Number	16.22	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.22.1	The hearing shall be conducted as follows:	
16.22.2	The Medical Executive Committee	
	16.22.2.1	The Medical Staff representative shall present an opening statement
	16.22.2.2	The Medical Staff representative shall then present the facts upon which he or she is relying by calling the witnesses and presenting written evidence to support the case.
	16.22.2.3	The Medical Staff representative may call any person or the opposing party in support of the case.
	16.22.2.4	The Affected Practitioner may be called by the body whose decision prompted the hearing and examined as if under cross examination.
	16.22.2.5	The Judicial Review Committee may also ask questions of the witnesses or call witnesses on its own.
	16.22.2.6	Any change or matter that is not supported by the Medical Executive Committee's initial presentation of evidence may, upon oral or written motion, be dismissed
	16.22.2.7	The Hearing Officer may permit the Medical Staff to reopen its case to present evidence; but, if no evidence is offered supporting an allegation, it must be dismissed.
16.22.3	The Affected Practitioner	
	16.22.3.1	At the close of the Medical Staff representative's case, the Affected Practitioner or his/her representative shall make an opening statement and shall make a case presentation of evidence and testimony.
	16.22.3.2	He or she may call any person or opposing party in support of the case.
16.22.4	Within reasonable limitations, both sides at the hearing may, as long as the following rights are exercised in an efficient and expedient manner:	
	16.22.4.1	Call and examine witnesses for relevant testimony
	16.22.4.2	Introduce relevant exhibits or other documents
	16.22.4.3	Cross-examine witnesses
	16.22.4.4	Impeach witnesses who shall have testified orally on any matter relevant to the issues
	16.22.4.5	Otherwise rebut evidence
16.22.5	Judicial rules and evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not be strictly applied to a hearing conducted under this Section.	
	16.22.5.1	Although, said rules under State of Washington law shall serve as a useful guide to the Hearing Officer in overseeing the proceedings.
	16.22.5.1	Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

16.22.6	The Hearing Officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration which could have been judicially noticed by the courts of the State of Washington.	
	16.22.6.1	Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing.
	16.22.6.2	Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or written or oral presentation of authority.
	16.22.6.3	Reasonable additional time shall be granted, if requested, to present written rebuttal of any evidence admitted in official notice.
16.22.7	Upon the close of the initial presentations of the opposing parties, each party shall be entitled to present evidence to rebut the presentation of the other, subject to reasonable limitations by the Hearing Officer as to order, time, relevance, and repetition.	
16.22.8	Upon the close of all presentations and evidentiary rebuttals, the parties shall be entitled, subject to reasonable limitations by the Hearing Officer, to submit a written statement and give closing statements and argument.	
16.22.9	Upon the close of all presentations, rebuttals, statements, and argument, the Hearing Officer shall declare this hearing finally adjourned, and all persons other than the Judicial Review Committee and Hearing Officer shall thereupon leave the meeting.	
16.22.10	The Judicial Review Committee shall thereafter, at the convenience of its members, but subject to the provisions of MSP 16.24 below, deliberate in order to reach its decision.	
16.22.11	The hearing process shall be completed within a reasonable time after the notice of the request for the hearing is received, unless the Judicial Review Committee issues a written decision that the Affected Practitioner or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.	
16.22.12	Burdens of presenting evidence and proof	
	16.22.13.1	At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of the action or recommendation.
	16.22.13.2	The Affected Practitioner shall be obligated to present evidence in response.
	16.22.13.3	The Affected Practitioner shall have the burden to prove by a preponderance of the evidence that the proposed action or recommendation of the Medical Executive Committee should be rejected or modified.
	16.22.13.4	For a hearing regarding denial of an initial application for Medical Staff membership which would be a reportable action, the applicant shall bear the burden of persuading the Judicial Review Committee by a preponderance of the evidence of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and clinical privileges.
	16.22.13.5	An applicant shall not be able to introduce information requested by the Medical Staff, but not produced during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

Published to the Medical Staff	June 27, 2012
Medical Executive Committee recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Recess, Adjournment, and Conclusion	
Number	16.23	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.23.1	The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing.
16.23.2	Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if they are to be submitted, the hearing shall be concluded and the matter submitted for determination by the Judicial Review Committee.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Deliberations and Basis for Recommendation	
Number	16.24	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.24.1	Upon the closing of the hearing, the Judicial Review Committee may thereupon, at a time convenient to itself, conduct its deliberations outside the presence of the Affected Practitioner for whom the hearing has been convened.
16.24.2	The Hearing Officer my participate in the deliberations of the Judicial Review Committee and offer advice; but, the Hearing Officer is not allowed to vote.
16.24.3	The recommendations of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences for the evidence and the testimony.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Petition Yes/No	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2012

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Basis for Decision	
Number	16.25	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.25.1	The decision of the Judicial Review Committee shall be based on application of the burden of proof to the evidence produced at the hearing.	
16.25.2	This evidence may contain the following	
	16.25.2.1	Oral testimony of witnesses
	16.25.2.2	Written statements presented in connection with the hearing
	16.25.2.3	Any material contained in the documentary evidence, including, without limitation, medical records, regarding the Affected Practitioner so long as this material has been admitted into evidence at the hearing and the Affected Practitioner had the opportunity to comment on and, by other evidence, refute it.
	16.25.2.4	Any and all applications, references, and accompanying documents
	16.25.2.5	All officially noticed matters
	16.25.2.6	Any other admissible evidence

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Decision and Report of the Judicial Review Committee	
Number	16.26	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.26.1	Within 30 working days after the final adjournment of the hearing, the Judicial Review Committee shall make a written report and recommendation with reasons and facts upon which the recommendation is based and shall forward the same together with the haring record and other documentation to the Medical Executive Committee, the Board, and the Affected Practitioner.	
16.26.2	However, if a member is currently under suspension, the time for the decision and report shall be 15 working days.	
16.26.3	The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing, the applicable burden of proof, and the conclusion reached.	
16.26.4	The report may recommend confirmation, modification, or rejection of the original adverse recommendation.	
16.26.5	If the recommendation is one that must be reported to the National Practitioner Data Bank, if and when it becomes a final action of the Board, the Judicial Review Committee's report and recommendation shall include the actual coding and a 600-character (or less) description of the underlying action, which is proposed to be reported to the National Practitioner Data Bank in the Adverse Action Report.	
16.26.6	The decision also shall state that the action, if adopted, will be reported to the applicable State of Washington licensing board.	
16.26.7	Both the Affected Practitioner and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision.	
	16.26.7.1	This explanation shall describe their respective rights in the appellate procedure.
16.26.8	The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in the Medical Staff Bylaws and Policies.	
16.26.9	If the Board rejects a recommendation from the Judicial Review Committee, and approved by the Medical Executive Committee, that is favorable to the Affected Practitioner, the Board shall notify the Affected Practitioner in writing of their decision and the basis for their decision within 10 working days.	
	16.26.9.1	The Affected Practitioner, then, shall be entitled to pursue an appeal as provided in these Bylaws and Policies.

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	3/21/2019
Board of Directors	4/16/2019

Reviewed: Bylaws Committee – July 27, 2020

Title	Fair Hearing – Board Decision Giving Right to a Hearing	
Number	16.27	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.27	If a decision of the Board, rather than the Medical Executive Committee, gives rise to the right of a hearing under the Medical Staff Bylaws and Policies, the Board shall have the rights and responsibilities of the Medical Executive Committee with respect to the process and procedures applicable in the hearing.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing - Appeals	
Number	16.28	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.28.1	Time for requesting an appeal	
	16.28.1.1	Within 15 working days after the giving of Notice to the parties of the decision of the Judicial Review Committee, either the Affected Practitioner or the body whose decision prompted the hearing may request an appellate review by the Board.
	16.28.1.2	The request shall be in writing and must be received by the Chair of the Board within the applicable time period set forth above, with copies delivered to the other parties.
	16.28.1.3	The request shall include a brief statement of the reason(s) for the appeal.
16.28.2	Appellate review body	
	16.28.2.1	If a decision of the Medical Executive Committee gave rise to the right to a hearing under the Medical Staff Bylaws and Policies, the Judicial Review Committee shall be the appellate review body.
	16.28.2.2	If a decision of the Board of Directors gave rise to the right to a hearing under the Medical Staff Bylaws and Policies, the appellate review body shall be the full Board or a subcommittee of the Board appointed by the Board Chair.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Hospital Board Action	
Number	16.29	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.29.1	Effect of Reversal of Precautionary Suspension and Stay	
	16.29.1.1	If the recommendation of the Judicial Review Committee is to lift any suspension that is currently in place, that recommendation shall be deemed acceptable to the Board and shall be implemented and effective immediately, unless stayed by the Board or its designee pending appeal.
	16.29.2	The effect of a stay of the Judicial Review Committee's lifting of a suspension shall be to keep the suspension in place during the pendency of the appeal.
	16.29.3	Such a stay may be sought orally by the Medical Executive Committee, provided notice and an opportunity to be heard is given to the Affected Practitioner.
	16.29.4	Following the Judicial Review Committee's recommendations to lift a suspension in lieu of a stay, the Affected Practitioner may seek and automatically be granted a voluntary leave of absence so as not to accrue days under suspension for reporting purposes.
16.29.2	Action by Hospital Board on Judicial Review Committee Recommendation and Waiver of Appeal Rights: Final Decision	
	16.29.2.1	The Board shall take no action regarding the underlying matter until after the expiration of time for requesting appellate review.
	16.29.2.2	If an appellate review is not requested in a timely manner, all parties shall be deemed to have waived all rights to appeal.
16.29.3	Appeal Board	
	16.29.3.1	The Board may sit *en banc* as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than 3 members of the Board.
	16.29.3.2	Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, solong as that person did not participate in bringing the charges or take part in a prior hearing on the same matter.
	16.29.3.4	No person serving on the Appeal Board shall be in direct economic competition with the member involved.
	16.29.3.5	The Affected Practitioner shall be entitled to orally question and challenge the impartiality of the Appeal Board members.
	16.29.3.6	The Appeal Board may, in its sole discretion, select an attorney to assist in the process.
	16.29.3.7	If an attorney is selected, he or she may action as an appellate Hearing Officer and shall have all the authority of and carry out all of the duties assigned to a Hearing Officer as described in MSP 16.10 – Fair Hearing – Hearing Officer.
	16.29.3.8	That attorney shall not be entitled to vote with respect to the appeal.
16.29.4	Time, Place, and Notice	
	16.29.4.1	If an appellate review is to be conducted, the Appeal Board shall, within 15 working days after receipt of the notice of appeal, schedule a review date and

		cause each side to be given notice of the time, place, and date of the appellate review.	
	16.29.4.2	The date of appellate review shall not be less than 20 working days nor more than 40 working days from the date of such notice, provided, however, that when a request for appellate review concerning a member who is under suspension, which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed 15 working days from the date of notice.	
	16.29.4.3	The time for appellate review may be extended by the Appeal Board for good cause.	
16.29.5	Grounds for Appeal		
	16.29.5.1	A written request for appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal.	
	16.29.5.2	The grounds for appeal shall be as follows:	
		16.29.5.2.1	Substantial non-compliance with the procedures required by the Bylaws and applicable law which has created demonstrable prejudice
		16.29.5.2.2	The decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted.
		16.29.5.2.3	The recommendation was made arbitrarily, capriciously, or with bias.
		16.29.5.2.4	The text of the report to be filed to the National Practitioner Data Bank and the State of Washington licensing board is not accurate.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 9, 2018

- Bylaws Committee – July 27, 2020

<table>
<tr><td>Title</td><td colspan="2">Fair Hearing – Appellate Review Proceedings</td></tr>
<tr><td>Number</td><td colspan="2">16.30</td></tr>
<tr><td>Effective Date</td><td colspan="2">September 27, 2012</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Bylaws Committee
Medical Executive Committee</td><td>Associate Chief Medical Officer</td></tr>
<tr><td>Review Date</td><td colspan="2">July 27, 2021</td></tr>
</table>

<table>
<tr><td>16.30.1</td><td colspan="2">The Appeal Board shall limit its review to the record of the hearing before the Judicial Review Committee's report and recommendations and any written briefs submitted by the parties.</td></tr>
<tr><td></td><td>16.30.1.1</td><td>However, the Appeal Board may, in its sole discretion, accept additional issues or oral or written evidence subject to the same rights of cross-examination and rebuttal provided at the Judicial Review Committee hearing, but only upon a showing of good cause that such issues could not, with reasonable diligence, be presented to the Judicial Review Committee in the course of the hearing.</td></tr>
<tr><td></td><td>16.30.1.2</td><td>Such acceptance of additional issues or evidence may be based on the Appeal Board's own motion or upon the request of a party if, not less than 7 days prior to the appellate review meeting date, the party desiring to present such additional issues or evidence makes a written request to the Appeal Board, specifying the nature and relevance of the issues of evidence, and gives notice of such request to all other parties.</td></tr>
<tr><td></td><td>16.30.1.3</td><td>The Appeal Board shall give notice of its decision in such matters to all parties as soon as reasonably possible.</td></tr>
<tr><td>16.30.2</td><td colspan="2">Each party shall have access to the report and record of the Judicial Review Committee and all other material, favorable and unfavorable, that was considered in making the Judicial Review Committee</td></tr>
<tr><td></td><td>16.30.2.1</td><td>The Appeal Board may consider evidence excluded by the Judicial Review Committee, but only to determine whether or not its exclusion was proper and whether the exclusion of the proffered evidence was prejudicial.</td></tr>
<tr><td>16.30.3</td><td colspan="2">Each party shall have the right to submit a written brief in support of its/his/her position on appeal, provided that copies of such briefs shall be given to all other parties not less than 7 calendar days prior to the date of the appellate review.</td></tr>
<tr><td>16.30.4</td><td colspan="2">Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal.</td></tr>
<tr><td>16.30.5</td><td colspan="2">Each party or its/his/her attorney or representative shall be the right to appear personally and make oral argument at the appellate review.</td></tr>
<tr><td>16.30.6</td><td colspan="2">The Appeal Board may, from time to time, adjourn and continue the appellate review meeting to another date or dates if it determines, in its sole discretion, that such action is necessary or desirable in order to conduct a fair and thorough appellate review in the matter.</td></tr>
<tr><td></td><td>16.30.6.1</td><td>The Appeal Board shall give notice to the parties of any such future date and time, unless the parties were present when such date and time were announced by the Appeal Board.</td></tr>
<tr><td>16.30.7</td><td colspan="2">At the conclusion of the appellate review, including oral argument, the Appeal Board shall, at a time convenient to itself, conduct deliberations outside the presence of the parties</td></tr>
</table>

	and their representatives, in order to determine whether to affirm or reverse the decision of the Judicial Review Committee.
16.30.8	The Appeal Board shall, in its sole discretion, decide the order of procedures to be followed in the appellate review shall be thorough, orderly, efficient, and fair.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 21, 2012

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Final Decision Effective Date	
Number	16.31	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.31.1	The Appeal Board's final decision in the matter shall be made in accordance with the following rules.	
16.31.2	Within 15 working days after the adjournment of the appellate review proceedings, the Appeal Board shall render a final decision in writing.	
16.31.3	Final adjournment shall not occur until the Appeal Board has completed its deliberations.	
16.31.4	The Appeal Board may affirm the decision, reverse the decision, or remand the matter for further review by the Judicial Review Committee.	
16.31.5	The Appeal Board may remand the matter to the Judicial Review Committee or other Medical Staff Committee for reconsideration, stating the purpose for the referral.	
	16.31.5.1	Such referral may include instructions so that the Committee may arrange for further proceedings on specific issues, if needed.
	16.31.5.2	The Appeal Board shall give timely notice of such referral to the parties.
	16.31.5.3	The Committee to which the matter has been referred shall conduct such review in accordance with any such instructions, and shall deliver its written recommendation to the Appeal Board within 45 calendar days after the receipt of the referral, or within such other time identified by the Appeal Board, except as the parties may otherwise agree for good cause as determined by the Appeal Board.
16.31.6.	The decision of the Appeal Board shall be in writing and shall specify the reasons for the action taken, provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any new evidence was presented), and provide the decision reached, if such findings and conclusions differ from those of the Judicial Review Committee.	
	16.31.6.1	If the full Board is sitting as the Appeal Board, then the final action of the Appeal Board shall constitute the final action of the Board with regard to the action or recommendation of the Medical Executive Committee.
	16.31.6.2	If the Appeal Board is comprised of fewer members that the full Board, then the decision of the Appeal Board shall be considered by the full Board for final action within 30 days of receipt of the Appeal Board's decision.
16.31.7	The final action of the Appeal Board and/or the Board shall include the text of the report which shall be made to the National Practitioner Data Bank and State of Washington licensing board, if any, and shall be delivered in person, by overnight mail with confirmed receipt, or by certified mail at least ten working days prior to submission to	
	16.31.7.1	Chief of Staff
	16.31.7.2	Medical Executive Committee
	16.31.7.3	Professional Performance Committee
	16.31.7.4	Subject of the hearing
	16.31.7.5	President
16.31.8	The Board shall act within a reasonable time.	

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Conclusion of Appellate Review	
Number	16.32	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.32.1	The appellate review shall not be deemed to be concluded until the Board takes the final action as provided in this Chapter and all proceedings have been completed or waived.
16.32.2	Failure of the Medical Executive Committee, Judicial Review Committee, or Board to meet any of the time lines with respect to conduct of the hearing or any appeal shall not be a basis for invalidating any action taken by the Medical Executive Committee, Judicial Review Committee, or Board.
16.32.3	However, such failure, without good cause, shall release the Affected Practitioner from any further obligations to exhaust all remedies.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 11, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Challenges to Proceedings Participants	
Number	16.33	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.33.1	The Affected Practitioner shall be deemed to approve Judicial Review Committee members, Hearing Panel members, and legal representatives of the Judicial Review Committee, the Hearing Panel, or the Board unless the Affected Practitioner objects to such member/advisor within the timeframes specified herein.	
16.33.2	If no timeframes are set forth within 10 working days of when the Practitioner is notified of the proposed Judicial Review Committee panel, Hearing panel, or Board members or advisors or legal representatives objections may be made.	
16.33.3	Objections to Judicial Review Committee panel, Hearing Panel or Board members shall be made to the body or person who appoints the panel, committee, or board members.	
16.33.4	If such body determines that actual bias or prejudice are likely to impact the integrity of the panel, committee, or board, a replacement will be appointed.	
16.33.5	In the case of the Board, the individual shall not participate in any vote concerning the hearing or appeal at issue.	
16.33.6	Challenges to advisors or legal representatives shall be made to the body that they represent who shall determine if the concerns of bias and prejudice require removal of the advisor or legal representative.	
	16.33.6.1	Any claim of bias shall be directed to the Chief of Staff or the Associate Chief Medical Officer.

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	3/21/2019
Board of Directors	4/16/2019

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Reporting Adverse Actions	
Number	16.34	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.34.1	After all requirements of the Fair Hearing Plan as contained in the Medical Staff Bylaws and Policies have been met, any adverse action taken against a member of the Medical Staff will be reported to the appropriate State of Washington licensing board and/or the National Practitioner Data Bank, as required by law.
16.34.2	Any report submitted to the National Practitioner Data Bank will be made within the guidelines of the National Practitioner Data Bank Guidebook.
13.34.3	The Affected Practitioner shall have a right to a copy of any such report.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 12, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Right to One Hearing	
Number	16.35	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.35.1	Except in circumstances where a new hearing is ordered by the Board or a court because of procedural irregularities or otherwise for reasons not the fault of the Affected Practitioner, no member may be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 12, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Informal Interviews	
Number	16.36	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.36.1	Nothing in the Medical Staff Bylaws or Medical Staff Policies, Chapter 16 – Fair Hearing, shall be deemed to prevent any committee or person contemplating any action or recommendation from inviting the Affected Practitioner to participate in an informal discussion of the contemplated action or recommendation.
16.36.2	Indeed, such informal discussions are encouraged and shall not be deemed to constitute a hearing under this Chapter.
16.36.3	Likewise, in such informal discussions, statements made by the Affected Practitioner which are intended to help resolve issues or compromises shall not be used to prejudice the Affected Practitioner in any subsequent formal proceedings.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 13, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Confidentiality of Proceedings	
Number	16.37	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.37.1	Except as otherwise authorized in the Medical Staff Bylaws and Policies, all parties, participants, and attendees shall keep the hearing and appellate review proceedings and the contents thereof confidential.
16.37.2	No one shall disclose or release any information from or about the proceedings to any person or the public.
16.37.3	If it is determined that a breach of confidentiality has occurred, the Medial Executive Committee shall undertake such corrective action as it deems appropriate and the Chair of the Judicial Review Committee or Board may impose sanctions on the violating individual.
16.37.4	Nothing in this section, however, shall be construed as limiting the parties' ability to adequately investigate and prepare their recommendations, their case, or otherwise protect or exercise their rights to a fair hearing and appeal under these Bylaws.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 13, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Exceptions in Hearing and Appeal Rights	
Number	16.38	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.38.1	In addition to other exceptions set forth in the Medical Staff Bylaws and Policies, the hearing and appeal rights under the Medical Staff Bylaws and Policies are not applicable under the following circumstances			
	16.38.1.1	Medico-Administrative Practitioner		
		16.38.1.1.1	The hearing and appeal rights under the Medical Staff Bylaws and Policies do not apply to those persons serving St. Michael in a medico-administrative capacity.	
		16.38.1.1.2	Termination of such persons' rights to practice shall instead be governed by the terms of their individual employment contracts with St. Michael.	
		16.38.1.1.3	However, the hearing and appeal rights of the Bylaws and Policies shall apply to the extent that Medical Staff membership status or clinical privileges, which are independent of the Medico-Administrative Practitioner's contract, are also removed or suspended.	
	16.38.1.2	Automatic Suspension or Limitation of Privileges		
		16.38.1.2.1	No hearing is required when a member's Medical Staff membership or clinical privileges are automatically suspended in accordance with the Medical Staff Bylaws and Policies.	
	16.38.1.3	Removal from Emergency Department Call Panel		
		16.38.1.3.1	None of the hearing and appeal rights under these Bylaws and Policies are available for any actions or recommendations affecting a practitioner's emergency department call panel obligations.	
	16.38.1.4	Denial of Applications for Failure to Meet Minimum Qualifications		
		16.38.1.4.1	Practitioners shall not be entitled to any hearing or appellate review pursuant to MSP 16 – Fair Hearing if they are unable to apply for membership or privileges or if they are denied or limited because of their failure to	
			16.38.1.4.1.1	Have a current unrestricted license to practice medicine, dentistry, or podiatry in the State of Washington or to possess another appropriate license or certificate
			16.38.1.4.1.2	Maintain an unrestricted Drug Enforcement Administration certificate (where it is required for clinical privileges requested)
			16.38.1.4.1.3	Maintain professional liability insurance as required by the Medical Staff Bylaws and Policies
			16.38.1.4.1.4	Meet any of the criteria and qualifications specified Chapter 4 - Appointment

			16.38.1.4.1.5	Meet any generally applicable criteria or qualifications adopted by the Medical Staff or by a Clinical Section
			16.38.1.4.1.6	File a complete application or provide additional requested information in a timely manner after notice of omitted items.
	16.38.1.5	Failure to Meet Minimum Activity Requirements		
		16.38.1.5.1	Practitioners shall not be entitled to hearing or appellate review rights pursuant to this Chapter of the Medical Staff Policies if their membership or privileges are denied, restricted, or terminated or their Medical Staff Categories are changed or not advanced because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws, Policies, Section Rules and Regulations or Clinical Section credentialing criteria.	

Approval Process:

Bylaws Committee	July 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	July 21, 2012
Published to the Medical Staff	July 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 16, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Hearing Rights Regarding Exclusive Contracts	
Number	16.39	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.39.1	Medical Staff members shall not have any right to a hearing as a result of loss or reduction of membership or clinical privileges due to an exclusive use or closed department agreement or policy of the Board.
16.39.2	The Board will confer with the Medical Staff, through the Medical Executive Committee, regarding quality care issues related to exclusive arrangements for practitioner services or closed departments prior to executing an exclusive contract or closing a department.
16.39.3	The Board, however, retains the exclusive authority to make any decisions regarding exclusive contracts or exclusive use departments.
16.39.4	Those specific privileges of a member that are terminated because of institution of an exclusive contract must be stricken from the list of approved privileges maintained by the Medical Staff for that member.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Hearing Rights for Advanced Practice Clinicians and Allied Health Professionals	
Number	16.40	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.40.1	Only physicians, dentists, and podiatrists who are Medical Staff members or who have applied for Medical Staff membership have the hearing rights set forth in Chapter 16 – Fair Hearing of these Policies.
16.40.2	Advanced Practice Clinicians or applicants for Advance Practice Clinician privileges shall have only those hearing rights set forth in MSP 19.9 – Advanced Practice Clinicians – Fair Hearing.
16.40.3	All other allied health practitioners or applicants for privileges as an allied health practitioner shall not have hearing rights.
16.40.4	No hearing rights are afforded any Advanced Practice Clinician or allied health professional related to matters arising strictly out of an employee/employer relationship whether that employer is CHI Franciscan or an independent entity.

