VIRGINIA MASON MEDICAL CENTER

MEDICAL STAFF
RULES & REGULATIONS

Approved by the Board of Virginia Mason Medical Center – June 10, 2021

PREAMBLE

Welcome to the Medical Staff of Virginia Mason Medical Center. Everything we do is ultimately to improve the health and well-being of our patients. The Virginia Mason Rules and Regulations that follow are a reflection of that and of our strategic plan.

Our vision is to be the quality leader and to transform healthcare. To become the quality leader, we must improve how we deliver healthcare by eliminating waste and standardizing excellence in our work.

Our mission is to improve the health and well-being of the patients we serve. Preventing disease, providing effective treatment and healing illness are our priorities and are what give our staff the energy to achieve our vision.

Please review the rules and regulations carefully and understand that these standards are part of a set of rules for which you will be held accountable. Should you have questions, please feel free to contact our Medical Staff Services office.

Again, we welcome you to our Medical Staff, and are glad you have joined our team.

VIRGINIA MASON MEDICAL CENTER

RULES AND REGULATIONS OF THE MEDICAL STAFF

I. CARE OF PATIENTS

A. Admissions

1. Patients are admitted to the Virginia Mason Hospital on the basis of medical need, and not on the basis of race, color, creed, ethnicity, religion, national origin, culture, language, marital status, sex, sexual orientation, gender identity or expression, physical or mental disability.

2. Any questions about financial issues or insurance coverage are referred to Patient Financial Services. (206) 223-6601.
Refer to Financial Assistance Policy.

3. Priorities for admission, particularly in times of high census, are as follows:
   a) Emergency
   b) Urgent medical or surgical condition
   c) Scheduled surgical procedure
   d) Elective admission

4. Virginia Mason Hospital (VMH) provides inpatient care to patients after their 15th birthday. Arrangements for admission of pediatric/adolescent patients should be made to Seattle Children's Hospital or Swedish Hospital Pediatrics should admission needs arise.
   a) Patients under the age of 15 years who require hospitalization after presenting in the emergency department or following ambulatory surgery or a special procedure must be transferred to an appropriate hospital (Seattle Children's Hospital or Swedish Medical Center)
   Refer to Pediatric Patients – Surgery Eligibility Policy
   b) The patient's attending physician is responsible for informing the child's parents or guardian that circumstances requiring hospitalization will require transfer to Seattle Children's Hospital or Swedish Medical Center.
   Refer to Transfer of Patient to Other Hospital or Agency Protocol.

5. Verification of Patient Identifiers
Two patient identifiers must be used to identify a patient, (e.g., patient name, medical record number (MRN), or date of birth (DOB)) at every encounter.
Refer to Verification of Patient Identification Policy.

6. Hospital Admission
A provisional diagnosis must be made for every patient prior to admission. In the case of an emergency, the provisional diagnosis shall be documented within 24 hours of admission.

Physicians and Advanced Registered Nurse Practitioners must evaluate all patients in a timely manner, as dictated by clinical acuity, and must establish a plan of care, communicate with the care team, and write orders within six hours of admission.

Patients admitted by an Advanced Registered Nurse Practitioner must be under the care of a physician and this must be documented in the patient's medical record. Patients admitted by a Certified Nurse Midwife (CNM) are not required to be under the care of a physician unless the patient is a Medicare Beneficiary.

7. Patients being admitted for elective procedures must have a completed pre-admission form sent in advance to the Admitting Office. Physicians and Advanced Registered Nurse Practitioners must verify and review results of all tests, studies and consults ordered.

8. Admission to Critical Care Unit (CCU)
   a) All patients entering a critical care unit must be evaluated within two hours of admission by an attending physician or "senior resident".
   b) If a senior resident performs the initial evaluation, communication between the senior resident and the responsible attending physician must occur within two hours of admission to the Critical Care Unit.
   c) If the admission involves transfer of care from one service to another, communication between the attending physician or Advanced Registered Nurse Practitioner (ARNP) of the transferring service and attending physician of the receiving service must occur within two hours of admission to the unit.

9. Informed Consent
Patients, or legal representatives for patients not competent, have a right to participate in and make informed decisions about whether to accept or reject medical treatments and procedures.

Healthcare providers have ethical and legal obligations to communicate sufficient information about proposed medical treatments and procedures, including non-treatment, to patients or their legal representatives, as part of the informed consent process.

With the exception of emergency situations in which a delay of care could compromise outcomes (e.g. life or limb threatening emergencies or risk of serious impairment of health), Virginia Mason requires healthcare providers to engage in the informed consent process prior to providing surgical and other

medically invasive treatment and procedures that involve more than a minimal degree of patient risk.
Refer to Informed Consent Policy.

