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INITIAL APPROVAL BY:
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Medical Executive Committee - May 30, 1996
CHI-FH Board of Directors - May 31, 1996

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PREAMBLE

WHEREAS, Franciscan Health System, doing business as CHI Franciscan, is a non-profit corporation organized under the laws of the State of Washington; and

WHEREAS, CHI-FH’s purpose is to serve as a health system providing patient care, education and research consistent with the Mission Statement of CHI-FH and Catholic Health Initiatives (“CHI”); and

WHEREAS, it is recognized that the Medical Staff wants to provide a structure to maintain and improve quality medical care within the Health System and must accept and discharge this responsibility, subject to the ultimate authority of the Board, and that the cooperative efforts of the Medical Staff, the Health System’s management and the Board are necessary to fulfill the Health System’s obligation to its patients;

THEREFORE, the Medical Staff adopts these Bylaws.

DEFINITIONS

A. “Allied Health Professionals” (AHP) means Certified Registered Nurse Anesthetists (CRNA), Advanced Practice Registered Nurses (APRN), Physician Assistants (PA) and other licensed independent practitioners. An AHP is an individual (other than a physician, oral surgeon, dentist, podiatrist or optometrist) who is licensed or certified to practice a health care profession and may be credentialed pursuant to the Credentialing Manual, but is not eligible for Medical Staff membership or entitled to certain rights granted Medical Staff members pursuant to these Bylaws.

B. “Board” means the Health System’s Board of Directors.

C. “Campus” denotes sites or facilities known as St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital (a Critical Access Hospital), St. Francis Hospital and St. Joseph Medical Center.

D. Clinical Privileges” or “Privileges” refers to permission granted by the Board, acting upon Medical Executive Committee recommendations, to members to render specific types of care to inpatients and outpatients, with reasonable access to and use of Hospital equipment, facilities, and Hospital personnel necessary to effectively exercise such privileges, at Hospital facilities.

E. Clinical Sections” are the Medical Staff groups of like specialty, practice, or clinical interest, as set forth in the Organizational Manual.

F. “Critical Access Hospital” means a hospital that meets the definition of “critical access hospital” set forth at section 1820(c)(2) of the Social Security Act and is certified as a critical access hospital by the Centers for Medicare & Medicaid Services.

G. “Health System” refers to CHI Franciscan (CHI-FH), a member of Catholic Health Initiatives (CHI).

H. “Hospital” denotes the single entity of the five Campus sites of St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital and St. Joseph Medical Center.
I. “Joint Conference” is defined as a meeting between representatives of the Operating Committees and the physician members of the Medical Executive Committee.

J. “Medical Executive Committee” means the selected representatives from each Campus, as set forth in Article IV, Section 2, who are authorized to act on behalf of the Medical Staff, as set forth in these Bylaws.

K. The term “Medical Staff” is defined as all medical and osteopathic physicians, dentists and podiatrists holding licenses who are privileged to attend patients at the Health System.

L. Franciscan Quality Council denotes the coordinating body for Hospital/Medical Staff quality programs.

M. “Policies and Manuals” means the Rules and Regulations, the Credentialing Manual, the Organizational Manual, the Credentialing Guidelines for Dependent Allied Health Professionals, and any other rules that are determined necessary by the Medical Executive Committee to further define the general policies contained in these Bylaws.

N. “Virtual Health Services” is the provision of clinical services to patients by physicians and practitioners from a distance via electronic communication including but not limited to telemedicine and telehealth services.

ARTICLE I. MEDICAL STAFF MEMBERSHIP

SECTION 1. NATURE OF MEDICAL STAFF MEMBERSHIP

Membership on the Medical Staff of CHI Franciscan is a privilege which shall be extended only to professionally competent physicians, podiatrists and dentists who continuously meet the qualifications, standards and requirements set forth in these Bylaws and associated policies of the Medical Staff and the Health System and who are approved by the Board.

SECTION 2. GENERAL QUALIFICATIONS FOR MEMBERSHIP

A. In addition to those more detailed qualification requirements set forth in the Credentialing Manual, only physicians with Doctor of Medicine or Doctor of Osteopathy degrees, dentists with Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) degrees or podiatrists with Doctor of Podiatric Medicine (DPMs) holding a license to practice in the State of Washington, who can document their background, experience, training, judgment, individual character and demonstrated competence, physical and mental capabilities, adherence to the ethics of their profession and ability to work with others with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by them will be given a high quality of medical or dental care, shall be qualified for membership on the Medical Staff. No physician or dentist shall be entitled to membership on the Medical Staff or to the exercise of particular Clinical Privileges merely by virtue of licensure to practice in this or in any other state, or of membership in any professional organization, or of privileges at another hospital or health system. No applicant who is currently excluded from any health care
program funded in whole or in part by the federal government, including Medicare or Medicaid, is eligible or qualified for Medical Staff or Allied Health Professional Staff membership.

B. Allied Health Professionals (Categories I, II and III) are not members of the organized Medical Staff. They are granted clinical privileges without membership.

SECTION 3. NONDISCRIMINATION

The Health System will not discriminate in granting staff appointment and/or Clinical Privileges on the basis of race, gender, faith, national origin, age, disability, creed, veteran's status, sexual orientation, gender identity or gender expression.