Approval Process:

Bylaws Committee	7/23/2018
Medical Executive Committee Approval for distribution to the Medical Staff	10/18/2018
Published to the Medical Staff	
Medical Executive Committee Recommendation for Approval to Board of Directors	3/21/2019
Board of Directors	4/16/2019

Reviewed:

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Disputing Report Language	
Number	16.41	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.41.1	If no hearing was requested or the language to be reported has not been previously disclosed to a member, who is subject of a proposed adverse action report to the Washington State licensing Board or the National Practitioner Data Bank, may request an informal hearing to dispute the text of the report to be filed.
16.41.2	The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report to be filed is consistent with the final action issued.
16.41.3	The meeting shall be attended by the subject of the report, the Chief of Staff, the Chief of the subject's section, and the St. Michael authorized representative or their respective designees.
16.41.4	If a hearing was held, the dispute process shall be deemed to have been completed.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 16, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing - Reapplication	
Number	16.42	
Effective Date	September 20, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.42.1	Nothing in the Medical Staff Bylaws and Policies shall restrict the right of the applicant to reapply for appointment to the Medical Staff or restrict the right of a person to apply for reappointment or an increase in clinical privileges after the expiration of 2 years from the date of such Board decision unless the Board provides otherwise in the written decision.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 16, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Challenges to Generally Applicable Policies, Rules, and Regulations	
Number	16.43	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.43.1	Any Practitioner who is adversely affected by a general criterion, qualification, rule or policy (hereinafter "General Rule") of the Medical Staff may petition the Medical Executive Committee, in writing, to review the General Rule.
16.43.2	The Medical Executive Committee shall then inform the Practitioner, within a reasonable time, as to whether it will review the General Rule and, if so, how the review will be conducted.
16.43.3	If the Medical Executive Committee chooses not to review the General Rule, or does not modify the General Rule as requested, the adversely affected Practitioner may petition the Board, in writing, to review the General Rule, or may invoke the Conflict Management Process, as outlined in the Medical Staff Bylaws, Article X, Section 2.
16.43.4	In response to any such petition from a Practitioner, the Board may review the General Rule or ask the Medical Executive Committee to do so.
16.43.5	No adversely affected Practitioner shall initiate any legal action relating to a General Rule until he has afforded the Medical Executive Committee and, if necessary, the Board a reasonable opportunity to review and reconsider the General Rule.
16.43.6	In the event there is a conflict between a decision of the Medical Executive Committee and the Board regarding a General Rule, the Board's Conflict Management Plan shall be enacted.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 16, 2018

- Bylaws Committee – July 27, 2020

Title	Fair Hearing – Expunction of Disciplinary Action	
Number	16.44	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	July 27, 2021	

16.44.1	Upon petition, the Medical Executive Committee may recommend to the Board that the Board expunge previous corrective action upon a showing of good cause or rehabilitation.
16.44.2	Said expunction shall be reported to the National Practitioner Data Bank and the State of Washington licensing board.
16.44.3	Said expunction shall also require the removal of all references to the prior corrective action from the Practitioner's quality/peer review file.
16.44.4	No further reference may be made to an expunged corrective action and, once expunged, the Practitioner may thereafter truthfully deny that any corrective action was taken.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Board of Directors	September 20, 2012
Board of Directors	September 27, 2012

Reviewed: July 16, 2018

- Bylaws Committee – July 27, 2020

Title	Mandatory Reporting	
Number	17	
Effective Date	March 28, 2013 Revised January 25, 2017	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate - Chief Medical Officer President
Review Date	April 18, 2019	

17.1	In accordance with RCW 70.41.210, the President shall report or ensure reporting to the Washington State Department of Health or appropriate disciplinary authority, when the practice of a healthcare practitioner, who is subject to the Medical Staff Bylaws and Policies, is restricted, suspended, limited, or terminated based upon a finding of unprofessional conduct as defined in RCW 18.130.180.
17.2	The President shall report or ensure reporting of voluntary restriction or termination of the practice of a healthcare practitioner who is under investigation regarding an allegation of unprofessional conduct, in return for the Medical Staff not conducting an investigation of alleged unprofessional conduct, or in return for the Medical Staff not taking a recommended action.
17.3	Reports shall be made within 15 days of the date of the finding or unprofessional conduct under RCW 18.130.180 which results in any of the following actions regarding the practice of a healthcare practitioner ● Restriction ● Suspension ● Limitation
17.4	Reports shall be made within 15 days of the date the hospital accepts a voluntary restriction or termination of the practice of a healthcare practitioner, including voluntary resignation, which occur while the healthcare practitioner was under investigation for, or the subject of proceedings regarding, unprofessional conduct under RCW 18.130.180.
17.5	The practitioners covered by this policy are ● Physicians ● Dentists ● Podiatrists ● Advanced Registered Nurse Practitioners ● Physician Assistants – Certified ● Certified Registered Nurse Anesthetists ● RN First Assistants

Approval	
Bylaws Committee	July 25, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	September 15, 2016
Published to the Medical Staff	October 28, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	January 19, 2017
Board of Directors	January 25, 2017

Reviewed: April 18, 2018

Title	Medical Staff Quality Improvement Plan – Scope of Accountability	
Number	18.1	
Effective Date	August 22, 2017	
Accountability	Medical Staff	Administration
	Credentials Committee Medical Staff Quality Committee Multispecialty Peer Review Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer Manager – Quality and Patient Safety Manager – Peer Review
Review Date	September 28, 2021	

18.1.1	The Board of Directors has delegated to the organized Medical Staff the responsibility of assuring quality of care and patient safety.			
18.1.2	The Medical Executive Committee (MEC) has responsibility for this function.			
18.1.3	The MEC has delegated the work for carrying out this responsibility to the following committees:			
	18.1.3.1	Credentials Committee		
		18.1.3.1.1	To evaluate and direct the objective credentialing activities for the Medical Staff, advanced practice clinicians, allied health professionals, and others who fall within the purview of the Medical Staff credentialing process	
		18.1.3.1.2	To direct practitioner educational activities as it pertains to privileging	
	18.1.3.2	Medical Staff Quality Committee (MSQC)		
		18.1.3.2.1	To evaluate and direct the quality improvement activities which relate to the organization's clinical systems and processes which directly affect the ability of the practitioners to deliver quality and safe medical care.	
	18.1.3.3	Multispecialty Peer Review Committee (MPRC)		
		18.1.3.3.1	To provide peer review for credentialed members of the Medical Staff and advanced practice clinicians	
		18.1.3.3.2	To evaluate and monitor practitioner performance	
		18.1.3.3.3	To identify areas of potential professional growth and suggest improvements for individual practitioner performance with direct oversight of the Professional Performance Committee (PPC) for the six Joint Commission and American Council on Graduate Medical Education (ACGME) clinical competencies which are	
			18.1.3.3.3.1	Patient Care
			18.1.3.3.3.2	Medical Knowledge
			18.1.3.3.3.3	Practice Based Learning and Improvement
			18.1.3.3.3.4	Interpersonal and Communication Skills
			18.1.3.3.3.5	Professionalism
			18.1.3.3.3.6	System-Based Practice
	18.1.3.4	Professional Performance Committee		
		18.1.3.4.1	To oversee the accountability and effectiveness of the Credentials Committee and Multispecialty Peer Review Committee and ensure integration of their respective findings, conclusions, and recommendations	

		18.1.3.4.2	To develop systematic approaches to evaluate and improve practitioner performance in the Joint Commission and ACGME clinical competencies as outlined above
		18.1.3.4.3	To evaluate and investigate reports regarding practitioner behavior

Approval Process:

Credentials Committee	January 24, 2017
Medical Staff Quality Committee	March 13, 2017
Multispecialty Peer Review Committee	February 9, 2017
Professional Performance Committee	February 14, 2017
Bylaws Committee	March 27, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	April 20, 2017
Published to the Medical Staff	April 28, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	July 20,2017
Board of Directors	August 22, 2017

Reviewed by:

- 8/13/2020 Multispecialty Peer Review Committee – suggested name change to St. Michael
- 9/28/2020 Bylaws Committee – no name changes as all governing documents are maintained under the name St. Michael

Title	Medical Staff Quality Improvement Plan – Confidentiality Protections	
Number	18.2	
Effective Date	June 20,2017	
Accountability	Medical Staff	Administration
	Credentials Committee Medical Staff Quality Committee Multispecialty Peer Review Committee Professional Performance Committee Medical Executive Committee	Chief Medical Officer Manager – Quality and Patient Safety Manager – Peer Review
Review Date	September 28, 2021	

18.2.1	Washington State law provides confidentiality protection to hospital peer review activities.	
18.2.2	RCW 70.41.200 provides that information and documents created specifically for, collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action.	
	18.2.2.1	No person who was in attendance at a meeting of a quality improvement committee or who participated in creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared for the committee.
18.2.3	RCW 4.24.250 provides that the proceedings, reports, and written records of a regularly constituted review committee or board of a hospital whose duty it is to review and evaluate the quality of patient care are not subject to subpoena or discovery proceedings in any civil action.	

Approval Process:

Bylaws Committee	January 23, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	February 16, 2017
Published to the Medical Staff	February 24, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	May 18, 2017
Board of Directors-Quality & Value Committee	June 20, 2017

Reviewed:

- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Definitions	
Number	18.3	
Effective Date	June 20, 2017	
Accountability	Medical Staff	Administration
	Credentials Committee Medical Staff Quality Committee Multispecialty Peer Review Committee Professional Performance Committee Medical Executive Committee	Chief Medical Officer Manager – Quality and Patient Safety Manager – Peer Review
Review Date	September 28, 2021	

18.3.1	Peer Review: The evaluation of an individual practitioner's professional performance for all relevant competency categories using multiple sources of data and identification of opportunities to improve care. Through this process, practitioners receive feedback for potential individual professional improvement or confirmation of individual professional achievement related to the effectiveness of their performance in each of the practitioner competencies.	
18.3.2	Peer Review Body: A committee designated by the Medical Executive Committee (MEC) to conduct the review of individual practitioner's performance on behalf of the organized Medical Staff. The peer review body for St. Michael will be the Multispecialty Peer Review Committee (MSPRC) as described in its charter, unless otherwise designated for specific circumstances by the MEC. Members of the peer review body may render assessments of practitioner performance based upon information provided by individual reviewers with appropriate subject matter expertise.	
18.3.3	Peer: An individual practicing in the same profession who has the expertise to evaluate the subject matter under review. The level of expertise required will be determined on a case by case basis.	
	18.3.3.1	In most circumstances an Advanced Registered Nurse Practitioner may be considered a peer of a Physician Assistant Certified and vice versa.
18.3.4	Ongoing Professional Performance Evaluation (OPPE): Routine monitoring and evaluation of current competency for practitioners with granted privileges, generally reported on an every 8 months basis	
18.3.5	Focused Professional Performance Evaluation (FPPE): Confirmation of current competency based on any of the following circumstances, and generally reported on a quarterly basis	
	18.3.5.1	A new practitioner who has been granted clinical privileges and is considered to be in a provisional, or probationary, status
	18.3.5.2	A practitioner who has been granted a new clinical privilege
	18.3.5.3	A potential concern has been identified from the OPPE process
18.3.6	Practitioner Competencies: The six Joint Commission/American Council on Graduate Medical Education clinical competencies.	
	18.3.6.1	Patient Care
	18.3.6.2	Medical and Clinical Knowledge
	18.3.6.3	Interpersonal and Communication Skills
	18.3.6.4	Professionalism
	18.3.6.5	System Based Practice
	18.3.6.6	Practice Based Learning and Improvement

18.3.7	Peer Review Data: Data from case reviews and aggregate data based upon review, rule, and rate indicators in comparison with generally recognized standards, benchmarks, and norms. The data may be objective or perception-based as appropriate for the competency under evaluation.
18.3.8	Review Indicators: A type of indicator identified as a significant event that would require analysis by a peer review body to determine cause, effect, and severity
18.3.9	Rule Indicators: A type of indicator representing a general rule, standard, or generally recognized professional guideline or accepted practice where individual variation does not directly cause adverse patient outcomes
18.3.10	Rate Indicator: A type of indicator identifying cases or events which are aggregated for statistical analysis prior to review by the appropriate committee, section, or administrative function

Approval Process:

Bylaws Committee	January 23, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	February 16, 2017
Published to the Medical Staff	March 10, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	May 18, 2017
Board of Directors	June 20, 2017

Reviewed:

- June 25, 2018 – Bylaws Committee
- August 13, 2020 – Multispecialty Peer Review Committee, suggested name change to St. Michael
- September 28, 2021 – Bylaws Committee, name change of all governing documents to remain as St. Michael; minor wording changes, no effect on content

Title	Medical Staff Quality Improvement Plan – Quality Improvement Goals of the Medical Staff	
Number	18.4	
Effective Date	June 20, 2017	
Accountability	Medical Staff	Administration
	Credentials Committee Medical Staff Quality Committee Multispecialty Peer Review Committee Professional Performance Committee Medical Executive Committee	Chief Medical Officer Manager – Quality and Patient Safety Manager – Peer Review
Review Date	September 28, 2021	

18.4.1	To assure all care carried out under the auspices of the St. Michael Medical Staff is provided by qualified practitioners	
18.4.2	To assure current clinical competency of providers who care for patients in a St. Michael facility	
18.4.3	To seek to continually improve the quality and safety of care rendered through	
	18.4.3.1	Evaluation of patient outcomes
	18.4.3.2	Improvement of systems and processes
	18.4.3.3	Review of individual cases
	18.4.3.4	Review of aggregate data
	18.4.3.5	Timely periodic reporting to individuals and groups
18.4.4	To carry out ongoing evaluation of the professional performance of credentialed practitioners (OPPE)	
18.4.5	To carry out focused evaluation of the professional performance, when indicated, of individual credentialed practitioners (FPPE)	

Approval Process:

Bylaws Committee	January 23, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	February 16, 2017
Published to the Medical Staff	March 17, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	May 18, 2017
Board of Quality and Value Committee	June 20, 2017

Reviewed:

- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Information Management	
Number	18.5	
Effective Date	August 22, 2017	
Accountability	Medical Staff	Administration
	Medical Staff Quality Committee Multispecialty Peer Review Committee Professional Performance Committee Medical Executive Committee	Chief Medical Officer Manager – Quality and Patient Safety Manager – Peer Review
Review Date	September 28, 2021	

18.5.1	All peer review information is privileged and confidential in accordance with the St. Michael Medical Staff Bylaws, state and federal laws, regulations, and accreditation requirements pertaining to confidentiality and non-discoverability.		
18.5.2	The reviewed practitioner will receive practitioner specific feedback on a timely and periodic basis		
18.5.3	The Medical Staff will use the practitioner specific peer review, OPPE, and FPPE results in making its recommendations to St. Michael regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.		
18.5.4	Specific practitioner names will not be disclosed in aggregate reporting or in reviews conducted for evaluation of systems or processes.		
18.5.5	Any written documents that the Medical Staff determines should be retained related to practitioner specific peer review information will be kept by St. Michael in a secure, locked location. Practitioner specific peer review information may include		
	18.5.5.1	Individual case review findings	
	18.5.5.2	Aggregate performance data for all the general competencies measured for that practitioner	
	18.5.5.3	Any written correspondence with the practitioner regarding commendations, improvement opportunities, or corrective action.	
	18.5.5.4	Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed after the committee decision is made. Working notes include potential issues identified by St. Michael staff, preliminary case rating, questions, and notes of the practitioner reviewer(s).	
	18.5.5.5	Peer review data will be retained for 4 years after the most recent reappointment of the provider.	
	18.5.5.6	Information related to formal investigations and corrective actions will be retained indefinitely.	
18.5.6	Peer review information in a practitioner's quality file is available only to authorized individuals who have a legitimate need to know this information based upon the responsibilities.		
	18.5.6.1	The CMO and Chief of Staff will mutually assure that only authorized individuals have access to individual provider quality files.	
	18.5.6.2	The following individuals shall be authorized to review the individual practitioner quality files:	
		18.5.6.2.1	The specific practitioner
		18.5.6.2.2	Section Chiefs
		18.5.6.2.3	Members of the Credentials Committee
		18.5.6.2.4	Members of the Professional Performance Committee

		18.5.6.2.5	Members of the Medical Executive Committee
		18.5.6.2.6	Medical Staff Services professionals
		18.5.6.2.7	Peer Review Specialists and Coordinator
		18.5.6.2.8	Individuals surveying for accrediting bodies with appropriate jurisdiction
		18.5.6.2.9	Other individuals with a legitimate purpose for access to be determined by the St. Michael Board of Directors
18.5.7	No copies of peer review documents will be created and/or distributed unless authorized by Medical Staff Bylaws or Policies, the MEC, or the St. Michael Board.		

Approval Process:

Bylaws Committee	February 27, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	March 16, 2017
Published to the Medical Staff	April 7, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	July 20, 2017
Board of Directors	August 22, 2017

Reviewed by:

- August 13, 2020 – Multispecialty Peer Revie Committee, minor wording changes, no effect on content
- September 28, 2020 – Bylaws Committee, minor wording changes, no effect on content

Title	Medical Staff Quality Improvement Plan – Occurrence Screens and Indicators Selection	
Number	18.6	
Effective Date	August 22, 2017	
Accountability	Medical Staff	Administration
	Medical Staff Quality Committee Multispecialty Peer Review Committee Professional Performance Committee Medical Executive Committee	Chief Medical Officer Manager – Quality and Patient Safety Manager – Peer Review
Review Date	September 28, 2021	

18.6.1	Occurrence screening is a non-judgmental reporting of a critical occurrence.
18.6.2	Based upon the criteria identified by the individual Sections and approved by the Professional Performance Committee, a critical occurrence may be a Review Indicator, triggering referral to the Multispecialty Peer Review Committee or to those sections or specialties (Anesthesiology, Emergency Medicine, Pathology, and Radiology) which have a mechanism for conducting peer review for cases within the specialties which do not involve care provided by another practitioner from another Section.
18.6.3	Review Indicators shall be objective, applied uniformly to all Medical Staff members and advanced practice clinicians based upon their scope of practice and privileges granted.
18.6.4	Review Indicators will be reviewed annually by the Section, and modified if necessary. Results of the annual review will be reported to the Professional Performance Committee.
18.6.5	Reportable adverse events, as defined by the Washington Administrative Code, and reportable sentinel events as defined by the Joint Commission are considered Review Indicators and will trigger referral for peer review.
18.6.6	Each Section shall define Rate Indicators which are relevant to their scope of practice and identify benchmarks based upon widely accepted professional standards. The Professional Performance Committee and Medical Executive Committee will review and approve Section defined Rate Indicators.
18.6.7	Rate Indicator findings will be reported to the Sections and Professional Performance Committee as scheduled.
18.6.8	Rate Indicators will be reviewed annually by the Section, and modified if necessary. Results of the annual review will be reported to the Professional Performance Committee and the Medical Executive Committee.
18.6.9	Rule Indicators will be defined by the Professional Performance Committee and shall be uniformly applied the all Medical Staff members and advanced practice clinicians.
18.6.10	Rule Indicators will be reviewed at least annually by the Professional Performance Committee, and modified if necessary due to changes in Medical Staff Bylaws and Policies, state and federal regulations, and accreditation standards.
18.6.11	The Professional Performance Committee, Multispecialty Peer Review Committee, Medical Staff Quality Committee, and the Medical Executive Committee may suggest Review, Rate, and Rule Indicators to the Sections to evaluate appropriateness of procedures, effectiveness of hospital policies, effectiveness of patient care, or individual performance as it relates to system-wide issues

Approval Process:

Bylaws Committee	February 27, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	March 16, 2017

Published to the Medical Staff	April 14, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	July 20, 2017
Board of Directors	August 22, 2017

Reviewed:

- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Chart Review Process	
Number	18.7	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Multispecialty Peer Review Committee Bylaws Committee Medical Executive Committee	Manager Peer Review Associate Chief Medical Officer
Review Date	September 28, 2021	

18.7.1	Individual practitioners shall be notified via letter of all their cases reviewed by the Multispecialty Peer Review Committee.		
	18.7.1.2	Copies of the letters shall be kept in the individual practitioners' quality files.	
18.7.2	Cases identified as pertaining to systems issues shall be referred to the St. Michael Quality Improvement and Safety Committee for review of hospital systems and the Medical Staff Quality Committee for medical staff system review after redaction of individual practitioner information.		
18.7.3	Cases found to have opportunities for improvement, minor or significant, shall be referred to the individual section chiefs for review by the sections after redaction of individual practitioner information.		
18.7.4	Cases identified for educational review in the individual sections shall be communicated to the section chief after redaction of individual practitioner information.		
18.7.5	Case review may occur outside the Multispecialty Peer Review Committee in the following areas:		
	18.7.5.1	Imaging Based Specialties	
		18.7.5.1.1	The St. Michael credentialed diagnostic radiologists participate in the American College of Radiology quality improvement program.
		18.7.5.1.2	Review of diagnostic cases for which a potential discrepancy has been identified will be submitted to the Radiology Section for review and scoring in the quality/executive session portion of their regularly scheduled Section meetings.
		18.7.5.1.3	Cases requiring evaluation of the care provided by the Imaging based specialist practitioner in conjunction with care provided by other specialists will be referred to the Multispecialty Peer Review Committee.
		18.7.5.1.4	Aggregate data of reviews and scoring conducted by the Section will be reported to the Professional Performance Committee as a part of the Multispecialty Peer Review Committee report.
		18.7.5.1.5	The St. Michael credentialed radiation oncologists participate in the St. Michael Medical Radiation Oncology Center's physician peer review process.
		18.7.5.1.6	Cases requiring evaluation of the care provided by the radiation oncologist will be reviewed by the Radiation Oncology Quality Assurance Team. Any area for improvement will be assigned a corrective action plan and implemented with the individual through the Section the provider is assigned to in consultation with the Radiation Oncology Assurance Team.
		18.7.5.1.7	Aggregate data of reviews and scoring conducted by the Section will be reported to the Professional Performance Committee as a part of the Multispecialty Peer Review Committee report.
	18.7.5.2	Emergency Medicine	
		18.7.5.2.1	Cases requiring evaluation only of the care being provided in the Emergency Department will be submitted to the Emergency Medicine Section for review and scoring in the quality/executive session portion of their regularly scheduled Section meetings.

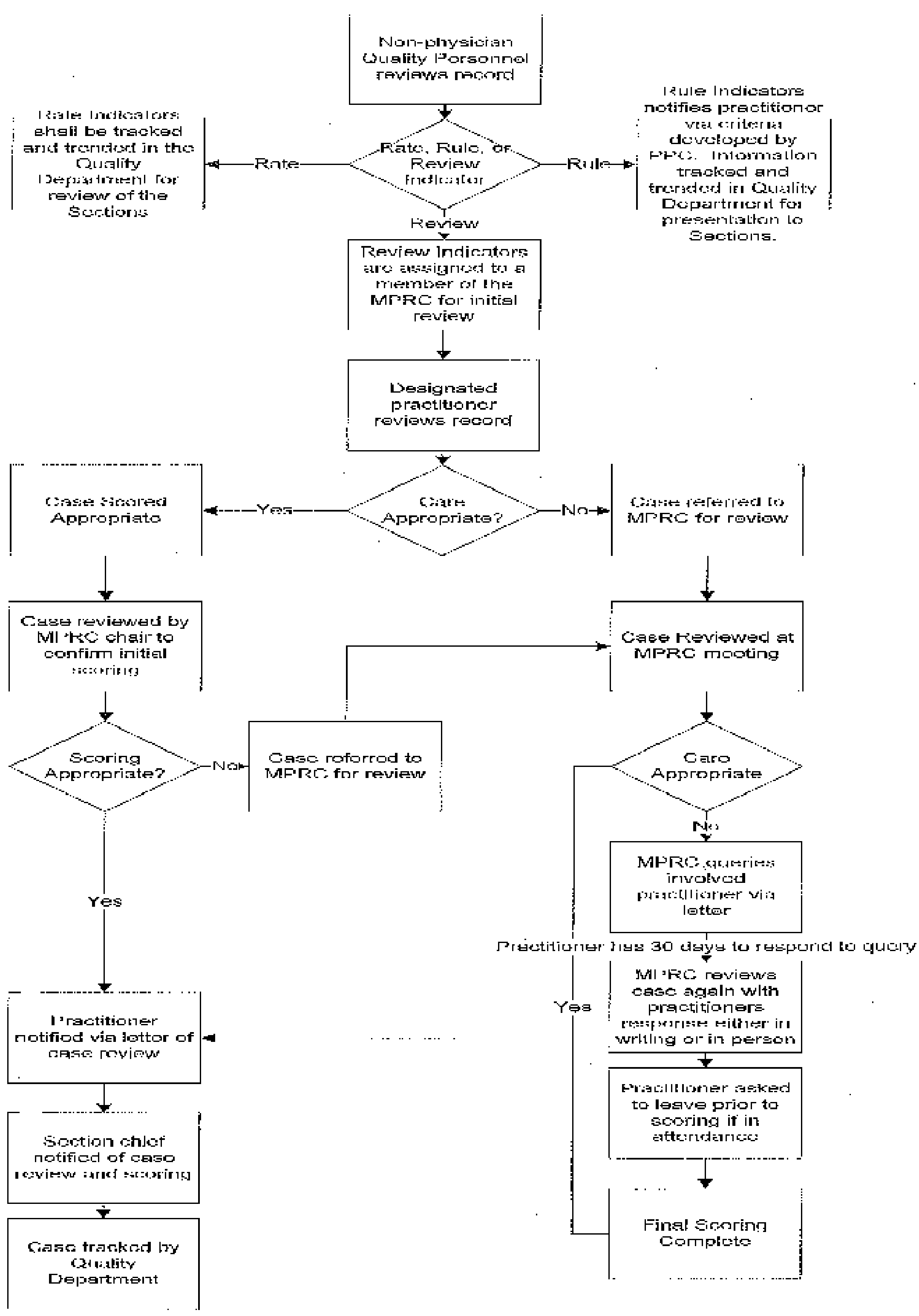
		18.7.5.2.2	Cases requiring evaluation of the care provided by the Emergency Medicine practitioner in conjunction with care provided by other specialists will be referred to the Multispecialty Peer Review Committee.
		18.7.5.2.3	Aggregate data of reviews and scoring conducted by the Section will be reported to the Professional Performance Committee as a part of the Multispecialty Peer Review Committee report.
	18.7.5.3	Anesthesiology	
		18.7.5.3.1	Cases requiring evaluation only of the care being provided by an Anesthesiology practitioner will be submitted to the Anesthesiology Section for review and scoring in the quality/executive session portion of their regularly scheduled Section meetings.
		18.7.5.3.2	Cases requiring evaluation of the care provided by the Anesthesiology practitioner in conjunction with care provided by other specialists will be referred to the Multispecialty Peer Review Committee.
		18.7.5.3.3	Aggregate data of reviews and scoring conducted by the Section will be reported to the Professional Performance Committee as a part of the Multispecialty Peer Review Committee report.
	18.7.5.4	Pathology	
		18.7.5.4.1	The St. Michael credentialed Pathologists participate in the American College of Pathology quality improvement program.
		18.7.5.4.2	Cases requiring evaluation of the care being provided by a Pathology practitioner in conjunction with care by other specialist will be referred to the Multispecialty Peer Review Committee.
18.7.6	Data sources utilized for case review, evaluation, and assessment of overall quality of care rendered and patient safety shall include, but are not limited to		
	18.7.6.1	Patient's electronic health records, including documents, documentation, images, test results, scanned records, and reports	
	18.7.6.2	Monitoring activities such as Core Measures, Cath PCI, Get With the Guidelines data, SCOPE, STS, Mortality reports and ED 72-Hour Return reports, Readmission reports, etc.	
	18.7.6.3	Occurrence and incident reports, patient grievances, staff referrals, adverse events, and sentinel events	
	18.7.6.4	Process or outcome studies	
	18.7.6.5	Tissue review reports	
	18.7.6.6	Drug usage reports	
	18.7.6.7	Blood utilization reports	
	18.7.6.8	Pharmacy and therapeutics reports	
	18.7.6.9	Patient questionnaires or surveys	
	18.7.6.10	Letters or comments of complaint or commendation	

Approval Process:

Multispecialty Peer Review Committee	12/13/2018
Bylaws Committee	1/28/2019
Medical Executive Committee Approval for distribution to the Medical Staff	2/21/2019
Published to the Medical Staff	3/17/2019
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed


Non-physician Quality Personnel reviews record
Rate, Rule, or Review Indicator
Rate
Rate Indicators shall be tracked and trended in the Quality Department for review of the Sections
Rule
Rule Indicators notifies practitioner via criteria developed by PPC. Information tracked and trended in Quality Department for presentation to Sections.
Review
Review Indicators are assigned to a member of the MPRC for initial review
Designated practitioner reviews record
Care Appropriate?
Yes
Case Scored Appropriate
No
Case referred to MPRC for review
Case reviewed by MPRC chair to confirm initial scoring
Scoring Appropriate?
No
Case referred to MPRC for review
Case Reviewed at MPRC meeting
Care Appropriate
No
MPRC queries involved practitioner via letter
Practitioner has 30 days to respond to query
MPRC reviews case again with practitioners response either in writing or in person
Practitioner asked to leave prior to scoring if in attendance
Final Scoring Complete
Yes
Yes
Practitioner notified via letter of case review
Section chief notified of case review and scoring
Case tracked by Quality Department

Title	Medical Staff Quality Improvement Plan – Peer Review Findings Types	
Number	18.8	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Multispecialty Peer Review Committee Bylaws Committee Medical Executive Committee	Manager – Peer Review Associate Chief Medical Officer
Review Date	September 28, 2021	

18.8.1	Below is a list of scoring designations applied to the Peer Review process:	
	18.8.1.1	Not Appropriate for Peer Review – This designation is for a case that does not meet a quality indicator for review or otherwise qualify for a review. These are for limited instances where there is a clear misuse of the peer review process.
	18.8.1.2	Exceptional Care – Clinical care that goes above and beyond the expected and acceptable routine community standard of care.
	18.8.1.3	Care Appropriate – This designation is for cases upon review that qualified for review based upon a quality standard, but were found not to deviate from the applicable standard of care.
	18.8.1.4	Opportunity for Improvement Minor – This determination is for when the clinical practice or documentation could have been improved and/or clinical practice or documentation was considered to have deviated from the usual community standard of care.
	18.8.1.5	Opportunity for Improvement Significant – This determination is for when the clinical practice or documentation could have been improved and/or clinical practice or documentation was considered to have deviated substantially from the usual community standard of care.
18.8.2	Sometimes, in addition to findings regarding the practitioner’s provision of care, systems issues will be identified which may have contributed to the patient’s care and may or may not have affected the outcome.	
	18.8.2.1	Systems issues may be noted in the scoring of the case.
	18.8.2.2	Identified systems issues will be reported to the operational leadership to be addressed.
	18.8.2.3	When appropriate, findings of the systems review may be included in the peer review findings documented in the Quality file.