10. Advance Care Planning
At the time of admission to the hospital the attending physician or ARNP must document "Code Status" when writing admission orders. It is expected, in patients with a serious or life limiting illness, that the managing physician will discuss issues of life support with the patient and appropriate family members or legal decision makers. If a current Advance Care Planning Note is in the electronic record, this should be reviewed and updated. If there is not an Advance Care Planning Note in the chart, then one should be created.

Advance Care Planning Note should include:

a) Patient wishes regarding life support
b) Reference to an advance directive if available
c) Reference to Physician Orders for Life Sustaining Treatment (POLST)
d) Identification of any durable power of attorney for healthcare.

Refer to Shared Decisions for Life-Sustaining Treatment Policy.

11. Physical Restraints
Physical restraints are defined as "any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of the patient to move his or her arms, legs, body or head freely."

Restraint use is limited to clinically appropriate situations in order to protect the safety of the patient or others, as assessed by a registered nurse, physician, advanced registered nurse practitioner (ARNP) or certified physician's assistant (PA-C). Restraints should be removed as soon as safely possible.

There are two types of restraints that may be used at Virginia Mason:

- Non-violent restraints for preventing interference with care
- Violent restraints for preventing immediate risk of harm to self or others.

Non-violent restraint use is initiated by order of a physician, PA-C or ARNP who has been granted clinical privileges at Virginia Mason Medical Center.

a) The continued need for the restraints must be evaluated at least every four hours, or more often as dictated by the patient's condition.
b) Restraints are to be discontinued as soon as a registered nurse, physician, ARNP or PA-C has assessed the patient and determined that the criteria for restraint use are no longer being met.
c) If a patient demonstrates new behavior that interferes with treatment, a new restraint order is required for each episode of restraint use.

Violent restraints are to be used only when a patient presents immediate, serious danger to self or others.

a) A face-to-face assessment by the physician, PA-C or ARNP is required within one hour of the application of violent restraints to determine if they are appropriate and, if so, an order to continue violent restraints must be written.

b) Violent restraint order renewal must occur every four hours for adults, and every two hours for those less than 18 years of age.

c) The managing physician, PA-C or ARNP must perform and document a face-to-face assessment every 24 hours in order to assess the need for continued use of violent restraints.

B. Medical Records

1. All clinician documentation created as part of a hospital encounter must be recorded in the Clinical Information System (CIS) by direct entry or transcription, with the exception of drawings and approved Virginia Mason Medical Center paper forms. Handwritten documentation must be legible.

2. All clinical services provided must be documented.

3. Teaching physicians must accurately document their role in the teaching process.

4. Code status, as well as appropriate conversations regarding advanced care planning, must be documented on every patient admitted to the hospital as part of admission orders and updated as circumstances change.

5. Inpatient medical records must contain the following physician documentation:

a) History and Physical

Refer to Medical Staff Bylaws for requirements related to History & Physical exams.

b) Progress Notes

Must be completed daily by the attending physician or the physician assuming the attending physician's responsibilities, or an Advanced Registered Nurse Practitioner.

c) Consultations

Must be documented by the consulting physician.

d) Brief Operative Note

Must be documented in the record immediately after surgery/procedure, if the Operative/Procedure Report is dictated. It can be recorded on the Brief Operation Report form, in the Progress Notes or electronically in the CIS.

e) Operative/Procedure Reports

Must be dictated or written the day of surgery or procedure, and must contain the following:

Preoperative and postoperative diagnosis
Name of primary surgeon and assistants
Procedure performed and description of procedure
Findings
Estimated blood loss, as indicated
Specimens removed, as indicated

f) Inpatient Diagnostic and Therapeutic Orders

Refer to Section C, The Use of Medications within the Medical Center.

All orders must be entered into the Clinic Information System. The only exceptions will be the use of paper orders during Clinical Information System (CIS) downtimes or when orders are not yet available via the electronic medical record, e.g. some chemotherapy orders.

To ensure patient safety, certain abbreviations cannot be used when writing orders.

Refer to Use of Abbreviations in the Medical Record Protocol for recommended abbreviation alternatives and updates of unacceptable abbreviations.

Medical student orders require a co-signature before being acted upon.

Orders with Nursing (except ARNP) or Pharmacy initiated changes will be acted upon but require a co-signature within 48 hours.

Verbal and telephone orders will be acted upon but require a co-signature within 48 hours.

Authentication of proposed change or medical student and verbal/telephone orders must be completed by the prescribing physician or ARNP who is responsible for the care of the patient.

All providers managing or consulting on hospital patients are required to receive training in reading and writing orders in the CIS.

g) Discharge Summary
Discharge Summaries must be completed for all patients admitted to inpatient status, regardless of length of stay.

Observation patients are considered outpatient status and do not require dictated Discharge Summaries.

Discharge Summaries must be dictated or written the day of discharge and include the following:

- Reason for hospitalization
- Significant findings
- Procedures performed and care, treatment, and services provided
- Patient's condition at discharge
- Final diagnosis(es)
- Discharge medications or reference the medication reconciliation list
- Instructions to patient, and family, as appropriate
- Date of admission and date of discharge

6. Hospital Outpatient Records must contain the following practitioner documentation:
   a) History and Physical: Same requirements as outlined for Inpatient status.
   b) Brief Operative Note: Same requirement as outlined for Inpatient status.
   c) Operative/Procedure Report: Same requirements as for Inpatient status.

7. Emergency Department Records contain the following documentation:
   a) Times and means of arrival
   b) Conclusions at termination of treatment, including:
      Final disposition
      Condition
      Instructions for follow-up care, treatment and services. \
      Documentation if the patient left against medical advice.
      Notation that a copy of the ED record is available to practitioner or medical organization providing follow-up care.

8. Problem and Diagnosis Lists must be maintained as outlined in the Problem and Diagnosis List Policy.

9. Dictation
   Dictation of reports and notes for patients must be dictated to an accepted Virginia Mason dictation system. The Health Information Services Department will provide instructions for use of the dictation system and descriptions of the various report/note types available for transcription

10. Authorized Entries, Authentication, Amendments and Abbreviations
    Authorized Medical Staff entries: Physicians, Podiatrists, Residents, Advanced Registered Nurse Practitioners and Physician Assistants are authorized to make entries in the medical record.
    a) Authentication: Physicians, Podiatrists, Residents, Advanced Registered Nurse Practitioners and Physician Assistants are required to authenticate transcribed documents, electronic health record entries (e.g. Orders) and computer generated documents (e.g. notes entered directly into CIS).
    b) Amendments to the record must be made as outlined in Virginia Mason's Health Information Services Policy.
    Refer to Amendment to Health Information Policy.
    c) Abbreviations in the record: The specified abbreviations outlined in Virginia Mason's Health Information Services protocol "Use of Abbreviations in Legal Medical Record" cannot be used when documenting clinical information in the medical record (inpatient and outpatient). *Refer to Use of Abbreviations in the Medical Record protocol.*

11. As defined by standard process, paper documents will be scanned into CIS, including but not limited to consents, approved paper forms, and outside records used for clinical evaluation and decision making.

12. As defined by standard process, medical photography and clinical photographs will be stored in a designated secure network folder.

13. Medical Record Completion Requirements
    Inpatient and Hospital Outpatient records are considered incomplete when missing required operative/procedure reports, discharge summaries and signatures on transcribed documents, electronic health record entries (e.g. orders), and notes entered directly into the CIS. Health Information Services will provide periodic notifications regarding incomplete records.
    a) Any record remaining incomplete three (3) days after discharge or procedure will be considered delinquent. Any record remaining incomplete due to lack of signature three (3) days post completion of report or entry will be considered delinquent.
       Refer to Medical Staff Bylaws, Article X, Section D. regarding process related to delinquent medical records.
    b) The Chair of the Patient Health Information Steering Committee (PHISC) or designee may declare any medical record complete for purposes of filing, as appropriate.

14. Ownership
    Medical Records are the property of Virginia Mason and must not be removed from Medical Center premises without subpoena.

15. Medical Records are retained as outlined in the Virginia Mason Health Information Services *"Health Information Retention" Policy.*

C. Use of Medications within the Medical Center

1. All orders for medications must be entered directly into the clinical information system via Computerized Provider Order Entry (CPOE) or written onto an approved pre-printed order sheet. All orders must be generated in accordance with Virginia Mason Medical Center guidelines and policies for safe medication practices.

   Reference policies:
   a) Ordering Medications
   b) Verbal and Telephone Orders,
   c) Allergy Information
   d) High Risk Medications
   e) Look-Alike-Sound-Alike Medications
   f) Drug-Drug and Drug-Food Interaction
   g) Patients Own Medications
   h) Order Clarification
   i) Medication Reconciliation
   j) Opioid Prescribing Limits
   k) Appropriate Use of Antimicrobials
   l) Ordering Chemotherapy (stewardship)
   m) Follow evidence based protocols adopted by the organization

2. Orders must be entered or signed by an individual authorized to prescribe. Healthcare providers authorized to prescribe include physicians, physician assistants, advanced registered nurse practitioners and pharmacists.

3. The Pharmacy and Therapeutics Committee is a standing committee of the Medical Executive Committee that is responsible for ensuring the safe and effective use of all medications in the Medical Center. Duties and responsibilities are outlined in Appendix A.