Reference:
CHI Franciscan Health Peer Review Policy 50.00

Approval Process:

Bylaws Committee	1/28/2019
Multispecialty Peer Review Committee	2/14/2019
Medical Executive Committee Approval for distribution to the Medical Staff	2/21/2019
Published to the Medical Staff	3/17/2019
Medical Executive Committee Recommendation for Approval to Quality and Value Committee	5/16/2019
Board of Directors	6/18/2019

Reviewed:
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – External Review	
Number	18.9	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Multispecialty Peer Review Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	September 28, 2021	

18.9.1	The External Review Process shall be initiated through a recommendation from the Multispecialty Peer Review Committee chair to the chair of the Professional Performance Committee.			
18.9.2	Requests for External Peer Review must be reviewed and authorized by the Medical Executive Committee.			
18.9.3	External Peer Review may be utilized under the following circumstances if deemed appropriate by consultation between the Medical Executive Committee and Hospital Executives			
	18.9.3.1	Ambiguity		
		18.9.3.1.1	Ambiguous or conflicting recommendations from the MPRC	
		18.9.3.1.2	No consensus by the MPRC for a particular recommendation	
	18.9.3.2	Lack of internal expertise. When it is determined that:		
		18.9.3.2.1	No one on the Medical Staff has adequate expertise in the specialty under review.	
		18.9.3.2.2	The only practitioners on the Medical Staff with expertise are partners, associates, or direct competitors of the practitioner under review and this potential for conflict of interest cannot be appropriately resolved by Medical Staff leadership.	
	18.9.3.3	New Technology		
		18.9.3.3.1	When a Medical Staff member requests permission to utilize new technology or perform a procedure new to St. Michael and the Medical Staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved	
	18.9.3.4	Miscellaneous Issues		
		18.9.3.4.1	When the Medical Staff needs an expert witness	
			18.9.3.4.1.1	For a Fair Hearing
			18.9.3.4.1.2	For evaluation of a credentials file
			18.9.3.4.1.3	For assistance in developing a benchmark for quality monitoring

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Quality & Value Committee	September 20,2012
Board of Directors	September 27, 2012

Reviewed:

- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, minor wording changes, no effect on contect
- September 28, 2020 – Bylaws Committee, no changes needed

<table>
<tr><td>Title</td><td colspan="2">Confidentiality of Medical Staff and Advanced Practice Clinicians Quality File, Medical Section Quality Minutes, and Peer Review Information</td></tr>
<tr><td>Number</td><td colspan="2">18.10</td></tr>
<tr><td>Effective Date</td><td colspan="2">September 23, 2015</td></tr>
<tr><td rowspan="2">Accountability</td><td>Medical Staff</td><td>Administration</td></tr>
<tr><td>Bylaws Committee
Credentials Committee
Professional Performance Committee
Multispecialty Peer Review Committee
Medical Executive Committee</td><td>Associate Chief Medical Officer
Manager – Peer Review
Manager – Quality Department</td></tr>
<tr><td>Review Date</td><td colspan="2">September 28, 2021</td></tr>
</table>

<table>
<tr><td>18.10.1</td><td colspan="2">St. Michael Medical Center (HaMC) is committed to consistently maintaining the confidentiality of Medical Staff quality files, medical section quality minutes, and peer review information to ensure that such information remains privileged and protected from disclosure to the fullest extent permitted by State and Federal laws. It is, therefore, the policy of this organization to maintain the confidentiality of all records, discussions, and deliberations relating to credentialing and peer review, quality improvement activities, and other deliberations of Medical Staff committees.</td></tr>
<tr><td>18.10.2</td><td colspan="2">This requirement of confidentiality extends to:</td></tr>
<tr><td></td><td>18.10.2.1</td><td>The quality records and minutes of all Medical Staff Sections and Committees</td></tr>
<tr><td></td><td>18.10.2.2</td><td>The contents of all Medical Staff quality files concerning individual practitioners, including Advanced Practice Clinicians (APC),</td></tr>
<tr><td></td><td>18.10.2.3</td><td>The discussions and deliberations which take place within the confines of or under the aegis of the Medical Staff Sections and Committees</td></tr>
<tr><td></td><td>18.10.2.4</td><td>St. Michael will permit disclosure of the aforementioned only as described in this policy</td></tr>
<tr><td>18.10.3</td><td colspan="2">This policy applies to all records maintained by or on behalf of the Medical Staff of St. Michael, including the records and minutes of all Medical Staff Sections and Committees and the quality files concerning individual practitioners which include the records of re- credentialing, peer review and quality assurance related to those practitioners. The purpose of this policy is to provide a guideline for access to information contained in a practitioner’s credentialing files, quality files, and quality minutes of Medical Staff meetings.</td></tr>
<tr><td>18.10.4</td><td colspan="2">Information contained in the quality file is considered independent from the credentialing file and will be maintained separately.</td></tr>
<tr><td>18.10.5</td><td colspan="2">Quality improvement/peer review information shall be used only for internal re-credentialing, peer review and quality activities afforded protection under applicable State and Federal law and is, therefore, not discoverable and may not be disclosed.</td></tr>
<tr><td>18.10.6</td><td colspan="2">Responsibility: Personnel in the Medical Staff Services Office, the Quality Department, the Peer Review Department and all members of the Medical Staff.</td></tr>
<tr><td>18.10.7</td><td colspan="2">Location and Security Precautions: All St. Michael Medical Staff quality files shall be maintained under the care and custody of St. Michael’s authorized representatives(s) in the Quality Department.</td></tr>
</table>

18.10.8	The Quality Department will be locked except during those times that the office staff is present and able to monitor access in accordance with this policy.	
18.10.9	The Medical Staff quality files are kept in a locked file cabinet at all times. Access is granted via a key which is only available to Peer Review Department staff.	
18.10.10	Medical Staff records will only be released from the Quality Department in accordance with this policy.	
18.10.11	Records stored electronically must have individual user accounts and password and must possess read/write control protections.	
18.10.12	Files not being used are to be stored within secured cabinets. No quality files are to be left in work stations when unattended. At the end of the day, all quality files are to be returned to locked file cabinets.	
18.10.13	While records are being reviewed, or during transport to Credentials Committee meetings or between St. Michael facilities, Medical Staff Services or Quality Department staff must accompany them at all times.	
18.10.14	Medical Staff quality files are to be viewed only within St. Michael facilities and only in the presence of Medical Staff Services or Peer Review Department Staff. Files must be placed in the St. Michael department's locked file cabinet at the close of each day.	
18.10.15	The Confidential Information defined herein is the property of HaMC. HaMC does not desire to waive, in any manner or for any purpose, the privileged nature of any of said information, for any reason.	
18.10.16	Members of the Medical Staff recognize that confidentiality is vital to effective credentialing, peer review and quality assessment/improvement activities. Committees, Officers of the Medical Staff and those involved with credentialing, peer review and quality assessment/improvement duties bear the responsibility for evaluation and improvement of the quality of care rendered in this Hospital. Accordingly, the records and proceedings for those committees and the participating medical providers shall be afforded the fullest protection available under RCW 4.24.250, 43.70.510, 70.41.200, 18.20.390, and 74.42.640. The confidentiality of these activities is to be maintained and these communications and information will be disclosed only in furtherance of credentialing, peer review, and quality assessment/ improvement activities.	
18.10.17	Persons assisting the organized hospital Medical Staff credentialing, peer review or quality assurance activities shall have access to Medical Staff quality files to the extent necessary to perform official functions. More particularly:	
	18.10.17.1	Medical Staff Officers: Medical Staff Officers shall have access to all Medical Staff Records to the extent necessary to perform their official functions.
	18.10.17.2	Medical Staff Committee Members: Medical Staff committee members shall have access to the records of committees on which they serve and to the credentials and quality files of practitioners whose competency or performance the committee is reviewing.
	18.10.17.3	Administrator or Designated Representative: The Board of Directors, the St. Michael President or his/her designated representative shall have access to all Medical Staff Records.
	18.10.17.4	A person permitted access to Medical Staff quality files under this policy shall be given a reasonable opportunity to inspect the records in question and to make notes while in the presence of Medical Staff Services or Peer Review Department staff, but will not be allowed to

		remove the file from the St. Michael facility or to make copies of any of the material within the file. Removal or copying shall only be allowed upon the express permission of the Chief Medical Officer (CMO) or his/her designated representative.	
	18.10.17.5	Viewing of the files must be done with Medical Staff Services or Peer Reviewe Department staff in attendance.	
	18.10.17.6	A Medical Staff member is permitted to view his/her own quality file in accordance with the viewing access noted above.	
	18.10.17.7	Medical Staff member (s) must schedule an appointment to view the quality file with the Medical Staff Services or Peer Review Department staff.	
18.10.18	Access by Persons or Organizations Outside The Hospital Or Medical Staff: Credentialing or Peer Review at other health care facilities		
	18.10.18.1	No information contained in a quality file, or other information which is subject to this Policy, may be released in response to a request from another health care facility or its Medical Staff. That request must be limited to include information that a practitioner is a member of the requesting facility's Medical Staff, exercises privileges at the requesting facility, or is an applicant for Medical Staff membership or privileges at that facility. No adverse information shall be released until a copy of a signed authorization, and release from liability, has been received. Disclosure shall be limited to the specific information requested/authorized.	
	18.10.18.2	If a practitioner has been the subject of corrective action at St. Michael Medical Center, special care must be taken. All responses to inquiries regarding that practitioner shall be reviewed and approved by the Director of Medical Staff Services and/or Chief of Staff, Chief Medical Officer or his/her designee. No adverse information will be released without legal consultation.	
	18.10.18.3	Access by Hospital Surveyors: Hospital surveyors (from the TJC, DOH, DHS, CMS or any other Hospital Surveyors) shall be entitled to inspect Medical Staff Records on the Hospital premises in the presence of Hospital or Medical Staff personnel provided that:	
		18.10.18.3.1	No originals or copies may be removed from the premises;
		18.10.18.3.2	Access is only with the concurrence of the Chief of Staff/CMO/President or designee; and
		18.10.18.3.3	The surveyor demonstrates the following: a) Specific statutory, regulatory, or other authority to review the requested materials. That the materials sought are directly relevant to the matter being investigated. b) That the materials sought are the most direct and least intrusive means to carry out the survey or a pending investigation, bearing in mind that credentials/quality files regarding individual practitioners are strictly confidential.

			c) Sufficient specificity to allow for the production of individual documents without undue burden to the Hospital or Medical Staff. d) In the case of requests for documents with practitioner identifiers not eliminated, the need for such identifiers is clear.
	18.10.18.4	All subpoenas of Medical Staff Records shall be referred to the CMO/President or Risk Management Department, who will consult with legal counsel and follow hospital policy regarding the appropriate response. The CMO will advise the Chief of Staff of receipt of the subpoena.	
	18.10.18.5	All other requests by persons or organizations outside the Hospital for information contained in the Medical Staff Records shall be forwarded to the Medical Staff Services Department. The release of any such information shall require the concurrence of the Chief of Staff/CMO/President or the designated representative.	
Related Documents	St. Michael Medical Center Medical Staff Bylaws, Medical Staff Policies Credentials Policies and Procedures Peer Review Policies and Procedures		

Approval Process:

Credentials Committee	February 24, 2015
Bylaws Committee	April 27, 2015
Medical Executive Committee Approval for distribution to the Medical Staff	May 21, 2015
Published to the Medical Staff	June 19, 2015
Medical Executive Committee Recommendation for Approval to Board of Directors	September 17, 2015
Board of Directors	September 28, 2015

Reviewed:

- December 28, 2016 – Bylaws Committee, no changes needed
- December 28, 2017 – Bylaws Committee, no changes needed
- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – IRIS Reports	
Number	MSP 18.11	
Effective Date	May 15, 2018	
Accountability	Medical Staff	Administration
	Multispecialty Peer Review Committee Credentials Committee Professional Performance Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	September 28, 2021	

18.11.1	IRIS means Incident Report Information System.				
18.11.2	An IRIS report may make reference to physician or advanced practice clinician clinical performance or behavior.				
18.11.3	IRIS reports regarding a physician or advanced practice clinician will be forwarded to the Associate Chief Medical Officer (ACMO) for review.				
	18.11.3.1	The ACMO will notify the practitioner within 10 working days of receipt of the IRIS report.			
	18.11.3.2	The ACMO will get the perspective of the physician or advanced practice clinician about whom the IRIS report was filed.			
		18.11.3.2.1	The ACMO may contact the physician or advanced practice clinician directly for a response; or,		
		18.11.3.2.2	The ACMO may ask the appropriate Section Chief to assist in the evaluation of the IRIS report.		
			18.11.3.2.1	The Section Chief is responsible for obtaining the practitioner's perspective on the event and ensuring that it is documented in the IRIS report either by	
				18.11.3.2.1.1	Documenting findings himself/herself; or,
				18.11.3.2.1.2	Asking the involved practitioner(s) to document additional information which might help in the review of the matter or contribute to the peer review process
18.11.4	If it is determined by the ACMO or Section Chief that the incident was solely due to a systems problem or that a systems problem contributed to the practitioner's performance, the matter will be referred to the appropriate administrative leader to be addressed. In the case of the latter, the incident may also be referred to Peer Review.				
18.11.5	IRIS reports that meet criteria for referral to Peer Review will be forwarded to the Peer Review Specialist for initial screening.				
	18.11.5.1	The Peer Review Specialist is an RN responsible for the administration and facilitation of peer review and supports the Multispecialty Peer Review Committee.			
	18.11.5.2	The Peer Review Specialist evaluates the IRIS report and makes a determination regarding the disposition of the report, which may include			
		18.11.5.2.1	Refer to Multispecialty Peer Review Committee		

		18.11.5.2.2	Include information in tracking and trending of rate or rule indicators
18.11.6	If the IRIS report is being referred to the Multispecialty Peer Review Committee, the practitioner and Section Chief will be notified. Notification of the practitioner will be consistent with the work flow for any other trigger for notification by the Multispecialty Peer Review Committee.		
18.11.7	The initial IRIS report and subsequent documentation will be placed in the practitioners quality file.		
	18.11.7.1	IRIS reports and supporting documentation are retained as active reports for the duration of the practitioner's reappointment cycle.	
	18.11.7.2	Past reports and documentation may be retained in the quality file but are generally not to be used for consideration in making recommendations during the current cycle.	
		18.11.7.2.1	In some instances, references to reports from previous reappointment cycles may be used for the current review if, in the opinion of the Section Chief or Credentials Committee Chair, they are considered relevant to the current deliberations.
		18.11.7.2.2	Access to Medical Staff quality files is described in Medical Staff Policy 18.10 – Confidentiality of Medical Staff and Advanced Practice Clinician Quality Files, Medical Section Quality Minutes, and Peer Review Information.

Approval Process:

Bylaws Committee	September 25, 2017
Medical Executive Committee Approval for distribution to the Medical Staff	October 19, 2017
Published to the Medical Staff	December 22, 2017
Medical Executive Committee Recommendation for Approval to Board of Directors	April 19, 2018
Board of Directors	May 15, 2018

Reviewed:

- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Medical Staff Quality Committee	
Number	18.12	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Medical Staff Quality Committee Bylaws Committee Medical Staff Executive Committee	Associate Chief Medical Officer Manager – Quality Improvement
Review Date	September 28, 2021	

18.12.1	The Medical Staff Quality Committee has the primary responsibility to evaluate clinical processes as they relate to the Medical Staff and where available, analyze collected metrics and data to identify and encourage excellence in clinical care.	
18.12.2	The Medical Staff Quality Committee will identify and use best practice protocols and appropriate national or regional benchmarking data as a standard of comparison to St. Michael data, and make recommendations to the Medical Staff to improve care and reward excellence.	
18.12.3	The Medical Staff Quality Committee reports to the Medical Executive Committee.	
18.12.4	Responsibilities of the Medical Staff Quality Committee shall include	
	18.12.4.1	Regularly provide feedback to practitioners, sections, and committees
	18.12.4.2	Recommend additional Review Indicators to the Professional Performance Committee by which episodes of care are subjected to peer review by the Multispecialty Peer Review Committee
	18.12.4.3	Assure the identified systems and process issues which result in less than optimum patient care are brought to the attention of the Medical Staff and Hospital Leadership with recommendations for needed improvement.
	18.12.4.4	Review quality metrics and reports and recommend systems changes required to improve quality and safety of care, treatment and services offered, and to the Sections, when appropriate
	18.12.4.5	Recommend hospital-sponsored continuing medical education activities which relate to the type and nature of care, treatment, and services offered by the hospital based on findings of quality improvement activities and best practice protocols
	18.12.4.6	Review systems based issues referred from the Multispecialty Peer Review Committee identified through the peer review process.

Approval Process:

Medical Staff Quality Committee	3/25/2019 (email)
Bylaws Committee	3/25/2019
Medical Executive Committee Approval for distribution to the Medical Staff	4/18/2019
Published to the Medical Staff	4/30/2019
Medical Executive Committee Recommendation for Approval to Quality and Value Committee	7/18/2019
Board of Directors	8/20/2019

Reviewed:

- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Quality Improvement Activities	
Number	18.13	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	September 28, 2021	

18.13.1	Each Section shall actively participate in quality improvement activities.
18.13.2	Medical Staff Quality Improvement activities will be conducted with the technical support of the Quality Department, Medical Staff Services, and Operational Improvement.
18.13.3	All members of the Medical Staff, whether employed by CHI/Franciscan/St. Michael or not, are part of the same Quality Improvement process, without variation in the standards and methods applied.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Quality and Value Committee	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Quality Improvement Actions	
Number	18.14	
Effective Date	September 27, 2012	
Accountability	Medical Staff	Administration
	Medical Staff Quality Committee Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	September 28, 2021	

18.14.1	Actions which are deemed necessary as the result of findings of quality improvement activities may include, but are not limited to, the following:	
	18.14.1.1	Individual counseling with the involved practitioner
	18.14.1.2	Education and training programs for individuals or for groups of practitioners
	18.14.1.3	Physical changes in hospital equipment or facilities
	18.14.1.4	Changes in customary hospital processes and systems
	18.14.1.5	Development of new or revised policies or procedures
	18.14.1.6	Recommendations for adjustments to clinical privileges
	18.14.1.7	Individualized action plans for performance improvement and FPPE
	18.14.1.8	Requests for investigation to the Professional Performance Committee
	18.14.1.9	Enforcement of consequences as outlined in the Medical Staff Bylaws, Policies, and Rules and Regulations.

Approval Process:

Bylaws Committee	June 18, 2012
Medical Executive Committee Approval for distribution to the Medical Staff	June 21, 2012
Published to the Medical Staff	June 27, 2012
Medical Executive Committee Recommendation for Approval to Quality and Value Committee	September 20, 2012
Board of Directors	September 27, 2012

Reviewed:

- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Quality Improvement Reporting	
Number	18.15	
Effective Date	December 20, 2021	
Accountability	Medical Staff	Administration
	Medical Staff Quality Committee Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	December 20, 2022	

18.15.1	The Quality Department, Peer Review Office and Medical Staff Services Office will help coordinate quality improvement activities of the Medical Staff.	
18.15.2	Documentation of these activities will be retained in the Quality Department.	
18.15.3	The St. Michael Quality Improvement and Safety Committee shall provide oversight of the Quality Improvement Program.	
18.15.4	The primary responsibility delegated to each Section shall be to utilize quality improvement information from Rate Indicators, Ongoing Professional Performance Evaluation, and the Medical Staff Quality Committee that may contribute to excellence in patient care as provided by members of the Section.	
18.15.5	The Chief of each Section is responsible for monitoring of clinical practice within the Section and should become familiar with the individual and aggregate data pertaining to the quality of care rendered in the Section.	
18.15.6	The Professional Performance Committee will act upon any requests for investigation pursuant to Medical Staff Policies, Chapter 8.	
18.15.7	The Professional Performance Committee will review, as questions arise, all information available regarding clinical competence and behavior of practitioners currently appointed to the Medical Staff and, as a result of such review, make reports of its findings and recommendations to the Medical Executive Committee.	
18.15.8	The Credentials Committee shall use findings of Peer Review when considering the granting or renewal of clinical privileges.	
18.15.9	Members of the Medical Executive Committee will provide oversight of the Medical Staff Quality Improvement Plan in their roles as officers of the Medical Staff and Chiefs of the Sections.	
18.15.10	The Medical Executive Committee will receive reports from the Professional Performance Committee with regard to timeliness of reviews and findings arising out of peer review.	
18.15.11	The Medical Executive Committee will receive reports from the Medical Staff Quality Committee and make recommendations for appropriate actions to the St. Michael Quality Improvement and Safety Committee or other appropriate committees.	
18.15.12	Ongoing Professional Performance Evaluation (OPPE) is an ongoing systematic process for the evaluation of practitioner performance and identifying opportunities for improvement.	
18.15.13	Each practitioner is measured by the six clinical competencies as defined by the American Council on Graduate Medical Education and Joint Commission.	
	18.15.3.1	Patient Care
	18.15.3.2	Medical/Clinical Knowledge
	18.15.3.3	Practice Based Learning and Improvement
	18.15.3.4	Interpersonal and Communication Skills

	18.15.3.5	Professionalism
	18.15.3.6	Systems-Based Practice
18.15.14	Medical Staff who are classified as Active, Affiliate, Provisional, or Military and Advanced Practice Clinicians will receive an OPPE report every 12 months compiled by the Quality Department.	
18.15.15	OPPE Reports are available to the practitioner in his/her Quality file in the Peer Review Department.	
18.15.16	Focused Professional Practice Evaluation (FPPE) is a process used to confirm clinical competence in all new practitioners, practitioners who have been granted new privileges, and practitioners with potential performance issues.	
	18.15.16.1	FPPE for new practitioners or existing practitioners requesting new privileges is managed under the Credentialing process, facilitated and organized by Medical Staff Services, see MSP 18.17
	18.15.16.2	FPPE for existing practitioners with potential clinical performance issues affecting the quality of patient care shall be initiated and overseen by the Professional Performance Committee
	18.15.16.3	FPPE for practitioners with identified behavior issues shall be initiated and overseen by the Professional Performance Committee in collaboration with the Associate Chief Medical Officer
	18.15.16.4	The Professional Performance Committee shall determine the time frame of the FPPE for individual practitioners.
	18.15.16.5	The data shall be reported to the Section Chief and the Professional Performance Committee.
	18.15.16.6	These reports will be available in the practitioner's Quality file.

Reference:

- The Joint Commission - Standard MS.08.01.01

The organized medical staff defines the circumstances requiring monitoring and revaluation of a practitioner's professional performance.

Approval Process:

Multispecialty Peer Review Committee	8/13/2020
Professional Performance Committee	10/13/2020
Bylaws Committee	10/26/2020
Medical Executive Committee Approval for distribution to the Medical Staff	1/21/2021
Published to the Medical Staff	7/21/2021
Medical Executive Committee Recommendation for Approval to Board of Directors	11/18/2021
Board of Directors	12/20/2021

Title	Medical Staff Quality Improvement Plan – Process to Appeal MPRC Scoring	
Number	18.16	
Effective Date	December 20, 2021	
Accountability	Medical Staff	Administration
	Medical Staff Quality Committee Professional Performance Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Manager – Peer Review
Review Date	December 20, 2022	

18.16.1	Appeals to the Professional Performance Committee (PPC) are limited to Multispecialty Peer Review Committee (MPRC) scores of "opportunity for improvement minor" and "opportunity for improvement significant".		
	18.16.1.1	Scores assigned by the following Sections who review cases from their Section which are not assigned to MPRC may not be appealed to the PPC.	
		18.16.1.1.1	Anesthesiology
		18.16.1.1.2	Emergency Medicine
		18.16.1.1.3	Radiology
18.16.2	Barring unusual circumstances, the PPC will only consider appeals at their regularly scheduled monthly meeting.		
18.16.3	The appeal must be requested in writing within 90 calendar days of receipt of the MPRC scoring decision.		
18.16.4	The appellant must submit a written appeal statement summary to the PPC at least three weeks prior to the regularly scheduled PPC meeting at which the scoring will be considered.		
	18.16.4.1	The appeal statement may include factual information germane to the clinical care of the episode being reviewed.	
	18.16.4.2	If clinical facts provided in the appeal statement were not included in the medical record, that is itself an opportunity for improvement in clinical documentation.	
	18.16.4.3	The appeal statement should focus on the reason(s) provided by the MPRC supporting the score assigned.	
	18.16.4.4	The appellant will be permitted to cite any system issues impacting the care provided.	
	18.16.4.5	The appeal statement summary will be submitted to the Medical Staff Services Office (MSSO).	
	18.16.4.6	If the appellant does not provide a written summary, the case will not be scheduled for appeal to the PPC.	
18.16.5	The Peer Review Department will prepare a packet of information from the MPRC, the appeal statement, and any other information submitted by the appellant for consideration of the case scoring for review by members of the PPC.		
18.16.6	The information gathered by the Peer Review Department will be available for review by members of the PPC in the MSSO at least two weeks prior to the regularly scheduled meeting at which the appeal will be presented. It is the expectation that PPC members will arrange for time to come to the MSSO to review the packet.		
	18.16.6.1	To preserve peer review protections, the packet may not be copied or sent outside the MSSO.	

18.16.7	The appellant's appearance at the PPC meeting will be at a specified and protected time. If the appellant does not appear in person, the appeal will not be considered.	
18.16.8	There will be a time limit for the presentation and discussion determined by the PPC Chair and based upon the complexity of the case and information to be presented.	
	18.16.8.1	The time limit of presentation will be communicated to the appellant prior to the PPC meeting in the written notice of the date, time, and place of the PPC meeting.
18.16.9	The appellant's appearance at the PPC meeting is to provide an opportunity for the PPC members to ask questions, since he/she should have presented supporting information with the appeal summary statement. No new information will be considered.	
18.16.10	At the discretion of the PPC Chair, the appeal may take place in Executive Session.	
18.16.11	The options available to the PPC are	
	18.16.11.1	Uphold the MPRC scoring
	18.16.11.2	Modify the MPRC scoring
18.16.12	The decision of the PPC is final.	

Approval Process:

Multispecialty Peer Review Committee	8/13/2020
Professional Performance Committee	10/13/2020
Bylaws Committee	10/26/2020
Medical Executive Committee Approval for distribution to the Medical Staff	1/21/2021
Published to the Medical Staff	7/21/2021
Petition Yes/No	N/A
Medical Executive Committee Recommendation for Approval to Board of Directors	11/18/2021
Board of Directors	12/20/2021

Title	Medical Staff Quality Improvement Plan - Focused Professional Performance Evaluation	
Number	18.17	
Effective Date	August 20, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer Manager - Medical Staff Services
Review Date	December 20, 2022	

18.17.1	Focused Professional Performance Evaluation (FPPE) is a process used to confirm clinical competence for:		
	18.17.1.1	New practitioners at initial appointment entering their provisional year - managed under the credentialing process.	
	18.17.1.2	Current active and affiliate practitioners who have been granted additional privileges - managed under the credentialing process.	
	18.17.1.3	Current active and affiliate practitioners with potential clinical performance issues affecting the quality of patient care - managed under the peer review process, see MSP 18.7.	
	18.17.1.4	Current active and affiliate practitioners with identified behavior issues - managed under the disruptive behavior process, see MSP 15.	
18.17.2	The FPPE Process for new practitioners and current practitioners with new privileges is a time-limited period but may be extended with subsequent reviews, if necessary at the recommendation of the designated reviewer and approval by the section chief.		
18.17.3	This process applies to all medical staff and advanced practice clinicians.		
18.17.4	Minimum FPPE criteria for new privileges are defined by the Medical Staff, but each Section may develop more extensive FPPE criteria with approval and oversight by the Professional Performance Committee, as defined in its charter.		
18.17.5	Definition of minimum FPPE criteria:		
	18.17.5.1	Retrospective review by the section chief or designee of 100% of the practitioner's charts not to exceed 5 charts in three months. In the event that the practitioner has not completed a sufficient number of procedures at St. Michael, documentation from ambulatory surgery facilities (surgery centers) or other hospitals may be obtained.	
	18.17.5.2	Supervision or proctoring of 2 cases in the first month by a physician with active medical staff privileges designated by the section chief.	
		18.17.5.2.1	Supervision: Observing and directing; being available to provide patient care if necessary.
		18.17.5.2.2	Proctoring: Observing and evaluating the quality of care; not providing direct patient care; not serving as a surgical first assistant. However, in the case of an emergency, any practitioner, including the proctor, shall be expected to do all in

			his/her power to save the life of the patient or to save the patient from serious harm.
	18.17.5.3	For providers requesting refer and follow privileges that see patients solely in the ambulatory setting but desire hospital affiliation, evaluations will be obtained from Emergency Medicine providers and hospitalist team providers that have interacted with the practitioner.	
	18.17.5.4	The review period may be extended with subsequent reviews, if necessary, at the recommendation of the designated reviewer and approval by the section chief. If concerns are found during the review process, the Chief of Staff, Associate Chief Medical Officer, and Credentials Committee Chair will be notified. Measures for resolving performance issues include but are not limited to a. Retrospective case review b. Proctoring c. Mentoring d. External/internal peer review Corrective actions are implemented per the Medical Staff Bylaws. Information is not discoverable other than required by law; these matters concern internal quality control for the purpose of reducing morbidity or mortality and for improving patient care.	
18.17.6	Completed chart review forms, supervision/proctoring forms and evaluation forms are to be submitted to Medical Staff Services for inclusion in the practitioner's credentialing record.		
18.17.7	The standard Medical Staff review form or a similar form meeting all essential elements of the standard form may be used.		

Reference:
The Joint Commission - Standard MS.08.01.01
The organized medical staff defines the circumstances requiring monitoring and re-evaluation of a practitioner's professional performance.

Approval Process:

Bylaws Committee	5/24/2021
Medical Executive Committee Approval for distribution to the Medical Staff	6/17/2021
Published to the Medical Staff	7/21/2021
Medical Executive Committee Recommendation for Approval to Board of Directors	11/18/2021
Board of Directors	12/20/2021

Reviewed:
- June 20, 2018 – Bylaws Committee, no changes needed
- August 13, 2020 – Multispecialty Peer Review Committee, no changes needed
- September 28, 2020 – Bylaws Committee, no changes needed

Title	Medical Staff Quality Improvement Plan – Ongoing Professional Performance Evaluation	
Number	18.18	
Effective Date	December 20, 2021	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Program Manager, Medical Staff Peer Review Associate Chief Medical Officer
Review Date	December 20, 2022	

18.18.1	The purpose of the Ongoing Professional Performance Evaluation (OPPE) is to provide a method for concurrent monitoring of a practitioner's performance/competency which allows for the identification of concerns or trends that are not consistent with the competency standards. OPPE data is used in the ongoing peer review process for reappointment and to recommend further evaluation such as a Focused Professional Practice Evaluation (FPPE) for cause.	
18.18.2	OPPE is a summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. This process provides feedback to the practitioner and the organization on an ongoing basis, thus allowing for timely action and interventions to support performance improvement as well as confirmation of achievement related to professional practice and practitioner competencies.	
	18.18.2.1	Data collected for OPPE is determined by each medical section with identified performance targets and thresholds and is approved by the organized medical staff. Each department evaluates, reviews, and recommends relevant OPPE metrics at least every three years.
	18.18.2.2	In addition, the medical staff has approved system-wide indicators that are an expectation across all disciplines.
18.18.3	Monitoring of a practitioner's clinical competence involves collection, verification, and assessment of collected data. Management of the data collection is the responsibility of the data analysts in the Clinical Effectiveness department and is pulled from a number of data collection points.	
	18.18.3.1	Metrics are updated every 12 months.
18.18.4	Data collection includes both qualitative and quantitative metrics. Categories of metrics for review are grouped in accordance with the Accreditation Council for Graduate Medical Education (ACGME) and American Board of Medical Specialties' (ABMS) areas of general competency: ● Patient Care ● Medical/Clinical Knowledge ● Practice-Based Learning and Improvement ● Interpersonal and Communication Skills ● Professionalism ● Systems-Based Practice	
18.18.5	The OPPE report is placed in the practitioner's quality file and is used in the decision to maintain, limit, suspend, or revoke existing privilege(s) prior to or at the time of reappointment.	
	18.18.5.1	The OPPE report is shared with the appropriate Section Chief for review on a 12-month cycle.

		18.18.5.1.1	The Section Chief's review may identify concerning clinical or behavioral trends. If indicated, the Section Chief may recommend an FPPE for Cause to address the identified concerns.
	18.18.5.2	The ongoing performance data is used during the cycle of review by the Credentials Committee at the time of reappointment.	
18.18.6	Each practitioner has access to their performance data in their quality file.		
	18.18.6.1	An appointment must be made with Peer Review staff to review the file.	
18.18.7	OPPE data is considered confidential and is protected from disclosure under Washington State law: RCW 70.41.200, RCW 4.24.250, RCW 42.17.310, and WAC 246-320-225.		

Approval Process:

Bylaws Committee	6/28/2021
Medical Executive Committee Approval for distribution to the Medical Staff	7/15/2021
Published to the Medical Staff	7/21/2021
Medical Executive Committee Recommendation for Approval to Board of Directors	11/18/2021
Board of Directors	12/20/2021

Title	Advanced Practice Clinicians – General Provisions	
Number	19.1	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Director – Medical Staff Services Chief Medical Officer
Review Date	October 26, 2021	

19.1.1	The Joint Commission has established standards requiring delineation of clinical privileges, focused professional performance evaluation, and ongoing professional practice evaluation for Advanced Practice Clinicians who are permitted by law and by St. Michael to independently provide patient care services in a St. Michael facility.	
19.1.2	The Joint Commission has established standards requiring delineation of clinical privileges, focused professional performance evaluation, and ongoing professional practice evaluation for Advanced Practice Clinicians who are not permitted by law to independently provide patient care services in a St. Michael facility. Such advanced practice clinicians may be utilized by members of the Medical Staff to provide patient care services in a St. Michael facility.	
19.1.3	The Joint Commission accreditation standards and Medical Staff Policies governing patient care in the hospital setting mandate that the overall care of the hospitalized patient be coordinated by the attending physician for the individual patient. Clinical activities of all Advanced Practice Clinicians, whether independent or dependent, shall be conducted in conjunction with a physician member of the Medical Staff with privileges to care for hospitalized patients.	
19.1.4	All matters relating to the participation of Advanced Practice Clinicians providing patient care in a St. Michael facility are contained in the Advanced Practice Clinician policy. These matters shall include, but are not limited to the following:	
	19.1.4.1	Qualifications
	19.1.4.2	Credentialing criteria
	19.1.4.3	Delineation of privileges
	19.1.4.4	Application for initial clinical privileges or modification of existing clinical privileges
	19.1.4.5	Reappointment
	19.1.4.6	Quality improvement and peer review
	19.1.4.7	Investigations
	19.1.4.8	Progressive disciplinary process
	19.1.4.9	Hearings and appeals
19.1.5	For purposes of this policy, dentists and podiatrists are members of the Medical Staff and covered by all Bylaws and Policy provisions for the Medical Staff.	

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians - Definitions	
Number	19.2	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

19.2.1	An independent Advanced Practice Clinician is an individual who is licensed by the State of Washington for independent practice in the following healthcare professions:	
	19.2.1.1	Advanced Registered Nurse Practitioner
	19.2.1.2	Certified Registered Nurse Anesthetist
	19.2.1.3	Certified Nurse Midwife
	19.2.1.4	Clinical Psychologist
19.2.2	A supervised Advanced Practice Clinician is an individual who is licensed by the State of Washington to participate in the care of patients only under the supervision of a physicians and includes the following health care professionals:	
	19.2.2.1	Physician Assistant - Certified
	19.2.2.2	Registered Nurse Surgical First Assistant
19.2.3	These lists may be amended by the Board upon recommendation of the Medical Staff. The Board may choose to allow the addition of Advance Practice Clinician professions when a need for their service is identified.	

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians – Discrimination Prohibited	
Number	19.3	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Director – Medical Staff Services Chief Medical Officer
Review Date	October 26, 2021	

19.3.1	Appointment to the Advanced Practice Clinician staff and/or granting of clinical privileges shall not be granted nor denied solely on the basis of sex, age, race, creed, color, sexual orientation, marital status, national origin or any other criterion unrelated to the delivery of safe and effective patient care at a St. Michael facility.
19.3.2	Advanced Practice Clinician appointment and/or clinical privileges shall not be granted or denied solely on economic criteria that do not relate to clinical qualifications, professional responsibility or the ability to provide safe effective patient care at a St. Michael facility.
19.3.3	Advanced Practice Clinician appointment, reappointment, and the granting of clinical privileges will be based upon statutory, regulatory, or judicial requirements, credentialing criteria approved by the Medical Staff and the Board, and demonstrated current clinical competence.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians – Requesting Clinical Privileges	
Number	19.4	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Director – Medical Staff Services Chief Medical Officer
Review Date	October 26, 2021	

19.4.1	Every Advanced Practice Clinician seeking or holding clinical privileges must, at the time of initial application and thereafter, demonstrate that he/she possesses the following minimal qualifications:		
	19.4.1.1	Current valid unrestricted professional license issued by the State of Washington appropriate for the privileges requested	
	19.4.1.2	Graduation from an appropriately accredited professional school	
	19.4.1.3	Certification or current eligibility for certification by the appropriate certifying agency as specified by the credentialing criteria and appropriate for the clinical privileges requested	
	19.4.1.4	Training and experience consistent with the clinical privileges requested	
	19.4.1.5	Professional liability insurance in an amount prescribed by the Board of Directors	
	19.4.1.6	Appropriate prescriptive authority for clinical privileges requested	
	19.4.1.7	Dependent Advanced Practice Clinicians must provide documentation as to which member(s) of the Active or Provisional Active Medical Staff who shall be designated as supervising physician(s) for the candidate.	
		19.4.1.7.1	The application will not be considered complete for any Physician Assistant – Certified applicants until receipt of the signed Washington Practice Plan documenting approval by the WA Department of Health.
		19.4.1.7.2	The Practice Plan shall describe the specific duties that the applicant will be providing for the supervising physician's patients
	19.4.1.8	Documented current practice, including clinical outcomes, and continuing education consistent with clinical privileges requested which attest to a continuing ability to provide patient care at an acceptable level of quality and efficiency consistent with current standards of practice.	
	19.4.1.9	Demonstration of appropriate interpersonal relationships, including the ability to comply with the Disruptive Behavior Policy, Medical Staff Policies, Chapter 15.	
	19.4.1.10	Suitable physical and mental health status to demonstrate to the satisfaction of the Medical Staff that the applicant is professionally competent and safe to exercise clinical privileges granted and their other duties and responsibilities.	
	19.4.1.11	Freedom from abuse of any type of substance or chemical which may affect cognitive, motor, or communication ability in a manner which interferes with or which presents a reasonable probability of interfering with a person's ability to safely practice.	

		19.4.1.11.1	In demonstrating satisfactory compliance with this requirement, an Advanced Practice Clinician, when suspicion or knowledge of a problem exists, may be required to provide such information or obtain such examinations as may be reasonably requested by the St. Michael President, Chief Medical Officer, Chief of Staff, Department Chief, or Section Chief. In addition, a practitioner may be required to submit to immediate chemical testing for substance abuse if justified by physical manifestations, suspicion based on recent performance, or as follow up to concurrent monitoring of participation in a treatment program.
19.4.2	The Advanced Practice Clinician must be professionally based within St. Michael's primary or secondary service area.		
19.4.3	Applications will not be provided to or accepted from Advanced Practice Clinicians who wish to provide services not currently required by St. Michael or to provide services currently available from St. Michael employees or contractors not currently under the jurisdiction of the Medical Staff.		
19.4.4	No Advanced Practice Clinician shall be entitled to be granted clinical privileges solely by virtue of the fact that he/she is licensed in this or any other jurisdiction, or that he/she had had in the past or presently has such clinical privileges at another institution.		
19.4.5	By applying for clinical privileges the Advanced Practice Clinician:		
	19.4.5.1	Signifies a willingness to appear for interviews if requested	
	19.4.5.2	Authorizes St. Michael representatives to consult with others who have been associated with the applicant or who may have information bearing on the applicant's competence and qualifications	
	19.4.5.3	Authorizes St. Michael representatives to query the National Practitioner Data Bank regarding the applicant's professional activities	
	19.4.5.4	Consents to the inspection by St. Michael representatives of all records and documents that may be material to an evaluation of the applicant's professional qualifications and ability to carry out the clinical privileges requested	
	19.4.5.5	Releases from any liability all St. Michael representatives, including members of the Medical Staff with responsibility for reviewing applications, for their acts performed in good faith in connection with evaluating the applicant's qualifications for privileges requested	
	19.4.5.6	Releases from liability all individuals and organizations who provided information, in good faith, including otherwise privileged and confidential information to St. Michael's representatives concerning the applicant's ability, professional ethics, character, physical, mental, and emotional stability to carry out the clinical privileges requested in a competent manor, and other qualifications necessary to provide safe, quality patient care and to work collaboratively with others.	
19.4.6	All Advanced Practice Clinicians wishing to apply for clinical privileges at St. Michael will complete the application prescribed by the Board of Directors and provide all information requested, including supporting documentation. Such applications are subject to primary source verification conducted under the auspices of the Medical Staff.		

19.4.7	An application is deemed incomplete in the absence of all required and subsequently requested information. All questions and concerns raised about the Advanced Practice Clinicians by those responsible for reviewing application must be resolved for the application to be considered complete.		
19.4.8	The applicant alone shall bear the burden of proof by providing clear and convincing evidence that he/she meets all the qualifications for clinical privileges requested.		
19.4.9	Any information adverse to the applicant coming from other sources may be relied upon if disclosed to the applicant with sufficient specificity so that the applicant may respond to it.		
19.4.10	Applications for Advanced Practice Clinicians shall be reviewed by the following persons and committees		
	19.4.10.1	Chief of the Section to which the Advanced Practice Clinician will be assigned	
	19.4.10.2	Credentials Committee	
	19.4.10.3	Professional Performance Committee	
	19.4.10.4	Medical Executive Committee	
	19.4.10.5	Board of Directors, which has the final approval authority	
		19.4.10.6	In the event of an adverse decision by the Board of Directors, applicant may appeal the decision through the mechanism outlined in Section 19.7 of this chapter.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians - Prerogatives	
Number	19.5	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

19.5.1	Advanced Practice Clinicians may attend Medical Staff Meetings and Section Meetings.
19.5.2	Advanced Practice Clinicians may serve as voting members of Medical Staff Committees as specified in committee charters upon appointment by the Chief of Staff.
19.5.3	Advanced Practice Clinicians may vote at Section Meetings as provided by the Section Rules and Regulations.
19.5.4	Advanced Practice Clinicians may not vote at Medical Staff Meetings.
19.5.5	When a committee adjourns to Executive Session, Advanced Practice Clinicians who are members of the committee may participate and vote.
19.5.6	When a Section adjourns to Executive Session, participation of the Advanced Practice Clinicians will be at the discretion of the Section Chief.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians – Conditions and Duration of Clinical Privileges	
Number	19.6	
Effective Date	October 4, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

19.6.1	Clinical privileges shall be granted to the Advanced Practice Clinician solely by the Board, based upon recommendations from the Medical Executive Committee.	
19.6.2	The initial granting of clinical privileges shall be for a period to be determined by the Board, but no longer than 12 months.	
19.6.3	Renewal of clinical privileges shall be as determined by the Board, but for no longer than two years.	
19.6.4	All patients hospitalized at St. Michael must have an identified physician (MD or DO) member of the Medical Staff who is responsible for the coordination of the patient's general medical or surgical condition throughout the hospital course. The name of the coordinating physician shall be clearly identified on the patient's medical record.	
19.6.5	A dependent Advanced Practice Clinician shall participate only in the care of patients of his/her supervising physician(s).	
19.6.6	By accepting clinical privileges, an Advanced Practice Clinician	
	19.6.6.1	Acknowledges his/her obligation to abide by the St. Michael Medical Staff Bylaws, Policies, Rules and Regulations, and Plans.
	19.6.6.2	Agrees to act in an ethical, professional, and courteous manner toward all patients and their families, St. Michael staff, and the Medical Staff.
	19.6.6.3	Agrees to provide appropriately continuous care for his/her patients, either personally or by designation of an equally qualified and credentialed Advanced Practice Clinician or a physician in his/her absence.
	19.6.6.4	Agrees to immediately report in writing to the Chief Medical Officer any professional disciplinary actions imposed by any professional disciplinary board, state or federal agency, or professional organizations, including other hospitals or hospital systems.
	19.6.6.5	Agrees to immediately report in writing to the Chief Medical Officer any final judgment or settlement in a professional liability action in which he/she is a defendant.
	19.6.6.6	Agrees to immediately report in writing to the Chief Medical Officer any voluntary or involuntary relinquishment of professional license, certification, medical staff memberships, or clinical privileges.
	19.6.6.7	Acknowledges that any misrepresentation, misstatements, or omission of information from the application for appointment and clinical privileges is cause for immediate revocation of clinical privileges, without appeal, if already conferred.

Approval Process:

Bylaws Committee	February 23, 2015

Medical Executive Committee Approval for distribution to the Medical Staff	March 19, 2015
Published to the Medical Staff	June 17, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	September 15, 2016
Board of Directors	October 4, 2016

Reviewed:

- July 25, 2018 & October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians – Renewal of Clinical Privileges	
Number	19.7	
Effective Date	October 4, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Chief Medical Officer
Review Date	October 26, 2021	

19.7.1	The timeline and processes for requesting renewal of clinical privileges will follow that of the Medical Staff outlined in Medical Staff Policies Chapter 5, unless otherwise stated.
19.7.2	The Medical Staff Services Office shall, at least 120 days prior to the expiration date of one's present clinical privileges, provide the Advanced Practice Clinician with a packet prescribed by the Board for use in requesting reappointment and renewal of clinical privileges.
19.7.3	Each Advanced Practice Clinician requesting reappointment and renewal of clinical privileges shall, at least 60 days prior to the expiration date, send the completed packet and all requested supporting documentation and the reappointment fee to the Medical Staff Services Office.
19.7.4	Failure to submit the forms in a timely manner shall result in expiration of clinical privileges at the end of the Advanced Practice Clinician's current term. Such expiration does not create any requirements for reporting or any appeal rights. It is considered a voluntary resignation from the Medical Staff.

Approval Process:

Bylaws Committee	February 23, 2015
Medical Executive Committee Approval for distribution to the Medical Staff	March 19, 2015
Published to the Medical Staff	June 17, 2016
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	September 15, 2016
Board of Directors	October 4, 2016

Reviewed:

- October 6, 2017 – Bylaws Committee
- October 26, 2020 – Bylaws Committee

Title	Advanced Practice Clinicians – Peer Review	
Number	19.8	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Multispecialty Peer Review Committee Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

19.8.1	Advanced Practice Clinicians who have been duly appointed may serve as members of the Multispecialty Peer Review Committee.
19.8.2	All cases involving Advanced Practice Clinicians which meet the criteria for peer review will follow the same Multispecialty Peer Review Committee process as defined in the Medical Staff Quality Improvement Plan (MSP 18).
19.8.3	Whenever feasible an Advanced Practice Clinician will evaluate care provided by another Advanced Practice Clinician.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 - Bylaws Committee

Title	Advanced Practice Clinicians – Fair Hearing	
Number	19.9	
Effective Date	September 23, 2015	
Accountability	Medical Staff	Administration
	Bylaws Committee Credentials Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

19.9.1	An Advanced Practice Clinician may be entitled to a Fair Hearing if the Board has taken one of the following actions:	
	19.9.1.1	Denial of reappointment and renewal of clinical privileges
	19.9.1.2	Denial of requested clinical privilege
	19.9.1.3	Involuntary reduction of clinical privileges
	19.9.1.4	Suspension of clinical privileges
	19.9.1.5	Termination of clinical privileges
19.9.2	Request for a fair hearing must be submitted in writing to the President within 30 calendar days of the Board decision precipitating the request. Failure to request a fair hearing within 30 calendar days is considered a waiver of the right to a fair hearing.	
19.9.3	Though either party may consult legal counsel in preparation for the fair hearing, there is no right to counsel by either party during the fair hearing proceedings.	
19.9.4	19.9.4.1	The President shall appoint the Hearing Panel.
	19.9.4.2	The Hearing Panel shall consist of 3 practitioners, at least one of whom with the same professional credential as the Advanced Practice Clinician requesting the fair hearing.
	19.9.4.3	Members of the Hearing Panel may or may not hold privileges at St. Michael.
	19.9.4.4	Members of the Hearing Panel will be chosen for their expertise in the matter being presented.
	19.9.4.5	Members of the Hearing Panel shall not have a business relationship with the practitioner who requested the fair hearing.
	19.9.4.6	One member of the Hearing Panel will be designated as Chair by the President.
	19.9.4.7	The President shall specify the date, time, and location of the hearing and inform all participants.
	19.9.4.8	The hearing shall be held not less than 30 calendar days from the receipt of the request, but not more than 60 calendar days after. In the event of extenuating circumstances, both parties may mutually agree to an extension not more than an additional 30 calendar days.
	19.9.4.9	The decision of the Hearing Panel shall be submitted to the Board within 30 calendar days of the conclusion of the fair hearing.
	19.9.4.10	A copy of the Hearing Panel's decision shall be provided by the CMO. to the affected practitioner within 30 calendar days of the conclusion of the fair hearing.
	19.9.4.11	The affected practitioner may attach his/her written statement to the Hearing Panel's decision prior to the deliberations of the Board.
	19.9.4.12	The Board will review the report of the Hearing Panel and any statement provided by the affected practitioner at its next regularly scheduled meeting, as long as it is more than two (2) weeks. If not, then it will be reviewed at the following regularly scheduled Board of Directors meeting.