4. The *Drug Formulary* is a listing of all drugs approved for use in Virginia Mason and associated requirements pertaining to their use. Non-formulary drugs may be obtained through an exception process when patient care needs cannot be met with formulary agents.
   Refer to Non-formulary Medication Order Policy.

5. Non-FDA Approved pharmaceuticals/products: Routine use of non-essential alternative therapy products (e.g. herbal and dietary supplements, naturopathic remedies, certain vitamin components) is discouraged during inpatient hospitalization as they may contain pharmacologically active compounds about which limited safety and efficacy data are available.

6. Investigational Drugs will only be used pursuant to Virginia Mason's Institutional Review Board policy. Use of investigational drugs for hospital patients requires:
    a) Informed consent, signed by the patient or legal representative.
    b) Approval of the protocol by the Institutional Review Board or its chairman.
    c) Storage of investigational drugs must be in the Hospital Pharmacy, and are to be dispensed only upon the order of the principal investigator or designated associate investigator.

    Refer to Investigational Drug Policy and Protocol.

D. On-Call Standards

1. In accordance with the Medical Staff bylaws, certain Medical Staff are required to participate in emergency department call coverage or in other hospital coverage arrangements as determined by the Department to which the Member is assigned with approval by the Medical Executive Committee.

2. Response Standards
When on call, Medical Staff must be available by telephone within 10 minutes, and physically present at the hospital within 30 minutes when requested to do so by an Emergency Department physician or Medical Staff member requesting emergency consultation.

3. If an on-call physician fails to respond within the 10 minute time frame, the call will be escalated in stepwise fashion.
Refer to Emergency On-Call Protocol.

4. Medical Staff who are on call must refrain from alcohol and other substance consumption which may impair ability to perform their duties during the on-call period.

E. Emergency Care

1. Emergency patients will receive necessary stabilizing treatment regardless of their financial status and no person will be denied emergency treatment on the basis of race, color, creed, ethnicity, religion, national origin, culture, language, marital status, sex, sexual orientation, gender identity or expression, physical or mental disability.

2. Healthcare providers will offer a medical screen exam any patient who presents to the Emergency Department without first questioning their ability to pay.

3. Emergency Department patients are triaged to ensure care is provided to those with the most urgent/emergent need first.

4. If an individual has an emergency medical condition, the Emergency Department will provide examination, stabilization, and treatment within the capabilities of the hospital. A full description of the mechanism for providing emergency care, including provisions for compliance with Emergency Medical Treatment and Active Labor Act (EMTALA) legislation, is located within the ED. Consistent with EMTALA guidelines and in emergency situations where a person has presented to the ED with conditions that require care beyond the capabilities of the hospital, the ED provider will coordinate transfer to an appropriate healthcare facility.
   Refer to Inpatient Consultation Protocol.

F. Death of a Patient

1. When a patient expires in the hospital, every reasonable effort to identify and contact next of kin shall be made and shall be the responsibility of the managing physician.

2. Certain deaths must be reported to the Medical Examiner. *Refer to Autopsy Examinations Policy*. In the case of uncertainty regarding need to report a death, the Medical Examiner Office should be contacted at (206) 731-3232. Additional information is available about reporting requirements on the King County website.

3. Every death should be documented in the medical record with a note, which includes the time of death, and the Medical Examiner's case number if the case has been reported to the Medical Examiner.

4. Autopsy Reporting
   The Virginia Mason Medical Center policy related to the performance of an autopsy, consent for autopsy, and the release of human remains is defined in policy statements available in the Autopsy Examination Policy.

5. Legal permission must be obtained from the next of kin (see "Permission for Autopsy form" for details). The Medical Staff of Virginia Mason Medical Center considers the autopsy examination to be a pathology consultation and requires that "Autopsy Consultation Request" form be completed by a physician and submitted to the pathology department prior to the autopsy examination.

II. PROFESSIONAL RESPONSIBILITIES AND DUTIES

A. Responsibilities of the Managing Physician or Advanced Registered Nurse Practitioner

Every patient admitted to Virginia Mason Hospital shall have a managing physician or Advanced Registered Nurse Practitioner. The managing practitioner is responsible for coordination of a safe and efficient hospital stay for the patient. In order to assure this, the managing practitioner must:

1. Be continuously available, or clearly identify in the electronic medical record someone who is available, to care for the patient in the managing practitioner's absence. Standard work for contacting the managing practitioner is available on VNet.

2. Assure that the plan of care is updated in the medical record daily.

3. Provide care consistent with Virginia Mason organizational standards, policies and protocols including:
   a) Verification of Patient Identification
   b) Mediation Management Policies and Procedures
   c) Evidence Based Protocols (e.g., Sepsis, Central Line, Ventilator Acquired Pneumonia)
   d) Pre-procedure Timeout (Universal Protocol)

4. Communicate regularly with the patient, the care team, and the family. Include care team members, patients and their families when discussing care options and developing a plan of care. Document the plan of care in the medical record.