	19.9.4.13	The decision of the Board is final.
19.9.5	The following actions do not entitle an Advanced Practice Clinician to a fair hearing	
	19.9.5.1	Matters related to employment either by St. Michael or another entity
	19.9.5.2	Matters related to scope of practice as defined by the Washington State Department of Health and, in the case of Physician Assistants – Certified, the plan of supervision.
19.9.6	Confidentiality of the Proceedings	
	19.9.6.1	Except as otherwise authorized in the Medical Staff Bylaws and Policies, all parties, participants, and attendees shall keep the hearing proceedings and contents thereof confidential, and no one shall disclose or release any information from or about the proceedings to any person or the public.
	19.9.6.2	If it is determined that a breach of confidentiality has occurred, the MEC shall undertake such corrective action as it deems appropriate and the Board may impose sanctions on the violating individual.
	19.9.6.3	Nothing in this section, however, shall be construed as limiting the parties' ability to adequately investigate and prepare their recommendations, their case, or otherwise protect or exercise their rights to a fair hearing according to the Bylaws.
19.9.7	This policy only applies to Advanced Practice Clinicians, independent or supervised, as defined in Medical Staff Policy 19.3	

Approval Process:

Bylaws Committee	October 24, 2016
Medical Executive Committee Approval for distribution to the Medical Staff	November 17, 2016
Published to the Medical Staff	December 2, 2016
Medical Executive Committee Recommendation for Approval to Board of Directors	May 18, 2017
Board of Directors	June 20, 2017

Reviewed:

- July 25, 2018 – Bylaws Committee
- October 26, 2020 – Bylaws Committee

Title	Allied Health Professionals – General Provisions	
Number	20.1	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

20.1.1	Allied Health Professionals (AHPs) are practitioners who are not permitted by law to provide patient care services independently.
20.1.2	AHPs work in the hospital at the request of a physician, dentist, or podiatrist who need their services for the provision of patient care.
20.1.3	For purposes of this policy, Physician Assistant – Certified Is not included, though they are considered dependent practitioners by law. However, the scope of their practice is such that it is more appropriate to include them in the policy for Advanced Practice Clinicians.
20.1.4	Credentialing criteria and delineation of privileges for individual specialties within this classification are defined by the Medical Staff.
20.1.5	Allied Health Professionals are not members of the Medical Staff and are not entitled to Fair Hearing provisions.
20.1.6	Any policies, plans, or objectives formulated by the Board concerning the Hospital's current and projected patient care, teaching, and research needs, and the availability of required physical, personnel, and financial resources may also be considered by the applicable Medical Staff and Hospital authorities in determining qualifications for, making recommendations on or taking action on new applications for clinical privileges for Allied Health Professionals.
20.1.7	Processes for processing applications for appointment and requests for clinical privileges shall be derived from credentialing criteria established by the Medical Staff for each specialty..
20.1.8	Terms of appointment and reappointment will be for one year.
20.1.9	The evaluation process for reappointment will be defined in the credentialing criteria for each individual specialty.
20.1.10	Each AHP who desires reappointment must shall submit a request for reappointment and supporting documentation at least 60 calendar days prior to the expiration of current privileges.
20.1.11	Failure to submit the reappointment packet in a timely manner to allow for processing prior to expiration will result in loss of privileges and will necessitate re-applying for privileges.
20.1.12	Any condition described in MSP-10 – Automatic Suspension will apply to AHPs.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed: October 26, 2020 – Bylaws Committee

Title	Allied Health Professionals – List of Practitioners Covered by this Policy	
Number	20.2	
Effective Date	June 18, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

20.2.1	The practitioners covered by this policy are	
	20.2.1.1	Audiologist
	20.2.1.2	Dental Assistant
	20.2.1.3	Orthotist
	20.2.1.4	Prosthetist
	20.2.1.5	Registered Nurse
	20.2.1.6	Medical Scribes
20.2.2	Any professions to be added to this list shall be approved by the Medical Executive Committee pursuant to revision of this policy.	

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	1/17/2019
Published to the Medical Staff	1/21/2019
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	5/16/2019
Board of Directors	6/18/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

Title	Department and Section Rules and Regulations	
Number	21	
Effective Date	May 21, 2019	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

21.1	In accordance with Medical Staff Bylaws, Article XIV, each Department and Section will adopt rules and regulations which set forth the manner in which the business of the Department or Section will be conducted.		
21.2	Section Rules will include the following provisions		
	21.2.1	Specialties included in the Section	
	21.2.2	Scope of services	
	21.2.3	Qualifications for membership, including Board Certifications requirements, which must comply with Bylaws, Article III, Section 3.	
	21.2.4	Frequency of meetings and attendance requirements, if any	
	21.2.5	Call coverage obligations	
	21.2.6	Voting at Section meetings	
	21.2.7	Participation of Advanced Practice Clinicians	
	21.2.8	Other relevant elements determined by the Section to be pertinent to the work of the Section.	
21.3	Department Rules and Regulations will be developed to address those shared accountabilities and responsibilities applicable to the operation of the Department.		
	21.3.1	The drafting of Department Rules and Regulations will be coordinated by the Department Chief with administrative support from the Associate Chief Medical Officer and Medical Staff Services Office.	
	21.3.2	Any Section may submit a request for a provision to be included in the Department Rules and Regulations.	
	21.3.3	The Department Chief will submit proposed rules and regulations to all Section Chiefs within the Section for their review and comment. When this group achieves consensus the proposal will be presented to the Department.	
		21.3.3.1	Proposals may be submitted and voted upon in the individual Section or a meeting of the full Department.
		21.3.3.2	If the vote is taken in the individual Sections, the votes will be counted in the aggregate to determine ratification.
21.4	The Bylaws Committee will conduct a technical review of any Department or Section Rules and Regulations to ensure there is no conflict with Medical Staff Bylaws and/or Policies as these governance documents supersede Department and Section Rules and Regulations.		

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Reviewed: October 26, 2020 – Bylaws Committee

Title	Students and Observerships - Pre-Medical Students Observation	
Number	22.1	
Effective Date	January 27, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

22.1.1	The Medical Staff supports undergraduate students in pre-medical education programs. It is recognized that the pre-requisites for Medical School admission may include a number of hours observing a physician. In order to accommodate such requests in a consistent and fair manner, the Medical Staff has developed the following process.	
22.1.2	The pre-medical student may only observe patient care. No hands-on care is allowed.	
22.1.3	To be eligible to observe the student must	
	22.1.3.1	Be age 18 or older
	22.1.3.2	Be currently enrolled in a pre-medical education baccalaureate degree program
22.1.4	The request for privileges for a pre-medical student to observe in a St. Michael facility must come from a member of the Medical Staff. Such request should be submitted in writing to Medical Staff Services and include the following:	
	22.1.4.1	Name of student
	22.1.4.2	School in which the student is currently enrolled in a pre-medical education baccalaureate degree program or from which the student has graduated
	22.1.4.3	Dates of observation period
	22.1.4.4	Name(s) of other physician(s) who might be involved in the observation experience
	22.1.4.5	Proposed clinical observation experience(s)
22.1.5	The request for privileges for a pre-medical student to observe must commence a minimum of 30 days prior to the proposed date of the observation period.	
22.1.6	The request for a pre-medical student to observe will not be forwarded for review and approval until all requested documentation is provided.	
22.1.7	The student shall provide the following:	
	22.1.7.1	Current CV
	22.1.7.2	Letter from the school which confirms that the student is enrolled in a pre-medical education major and is in good standing with the school
	22.1.7.3	Government-issued photo identification
	22.1.7.4	Immunization record
	22.1.7.5	Washington State Patrol background check and disclosure statement
	22.1.7.6	Declaration from the student as to what medical school(s) he/she plans to apply and how many observation hours are required for admittance.
22.1.8	The student will agree to abide by all Medical Staff and Hospital policies as explained by the supervising physician and hospital staff. Failure to do so will result in immediate termination of the observation opportunity.	
22.1.9	The supervising physician is responsible for the behavior of the student at all times in any St. Michael facility, even when he/she is not in the presence of the physician.	
22.1.10	Though a supervising physician may have multiple pre-medical students at a given time, there can only be one student at a time participating in a particular clinical experience.	
22.1.11	All requests for a pre-medical student observation will be approved by the CMO upon completion of the application process.	

22.1.12	Generally, the duration of the observation period will be consistent with pre-requisite requirements. However, the supervising physician and CMO may mutually agree to extend the observation period.
22.1.13	For a student to observe care in a clinical area, it is required that the department director or clinic manager give express written approval in advance. Such approval shall not be considered carte blanche for all patient care services provided, recognizing that in some circumstances it would be in the patient's interest for the student not to observe.
22.1.14	The student will participate in a general orientation applicable to the anticipated clinical experience(s). Departments and clinics may have specific additional orientation required prior to observing in a particular department or clinic.
22.1.15	Though the general hospital admission consent includes participation of students, it is expected, as a matter of courtesy and respect for the patients and their families, that the physician discloses that a student will be observing the care being provided. If there is an objection, it is expected that the student will immediately excuse himself/herself from the setting.
22.1.16	The student shall not document in the patient medical record. The student may be listed by others in the medical record when participating in treatment (i.e. present in the OR as an observer during a procedure).
22.1.17	At the end of the observation period, the student and the supervising physician will be asked to complete an evaluation.

Approval Process:

Bylaws Committee	August 24, 2015
Medical Executive Committee Approval for distribution to the Medical Staff	September 17, 2015
Medical Executive Committee Recommendation for Approval to Board of Directors	January 21, 2016
Board of Directors	January 27, 2016

Reviewed:

- July 25, 2018 – Bylaws Committee
- October 26, 2020 – Bylaws Committee

Title	Students and Observerships - Physician Observerships – Foreign Medical Graduates	
Number	22.2	
Effective Date	January 27, 2016	
Accountability	Medical Staff	Administration
	Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Chief Medical Officer
Review Date	October 26, 2021	

22.2.1	The Medical Staff supports foreign medical graduates who are seeking admission to US medical residency programs. It is recognized that a number of hours observing a physician is a requirement for admission to many programs. In order to accommodate such requests in a consistent and fair manner, the Medical Staff has developed the following process.	
22.2.2	The observer may only observe patient care. No hands-on care is allowed.	
22.2.3	To be eligible to observe the person must be currently licensed to practice medicine in another country.	
22.2.4	The request for privileges to observe in a St. Michael facility must come from a member of the Medical Staff. Such request should be submitted in writing to Medical Staff Services and include the following:	
	22.2.4.1	Name of observer
	22.2.4.2	Dates of observation period
	22.2.4.3	Name(s) of other St. Michael physician(s) who might be involved in the observership experience
	22.2.4.4	Proposed clinical observation experience(s)
22.2.5	The request for privileges for an observership must commence a minimum of 30 days prior to the proposed date of the observation period.	
22.2.6	The request for an observership will not be forwarded for review and approval until all requested documentation is provided.	
22.2.7	The observer shall provide the following:	
	22.2.7.1	Current CV
	22.2.7.2	Government-issued photo identification
	22.2.7.3	Documentation of medical license in another country
	22.1.7.4	Immunization record
	22.1.7.5	Washington State Patrol background check and disclosure statement
22.2.8	The observer will agree to abide by all Medical Staff and Hospital policies as explained by the supervising physician and hospital staff. Failure to do so will result in immediate termination of the observation opportunity.	
22.2.9	The supervising physician is responsible for the behavior of the observer at all times in any St. Michael facility, even when he/she is not in the presence of the physician.	
22.2.10	All requests for an observership will be approved by the ACMO upon completion of the application process.	
22.2.11	For a person to observe care in a clinical area, it is required that the department director or clinic manager give express written approval in advance. Such approval shall not be considered carte blanche for all patient care services provided, recognizing that in some circumstances it would be in the patient's interest for a limited number of people to participate in care.	

22.2.12	The observer will participate in a general orientation applicable to the anticipated clinical experience(s). Departments and clinics may have specific additional orientation required prior to observing in a particular department or clinic.
22.2.13	Though the general hospital admission consent includes participation of persons in training, it is expected, as a matter of courtesy and respect for the patients and their families, that the physician disclose that the person will be observing the care being provided. If there is an objection, it is expected that the observer will immediately excuse himself/herself from the setting.
22.2.14	The observer shall not document in the patient medical record. He/she may be listed by others in the medical record when participating in treatment (i.e. present in the OR as an observer during a procedure).
22.2.15	At the end of the observation period, the observer and the supervising physician will be asked to complete an evaluation.

Approval Process:

Bylaws Committee	August 24, 2015
Medical Executive Committee Approval for distribution to the Medical Staff	September 17, 2015
Medical Executive Committee Recommendation for Approval to Board of Directors	January 21, 2016
Board of Directors	January 27, 2016

Reviewed:

- June 16, 2017 – Bylaws Committee
- July 25, 2018 – Bylaws Committee
- October 26, 2020 – Bylaws Committee

Title	Emergency Department Call	
Number	23	
Effective Date	May 21, 2019	
Accountability	Medical Staff	Administration
	All Departments and Sections Bylaws Committee Medical Executive Committee	Associate Chief Medical Officer
Review Date	October 26, 2021	

23.1	Each Section and each specialty within the Section, if applicable, shall provide the Emergency Department with a list of physicians assigned to daily call, submitted monthly.
23.2	The call schedule will be submitted to the Emergency Department at least three working days prior to the end of each month.
23.3	St. Michael shall designate a person or persons responsible for the administrative coordination of the Emergency Department call schedules and to whom the schedules and updates need to be submitted.
23.4	The Emergency Department call schedule for Pediatrics is the same call schedule for the Nursery.
23.5	Specialty consultation shall be available within 30 minutes by telephone or in person by the member of the Medical Staff on call.
23.6	If a physician is unable to take the call assigned after the schedule has been posted, regardless of the reason, he/she is responsible for obtaining an alternate and informing the Emergency Department.
23.7	The on-call physicians are to provide coverage for those patients who have no current primary care physician or specialist, either for hospital admission or outpatient follow up care.
23.8	Each physician group, employed, private, or contracted, must also provide the Emergency Department with a call schedule for the physicians within the group to assure continuity of care for patients established with the group.
23.9	Private physicians are expected to provide back-up coverage for their patients either in person or by an alternate arrangement to assure continuity of care.
23.10	When a patient presents in the Emergency Department for care, the Emergency Department physician shall make the determination whether the patient needs the care of a specialty practitioner. That decision is final and binding upon all other practitioners.
23.11	In the event that a practitioner fails to meet his/her responsibilities regarding availability for consultation in the care of a patient in the Emergency Department, either by phone or in person, an IRIS report will be completed and forwarded to the Associate Chief Medical Officer.

Approval Process:

Bylaws Committee	10/22/2018
Medical Executive Committee Approval for distribution to the Medical Staff	11/15/2018
Published to the Medical Staff	11/28/2018
Petition Yes/No	No
Medical Executive Committee Recommendation for Approval to Board of Directors	4/18/2019
Board of Directors	5/21/2019

Reviewed:

- October 26, 2020 – Bylaws Committee

END OF POLICIES

APPENDIX A

COMMITTEE CHARTERS

MEDICAL STAFF
Charter
Bylaws Committee

Name	Bylaws Committee	
Purpose	To maintain the governance documents of the Organized Medical Staff at Harrison Medical Center.	
Responsibilities	• To ensure that Medical Staff Bylaws and Policies and Section Rules and Regulations are consistent with each other. • To ensure that Medical Staff Bylaws, Policies and Section Rules and Regulations are consistent with regulatory and accreditation standards • To review the Medical Staff Bylaws and Policies at least annually and make recommendations to the Medical Executive Committee for needed revisions. • To review and make recommendations to the Medical Executive Committee of any proposed changes in governance documents which may be requested by the Medical Staff in accordance with the Bylaws. • To facilitate any necessary changes in the Bylaws as requested by the Medical Executive Committee	
Reporting	The Bylaws Committee shall develop minutes of all meetings reflective of its deliberations and recommendations, which shall be transmitted to the Medical Executive Committee for further consideration and action.	
Chairperson	Member of the Active Medical Staff appointed by the Chief of Staff.	
Membership	• Five members of the Active Medical Staff appointed by the Chief of Staff, ensuring representation of different departments. • One Advanced Practice Clinician appointed by the Chief of Staff • Associate Chief Medical Officer • President/CEO or designee (ex-officio) • Hospital Legal Counsel (ex-officio) • Director Medical Staff Services • Support staff from the Medical Staff Services Office	
Voting	All members of the committee except ex-officio members and support staff are eligible to vote.	
Quorum	The Bylaws Committee is a Medical Staff committee. A quorum is defined as the number of Active Medical Staff members present.	
Support	Administrative support will be provided by the Medical Staff Services Office.	
Meetings	The committee shall meet as often as necessary to perform the duties described above in a timely fashion to ensure ongoing compliance with the needs of the Medical Staff as well as regulatory or accreditation standards.	
Review	The Bylaws Committee charter will be reviewed annually.	
References	Medical Staff Bylaws Medical Staff Policies Department and Section Rules and Regulations Joint Commission Standards Washington State Department of Health Washington State Medical Quality Assurance Commission Center for Medicare and Medicaid Services Conditions of Participation	
Approvals	**Date**	**Signature**
Bylaws Committee	1/22/2018	/s/ Gary Gretch MD - Chair
Medical Executive Committee	2/15/2018	/s/ Jennifer Quimby MD – Chief of Staff

MEDICAL STAFF

Charter

Cancer Committee

Name	Cancer Committee
Purpose	To ensure patients have access to the full scope of services required to diagnose, treat, rehabilitate, and support patients with cancer and their families.
Responsibilities	1. Reviews and coordinates all aspects of care for cancer patients, including diagnosis, treatment, follow-up, and end results reporting. 2. Meets the Commission on Cancer (CoC) standards for cancer programs. 3. Ensures each required member or the member's designated alternate attends at least 75% of the cancer committee meetings held during each year. 4. Designates one coordinator from the committee for the following areas of cancer committee activity: Cancer Conference Coordinator, Quality Improvement Coordinator, Cancer Registry Quality Coordinator, Clinical Research Coordinator, Psychosocial Services Coordinator, and Survivorship Program Coordinator. 5. Ensures the cancer program has a policy and procedure for multidisciplinary cancer case conference(s) that includes all required information. The Cancer Conference Coordinator monitors and evaluates the multidisciplinary cancer case conference(s) and presents a report to the cancer committee that includes all required elements and any action plans to resolves issues not meeting the program's policy, each calendar year. 6. Ensure all physicians involved in the evaluation and management of cancer patients must be American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certified (or the equivalent), or demonstrate ongoing cancer-related education by earning 12 cancer-related Continuing Medical Education (CME) hours each calendar year. 7. Ensures one cancer program goal appropriate and relevant to the cancer program and its patient population is established each calendar year. At least two substantive status updates on goal progress in the minutes in the same calendar year as its establishment. For any goal extended into second year, at least one status update is documented in the minutes during the second year to indicate whether the goal was completed or retired. 8. Implements a quality control policy and procedure to evaluate the required areas of the cancer registry. The Cancer Registry Quality Control Coordinator, under the direction of the cancer committee, performs or oversees the required quality control review as outlined in the policy and procedure. The results, recommendations, and outcomes of the recommendations are reported to the cancer committee. 9. Ensures the Cancer Liaison Physician (CLP) or the CLP's alternate identifies, analyzes, and presents NCDB data specific to the cancer program, with preference for areas of concern and/or where benchmarks are not met, the cancer committee at a minimum of two meetings each calendar year. The CLP is present during the CoC site visit and meets with the site reviewer to discuss CLP activities and responsibilities. 10. Ensures the cancer program has a screening policy and procedure to identify participant eligibility for clinical research studies and how to provide clinical trial information to subjects. These processes are assessed to identify and address barriers to enrollment and participation. The number of accruals to cancer-related clinical research studies meets or exceeds the required percentage. The Clinical Research Coordinator monitors and reports clinical trial accrual to make sure the required percentage of patients are accrued to cancer-related clinical trials each year. 11. Ensures a physician conducts an in-depth analysis to determine whether initial diagnostic evaluation and first course of treatment provided to patients is concordant with evidence-based national guidelines. The report detailing all required elements of the study, including the results of the analysis and any recommendations for improvement, are reported to the cancer committee. 12. Ensures 90% of the eligible cancer pathology reports are structured using synoptic

reporting format as defined by the College of American Pathologists (CAP) cancer protocols, includes containing all core data elements within the synoptic format.

13. Ensures under the guidance of the Cancer Liaison Physician (CLP), the Quality Improvement Coordinator, and the cancer committee, one quality initiative based on an identified quality-related problem is initiated each year. The quality improvement initiative documentation includes how it is measured, evaluated, and improved performance through implementation of a recognized, standardized performance improvement tool. Status updates are provided to the cancer committee two times. A final presentation of a summary of the quality improvement initiative is presented after the quality improvement initiative is complete.
14. Ensures participation in special studies as requested by the Commission on Cancer (CoC) and complete data and documentation are submitted bythe established deadline for each special study.
15. Ensures all nurses providing direct oncology care hold a cancer-specificcertification or demonstrate ongoing education by earning 36 cancer- related continuing nursing education contact hours each accreditation cycle. There is a policy and procedure that ensures oncology nursing competency is reviewed each year per hospital policy.
16. Ensures adherence to guidelines for patient management and treatmentcurrently required by the CoC are followed.
17. Offers at least one cancer prevention event focused on decreasing the number of diagnoses of cancer. Where applicable the cancer prevention even is consistent with evidence-based national guidelines and interventions. A summary of the cancer preventionevent is presented to the cancer committee.
18. Ensures radiation treatment services and rehabilitation services are available on site or by referral. A designated inpatient medical oncology unit or a functional equivalent is available on site or by referral to providespecialized care to patients.
19. Ensures cancer risk assessment, genetic counseling, and genetic testing services are provided to patients either on-site or by referral, by a qualifiedgenetics professional. A policy and procedure is in place regarding geneticcounseling and risk-assessment services and includes all required elements. A process is in place pursuant to evidence-based national guidelines for genetic assessment for a selected cancer site and the process includes all required elements. The process for providing and referring cancer risk assessment, genetic counseling, and genetic testing services is monitored and evaluated, and contains all required elements.
20. Ensures palliative care services are available to cancer patients either on- site or by referral and a policy and procedure is in place regarding palliative care services that includes all required elements. The process for providingand referring palliative care services to cancer patients is monitored and evaluated and reported to the cancer committee.
21. Develops policies and procedures to guide referral to appropriate rehabilitation care services on-site or by referral. The process for referring or providing rehabilitation care services to cancer patients is monitored andreviewed.
22. Ensures oncology nutrition services are provided, on-site or by referral, bya Registered Dietitian Nutritionist. The process for referring or providing oncology nutrition services to cancer patients is monitored and reviewed.
23. Identifies a survivorship program team, including its designated coordinatorand members and ensures the survivorship program is monitored and evaluated. The report is given to the cancer committee and contains all required elements.
24. Identifies at least one patient, system, or provider-based barrier to focus onfor the year accessing health and/or psychosocial care that its patients withcancer are facing. Develops and implements a plan to address the barrier. Identifies resources and

processes to address the barrier. Evaluates the resources and processes adopted to address the barrier to care and identifies strengths and areas for improvement.

25. Ensures policies and procedures are in place to provide patient access to psychosocial services either on-site or by referral. Implements a policy andprocedure that includes all requirements for providing and monitoring psychosocial distress screening and referral for psychosocial care. Cancer patients are screened for psychosocial distress at least once during the firstcourse of treatment. The psychosocial distress screening process is evaluated, documented, and the findings are reported to the cancer committee by the Psychosocial Services Coordinator.
26. Offers at least one cancer screening event focused on decreasing the number of individuals with late-stage cancer. Where applicable, the cancer screening event is consistent with evidence-based national guidelines and evidence- based interventions. A process is developed to followup on all positive findings. A summary of the cancer screening event is presented to the cancer committee.
27. Ensures complete data for all requested analytic cases are submitted to theNational Cancer Database (NCDB) in accordance with the annual Call for Data specifications. Ensures cases meet the quality criteria ad defined in the annual Call for Data specifications on the initial submission. If cases donot meet the quality criteria on initial submission then identified errors in submitted cases and rejected records are corrected and resubmitted by thedue date specified.
28. Ensures the Cancer Liaison Physician or the CLP's alternate identifies, analyzes, and presents National Cancer Data Base (NCDB) dataspecific to the cancer program, which preference for areas of concern and/or where benchmarks are not met, to the cancer committee at the minimum of two meetings each calendar year.
29. Monitors the cancer program's Expected PerformanceRates (EPR) for accountability and quality improvement measures selectedby the Commission on Cancer. For each accountability and quality improvement measure selected by the CoC, the quality reporting tools showa performance rate equal to or greater than theexpected EPR specified by the CoC. If the expected EPR is not met, the program has implemented an action plan that reviews and addresses program performance belowthe expected EPR.
30. Ensures case abstracting is performed by a Certified Tumor Registrar. Non-credentialed cancer registry staff in three-year graceperiod who abstract cases are supervised by a Certified Tumor Registrar. All non-credentialed cancer registry staff demonstrate completion of three hours of cancer-related continuing education applicable to their roles.
31. Ensures an 80% follow-up rate is maintained for all eligible analytic cases from the cancer registry reference date. A 90% follow-up rate is maintained for all eligible analytic cases diagnosed within the last 5 years or from the cancer registry reference date, whicheveris shorter.
32. Ensures all newand updated cancer cases are submitted at least once each calendar month. All complete analytic cases for all disease sites are submitted via Rapid Cancer Reporting System (RCRS) as specified by theannual Call for Data. Rapid Cancer Reporting System data and required quality measure performance rates are reviewed by the cancer committeeat least twice each year.
33. Ensures the cancer program provides diagnostic imaging services, radiation oncology services, and systemic therapy services on-site or byreferral.
34. Ensures quality assurance practices are in place for required servicesavailable on-site.
35. Ensures all sentinel nodes for breast cancer are identified using tracers orpalpation, removed, and subjected to pathologic analysis. The operative reports for sentinel node biopsies for breast cancer document the requiredelements in synoptic format.