5. Assemble and coordinate necessary consultative expertise relative to the patient's acute conditions.

6. Ensure a safe and timely transition between care settings.

7. Be responsible for completion of documentation in the medical record pertaining to the episode of care.

8. Communicate explicitly when responsibility for care is transferred to another provider. Ensure safe and complete handoffs from hospital to home to include; medication reconciliation, handoffs between care team members, and to the patient and family.

9. Shared Decisions about Life-Sustaining Treatments are complex and patient specific. These decisions involve eliciting the patient's perspective and the clinical expertise of the attending of record along with any other clinicians involved in the patient's care.

10. When disagreements exist over changes to the Plan of Care to continue, limit or withdraw life-sustaining treatments, clinicians must continue treatment(s) already started or offered until:
    a) A consensus of all parties (clinicians, patient, surrogates) is reached,
    b) The treatment proves to be medically futile, or
    c) A conflict resolution process is complete.

    Refer to Shared Decisions for Life-Sustaining Treatment Policy and Bioethics resources.

11. Attendant Policy
    An attendant will be available, upon request, for all examinations and/or treatments, regardless of the gender of the patient or his/her healthcare provider in the hospital and clinic settings.
    Refer to Attendant Availability for Examinations and/or Treatments Policy.

12. Disclosure of Unanticipated Outcomes
    The attending physician, or his/her designee, will communicate with the patient, and as appropriate, family members or substitute decision makers, as soon as practical after the unanticipated outcome is identified.
    Refer to Response to Unanticipated Outcomes of Care Policy.

B. Citizenship and Membership

1. Unprofessional Conduct
   Practitioners will not engage in behaviors that could be construed as unprofessional, including but not limited to diversion of controlled substances, practice beyond the scope of practice as defined by law or rule, sexual contact with a patient, or the willful betrayal of a practitioner-patient privilege as recognized by law.

   Unprofessional Conduct is further defined by Washington State Law RCW 18.130.180.

2. Medical Staff will exhibit respectful behaviors consistent with the Physician Compact and Virginia Mason Health System Standard of Conduct.

3. Medical Staff will not engage in behaviors that could be construed as unprofessional, including but not limited to: inappropriate touching, sexual or otherwise; verbal or physical abuse; racial or ethnic discrimination; sexual comments; or innuendos.

4. In accordance with Virginia Mason's Standards of Conduct, practitioners will avoid any inappropriate and disruptive behaviors that may interfere with patient care delivery and services or any acts that interfere with the orderly conduct of the organization's or individual's abilities to perform their jobs effectively. Disruptive and inappropriate behavior includes, but is not limited to, abusive language, condescending voice intonation, angry outbursts, bigotry, bullying, demeaning behavior, offensive jokes, physical violence, and sexual misconduct. Behaviors that are also considered intimidating and disruptive include those which undermine a culture of safety include passive behaviors such as reluctance or refusal to answer questions, return phone calls, or return pages.
   Refer to policies:
   a) Standards of Conduct
   b) Physician Compact
   c) Sexual Misconduct Policy
   d) Drug Free Workplace

5. Obtaining Guidance in Instances of Uncertainty
   Medical Staff members are expected to be knowledgeable regarding rules, regulations, policies, laws and statutes that govern the work they perform. In areas of uncertainty, members have a duty to seek appropriate guidance within the organization.

6. Fitness for Duty Requirements
   Medical Staff members shall comply with applicable fitness for duty requirements per hospital policies.
   Refer to Fitness for Duty Policy.

7. Communication by Electronic Mail
   In order to support effective and timely communication, members of the Medical Staff are required to maintain an e-mail address and confirm that it is correctly identified on VNet. When unavailable or unable to respond to emails in a timely manner, it is required that an auto-reply message be activated providing appropriate notification of your absence.

8. Practitioners generally should not treat themselves or members of their immediate families. In emergency settings or isolated settings where there is no other qualified practitioner available, practitioners should not hesitate to treat themselves or family members until another practitioner becomes available. Except in emergencies, it is not appropriate for practitioners to write prescriptions for controlled substances for immediate family members. But

note: state law expressly prohibits a practitioner from prescribing or dispensing controlled substances for his or her own use.

Finally, while practitioners should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

9. Medical Staff Participation
In order to conduct business and assure quorum, Virginia mason expects that Active Category members of the Medical Staff attend the annual Medical Staff Meeting, Special Medical Staff Meetings, and participate in Electronic Voting.

10. Supervision of Physician Assistants

Physicians may only supervise a total of five (5) physician assistants through a formal and approved delegation agreement, with no more than three (3) being remote supervision, in accordance with Washington State law. Should a physician wish to petition the state for an exception to this rule, the physician must also petition an exception through Medical Staff Services for review by the Credentials Committee and the Medical Executive Committee. Requests for an exception to this rule will be reviewed on a case by case basis, with patient safety being at the forefront of the recommendation. The Board of Directors has the final authority to grant exceptions to rules and regulations.

C. Teaching Responsibilities

1. Graduate Medical Education Residency Programs and Committees
In keeping with its core educational mission, the Hospital will be the setting for certain graduate medical education residency and fellowship programs approved by the Accreditation Council of Graduate Medical Education (ACGME) and sponsored by Virginia Mason or other educational institutions.

2. Clinical Faculty
All members of the Active and Courtesy Medical Staff shall be members of the Clinical Faculty. Members of the Clinical Faculty shall be familiar with and contribute to the educational mission of Virginia Mason and any other sponsoring institution, and shall be supportive of house staff from any such institutions.

3. Core Teaching Faculty
Each ACGME-approved residency and fellowship training program shall receive specific support from the Core Teaching Faculty. Virginia Mason Program Directors appoint and approve the Core Teaching Faculty for each Virginia Mason teaching program. The rights and responsibilities of the Core Teaching Faculty at Virginia Mason, including application processes,

performance standards, and procedures for revoking or restricting Core Teaching Faculty status, shall be established by the Graduate Medical Education Committee (GMEC) and are set forth in the Resident Manual.

Only patients of the Core Teaching Faculty staff will be considered teaching cases. However, emergency care will be rendered to all patients by the house staff regardless of whether the patient's attending physician is a member of the Core Teaching Faculty.

a) Each teaching service patient must have an assigned Core Teaching Faculty attending physician who is responsible for the diagnostic and therapeutic management of that patient.
b) Members of the house staff may write patient care orders on all teaching service patients and emergency care orders on all patients, except that an attending physician must co-sign an admission order and admission history and physical. The Resident Manual provides further detail on other co-signature requirements.
c) Medical Staff are not prohibited from writing patient care orders. However, the Hospital GMEC may restrict the ability of the Medical Staff to write orders as a condition of Core Teaching Faculty appointment.

4. Medical Staff members who do not participate in the teaching program will not be subject to denial or limitation of clinical privileges for this reason alone.

5. Resident and Fellow Supervision and Working Environment
Resident and Fellow supervision requirements and clinical work hour standards are detailed in the Common Program Requirements of the ACGME. Roles, responsibilities and patient care activities of residents and fellows are described in the Resident Manual, and provided to the Medical Staff and Hospital Staff by posting to VNet. The Resident Manual also describes the mechanisms by which supervisors and Graduate Medical Education Program Directors make decisions about resident and fellows' involvement (and level of independence) in specific patient care activities.

6. There is a shared responsibility between the institution, teaching programs, faculty and residents/fellows to balance the provision of a sound academic and clinical education for the residents/fellows with concern for patient safety and resident well-being. Therefore, faculty must:
a) be familiar with the ACGME requirements and standards
b) contribute to their enforcement
c) notify Program Directors or the GMEC if they suspect compliance failure

7. Supervisory Lines of Responsibility for specific resident/fellow training programs are published in the current GME Resident Manual.

D. Integrity of Clinical Documentation and Coding

1. Clinical Coding (ICD-10-CM, CPT, HCPCS)
   Code assignments reported by Medical Staff members must be supported by clinical documentation in the medical record.
   a) Medical Staff members with responsibility for assigning clinical codes will remain familiar with internally published coding guidelines. If questions arise, members will obtain coding guidance from a certified coder in Professional Support Services, HIS Coding, or the Corporate Integrity Office.

2. Billing
   Charges initiated by Medical Staff members must be consistent with services provided and be supported by documentation and code assignments.
   a) Fees for professional services are governed by organizational policy. Individual providers may not make independent decisions regarding fee adjustments. Medical Staff members may discuss fee modifications with their respective Clinical Section or Department Head, Department Manager, or designated Finance representative.
   b) Teaching physicians submitting charges for services provided in a teaching capacity must do so in accordance with the Centers for Medicare and Medicaid rules for supervising physicians in teaching settings, Official Medicare guidelines, regardless of the patient's actual payer status.

3. Reporting Known or Potential Compliance Violations
   Medical Staff members have a duty to report known, potential or perceived violations of rules, regulations, policy, laws or statutes to their manager or Integrity Hotline.
   Refer to Standards of Conduct Policy.