	(Phased in standard). 36. Ensures axillary lymph node dissections for breast cancer include removalof level I and II lymph nodes within an anatomic triangle comprised of the axillary vein, chest wall (serratus anterior), and latissimus dorsi, with preservation of the main nerves in the axilla. The operative reports for axillary lymph node dissections for breast cancer document the required elements in synoptic format. *(Phased in standard).* 37. Ensures wide local excisions for melanoma include the skin and all underlying subcutaneous tissue down to the fascia (for invasive melanoma)or the skin and the superficial subcutaneous fat (for in situ disease). The Operative reports for wide local excisions of primary cutaneous melanomasdocument the required elements in synoptic format. *(Phased in standard).* 38. Ensures resection of the tumor-bearing segment and complete lymphadenectomy is performed en bloc with proximal vascular ligation at the origin of the primary feeding vessel(s). Operative reports for resectionsfor colon cancer document the required elements in synoptic format. 39. Ensures pulmonary resections for primary lung malignancy include lymph nodes from at least one (named and/or numbered) hilar station and at least three distinct (named and/or numbered) mediastinal stations. The pathology reports for curative pulmonary resection document the nodalstations examined by the pathologist documented in synoptic format.
Reporting	The Cancer Committee shall develop minutes of all meetings reflective of its deliberations and recommendations which shall be transmitted to the Medical Executive Committee for further consideration and action.
Sub-Committee	1. The Breast Program Leadership Committee. 2. CME Planning Committee.
Chairperson	The Cancer Committee Chair is a physician of any specialty, selected according to facility rules and/or bylaws; can also represent one of the required physician specialties.
Membership	Required Physician Members: 1. Cancer Committee Chair 2. Cancer Liaison Physician 3. Physicians representing: a. Surgeon b. Medical Oncologist c. Radiation Oncologist d. Pathologist e. Radiologist 4. Required non-physician members: a. Cancer Program Administrator b. Oncology Nurse c. Social Worker d. Certified Tumor Registrar (CTR) 5. Required coordinator members: a. Cancer Conference Coordinator b. Quality Improvement Coordinator c. Cancer Registry Coordinator d. Clinical Research Coordinator e. Psychosocial Services Coordinator f. Survivorship Program Coordinator 6. Cancer Committee members strongly recommended, but not required, include: a. Specialty physicians representing the five major cancer sites at theprogram b. Palliative care professional c. Genetics professional

	d. Registered Dietitian Nutritionist e. Rehabilitation services professional f. Pharmacist g. Pastoral care representative h. American Cancer Society representative The membership of the cancer committee is multidisciplinary, representing physicians and advanced practice clinicians from the diagnostic and treatment specialties and non-physicians from administrative and support services. The Cancer Liaison Physician is a physician of any specialty who is an active member of the medical staff. The CLP is considered the physician quality leader of the Cancer Committee and serves as an alternate to the Cancer Committee Chair and oversees Cancer Committee meetings if the chair is not in attendance. The Cancer Liaison Physician can also represent one of the required physician specialties and/or the Quality Improvement Coordinator. Coordinators who are responsible for specific areas of program activity are designated from the membership. For each required member/role, one designated alternate member can be identified. The designated alternate must be qualified for the role. An individual can only serve as an alternate for one individual. All physicians involved in the evaluation and management of cancer patients and serving in a required physician position on the cancer committee must be American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA) board certified, or the equivalent, or demonstrate ongoing cancer-related education by earning 12 cancer-related Continuing Medical Education (CME) each calendar year. Appointments for required members and designated alternates must occur at the first meeting of a calendar year at least once during the accreditation cycle. The appointments are documented in the minutes. If a required member or alternate member cannot continue to serve on the cancer committee, a new member must be appointed at the next cancer committee meeting and documented in the minutes.
Voting	On matters related to patient issues, only the Medical Staff members of the committee may vote. On all other cancer program issues, the representatives of the various hospital departments listed above may vote, in addition to the members of the Medical Staff.
Quorum	In that the Cancer Committee is a Medical Staff committee, the quorum is defined as the number of Active Medical Staff members present at the meeting.
Support	Administrative support (agendas, minutes, correspondence, etc.) will be provided by the Tumor Registrar.
Meetings	Each calendar year, the Cancer Committee shall meet at least once each calendar quarter and more often as necessary. Quarters are defined by CoC as January 1 – March 31, April 1 – June 30, July 1 – September 30, and October 1 – December 31. Attendance at the cancer committee meetings may include participation through teleconference or videoconference calls as long as the remote attendee has access to appropriate meeting documents.
Review	Accreditation Survey by American College of Surgeons - Commission on Cancer
Disclaimer	This meeting may deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that

	may be presented during thecourse of this meeting, except in those settings which are protected from disclosure pursuant to RCW70-41-200 and RCA 4.24.250.
References	Medical Staff Bylaws Medical Staff Policies Commission on Cancer – Cancer Program Standards

Approvals	Date	Signature
Cancer Committee	6/8/2021	/s/ Jason Tcheng MD – Chairman
Bylaws Committee	6/28/2021	/s/ Gary Gretch MD - Chair
Medical Executive Committee	7/15/2021	/s/ Griffith Blackmon MD – Chief of Staff

MEDICAL STAFF

Charter
Credentials Committee

Name	Credentials Committee
Purpose	The Credentials Committee is a standing committee of the Medical Staff and makes recommendations on the appointment, reappointment, and delineation of privileges for the Medical Staff and Advanced Practice Clinicians.
Responsibilities	• To review the credentials and clinical qualifications of all applicants for Medical Staff or Advanced Practice Clinicians appointment. • To review the credentials and current clinical competence for all applicants for reappointment to the Medical Staff or Advanced Practice Clinicians. • To make recommendations to the Professional Performance Committee and Medical Executive Committee regarding Medical Staff and Advanced Practice Clinicians appointment, reappointment, and delineation of clinical privileges. • To coordinate, on behalf of the Board of Directors, development of appropriate criteria for delineation of clinical privileges. • To develop, for recommendation to the Bylaws Committee, Medical Staff policies for the credentialing and privileging functions to assure compliance with accreditation and regulatory standards governing these functions, and to review these annually. • To review annually the credentialing criteria and delineation of privileges documents to assure they are reflective of current scope of practice at Harrison facilities and are consistent with standards set forth by the various specialty certification boards. • To direct practitioner educational activities.
Reporting	Reports to • Professional Performance Committee • Medical Executive Committee
Chairperson	Member of the Active Staff appointed by the Chief of Staff.
Membership	The Credentials Committee will be comprised of representative members of the Medical Staff, Advanced Practice Clinicians, hospital leadership, and support staff. • At least five members of the Active Staff (excluding the Chair) appointed by the Chief of Staff with the advice and consent of the MEC • At least two Advanced Practice Clinicians appointed by the Chief of Staff with the advice and consent of the MEC. • At least one member of the Board of Directors appointed by the Chairman of the Board • President • Chief Medical Officer • Director Medical Staff Services • Other support staff from the Medical Staff Services Office and the Peer Review as needed to carry out the work of the committee
Agents of the Committee	In carrying out their responsibilities of reviewing applications requests for renewal or clinical privileges and making recommendations, the Department and Section Chiefs are acting as agents of the Credentials Committee and are afforded the same peer

	review and quality improvement protections as any member of the Credentials Committee.
Voting	All members of the committee except support staff are eligible to vote. Voting members must be present to vote.
Quorum	At least three members of the Medical Staff and one Advanced Practice Clinician must be present to constitute a quorum.
Support	Administrative support will be provided by the Medical Staff Services Office.
Meetings	The committee will meet at least 9 times per year, or more often if necessary to carry out the work of the committee in a timely fashion.
Review	The Credentials Committee charter will be reviewed annually.
Disclaimer	This committee may deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review information and activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW 70-41.
References	Medical Staff Bylaws Medical Staff Policies Joint Commission Standards Washington State Department of Health Washington State Medical Quality Assurance Commission

Approvals	**Date**	**Signature**
Credentials Committee	July 25, 2017	/s/ *Rana Tan*, MD - Chair
Bylaws Committee	September 25, 2017	/s/ *Gary Gretch*, MD - Chair
Medical Executive Committee	October 19, 2017	/s/ *Jennifer Quimby*, MD – Chief of Staff

MEDICAL STAFF
Charter
Ethics Committee

<table>
<tr><td>Name</td><td>Medical Ethics Committee</td></tr>
<tr><td>Purpose</td><td>The Medical Ethics Committee exists to assist in policy development and to provide learning opportunities and promote the resolution of medical ethical issues for patients, their families, physicians, staff members and the regional community. When requested, Committee members work closely with hospital and medical staff, patients and families in assisting them to make appropriate decisions respecting patient preference.</td></tr>
<tr><td>Responsibilities</td><td>In the spirit of assistance the Medical Ethics Committee:
Will conduct confidential case discussions, guided by trained committee members, providing recommendations which focus on the integrity of healthcare and the patients' best interests. Consultations may be presented to the committee by physicians, non-physician practitioners, nurses, administrators, staff members, patients and patient's families.
Will participate in the review and development of hospital policies to analyze ethical dimensions.
Will pursue and promote educational programs to foster a greater awareness of bioethical issues in the hospital environment and the community at large.
An entry in the patient's medical record shall be made when a Medical Ethics Consult is conducted; the chart entry shall include:
the day and time of the Consult;
identify the specific issue addressed;
the full names of the participants in the Consult, and
the recommendations of the consulting team.
The physician member of the on-call Consult team, or his/her designee, shall be responsible for making the chart entry.</td></tr>
<tr><td>Reporting</td><td>The Committee is a function of Harrison Medical Center's Medical Staff and reports to the Medical Executive Committee.</td></tr>
<tr><td>Chairperson</td><td>The committee chairperson is a physician appointed by the Chief of Medical Staff. The committee vice chairperson will be selected by the committee chairperson and approved by the full committee. Duties of the chairperson will include record keeping, chairing meetings, reporting to the Medical Executive Committee, ensuring that Committee positions are filled, providing for an educational plan, and overseeing yearly committee self-evaluations. Other officers will be selected by the Committee members.</td></tr>
<tr><td>Membership</td><td>The Committee will consist of individuals from the Harrison Medical Center community. The Committee will be multidisciplinary as follows:
1) Four physicians
2) One hospital chaplain
3) One service excellence coordinator
4) One medical social worker
5) Four registered nurses
6) Chief Medical Officer (CMO) or designee
7) One non-nursing hospital employee
8) Education services representation

Names of potential physician-members will be submitted by the Committee to the Chief of Staff for his/her approval.

Candidates for hospital employee positions shall be recommended by their respective department directors, interviewed and recommended by a Medical Ethics sub-committee,</td></tr>
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	and then approved by a majority of the Committee membership. Advisory personnel will be selected by the Committee as deemed necessary. A Committee member's term is four (4) years and is renewable.
Voting	On operational issues, all members of the committee, including the ex-officio members may vote. On matters related to peer review only the Medical Staff members of the committee may vote.
Quorum	A quorum shall consist of the members present at the meeting.
Support	Administrative support will be provided by the Medical Staff Services Office. The Committee will prepare an annual budget as part of the Medical Center's budget process and submit it to Medical Staff Services.
Meetings	Regular meetings will be held at least quarterly. Generally, meetings will be open to persons other than Committee members. It is an option, for the purpose of confidentiality, to hold closed meetings. Minutes and agendas of all meetings will be retained for future reference.
Review	The charter will be reviewed annually and a report of the review will be sent to the Chief Medical Officer and Bylaws Committee.
Disclaimer	* Note – Medical Ethics consults are advisory only. The ultimate decision regarding patient care is the responsibility of the attending physician in consultation of the patient and/or the decision maker as authorized by the patient.
References	The Joint Commission (LD.04.02.03; LD.04.02.05; RI.01.01.03; RI.01.02.01; RI.01.03.01; RI.01.03.03; RI.01.03.05; RI.01.05.01) University of Washington Medical Ethics Summer Seminar Jonsen A R, Siegler M, Winslade W J. *Clinical Ethics: A Practical Approach to Ethical Decisions in Clinical Medicine.* 6th ed. McGraw-Hill Medical Publishing Division; 2006

Approvals	**Date**	**Signature**
Ethics Committee	6/5/2013	/s/ Gary Gretch, MD - Chair
Bylaws Committee	6/17/2013	/s/ Gary Gretch, MD - Chair
Medical Executive Committee	6/20/2013	/s/ Glen Carlsen, MD – Chief of Staff

MEDICAL STAFF

Charter

Health Information Management Committee

<table>
<tr><td>Name</td><td>Health Information Management Committee</td></tr>
<tr><td>Purpose</td><td>To support and improve the quality of clinical care provided at all Harrison facilities by assuring timely, accurate, and accessible documentation of clinical services</td></tr>
<tr><td>Objectives</td><td>To ensure compliance with Medical Staff Policies, Chapter 14.
To address systems issues related to clinical documentation.
To review Harrison’s Medical Staff documentation and records completion performance in relation to benchmarked data.
To support the use of best practices for clinical documentation.
To provide peer assessments of an ongoing nature of the clinical documentation of members of the Medical Staff and Advanced Practice Clinicians.
To review data as needed to support the Medical Staff in carrying out the Medical Staff Quality Improvement Plan, MSP 18.</td></tr>
<tr><td>Reports to</td><td>Medical Executive Committee</td></tr>
<tr><td>Chairperson</td><td>A member of the Active Medical Staff appointed by the Chief of Staff, with the advice and consent of the Medical Executive Committee</td></tr>
<tr><td>Membership</td><td>At least three members of the Active Medical Staff appointed by the Chief of Staff which will include:
Harrison HealthPartners/FMG Representative
Emergency Department Representative
One member of the Advanced Practice Clinician Staff appointed by the Chief of Staff
Chief Medical Officer
Information Technology representative
Health Information Management Department representative
Peer Review Program Manager or designee
A representative from Nursing management appointed by the Chief Nursing Officer.
Clinical Documentation Manager
Division Manager, Medical Staff Services, or designee
Other members of the Medical Staff or Hospital staff as needed to address identified concerns to attend on an ad hoc basis.</td></tr>
<tr><td>Voting</td><td>All members of the committee may vote; however, in matters of Medical Staff governance or peer review, only physician members of the committee may vote.</td></tr>
<tr><td>Responsibilities</td><td>Supervise and evaluate clinical documentation to assure compliance with regulatory and accreditation standards and the requirements as set forth by Medical Staff Policies, Chapters 13 and 14.
Monitor timeliness of clinical documentation.</td></tr>
</table>

	• Acting upon the recommendations of the appropriate Medical Staff Departments, Sections, or Committees approve any new forms and formats for clinical documentation, including significant revisions of existing forms or formats
	
	• Acting upon the recommendations of the Content Oversight Team, Pharmacy & Therapeutics Committee, and appropriate Departments and Sections, approve order sets for Computerize Physician Order Entry
	
	• Review and declare complete for purposes of filing the incomplete records of deceased practitioners and of practitioners who have left the area and cannot be contacted or are unavailable to complete such records
	
	• Approve symbols and abbreviations to be used in clinical documentation through annual review.
	
	• Monitor compliance and report findings including, but not limited to, the following:
	  o Timeliness and completeness of history and physical examinations pertinent to the patient's clinical condition;
	  o Authentication of orders by signature, date, and time, including verbal or telephone orders;
	  o Accuracy of medical record documentation during Epic downtime
	  o Timeliness and completion of operative reports pertinent to the patient's clinical condition;
	  o Timeliness and completion of discharge summaries;
	  o Use of approved abbreviations and symbols.
	
	• Forward review or investigation to the Professional Performance Committee regarding any practitioner with three suspensions for failure to complete clinical documentation within a rolling twelve month period.
	
	• Make recommendations for improvement of clinical documentation to Medical Staff Departments, Sections, or Committees or to operational departments of the Hospital.
	
	• Review data to support the Medical Staff in carrying out the provisions of the Medical Staff Quality Improvement Plan as it relates to clinical documentation.

Support	Administrative Support: Medical Staff Services Department Technical Support: • Health Information Management Department • Peer Review Department • Information Technology Department • Clinical Documentation Improvement Department
Meetings	The committee will meet at least 4 times per year or as often as necessary to carry out the responsibilities assigned.
References	• Joint Commission Accreditation Standards • Washington State Department of Health Regulatory Standards • CMS Conditions of Participation • Harrison Medical Staff Bylaws • Harrison Medical Staff Policies

Approvals	Date	Signature
Health Information Management Committee	9/6/2018	/s/ Martin Bennett, MD - Chair
Bylaws Committee	9/24/2018	/s/ Gary Gretch, MD - Chair
Medical Executive Committee	10/18/2018	/s/ Malcom Winter, MD – Chief of Staff

MEDICAL STAFF

Charter

Infection Prevention Committee

PLACE HOLDER

MEDICAL STAFF

Charter

Maternal-Fetal Health Committee

<table>
<tr><td>Name</td><td>Maternal-Fetal Health Advisory Committee</td></tr>
<tr><td>Purpose</td><td>To provide a forum for interdisciplinary collaboration for those involved in providing labor and delivery and newborn services and to report its recommendations to the appropriate department, sections, and committees for action.</td></tr>
<tr><td>Responsibilities</td><td>To review policies, procedures, and protocols related to labor and delivery and newborn services
To identify opportunities for improvement
To provide ongoing pro-active assessment and performance improvement
To participate in evaluation of adverse events
To provide feedback that is meaningful and relevant to clinical departments
To promote patient safety
To improve the processes that support patient care
To facilitate interdisciplinary communication
To review perinatal & maternal core measures</td></tr>
<tr><td>Reporting</td><td>Obstetrics & Gynecology Section
Pediatrics Section
Anesthesiology Section
Medical Executive Committee</td></tr>
<tr><td>Chairperson</td><td>The Chair shall be appointed by the Chief of Staff.</td></tr>
<tr><td>Membership</td><td>Physicians and non-physician practitioners representing:
the Obstetrics & Gynecology Section
the Pediatrics Section
the Department of Family Practice
the Anesthesiology Section
the Emergency Medicine Section
the Neonatology Nurse Practitioners
the Neonatology Consultant
The Northwest Family Medicine Residency Program
Chiefs of Obstetrics & Gynecology and Pediatrics (ex-officio)
Chief Medical Officer
Vice President & Chief Nursing Officer
Director, Medical Staff Services & Physician Recruitment
Representatives from:
Nursing, including the Directors of Women and Children’s Services and Surgical Services, as determined by the CNO
Pharmacy
Respiratory Therapy
Quality Department</td></tr>
</table>

Voting	On operational issues, all members of the committee, including the ex-officio members may vote. For referral to peer review, only the Medical Staff members of the committee may vote.
Quorum	In that the Maternal-Fetal Health Advisory Committee is a Medical Staff committee, the quorum is defined as one Active Medical Staff member each from the Pediatric Section and the Obstetrics & Gynecology Section present at the meeting.
Support	Administrative support will be provided by the Medical Staff Services Office.
Meetings	The committee shall meet at least quarterly, but as often as necessary to carry out its assigned functions.
Review	The Maternal-Fetal Health Advisory Committee charter will be reviewed annually.
Disclaimer	This meeting may deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW 70.41.200 and RCA 4.24.250.
References	Medical Staff Bylaws Medical Staff Policies Joint Commission WA State Department of Health

Approvals	**Date**	**Signature**
Maternal-Fetal Health Advisory Committee	2/5/2021	/s/ Timothy Kennedy, MD - Chair
Bylaws Committee	2/27/2021	/s/ Gary Gretch, MD - Chair
Medical Executive Committee	3/18/2021	/s/ Griffith Blackmon, MD – Chief of Staff

MEDICAL STAFF
Charter
Medical Executive Committee

Name	Medical Executive Committee
Purpose	To serve as the governing committee of the organized Medical Staff
Responsibilities	• To ensure safe and effective medical care for patients as delegated by the Board Quality & Value Committee. • To act on behalf of the Medical Staff between meetings of the Medical Staff • To represent the interests of the Medical Staff to the Board Quality & Value Committee and Administration • To direct the work of the organized Medical Staff with regard to credentialing, privileging, quality improvement, peer review, and governance • To ensure compliance with accreditation and regulatory standards as it relates to the Medical Staff • To manage the funds in the Medical Staff Treasury
Reporting	In certain matters, as defined by Medical Staff Bylaws, the Medical Executive Committee reports to the Board Quality & Value Committee.
Chairperson	Chief of Staff, elected by the Medical Staff
Membership	Officers of the Medical Staff – with vote • Chief of Staff • Assistant Chief of Staff • Secretary-Treasurer • Section Chiefs • Chair of the Professional Performance Committee Ad hoc members – without vote • Department Chiefs • Bylaws Committee Chair • Peer Review Committee Chair • Credentials Committee Chair • Medical Staff Quality Committee Chair Ex-Officio members – without vote • Market President • Associate Chief Medical Officer • Chief Operating Officer • Chief Nursing Officer Other members of the Medical Staff may be asked to participate on an ad hoc basis, without vote, relative to the clinical or administrative services for which they are accountable
Voting	Only elected officers of the Medical Staff may vote.
Quorum	A quorum is defined as 50% of the voting members.

	Voting members who participate remotely may be counted toward the quorum. For an Executive Session, members may only participate in person.
Support	Administrative support will be provided by the Associate Chief Medical Officer and the Medical Staff Services Office.
Meetings	The committee will meet at least 10 times a year, but more often if necessary to conduct the business of the Medical Staff
Review	The charter of the Medical Executive Committee will be reviewed annually.
Disclaimer	This committee shall deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review information and activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW 70-41.
References	Medical Staff Bylaws Medical Staff Policies Joint Commission Washington State Department of Health CMS

Approvals	Date	Signature
Medical Executive Committee	9/20/2018	/s/ Malcolm Winter MD – Chief of Staff
Bylaws Committee	9/24/2018	/s/ Gary Gretch MD - Chair

MEDICAL STAFF
Charter
Medical Staff Quality Committee

Name	Medical Staff Quality Committee
Purpose	To analyze collected metrics data To identify and encourage excellence in clinical care by the Medical Staff To seek out and implement best practice protocols and other nationwide benchmarking data as a standard for comparison To make recommendations to the Medical Staff to improve care To recognize and acknowledge excellence
Responsibilities	Regularly provide feedback to physicians, advanced practice clinicians, departments, sections, and committees Recommend additional selection criteria (screens or indicators) by which episodes of care are subjected. Assure that identified systems or process issues which result in less than optimum patient care are brought to the attention of the Medical Staff and the hospital leadership with recommendations for needed improvements. To review quality metrics and reports and recommend systems changes required to improve quality and safety of care and report same to the MEC and/or Departments and Sections when appropriate Ensure that the Departments/Sections are engaged in effective quality improvement activities related to focused clinical issues, systems issues, and/or benchmarked data Review all systems issues findings identified by the Multispecialty Peer Review Committee to determine if findings identify a need for specific systems improvements Recommend hospital-sponsored continuing medical education activities which relate to the type and nature of care, treatment, and services offered by the hospital and are based upon findings of quality improvement activities and best practice protocols. To review mortality data and cases to determine if systems issues were a contributing factor Provide information to the Professional Performance Committee to support credentialing and privileging standards
Reporting	Reports to • Medical Executive Committee • Board Quality Improvement and Patient Safety Committee Reports any concerns about individual physician/practitioner performance identified by data collected by the MSQC to the Professional Performance Committee
Chairperson	A member of the Active Medical Staff appointed by the Chief of Staff with the advice and consent of the Medical Executive Committee

Membership	At least 5 members of the Active Medical Staff appointed by the Chief of Staff, one of whom shall serve as Chair Associate Chief Medical Officer Program Manager – Quality
Voting	All members of the committee listed above may vote. However, on matters related to peer review, only physician members of the committee may vote in Executive Session.
Quorum	There must be at least one physician member present. A quorum shall consist of all Active Staff members of the Medical Staff present.
Support	Administrative support is provided by the Quality staff.
Meetings	The committee shall meet at least 6 times per year, but more often if needed to carry out its responsibilities.
Review	The Medical Staff Quality Committee charter shall be reviewed at least annually.
Disclaimer	This committee may deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review information and activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW 70-41.
References	Medical Staff Bylaws Medical Staff Policies Joint Commission Washington State Department of Health CHI/Franciscan Health Living Our Mission Organizational Dashboards Other benchmarking entities as determined by the Medical Staff and Chief Medical Officer which may include, but is limited to, NCDR, SCOAP, COAP, etc.

Approvals	Date	Signature
Medical Staff Quality Committee	March 13, 2017	/s/ *Griffith Blackmon, MD* - Chair
Bylaws Committee (technical Review	March 27, 2017	/s/ *Gary Gretch, MD* - Chair
Medical Executive Committee	April 20, 2017	/s/ *Jennifer Quimby, MD* - Chief of Staff

MEDICAL STAFF
Charter
Multispecialty Peer Review Committee

<table>
<tr><td>Name</td><td>Multi-Specialty Peer Review Committee (MPRC)</td></tr>
<tr><td>Purpose</td><td>Provide individual patient care review for credentialed members of the Medical Staff and Advanced Practice Clinicians as part of the Medical Staff Peer Review process.</td></tr>
<tr><td>Responsibilities</td><td>The MPRC shall perform the following functions related to the evaluation of individual cases:
Perform initial review of all patient care of sufficient management complexity or seriousness of outcome requiring provider review based on patient care as identified by
Review Indicators
Ongoing departmental audits
Through referrals to the Quality staff or
Other reviews as requested by sections or committees.
Obtain reviews and recommendations from specialists on the medical staff when required.
Communicate with the provider involved with the patient care via letter to obtain input in writing.
Obtain final determination on cases in which the initial review identifies potential provider case issues by committee assent.</td></tr>
<tr><td>Reporting</td><td>Reports to
Professional Performance Committee
Medical Executive Committee</td></tr>
<tr><td>Chairperson</td><td>The Chair of the MPRC shall be appointed by the Chief of Staff and approved by the Medical Executive Committee (MEC) for a term of 3 years. To be eligible for appointment as Chair, the member must have served on the MPRC at some point in time for at least 2 years. The Chair may serve 2 consecutive terms as long as he/she is eligible to be an MPRC member. Following the 2 consecutive terms, the Chair is eligible for reappointment if an appropriate replacement cannot be found. The Chairperson shall be a voting member of the Professional Performance Committee.</td></tr>
<tr><td>Membership</td><td>The MPRC will be comprised of representative members of the Medical Staff and Advanced Practice Clinicians. The MPRC may invite providers from non-representative specialties for ad hoc participation, as needed.

The Chief of Staff, Chief Medical Officer, and peer review support staff are ex-officio members without a vote. Other persons may attend by invitation only.

The Chief of Staff will appoint MPRC members based on recommendation from the MPRC chair and other committee members, and approval by the MEC. MPRC members shall serve for a 3 year term except for the initial members who will be appointed to terms according to a consensus of the first committee. Members may serve up to 3 terms and are eligible for reappointment to the MPRC if an appropriate replacement cannot be found.</td></tr>
<tr><td>Voting</td><td>Only the members of the Medical Staff and Advanced Practice Clinicians appointed to the MPRC are eligible to vote.

Voting members must be present to vote.</td></tr>
</table>

Quorum	A quorum of the Committee shall be constituted by a minimum of four members present and eligible to vote. Ex-officio members and support staff shall not be counted in determining the presence of a quorum.
Support	Administrative support will be provided by the Peer Review Department.
Meetings	The MPRC shall meet at least 9 times per year in order to carry out the work of the committee in a timely fashion. Members shall be expected to attend a minimum of two-thirds of the regularly scheduled or special meetings.
Review	The MPRC charter shall be reviewed annually or more often as necessary to meet the needs of the peer review functions.
Disclaimer	This committee shall deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review information and activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW 70-41.
References	Medical Staff Bylaws Medical Staff Policies Washington State Department of Health Washington State Medical Quality Assurance Committee The Joint Commission

Approvals	**Date**	**Signature**
Multi-Specialty Peer Review Committee	11/8/2018	/s/ Satya Pulukurthy MD – Chair
Bylaws Committee	9/24/2018	/s/ Gary Gretch MD - Chair
Medical Executive Committee	11/15/2018	/s/ Malcolm Winter MD – Chief of Staff

MEDICAL STAFF
Charter
Professional Performance Committee

<table>
<tr><td>Name</td><td>Professional Performance Committee (PPC)</td></tr>
<tr><td>Purpose</td><td>Oversee the accountability and effectiveness of the Credentials Committee and the Multi-Specialty Peer Review Committee. Develop systematic approaches to evaluating and improving provider performance in the six Joint Commission/ACGME General Competencies:
• Patient care
• Medical/clinical knowledge
• Interpersonal and communication skills
• Professionalism
• Systems-based practice
• Practice-based learning and improvement</td></tr>
<tr><td>Responsibilities</td><td>• Coordinating the peer review and quality review processes of the Medical Staff
• Evaluating current competency through Ongoing Professional Performance Evaluation (OPPE) and Focused Professional Performance Evaluation (FPPE)
• Review practitioner behavior reports
• Addressing practitioner behavior issues, including requests for investigation
• Implementing the Fair Hearing Process when needed
• Design peer review policies and procedures
• Review medical staff indicators and targets in collaboration with the departments or specialties
• Evaluate rule and rate indicators for outliers and decide if additional data is needed to explain patterns
• When an improvement opportunity is identified by patient care review or aggregate data, request appropriate department chief develop plan and track implementation.
• Oversee any other medical staff department/specialty specific peer review activities</td></tr>
<tr><td>Reporting</td><td>The Professional Performance Committee reports to the Medical Executive Committee. The minutes of the meeting shall serve as the committee report. The minutes will be posted on the password protected MEC SharePoint site.</td></tr>
<tr><td>Chairperson</td><td>A member of the Active Staff appointed by the Chief of Staff with advice and consent of the Medical Executive Committee</td></tr>
<tr><td>Membership</td><td>• At least 5 members of the Active Staff (excluding the Chair) appointed by the Chief of Staff.
• At least 2 Non-Physician Practitioners appointed by the Chief of Staff.
• At least 1 member of the Board of Directors appointed by the Chairman of the Board.
• Chair of the Multi-Specialty Peer Review Committee (ex-officio with vote).
• Chair of the Credentials Committee (ex-officio with vote)
• Chief Executive Officer or designee
• Support staff from the Medical Staff Services Office and the Quality Department as needed to carry out the work of the committee.

PPC members shall serve a 3-year term with renewal of term at discretion of the Chief of Staff thereafter.</td></tr>
<tr><td>Voting</td><td>Only the members of the Medical Staff and Non-Physician Practitioners are eligible to vote.</td></tr>
</table>

Quorum	At least two members of the Medical Staff and one Non-Physician Practitioner must be present to constitute a quorum.
Support	Administrative support (agendas, minutes, correspondence, etc.) will be provided by Medical Staff Services. Quality Department shall provide periodic and ad hoc reports of quality data and performance improvement activities of the Medical Staff Sections in aggregate and individual providers through OPPE.
Meetings	The PPC will meet least at least 6 times annually to carry out the responsibilities of the committee in a timely fashion. Review & approval of Credentialing Actions are deferred to the PPC Chairperson when no meeting takes place.
Review	The PPC charter will be reviewed annually.
Disclaimer	This meeting may deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW70-41-200 and RCA 4.24.250.
References	Medical Staff Bylaws Medical Staff Policies Joint Commission Standards WA State DOH & DOL Regulations

Approvals	**Date**	**Signature**
Professional Performance Committee	June 12, 2018	/s/ *Todd Garvin*, MD - Chair
Bylaws Committee	June 25, 2018	/s/ *Gary Gretch*, MD - Chair
Medical Executive Committee	July 19, 2018	/s/ *Malcolm Winder.* MD – Chief of Staff

MEDICAL STAFF
Charter
Robotics Committee

Name	Robotics Committee
Purpose	To provide awareness and guidelines for the safe use of current and future new robotics technologies. To serve in an advisory capacity to the medical staff and hospital in all matters pertaining to robotics technologies.
Responsibilities	• To establish guidelines for credentialing, privileging, mentoring, and proctoring guided by community and industry standards. • To coordinate clinical practices in all departments using the robotic technology. • To monitor patient care through educational case reviews and to initiate the Multi-Specialty Peer Review Process as needed. • To analyze and report on operative and clinical outcomes. • To recommend and approve policies and procedures related to the use of robotics technology.
Reporting	The Robotics Committee is a Medical Staff committee and reports to the Medical Executive Committee. The minutes of the meeting shall serve as the committee report.
Chairperson	A member of the Active Medical Staff appointed by the Chief of Staff. The Chairperson must be credentialed for robotics procedures.
Membership	• At least one physician from each specialty that utilizes the robotics technology • Associate Chief Medical Officer • Chief Nursing Officer • Director Medical Staff Services • Support staff from Medical Staff Services, the Quality Department and Surgery as needed to carry out the work of the committee
Voting	Only members of the Medical Staff are eligible to vote. Voting members must be present to vote.
Quorum	A quorum of the Committee shall be constituted by at least one member of each of the specialties utilizing robotics technology: • Gynecology • Urology • General Surgery / Thoracic Surgery
Support	Administrative support (agenda, minutes, correspondence, etc.) will be provided by Medical Staff Services. The Quality Department shall provide periodic ad hoc reports of quality data.
Meetings	Meetings will be held at least quarterly, however the group will meet as needed throughout the year to carry out its functions in a timely fashion.
Review	The Robotics Committee Charter shall be reviewed annually.
Disclaimer	This committee shall deal with quality assurance issues pursuant to Harrison Medical Center's Quality Improvement Program, including protected peer review information and activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW 70-41-200 and RCA 4.24.250.
References	Medical Staff Bylaws Medical Staff Policies Joint Commission Standards Washington State Department of Health

Approvals	Date	Signature
Robotics Committee	February 7, 2017	/s/ *Marc Mitchell DO* - Chair
Bylaws Committee (Technical Review)	March 27, 2017	/s/ *Gary Gretch, MD* - Chair
Medical Executive Committee	April 20, 2017	/s/ *Jennifer Quimby, MD* – Chief of Staff

MEDICAL STAFF
Charter
Utilization Management Committee

Name	Utilization Management Committee
Purpose	To ensure patients receive the appropriate level of care commensurate with their clinical condition.
Responsibilities	• To approve the Utilization Review Plan and review it at least annually. • To assure the hospital's Utilization Review Plan meets Condition of Participation (COP) requirements and that the plan is properly executed. • To measure and assess information relevant to inpatient and outpatient utilization, including the use of available facilities and services. • To provide leadership in associated quality improvement processes, including improving efficiency and reducing costs in the provision of healthcare appropriate to each patient. • To serve as physician advisors for non-coverage/decertification processes for admissions or continued stays determined as not medically necessary. • To identify gaps in provider knowledge and performance and to address the need by offering continuing education for providers. • To oversee correspondence to the **quality improvement** organization and other agencies. To prepare meeting minutes for the Medical Executive Committee (MEC) monthly.
Code 44	St. Michael physician committee members and physicians from other Virginia Mason Franciscan medical staffs are expected to respond to requests for Code 44 reviews at their respective facilities in a timely manner. A Code 44 is a patient admitted to inpatient status who is found not to have met criteria for inpatient and is changed to observation status.
Reporting	St. Michael Medical Executive Committee – monthly.
Chairperson	Member of the St. Michael Active Medical Staff appointed by the Chief of Staff.
Membership	At least two physician members of the St. Michael Active Medical Staff and Provisional-Active Medical Staff appointed by the Chief of Staff representing a cross-section of specialties that relate closely to the responsibilities of the UM committee. Physicians and other staff from Virginia Mason Franciscan Health are permitted to attend as guests of the committee for purposes of collaboration and education. At least one physician representing the following specialties: • Emergency Medicine • Hospitalist Groups – Sound and Kaiser (one from each Hospitalist group) • Physician Advisor Hospital representation: • Associate Chief Medical Officer – Peninsula Region • Chief Nursing Officer • Chief Operating Officer • Manager - Care Management • Program Manager - Quality • RN and Social Worker from St. Michael Care Management • Corporate Responsibility Officer • Support staff from Saint Michael Medical Staff Services Other members of the Virginia Mason Franciscan Health staff as needed to address specific areas of concern.
Voting	On operational issues, all members of the committee, including the ex-officio members may vote.

	For referral to St. Michael peer review, only the St. Michael Medical Staff members of the committee may vote, in Executive Session.
Executive Session	Should the Utilization Management Committee have a need to discuss the individual performance of a St. Michael physician, the committee will adjourn to Executive Session with only St. Michael physician members participating. For individual performance issues related to a non- St. Michael physician, the matter will be referred to the Virginia Mason Franciscan Health System CMO.
Quorum	In that the Utilization Management Committee is a St. Michael Medical Staff committee, the quorum is defined as the number of Active and Provisional-Active St. Michael Medical Staff members present at the meeting.
Support	Technical Support – Care Management staff from St. Michael Medical Center Administrative Support (agendas, minutes, correspondence, etc.) will be provided by St. Michael Medical Staff Services.
Meetings	Monthly
Review	• Outlier Cases • Length of Stay Data • Avoidable Days • Denial Reports • CMI for Specialties Frequent Utilizers
Disclaimer	This meeting may deal with quality assurance issues pursuant to St. Michael Medical Center's Quality Improvement Program, including protected peer review activities. Participants shall refrain from communicating any matters related to quality improvement and peer review that may be presented during the course of this meeting, except in those settings which are protected from disclosure pursuant to RCW70.41.200 and RCA 4.24.250.
References	St. Michael Medical Staff Bylaws St. Michael Medical Staff Policies CMS Conditions St. Michael Utilization Management Plan
Legend of Abbreviations	COP Conditions of participation LOS Length of stay CMI Case mix index RAC Recovery audit contractors HINN Hospital issued notice of non-coverage ABN Advanced beneficiary notices Code 44 Medicare condition code 44, billing

Approvals	**Date**	**Signature**
Utilization Management Committee	5/28/2021	Kelly Carlisle MD - Chair
Bylaws Committee (Technical Review)	8/23/2021	Gary Gretch MD - Chair
Medical Executive Committee	9/16/2021	Griffith Blackmon MD – Chief of Staff

APPENDIX B

SECTION
RULES & REGULATIONS

MEDICAL STAFF
Rules and Regulations
Cardiology Section

Effective Date	September 23, 2015	
Accountability	Medical Staff	Administration
	Cardiology Section Bylaws Committee Medical Executive Committee	Executive Director – Cardiovascular Service Line Chief Medical Officer
Review Date	September 23, 2016	

Card R&R 1	The Cardiology Section is organized and staffed to provide care for any patient presenting at Harrison requiring inpatient cardiology services. And, in the case of Harrison employed physicians and providers in this Section, to provide care to patients presenting to the Harrison Health Partners Cardiovascular Clinic.	
Card R&R 2	Responsibilities of the Cardiology Section for Coverage	
	2.1	The Cardiology Section is responsible to provide continuous cardiology coverage for the Bremerton hospital campus 24 hours per day, 7 days a week.
	2.2	The Cardiology Section will provide telephone consultation services to the Silverdale hospital campus to facilitate appropriate transfer of patients to the Bremerton hospital campus who require cardiology services.
	2.3	This call coverage will include general cardiology, interventional cardiology, and nuclear cardiology.
Card R&R 3	Professional Staff of the Cardiology Section	
	3.1	Physician members of the Section will meet the professional standards as established in the Medical Staff Bylaws and Policies.
	3.2	Physician and advanced practice clinician members of the Section will meet credentialing criteria, as established by the Section and approved by the Board, for every procedure and service provided.
Card R&R 4	Meetings	
	4.1	The Chief of the Section of Cardiology or the designated alternate attends the Medical Executive Committee meetings.
	4.2	Other members of the Section are invited to attend meetings as detailed in Attachment A.
	4.3	A quorum for the Cardiology Section meeting will be defined as the number of Active Staff physicians present.
Card R&R 5	Physician Call	
	5.1	As stipulated in the Rules and Regulations of the Emergency Medicine Section, the Cardiology Section will submit a monthly cardiology call schedule to the Emergency Department within 5 days prior to the first of the month.
	5.2	The Cardiology Section call schedule will be submitted by the Chief of Cardiology or by the designated call schedule coordinator.
	5.3	Physicians covering call will comply with the expectations of call coverage as detailed in Attachment B.
	5.4	The maintenance of staff cardiology privileges in all aspects of cardiology care requires equal participation in the Section's call duties for that service, unless otherwise approved by the Section. General cardiology privileges, including privileges for all non-interventional cardiology procedures, stress EKG interpretation, echocardiogram interpretation, and cardiology consultation require equal participation in ED Cardiology call.

	5.5	Interventional cardiology privileges, including privileges for all coronary intervention procedures, require equal participation in interventional call. This is defined presently as the provision of interventional services during general ED call shifts, and an equal share in interventional back up coverage for each group within the call system (when the cardiologist on call is not privileged for interventional cardiology), unless otherwise approved by the Section..	
	5.6	Clinical cardiac electrophysiology privileges require equal participation in the general cardiology call rotation, unless otherwise approved by the Section.	
	5.7	To allow per diem cardiology coverage and cardiology moonlighting, such physicians are exempted from the above call coverage stipulations. Per diem and locum tenens privileges are limited to on-call inpatient services and hospital imaging interpretation and do not allow elective procedures outside of the specific coverage assignment.	
	5.8	Though short-term imbalances may develop due to vacations or other temporary absences, the call schedule will be rebalanced to approximate equal call rotations on a quarterly basis.	
	5.9	Holiday coverage will also be balanced separately and rebalanced over a period of several years to maintain long-term equanimity.	
		5.9.1	Harrison recognizes the following holidays: • New Year's Day • President's Day • Memorial Day • Independence Day • Labor Day • Thanksgiving Day • Christmas Day
		5.9.2	Call coverage duties on a holiday are the same as those for weekends (see attachment B).
		5.9.3	The holiday call schedule will be published for the year prior to the beginning of the year.
		5.9.4	The Section may agree to designate other days as holiday coverage, such designation to be made prior to the beginning of the year (example – day after Thanksgiving).
Card R&R 6	Voting		
	6.1	Physicians who are members of the Active Medical Staff or Provisional Active Medical Staff may vote at Section meetings.	
	6.2	Advanced Practice Clinicians within the Cardiology Section may vote in Section meetings.	
	6.3	On matters related to physician peer review, only physician members of the Section may vote.	

Approval Process:

Cardiology Section for distribution to its members	March 11, 2015
Published to the Cardiology Section	March 12, 2015
Cardiology Section	May 13, 2015
Bylaws Committee (for technical review)	June 22, 2015
Medical Executive Committee	September 17, 2015
Board of Directors	September 23, 2015

MEDICAL STAFF

Rules and Regulations

Attachment A – Schedule of Cardiology Section Meetings

Unless otherwise stated, the various meetings of the Cardiology Section will be as follows:

What	When
Cardiology Section Meeting	2nd Wednesday of each month 7:30 – 8:30 am
Cardiovascular Service Line Meeting	2nd Tuesday of each month 6:30 – 7:30 am
Cardiac Cath Conference	Each Wednesday of the month, except during the week of the Section meeting 7:30 – 8:30 am
Morbidity and Mortality Conference	1st Wednesday of each month 7:00 – 7:30 am

Attachment B – Expectations of Cardiology Call System

Interventional Cardiology

<table>
<tr><td rowspan="3">Interventional Call # 1</td><td>Daytime interventional hospitalist role</td></tr>
<tr><td>7:00 am – 5:00 pm after clinically appropriate sign out</td></tr>
<tr><td>Duties
All Emergency Department calls to Cardiology
Bremerton hospital cardiology consults for all patients
Inpatient Cardiology procedures
STEMIs
Echocardiography and Nuclear Medicine interpretations
Inpatient TEEs
Backup for all elective procedures
Daily rounds on all hospitalized patients on the Cardiology service at Bremerton
Rounding/discharge of patients status post procedure the day prior unless physician who performed procedure makes other arrangements with the call Cardiologist and/or Advanced Practice Clinician
Cross cover Cardiology inpatient services and answering service
Elective procedures on own patients
Telephone consults from other hospitals when direct communication with the Cardiologist is requested</td></tr>
<tr><td rowspan="3">Interventional Call #2</td><td>Nighttime interventional hospitalist role</td></tr>
<tr><td>5:00 pm – 7:00 am after clinically appropriate sign out</td></tr>
<tr><td>Duties
All Emergency Department calls to the Cardiologist
Telephone consults from other hospitals when direct communication with the Cardiologist is requested
Urgent Bremerton hospital consults on all patients
STEMIs
Echocardiogram and Nuclear Medicine interpretations not completed by day shift
Cross cover cardiology inpatient services and answering service
Clinic coverage and elective procedures are not expected for this role</td></tr>
<tr><td rowspan="5">Interventional Call #3</td><td>Clinic interventionalist</td></tr>
<tr><td>Weekend backup interventionalist</td></tr>
<tr><td>During clinic hours Monday - Friday</td></tr>
<tr><td>Weekends from 7:00 am Saturday through 7:00 am Monday</td></tr>
<tr><td>Duties
Monday – Friday
Full time clinic coverage
Elective procedures on own patients
Saturday – Sunday
48 hour STEMI backup</td></tr>
</table>

	• If after hours STEMIs occur and the initial phone management confirms indication for urgent catheterization with probable intervention, the Interventionalist will be called by the General Cardiology call to perform initial onsite management including LHC/intervention and initial admission. After this initial phase of STEMI care, the patient is signed-out back to the General Cardiology call physician, including critical care if necessary. • Daytime backup for inpatient weekend procedures
General Cardiology Noninterventionalists	Rotate through call role which provides weekend call coverage
	7:00 am Saturday through 7:00 am Monday
	Duties Monday – Friday • Full time clinic coverage • No hospital coverage • Elective procedures for own patients Saturday – Sunday • Emergency Department call • Transfers from other hospitals • Initial care of STEMI patients while onsite. May defer the initial onsite care of after-hours STEMI patients to interventionalist, after initial phone management and confirmation of indication for urgent catheterization • Assumes care after initial management of after-hours STEMI, including onsite critical care if necessary • Bremerton hospital rounds and consults • Inpatient procedures • TEE, Echocardiogram, and Nuclear Medicine interpretations • Daily rounds on Cardiology service • Cross cover Cardiology inpatient services and answering service
Cardiologists on Staff at Affiliated Hospitals	Active or Provisional Active members of the Harrison Medical Staff, who are also on the Active staff at a CHI/FH affiliated hospital and who take a full share of call at the affiliated hospital, are excused from the Harrison Cardiology call rotation obligation. This does not preclude a physician from volunteering to take Cardiology call at Harrison on a regular or substitute basis.

Approval Process:

Cardiology Section for distribution to its members	March 11, 2015
Published to the Cardiology Section	March 12, 2015
Cardiology Section	May 13, 2015
Bylaws Committee (for technical review)	June 22, 2015
Medical Executive Committee	September 17, 2015
Board of Directors	September 23, 2015

MEDICAL STAFF
Rules and Regulations
General Surgery Section

Effective Date	September 23, 2015	
Accountability	Medical Staff	Administration
	General Surgery Section Bylaws Committee Medical Executive Committee	Chief Medical Officer
Review Date	September 23, 2016	

GS R&R 1	The General Surgery Section is organized and staffed to provide care for any patient presenting at Harrison requiring inpatient or outpatient general surgery services. And, in the case of Harrison employed physicians and providers in this Section, to provide care to patients presenting to the Harrison Health Partners General Surgery Clinic.	
GS R&R 2	The General Surgery Section is responsible to provide continuous general surgery coverage for the Bremerton and Silverdale hospital campuses 24 hours per day, 7 days a week. The General Surgeon will facilitate inter-facility transfers between the Bremerton and Silverdale hospital campuses for access to resources appropriate for the patient's clinical condition and anticipated needs.	
GS R&R 3	Professional Staff of the General Surgery Section	
	3.1	Physician members of the Section will meet the professional standards as established in the Medical Staff Bylaws and Policies.
	3.2	Physician and advanced practice clinician members of the Section will meet credentialing criteria, as established by the Section and approved by the Board, for every procedure and service provided.
	3.3	Members of General Surgery must be Board Admissible or Board Certified to be granted clinical privileges in the Section. All members of the Section are expected to participate in the maintenance of certification program of the American College of Surgery.
GS R&R 4	Meetings	
	4.1	The Chief of the General Surgery or the designated alternate attends the Medical Executive Committee meetings.
	4.2	A quorum for the General Surgery Section meeting will be defined as the number of Active Staff physicians present.
	4.3	The General Surgery Section meets as often as required to carry out the business of the Section, but no less often than quarterly.
GS R&R 5	Physician Call	
	5.1	As stipulated in the Rules and Regulations of the Emergency Medicine Section, the General Surgery Section will submit a monthly general surgery call schedule to the Emergency Department within 5 days of the end of the previous month.
	5.2	The General Surgery Section call schedule will be submitted by the Chief of General Surgery or by the designated call schedule coordinator.
	5.3	Active Staff members of the General Surgery Section are required to take an equal share of Emergency Department call.
	5.4	When the age of the General Surgeon and years of service at Harrison total at least 65, the surgeon may request to be excused from Emergency Department call and not jeopardize his/her active staff standing.
	5.5	This request needs to be approved by a 2/3 majority of the Active Staff members of the Section.
	5.6	Such request shall only be permitted if there are 6 or more General Surgeons remaining on the call schedule after the exemption is granted.

	5.7	General Surgeons may be temporarily exempted from call duties due to illness or other factors, upon written request from the physician and approval by the General Surgery Section.
GS R&R 6	Voting	
	6.1	Section members who are members of the Active Medical Staff or Provisional Active Medical Staff may vote at Section meetings.
	6.2	Advanced Practice Clinicians within the General Surgery Section may vote in Section meetings.
	6.3	On matters related to physician peer review, only physician members of the Section may vote.

Approval Process:

General Surgery Section for distribution to its members for 60 day review period	3/20/15
Published to the General Surgery Section	3/27/15
General Surgery Section	6/19/15
Bylaws Committee (for technical review)	6/22/15
Medical Executive Committee	9/17/15
Board of Directors	9/23/15

MEDICAL STAFF
Rules and Regulations
Inpatient Medicine Section

Effective Date	May 15, 2018	
Accountability	**Medical Staff**	**Administration**
	Inpatient Medicine Section Bylaws Committee Medical Executive Committee	Director – Medical Staff Services Associate Chief Medical Officer
Review Date	May 15, 2019	

IM-R&R 1	The Inpatient Medicine Section is composed of the physicians and practitioners in the following specialties who provide medical care for patients in the hospital setting, generally on a bedded nursing unit.		
	1.1	Family Medicine	
	1.2	Hospitalist	
	1.3	Internal Medicine	
	1.4	Subspecialty physicians who practice exclusively as Hospitalists may be a member of the Section.	
IM-R&R 2	To be granted clinical privileges in this Section, physicians and practitioners must be Board Certified or Board Admissible at the time of initial appointment.		
	3.1	The above provision regarding Board status does not apply to physicians who were members of the Harrison Medical Staff prior to June 1, 1998.	
	3.2	Section members are required to maintain ABMS or AOA Board Certification to maintain privileges to practice inpatient medicine.	
		3.2.1	The requirement does not apply for any physicians who were members of the Section as of May 1, 2018.
IM-R&R 3	Some members of the Section may also have an ambulatory practice as well as a hospital practice. Those individuals may also attend the Primary Care – Ambulatory Section meetings. However, the physician may only have membership and voting rights in one section.		
IM-R&R 4	The Inpatient Medicine Section will meet at least quarterly, but more often if necessary to carry out the work of the Section.		
	4.1	Advanced Practice Clinicians who hold privileges in this Section may vote in Section meetings.	
	4.2	In matters related to medical staff governance or peer review only members of the Medical Staff may vote.	
IM-R&R 5	To facilitate credentialing and privileging review, the Section will have Co-Chiefs, one of whom is Board Certified in Family Medicine and the other in Internal Medicine.		
	5.1	One or both Co-Chiefs may attend the Medical Executive Committee. However, the Section only has one vote.	
	5.2	In the event it is determined that only one Co-Chief attend the MEC, for the sake of continuity, he/she shall alternate with the other Co-Chief on an annual basis. Nevertheless, this does not preclude one Co-Chief substituting for the other if the need arises.	
	5.3	The Co-Chiefs shall be elected by the Section as a whole regardless of the specialty of the physician voting.	

IM-R&R 6	Those members of the Section who also have ambulatory practices are expected to maintain continuity of care for their hospitalized patients, either in person or by arrangement for coverage by another physician.	
	6.1	It is the physician's responsibility to ensure the Emergency Department and applicable nursing units are made aware of any alternate coverage arrangements.

Approval:

Inpatient Medicine Section	March 21, 2018
Bylaws Committee (technical review)	March 26, 2018
Medical Executive Committee	April 19, 2018
Board Quality and Value Committee	May 15, 2018

MEDICAL STAFF
Rules and Regulations
Obstetrics & Gynecology Section

Effective Date		
Accountability	Medical Staff	Administration
	Obstetrics/Gynecology Section Bylaws Committee Medical Executive Committee	Chief Medical Officer
Review Date	One year from the date approved by the Board of Directors	

OB/G R&R 1	Authority		
	1.1	The Section of Obstetrics and Gynecology is established as a section in the Department of Surgery of the Medical Staff of Harrison Medical Center by action of the Medical Staff in accordance with its bylaws.	
	1.2	The Section of Obstetrics and Gynecology shall be directed by the Chief of Obstetrics and Gynecology, who shall be elected in accordance with the Medical Staff Bylaws, Article V and the Medical Staff Policies, Chapter 1. All members of the section who maintain active or provisional-active staff appointments shall be eligible to serve on committees, perform designated duties and responsibilities of the section, and vote on any section business matters.	
OB/G R&R 2	Purposes		
	2.1	The purposes of the Section of Obstetrics and Gynecology shall be:	
		2.1.1	To assure the highest possible quality and safety of obstetric and gynecologic care required to meet the needs of Harrison Medical Center patients and their families
		2.1.2	To provide comprehensive care to women during pregnancy, labor, and delivery, and in the postnatal period
		2.1.3	To provide comprehensive surgical and medical gynecological care
		2.1.4	To maintain an environment in which section members and other practitioners can continually improve their professional abilities
		2.1.5	To support appropriate educational opportunities for student and graduate nurses and other healthcare personnel
		2.1.6	To establish basic policies as to how the Section carries out its responsibilities
		2.1.7	To delineate responsibilities, duties, and roles of section members
OB/G R&R 3	Membership		
	3.1	Membership in the Section shall be limited to those physicians who:	
		3.1.1	Are Diplomats of the American Board of Obstetrics and Gynecology, or are Board Eligible in Obstetrics and Gynecology
		3.1.2	Hold provisional active or active staff appointments at Harrison Medical Center
		3.1.3	Hold core privileges in Obstetrics ~~or Gy~~necology, or hold OB Hospitalist privileges in Obstetrics or Gynecology

		3.1.4	In regards to voting:	
			3.1.4a	On obstetrical related matters, a section member must have core obstetrics privileges.
			3.1.4b	On gynecological related matters, a section member must have core gynecology privileges.
			3.1.4c	On county call related matters, only a section member participating in county call with privileges in core obstetrics and core gynecology may vote.
			3.1.4d	In addition, to be eligible for relevant voting members who hold OB Hospitalist privileges in Obstetrics or Gynecology, they must be full time at Harrison Medical Center (full time is defined as having five 24hr shifts in a 28 day cycle for three consecutive months directly preceding the month of the vote).
	3.2	A quorum for the Obstetrics/Gynecology section meeting will be defined as the number of Active Staff physicians present.		
	3.3	Physicians holding affiliate staff appointments or temporary staff privileges and meeting qualifications 1, 2, or 3 above may serve on section committees and participate in department activities but may not vote on section business.		
	3.4	To qualify for membership in the section, practitioners must agree to abide by these rules and regulations and must agree to participate actively in section affairs and functions.		
	3.5	To maintain membership in the section, practitioners:		
		3.5.1	Are expected to attend at least two section meetings per year. Failure to do so will result in focused review of the practitioner's membership qualifications at time of reappointment.	
		3.5.2	Are encouraged to serve on committees as assigned	
		3.5.3	Must complete assigned quality review activities	
OB/G R&R 4	Organization			
	4.1	The section shall have the following officers:		
		4.1.1	A Chief of Obstetrics and Gynecology, who will be elected by the Medical Staff in accordance with Medical Staff Bylaws Article VI.	
		4.1.2	An Assistant Chief of Obstetrics and Gynecology, who will be appointed by the Section Chief. The Assistant Chief will carry out the duties of the Chief in his/her absence.	
	4.2	Committees may be appointed from time to time by the Chief.		
	4.3	Section meetings shall be held at least five times per year or as often as necessary to carry out its various functions.		
OB/G R&R 5	Clinical Privileges			
	5.1	Clinical privileges shall be granted in accordance with Medical Staff Policies, Chapter 7		
	5.2	The Delineation of Privileges form for the Obstetrics and Gynecology Section is an attachment to these Rules and Regulations.		
OB/G R&R 6	Call Coverage			
	6.1	Unassigned Call Coverage: Unassigned Call Coverage has no age end-date.		