E. Industry Relations

1. In their dealings with industry vendors, Medical Staff members will adhere to Virginia Mason Medical Center policies regarding conflicts of interest, industry relations, and gifts to ensure that these relationships are consistent with Virginia Mason's strategic mission, vision, values and legal requirements.
   Refer to Industry Relations Policy.
   a) Medical Staff members are specifically prohibited from accepting vendor gifts, including those of nominal value such as prescription pads and pens onsite at Virginia Mason.
   b) Medical Staff members are specifically prohibited from working with vendors directly.
   c) Medical Staff members are specifically prohibited from working directly with vendors to procure medications.

2. In situations of uncertainty, members will seek guidance from the Legal Department or the Corporate Integrity Office and act in a manner consistent with the guidance received.

III. QUALITY OF CARE

A. Workplace Safety & Patient Safety

1. Ensuring the safety of our patients and our workforce is a top priority and requires that actual or potential risks to patients and our workforce are recognized, eliminated, or mitigated to the extent possible.

2. All practitioners are required to identify and report all potentially reportable events, unanticipated outcomes, complaints or allegations of sexual assault or sexual misconduct, workplace and patient safety concerns. Workplace safety concerns that should be reported include observations of disrespectful, aggressive, or violent behaviors exhibited by patients or staff. All reports must be made using the Patient Safety Alert and Response System.
3. *Refer to policies:*
   a) Reportable Events
   b) Unanticipated Outcomes
   c) Patient Safety Alert (PSA)
   d) Allegations of Sexual Assault or Sexual Misconduct

4. Complaints/allegations of sexual assault or sexual misconduct must be reported immediately to the Patient Safety Office.

B. Control of Infections

1. Infection prevention and control training will be provided for each new Medical Staff member on hire and at least annually to assist staff in their responsibilities in this area.

2. Compliance with all Virginia Mason Medical Center infection control and occupational/employee health policies and procedures, as approved by the Infection Prevention and Antimicrobial Stewardship (IPAMS) Committee is required.

3. All team members will perform hand hygiene in compliance with organizational policy.
   Refer to Hand Hygiene Policy.

4. Patients with known or suspected infections must be cared for in accordance with standard and transmission-based precautions consistent with nationally-recognized guidelines and organizational policy.
   Refer to Standard and Transmission-Based Precautions Policy.

5. All Medical Staff shall facilitate the timely reporting of diseases of potential public health significance consistent with Washington State law and Virginia Mason policies and procedures by notifying the Infection Prevention and Control Department of confirmed or suspected infections developed after admission or after procedures for review, investigation, and reporting, if required.
   Refer to Reporting Notifiable Conditions to Public Health Policy.

6. Medical Staff will participate in and contribute to the work of the Infection Prevention and Antimicrobial Stewardship Committee on request.

C. Professional Practice Evaluation

1. Medical Staff will participate in quality and peer review activities.
   A basic responsibility of members of the Medical Staff and Allied Health Professionals with clinical privileges is to participate in quality and peer review activities. Quality improvement principles are applied to both peer review and system analysis activities in order to promote individual and organizational learning.
   a) System Quality Improvement – Practitioners may be asked to participate in the review and analysis of Patient Safety Alerts and Clinical Quality Indicators and assist in the development and implementation of system improvement activities.
   b) Professional Practice Evaluation – Core clinical competencies are subject to review and include patient care and procedural skills, medical knowledge, practice based learning and improvement, interpersonal and communication skills, professionalism, and system based practices. All initially requested privileges shall be subject to a period of focused professional practice evaluation (FPPE). The Medical Staff and privileged AHPs will also engage in ongoing professional practice evaluation (OPPE). *Refer to the Credentialing and Privileging Policy and Procedure Manual.*
   c) Medical Staff Members and Allied Health Professionals are expected to participate as reviewers in the Clinical Care Review process and FPPE process which supports Professional Practice Evaluation.

2. Performance is evaluated at regular intervals, and on an as-needed basis. Virginia Mason collects and reviews various peer review, quality, and service metrics through the quality and credentialing processes.

3. Evaluation of these results may result in the development of a performance improvement plan. Progressive discipline, up to and including termination of privileges, may occur for failure to:
    a) Engage in a performance improvement plan
    b) Comply with a performance improvement plan
    c) Meet the objectives of a performance improvement plan

4. Information that may be used to identify the need for performance improvement includes, but is not limited to, yearly performance evaluations by the Chief, patient satisfaction scores, patient complaints, peer review metrics, peer review surveys, focused reviews, case reviews, 360 surveys, clinical care reviews and claims history.

IV. DEFINITIONS

1. "Allied Health Professional" or "AHP" means an individual, other than a licensed Physician or podiatrist, who exercises professional judgment within the areas of his or her professional competence and the limits established by the Board of Directors, the Medical Staff, and applicable State laws; who is licensed or certified to render direct or indirect medical, dental, or podiatric care, either with or without the supervision or direction of a Member possessing privileges to provide such care in the Hospital; and who may be eligible to exercise Clinical Privileges and prerogatives in conformity with any rules adopted by the Board of Directors, the Medical Staff Rules & Regulations, these Bylaws, and the Credentialing Manual. AHPs are not eligible for Medical Staff membership. Allied Health Professionals include, without limitation: Advanced Registered Nurse Practitioners, Physician Assistants – Certified, Dentists, Optometrists, Clinical Pharmacists, and Certified Registered Nurse Anesthetists.

2. "Board Certification," with respect to Physicians and podiatrists, relates to obtaining certification in their primary area of practice at the Hospital, from the appropriate specialty/subspecialty Board. "Board Certification," with respect to AHP, relates to certification by a recognized certifying agency, if applicable.

3. "Board of Directors" or "Board" means the governing body of Virginia Mason Medical Center.

4. "Clinical Activity" includes admitting, consulting, performing procedures, ordering medications, reading medical imaging, examining specimens and biopsies, administering and monitoring anesthesia, or otherwise being directly involved in the care of a patient.

5. "Clinical Privileges" or "Privileges" means the permission granted by the Board of Directors to a Member, AHP or Non-ACGME Fellow to render specific patient services.

6. "Credentialing Manual" means the *Credentialing and Privileging Policy and Procedure Manual*, adopted by the Medical Staff and approved by the Board, as amended from time to time, which is made a part of and incorporated into these Bylaws.

7. "Hospital" means the facilities of the Virginia Mason Medical Center that are licensed as an acute care hospital under Section 70.41 of the Revised Code of Washington ("RCW").

8. "Hospital Administration" or "Hospital Administrator" means the administrative executive leader accountable and responsible for administrative oversight of the Hospital.

9. "Medical Staff" means the organizational component of the Hospital that includes all Physicians and podiatrists who have been granted recognition as Members pursuant to these Bylaws.

10. "Member" means any Physician or podiatrist who has been appointed to the Medical Staff.

11. "Physician" means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine or osteopathy.

12. "Practitioner" means a Physician, podiatrist, Allied Health Professional, or non-ACGME fellow.

13. "Professional Competence or Conduct" means an individual's level of competence or his or her professional conduct that affects or could adversely affect the health or welfare of a patient or patients.

APPENDIX A - MEDICAL STAFF COMMITTEES

Medical Executive Committee	Refer to Medical Staff By-laws
STANDING COMMITTEES	
Credentials Committee	The purpose of the Credentials Committee is to review applications, approve applicant credentials, make recommendations for appointment and reappointment to all categories of the medical, dental and allied health professional staff, and to make recommendations regarding the granting of Clinical Privileges. This Committee also develops and recommends policies and procedures for all credentialing and privileging activities.
Per-Operative and Procedural Services Steering Committee	The purpose of the Peri-Operative and Procedural Services Steering Committee is to provide policy direction and support for efforts to continuously improve the quality of perioperative services at the Hospital.
Pharmacy and Therapeutics Committee	The purpose of the Pharmacy and Therapeutics Committee is to serve in an oversight role for all matters that pertain to the use of medications including establishing policy on the safe and therapeutic use of medications, standards that define best practices (e.g., clinical guidelines, protocols, pathways), and performance improvement efforts related to the procurement, prescribing, dispensing, administering and monitoring of medications. The Pharmacy and Therapeutics Committee is responsible for approving medication management policies and drug formulary decisions, including: • Defining an "evidence based" Drug Formulary • Developing and monitoring of policies involving the use of medications in the Medical Center • Monitoring and evaluating adverse drug reactions and medication errors, and making appropriate recommendations for system changes to prevent such occurrences
Quality Assessment Committee	The purpose of the Quality Assessment Committee is to monitor and evaluate the quality of medical care promoting improvement

	to quality and ensuring compliance with regulatory and licensing bodies.
Graduate Medical Education Committee	The purpose of the Graduate Medical Education Committee is to set policy relating to the eight Virginia Mason graduate medical education programs (Internal Medicine, General Surgery, Transitional Year, Anesthesiology, Urology, Diagnostic Radiology, Female Pelvic Medicine and Reconstructive Surgery Fellowship, and Pain Medicine Fellowship), advise on medical student programs, appoint teaching faculty, and act in an advisory capacity to the Designated Institutional Official.
Utilization Review Committee	The purpose of the Utilization Review Committee is to provide review of services furnished to all patients, regardless of payer and promote appropriate and efficient utilization of services provided by Virginia Mason Hospital and the Medical Staff.