	6.2	Continuous Call Coverage: A provider with OB and or GYN privileges must have an OB/GYN physician or group who provides consultative, continuation of care, and referral services on a 24/7/365 days per year basis. This OB/GYN will not be defaulted to the county call or OB hospitalist, but will be pre-arranged.	

OB/G R&R 7	Amendments and Review		
	7.1	The Obstetrics and Gynecology Section will develop Rules and Regulations in accordance with Medical Staff Bylaws, Article XIV, Section A.	
	7.2	These Rules and Regulations shall be reviewed at least annually by a process determined by the Section Chief.	
	7.3	Requests for amendment of these Rules and Regulations may be submitted by any member of the Section.	
		7.3.1	The request shall be published to all section members at least two weeks prior to the section meeting at which the proposed amendment is to be considered.
		7.3.2	The amendment may be passed by a simple majority of all members attending the meeting or through a vote by email.
		7.3.3	The amendment will be forwarded to the Medical Executive Committee for approval.
		7.3.4	Final approval shall rest with the CHI FH Board Quality & Value Committee. Changes will become effective upon the date of the Board approval.

Approval Process:

Obstetrics/Gynecology Section	6/25/2021
Bylaws Committee (for technical review)	10/25/2021
Medical Executive Committee	11/18/2021
Board of Directors	12/20/2021

MEDICAL STAFF
Rules and Regulations
Ophthalmology Section

Effective Date	October 28, 2015	
Accountability	Medical Staff	Administration
	Ophthalmology Section Bylaws Committee Medical Executive Committee	Chief Medical Officer Director – Medical Staff Services
Review Date	October 18, 2018	

OP R&R 1	The Ophthalmology Section is organized and staffed to provide care for any patient presenting at Harrison requiring inpatient or outpatient ophthalmology services.		
OP R&R 2	Continuity of Care		
	2.1	Section members are responsible for providing continuous ophthalmology coverage for patients presenting from their practices at the Bremerton and Silverdale hospital campuses 24 hours per day, 7 days a week. This coverage shall be provided either in person or by sign out to a covering physician with ophthalmology privileges at Harrison.	
	2.2	The ophthalmologist will facilitate inter-facility transfers between the Bremerton and Silverdale hospital campuses for access to resources appropriate for the patient's clinical condition and anticipated needs. He/she may also facilitate transfers to other facilities for services and resources not available at Harrison.	
OP R&R 3	Professional Staff of the Ophthalmology Section		
	3.1	Physician members of the Section will meet the professional standards as established in the Medical Staff Bylaws and Policies.	
	3.2	Physician members of the Section will meet credentialing criteria, as established by the Section, for every procedure and service provided. If in the future, advanced practice clinicians are added to the ophthalmology services, the Section will develop credentialing criteria within the scope of practice for these clinicians.	
	3.3	Members of Ophthalmology Section must be Board Admissible or Board Certified by the American Board of Ophthalmology to be granted clinical privileges in the Section.	
		3.3.1	Section members who provide subspecialty services may be required to have subspecialty certification for some procedures and services.
		3.3.2	All members of the Section are expected to participate in the maintenance of certification program of the American Board of Ophthalmology. Members of the Section who were granted privileges prior to July 1, 2015 are exempted from this requirement.
OP R&R 4	Meetings		
	4.1	The Chief of the Ophthalmology or the designated alternate attends the Medical Executive Committee meetings.	
	4.2	A quorum for the Ophthalmology Section meeting will be defined as the number of Active Staff physicians present.	
	4.3	The Ophthalmology Section meet as often as required to carry out the business of the Section, but no less often than quarterly, or as otherwise required by the Medical Staff Bylaws.	
OP R&R 5	Officers		
	5.1	The Chief of the Ophthalmology Section shall be elected by the Active Staff members of the Section in accordance with the processes outlined in the Medical Staff Bylaws.	

	5.2	The Immediate Past Chief of Ophthalmology will serve as the Assistant Chief of the Section.
OP R&R 6	Physician Call	
	6.1	As stipulated in the Rules and Regulations of the Emergency Medicine Section, the Ophthalmology Section will submit a monthly call schedule to the Emergency Department within 5 days of the end of the previous month.
	6.2	The Section will endeavor to provide full coverage for the Emergency Department; however, it is understood that some days could be uncovered due to various circumstances. Nevertheless, individual Section members are responsible for ensuring full coverage for patients from their own practices who present in the Emergency Department.
	6.3	The Ophthalmology Section call schedule will be submitted by the Chief of Ophthalmology or by the designated call schedule coordinator.
OP R&R 7	Voting	
	7.1	Section members who are members of the Active Medical Staff or Provisional Active Medical Staff may vote at Section meetings.

Approval Process:

Ophthalmology Section for distribution to its members for 60 day review period	June 11, 2015
Published to the Ophthalmology Section	June 11, 2015
Ophthalmology Section	September 16, 2015
Bylaws Committee (for technical review)	September 28, 2015
Medical Executive Committee	October 15, 2015
Board of Directors	October 28, 2015

MEDICAL STAFF
Rules and Regulations
Pediatrics Section

Effective Date	March 20, 2018	
Accountability	**Medical Staff**	**Administration**
	Pediatrics Section Bylaws Committee Medical Executive Committee	Director Medical Staff Services Associate Chief Medical Officer
Review Date	5/25/2022	

Ped R&R 1	The Pediatrics Section is organized to provide care or oversight of care of any newborn, infant, pediatric, or adolescent patient presenting at Harrison requiring inpatient, outpatient, observation, or emergency services.	
Ped R&R 2	Recognizing that Harrison may not have the resources to care for the needs of all patients falling within the stewardship of the Pediatric Section, criteria will be established to identify those situations in which it is appropriate to transfer the patient to another	
	2.1	Transfer criteria will be approved by the Pediatric Section and appended to the Rules
	2.2	When appropriate for the clinical needs of the patient, the physician or Neonatal Nurse Practitioner to whom the patient is assigned will stabilize and manage the patient
Ped R&R 3	Professional Staff of the Pediatrics Section	
	3.1	Physicians and advanced practice clinicians assigned to the Pediatrics Section will meet the professional standards as established in Medical Staff Bylaws and
	3.2	Physician and advanced practice clinicians assigned to the Pediatrics Section will meet credentialing criteria as established by the Section and approved by the Board Qualities and Values Committee for services provided, including procedures.
	3.3	Physician members of the Pediatrics Section must be Board Admissible or Board Certified by the American Board of Pediatrics to be granted clinical privileges in the Section, including Courtesy Privileges. All Active Staff Members of the Section are expected to maintain certification with the American Board of
	3.4	Advanced Practice Clinicians must be certified by neonatal nurse practitioner certifying agencies for initial appointment and maintain certification to maintain clinical
	3.5	Other members of the Medical Staff who are not members of the Pediatric Section may care for patients who fall within the stewardship of the Pediatric Section. It is expected that those physicians, dentists, and podiatrists meet the credentialing and privileging standards established by their respective Sections with regard to
Ped R&R 4	Admission of Newborn and Pediatric Patients	
	4.1	An appropriately privileged physician or neo-natal nurse practitioner (NNP) may admit newborns and neonates up to age 28 days.
	4.2	An unassigned newborn or neonate will be assigned to the Pediatrician on call at the time of birth.
	4.3	A newborn or neonate who is an established patient of a physician with privileges to care for such patients will be assigned to that physician.

Ped R&R 5	Admission of Infants, Pediatric, and Adolescent Patients	
	5.1	Infants, pediatric, and adolescent patients may be admitted to a bedded nursing unit as inpatients, outpatients, or for observation by a physician, dentist, or podiatrist with privileges appropriate of the clinical needs and age of the patient.

	5.2	Admission to a bedded nursing unit is contingent upon the availability of skilled nursing and support staff appropriate for the clinical needs and age of the patient for the
Ped R&R 6	Pediatric and Adolescent patients may be scheduled for outpatient surgical and dental procedures with the intent to discharge from the PACU to home. Such patients are under the care of an appropriately privileged physician, dentist, or podiatrist who is performing the procedure. Involvement of a pediatrician is not necessary unless the clinical condition of the patient warrants pediatric consultation.	
Ped R&R 7	In that the hospital pediatric service provides care for patients whose primary care physician does not have Active Staff pediatric privileges at Harrison, to assure optimal continuity of care, hand-offs of patient being admitted to and discharged from the hospital are expected to be communicated by physician to physician conversations in most circumstances. Depending upon the patient's clinical condition and needs, physician to physician	
Ped R&R 8	Pediatric Section	
	8.1	The Pediatric Section will meet at least quarterly, or more often as necessary to carry out the business of the Section.
	8.2	The Pediatric Section meetings are open to Family Medicine physicians who care for
	8.3	A designated representative of the Emergency Medicine physicians is encouraged.
	8.4	In Section meetings, only Active Staff Pediatricians and NNPs may vote on Section business.
	8.5	A quorum is defined as the number of Active Staff Pediatricians present (or participating via teleconference) and voting.
	8.6	A Pediatrician will be elected as Chief of Pediatrics in accordance with the Medical Staff Bylaws and Policies. He/she will represent the interests of the Section on the Medical Executive Committee. If the Chief is unable to attend a MEC meeting, an alternate may be designated to represent the Section.
	8.7	The Chief may designate a physician to serve as Assistant Chief to act on Section business in his/her absence.
Ped R&R 9	Call Coverage	
	9.1	The Chief, or a designee, is responsible for preparing a monthly call schedule and submitting it to the Emergency Department.
	9.2	All Active Staff Pediatricians are expected to take a fair and equitable share of call. The call requirement is waived for the Medical Director overseeing the neonatal practitioner group providing services for the Nursery.
	9.3	To support the nursery designation regulatory standards, the Section will assure that there is coverage for the Nursery every day.

Approval:

Pediatrics Section	February 8, 2021
Bylaws Committee (Technical Review)	February 22, 2021
Medical Executive Committee	March 18, 2021
Board Quality and Value Committee	May 25, 2021

MEDICAL STAFF
Rules and Regulations
Primary Care Ambulatory

Effective Date	May 15, 2018	
Accountability	**Medical Staff**	**Administration**
	Primary Care Ambulatory Section Bylaws Committee Medical Executive Committee	Manager, Medical Staff Services Associate Chief Medical Officer
Review Date	March 19, 2020	

PCA-R&R 1	The Primary Care Ambulatory Section is composed of the physicians and practitioners who provide medical care for patients in the ambulatory setting, including primary care clinics or urgent care.		
PCA-R&R 2	The Primary Care Ambulatory Section is composed of physicians and practitioners whose medical practice specialty is		
	2.1	Family Medicine	
	2.2	Internal Medicine	
	2.3	Urgent Care	
	2.4	Subspecialty physicians who practice exclusively as primary care ambulatory physicians may be a member of the Section.	
PCA-R&R 3	To be granted clinical privileges in the Primary Care Ambulatory Section, physicians must be Board Certified or Board Admissible by an ABMS or AOA accredited Board at the time of initial appointment.		
	3.1	The above provision regarding Board status does not apply to physicians who were members of the Harrison Medical Staff prior to June 1, 1998.	
	3.2	Advance Practice Clinicians assigned to the Primary Care Ambulatory Section shall be required to hold and maintain certification for their credentials as define by the Medical Staff Bylaws and Medical Staff Policies governing such.	
		3.2.1	Certification requirements of the Washington State Department of Licensing for Advanced Registered Nurse Practitioners shall also apply.
PCA-R&R 4	Some members of the Section may also have a hospital practice as well as an ambulatory practice. Those individuals may also attend the Inpatient Medicine Section meetings. However, the physician may only have membership and voting rights in one section.		
PCA-R&R 5	The Primary Care Ambulatory Section will meet at least quarterly, but more often if necessary to carry out the work of the Section.		
	5.1	Advanced Practice Clinicians who hold privileges in this Section may vote in Section meetings.	
	5.2	In matters related to medical staff governance or peer review only members of the Medical Staff may vote.	
	5.3	At the discretion of the Section Chief, continuing medical education opportunities may be substituted for a quarterly meeting.	
PCA-R&R 6	To facilitate credentialing and privileging review, the Primary Care Ambulatory Section will have three Co-Chiefs, at least one of whom is Board Certified in		

	Family Medicine and one in Internal Medicine. One Chief will represent each of the three distinct populations: Ambulatory Family Medicine, Ambulatory Internal Medicine and Urgent Care.	
	6.1	All Co-Chiefs may attend the Medical Executive Committee. However, the Section only has one vote.
	6.2	In the event it is determined that only one Co-Chief attend the MEC, for the sake of continuity, he/she shall alternate with the other Co-Chief on an eight month basis. Nevertheless, this does not preclude one Co-Chief substituting for the designated Co-Chief as the need arises.
	6.3	The Co-Chiefs shall be elected by the Section as a whole regardless of the specialty of the physician voting.
PCA-R&R 7	Members of the Section are expected to maintain continuity of care for their hospitalized patients by arrangement for coverage the Hospitalist Service or another physician with the appropriate hospital privileges for the needs of the patient. Urgent Care physicians are exempted from this requirement.	
	7.1	It is the physician's responsibility to ensure the Emergency Department(ED) is made aware of any alternate coverage arrangements.
PCA-R&R 8	All primary care ambulatory physicians who are members of the active or provisional active medical staff are expected to participate in the ED county call rotation to provide follow-up care for those patients who do not have an established primary care physician. The Urgent Care physicians are exempted from this requirement.	
	8.1	A list will be maintained by the Medical Staff Services Office for use by the ED of all participating physicians.
	8.2	It is the responsibility of the patient referred for follow up care to contact the physician's office to make an appointment based upon the instructions received from the ED. The patient should identify himself/herself as having been referred from the ED.
	8.3	The primary care physician who has received a referral from the ED is only responsible for addressing the acute condition for which the patient sought care in the ED. Care of underlying chronic or other new conditions is a matter of mutual agreement by the PCP and the patient.
	8.4	Patients being referred from the ED shall not be required to provide payment up front in order to be seen. However, the PCP may bill and collect professional fees for any follow up care provided.
	8.5	If the PCP does not wish to serve as the PCP for the patient for the long term, it is recommended to he/she provides the patient with a letter confirming that the PCP will only be addressing the acute condition for which he/she was referred and advising the patient to find another PCP for ongoing care.
	8.6	Physicians who are age 60 or over and who have been a member of the Harrison Medical Staff, accepting referrals from the ED for at least 25 years, shall be exempt from the requirement of serving on the PCP call coverage rotation.
	8.7	Physicians may arrange for the follow up care to be provided in their practice by an advanced practice clinician with appropriate qualifications to meet the needs of the patient.

		8.7.1	The name of an advanced practice clinician may not be substituted for the physician on the call schedule. Delegation of care by the on call physician to an appropriately qualified advance practice clinician is a matter of clinic operations and is done solely at the discretion of the physician to whom the patient has been referred.
		8.7.2	The above being said, there is no prohibition for the ED physician to refer a patient for follow up care to an advanced practice clinician with who that patient has an established PCP relationship, regardless of their affiliation with the Harrison medical staff.

Approval Process:

Primary Care Ambulatory Section	12/17/2018
Bylaws Committee (technical review)	1/28/2019
Medical Executive Committee	2/21/2019
Board Quality and Value Committee	3/19/2019

MEDICAL STAFF
Rules and Regulations
Radiology

SECTION 1: DEFINITION

The Department ofRadiology includes, but is not limited to, the following technical imaging modalities: diagnostic, interventional, and therapeutic radiographic (x-ray) procedures including fluoroscopy and intravascular contrast studies, computer tomography, ultrasound, nuclear medicine (radionuclides), and magnetic resonance tmagmg.

We, the physicians of the Department ofRadiology ofHarrison Hospital, in order to comply with the current Medical Staff Bylaws, establish the following Rules and Regulations.

SECTION 2: ORGANIZATION

The Department ofRadiology professional and technical relationships are defined in the Radiology Department Policy Manual.

SECTION 3: OFFICERS

1. Chief of Radiology

The Chief of Radiology is elected in accordance with Article V, Section 3.3 of the Medical StaffBylaws.

The duties of the Chief ofRadiology are as follows:

a. Chairing the quarterly departmental meetings
b. Attending the Medical Executive Committee meetings
c. Reviewing and acting on disciplinary issues
d. Overseeing the committees of the Department ofRadiology
e. Reviewing and acting on questions of radiologic care as identified by the Quality Review Committee
f Coordination within the Department and between the Department of Radiology and other hospital departments
g. Recording and distributing minutes of all departmental meetings
h. Drafting correspondence pertaining to departmental policy and procedures

1 I. Evaluating, reviewing, and initiating changes within the Department of
2 Radiology
3
4 2. Assistant Chief of Radiology
5
6 The Assistant Chief ofRadiology is appointed by the Chief of Radiology and
7 assumes his duties in the absence of the Chief The term of office is the same as
8 that of the Chief
9
10 In the event that the Department of Radiology elects Co-Chiefs, an Assistant Chief may
11 not be necessary.
12 SECTION 4: COMMITTEES
13
14 1. Quality Review Committee
15
16 A three member Quality Review Committee will be drawn from the Active and
17 Associate Staff members of the Department. One of the three members will be
18 the Chief of the Department ofRadiology. The term of duty for the non-Chief
19 members will be one year. The Chairman of the Committee is responsible for
20 chairing the meetings and providing minutes of the proceedings. Membership
21 will be appointed by the Chief of the Department. The committee chair does not
22 have to be the Chief
23
24 a. Quality review is to identify potential or real problems of direct patient
25 care and radiologic patient care and initiate appropriate actions to remedy
26 such problems.

27 b. Based on quality review evaluations, identification of suitable educational
28 topics for presentation to the Department in its quarterly meetings.
29 c. Serving as an investigative committee in the event that the department is
30 requested to conduct an investigation of the performance of a department
31 physician.
32 d. Evaluating the technical and operational performance of the Department
33 ofRadiology with its evaluation forwarded to Hospital Administration.
34 e. Patient charts and x-ray filing jackets with x-ray reports may be evaluated
35 either by the Quality Review Committee to help determine adequacy of
36 care and radiologic diagnosis prior to advancement or reappointment of
37 privileges within the Department ofRadiology.
38

39 2. Radiation Safety Committee
40
41 A member of the Department ofRadiology, either Active or Associate Staffwill
42 join and participate in Radiation Safety Committee meetings and functions.
43
44 3. Liaison Committee
45

The Chairman of the Department ofRadiology and the Chief Technologist will form the primary membership of the Liaison Committee. Additional members will be appointed as desired by the primary membership. The purpose of this committee is to maintain communication between the technical radiologic as well as the professional radiologic staff and hospital administration.

All existing hospital Radiologic Department policies shall be available for review by the Chief ofRadiology.

Any changes in Harrison Hospital Radiology Department policies, except administrative policies, shall be reviewed by the Chief of Radiology prior to implementation and presented to the Department Staff for approval if the Chief of Radiology deems such approval appropriate.

SECTION 5: MEMBERSHIP AND CLINICAL PRIVILEGES

Membership and the granting of clinical privileges in the Department of Radiology will be carried out in accordance with the Medical Staff Bylaws, Article X, and Medical Staff Policies, Chapters 4 and 5.

SECTION 6: MEETINGS

Departmental meetings will be held at least quarterly for the purpose of quality review, Review ofhospital activities and policies, and determining policies of the Department of Radiology. The voting members of the Department will be both Active and Associate Staff of the Department. Votes will be determined by a simple majority rule except in the case of changes in the Rules and Regulations in the Department of Radiology at which time a quorum of fifty percent (50%) will be required and a sixty percent (60%) majority vote.

Active and Associate Staff members ofthe Department ofRadiology are expected to attend at least fifty percent (50%) of the regularly scheduled department meetings.

SECTION 7: AMENDMENTS

Proposals to amend these Rules and Regulations may be made at any regular meeting of the Department. Such proposed amendment shall lay-over for a period of one month, after which it may be voted upon at a regular meeting. A two-thirds majority vote of Department members present shall be required for approval. The proposed changes shall then be sent through appropriate channels for final approval, as outlined in the bylaws.

Approvals:

Department of Radiology:	September 11, 2000
Medical Executive Committee:	October 19, 2000
Joint Conference Committee:	October 26, 2000
Board of Directors:	October 26, 2000

MEDICAL STAFF
Rules and Regulations
Surgical Specialties

Effective Date	March 20, 2018	
Accountability	**Medical Staff**	**Administration**
	Surgical Specialties Section Bylaws Committee Medical Executive Committee	Director Medical Staff Services Chief Medical Officer
Review Date	March 20, 2019	

SS R&R 1	The Surgical Specialties Section is organized and staffed to provide care to any patient presenting at Harrison requiring inpatient or outpatient surgical services provided by the specialties included in this section.		
	1.1	In the case of Harrison employed physicians and providers in this Section, to provide care to patients presenting at the Harrison Health Partners clinics covered by selected specialties covered by this section.	
SS R&R 2	Specialties included within the Surgical Specialties Section are		
	• Cardio-Thoracic Surgery • Dentistry • Oral Surgery • Otolaryngology • Pathology • Plastic & Reconstructive Surgery • Thoracic Surgery • Urology • Vascular Surgery		
SS R&R 3	Qualifications for membership in the Surgical Specialties Section		
	3.1	Physicians	
		3.1.1	For initial appointment, Board Certification or Admissibility for Specialty Board appropriate for privileges being requested
		3.1.3	Specialty Boards acceptable for physicians are those accredited by the American Board of Medical Specialities or the American Osteopathic Association.
	3.2	Dentists and Oral Surgeons	
		3.2.1	Board Certification is not required for General Dentists as a condition of membership on the Medical Staff
		3.2.2	Board Certification or Admissibility is required for Oral Surgeons and Pediatric Dentists
		3.2.3	Specialty Boards acceptable for dentists are those accredited by the American Dental Association.
SS R&R 4	Credentialing and Privileging		
	4.1	Physician, dentist, and advanced practice clinician members of the Section will meet credentialing criteria, as established by the Section and approved by the Board, for every procedure or service provided.	
SS R&R 5	The Surgical Specialties Section is responsible to provide physician coverage for the Bremerton and Silverdale hospital campuses for the clinical services provided on the respective campuses. Such coverage may be available 24 hours per day, 7 days per week depending on physician staffing and hospital requirements.		
SS R&R 6	Members of the Section will facilitate inter-facility transfers between the Bremerton and Silverdale campuses for access to resources appropriate for the patient's clinical condition and anticipated needs.		

SS R&R 7	Physician and dentist members of the Section will meet the professional standards as established by the Medical Staff Bylaws and Policies.		
SS R&R 8	Meetings		
	8.1	The Surgical Specialties Section will meet as often as required to carry out the business of the section, but no less often than quarterly.	
	8.2	A quorum of the Surgical Specialties Section meeting will be defined as the number of Active Staff members present.	
	8.3	The Chief of the Surgical Specialties or a designated alternate attends the Medical Executive Committee meetings	
	8.4	Section members, physicians, dentists, and advanced practice clinicians are expected to attend at least two section meetings per year.	
		8.4.1	An exception is made for the Pathology service as most members of the group do not regularly work at Harrison. Those pathologists whose primary assignment is Harrison are expected to meet the attendance standard.
SS R&R 9	Voting		
	9.1	Section members who are members of the Active Medical Staff or Provisional Active Medical Staff may vote at Section meetings.	
	9.2	Advanced Practice Clinicians within the Section may vote in Section Meetings.	
	9.3	On matters related to peer review, only physician and dentist members of the Section may vote.	
SS R&R 10	Call Coverage		
	10.1	As stipulated in the Rules and Regulations of the Emergency Medicine Section, physician specialties within this Section, which participate in ED call coverage, will submit a monthly specialty call schedule to the Emergency Department within 5 days of the end of the previous month.	
	10.2	Each specialty will designate a member to be the point of contact for providing the schedule and responding to questions regarding call coverage for the specialty.	
	10.3	Members within a specialty are expected to take an equal share of Emergency Department call.	
	10.4	Section members may be temporarily excused from call duties due to illness or other factors upon written request from the physician and approved by the Section.	
SS R&R 11	Specialty Specific Addenda		
	11.1	It is recognized that, due to the diversity of specialties within the Section, there may be need for specialty specific rules.	
	11.2	Specialty specific rules must be approved by a majority of members of the specialty and approval by the Surgical Specialties Section and the Medical Executive Committee.	

Approval:

Surgical Specialties Section – approval for distribution for vote	October 14, 2016
Distributed to Section Members for vote	October 17, 2016
End of 60 day review period/approval	December 15, 2016
Bylaws Committee Technical Review	January 22, 2018
Medical Executive Committee	February 15, 2018
Board of Directors	March 20, 2018

END OF MEDICAL STAFF POLICIES