SECTION 4. ETHICAL REQUIREMENTS

A person accepting membership on the Medical Staff agrees to act in an ethical, professional and courteous manner; in accordance with the principals as embodied by the Corporate Responsibility Program of Catholic Health Initiatives and with the “Ethical and Religious Directives for Catholic Health Care Facilities” which are incorporated in these Bylaws as Appendix A.

SECTION 5. RESPONSIBILITIES OF MEMBERSHIP

A. Subject to any other provision of these Bylaws Active Staff members with appropriate privileges manage and coordinate the patient's care, treatment and services. He/She is not responsible for the actions of other physicians, dentists, Allied Health Professionals or Health System employees, unless under his/her supervision or sponsorship.

B. Each Medical Staff member must abide by the Bylaws, Rules and Regulations, Standards of Conduct Policy 310 and other policies and procedures of the Health System.

C. Each Medical Staff member records an appropriate history and physical examination as delineated in Article III, Section 2 of the Medical Staff Rules and Regulations. Specifically, a medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with state law and the Rules and Regulations. The history and physical shall be countersigned by the attending physician.

When the medical history and physical examination is completed within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition must be completed and documented by a physician, an oral and maxillofacial surgeon or other qualified licensed individual in accordance with state law and the Rules and Regulations.
D. In accordance with the Health Insurance Portability and Accountability Act of 1996 and as amended by the Balance Budget Act of 1997, immediately upon notice of any actual exclusion from any federally funded health care program, disclose to the Health System’s President and Chief Executive Officer or designee, by telephone call and in writing, any notice to the member or his or her representative of actual exclusion from any health care program funded in whole or in part by the federal government, including Medicare or Medicaid.

E. Each staff member shall notify the Chief Medical Officer or his/her designee immediately (within 10 working days) when it relates to any of the following:

1. Professional liability judgments or settlements;
2. Reports made to the National Practitioner Data Bank;
3. Changes in malpractice liability insurance coverage;
4. Staff membership at any hospital or health care facility/organization is modified: voluntary or involuntary denial, limitation, suspension, revoking or not renewing or subject to probationary conditions or any pending proceedings;
5. Clinical privileges at any hospital or health care facility/organization are modified: voluntarily or involuntarily denial, limitation, suspension, revoking, or not renewing or subject to probationary conditions, or any pending proceedings.

SECTION 6. PRACTITIONER RIGHTS

A. Any Active Medical Staff member has the right to an audience with the Medical Executive Committee. In the event a practitioner is unable to resolve a difficulty working with his/her respective clinical section chief or medical director, the physician may, upon presentation of a written notice, meet with the Medical Executive Committee to discuss the issue.

B. Any Active Medical Staff member has the right to initiate a recall selection of a Medical Staff officer and/or clinical section chief. A petition for such recall must be presented to the Medical Executive Committee, signed by at least ten percent (10%) of the members of the Active Staff. Upon presentation of such a valid petition, the Medical Executive Committee will schedule a special general staff meeting for purposes of discussing the issue and (if appropriate) entertain a “no confidence vote”. A three-fifths (3/5) majority of votes cast is required to sustain a “no confidence” motion. Voting shall be by mailed ballot.

C. Any practitioner may call a special staff meeting upon presentation to the Medical Executive Committee of a petition signed by ten percent (10%) of the members of the Active Staff. The Medical Executive Committee will schedule a general staff meeting for the specific purpose addressed by the petitioners. No business other than that in the petition may be transacted at the meeting. The meeting will be within thirty (30) days of receipt of the petition.

D. Any Active Medical Staff member may raise a challenge to any rule, regulation, or policy established by the Medical Executive Committee. In the event a rule, regulation, or policy is felt to be inappropriate, any Active Medical Staff member may submit a petition to the
Medical Executive Committee signed by ten percent (10%) of the members of the Active Staff. When such petition has been received by the Medical Executive Committee, it will either: (1) provide the petitioners with information clarifying the intent of such rule, regulation or policy and/or (2) schedule a meeting with the petitioners to discuss the issue. If scheduled, the meeting will be within thirty (30) days of receipt of the petition.

E. Any specialist/subspecialist group may request a clinical section meeting when a majority of the members/subspecialists believe that the clinical section has not acted in an appropriate manner.

F. Section 6 (A-E) above does not pertain to issues involving disciplinary action, denial of requests for appointment or Clinical Privileges or any other matter relating to individual “credentialing” actions. Section 7 and the Fair Hearing Plan provide recourse in these matters.

ARTICLE II. CATEGORIES OF AND APPOINTMENT TO THE MEDICAL STAFF

SECTION 1. THE ACTIVE STAFF CATEGORY

A. Qualifications:

1. Documentation of experience and training, completion of an Accreditation Council for Graduate Medical Education (ACGME), American Osteopathic Association (AOA), or American Podiatric Medical Association (APMA) approved residency and board admissibility or board certification at the time of initial appointment is required, except for dentists.

2. After the date of enacting these Bylaws, at the time of initial appointment, practitioners must have completed the minimum training requirements for board admissibility in the specialty in which they wish to practice. The adequacy of this training is determined by the Credentials Committee of the Medical Staff.

3. Each practitioner must meet the Privilege criteria defined by the Credentials Committee for each Privilege requested under the process defined in the Credentialing Manual.

4. Each practitioner must provide to the Health System evidence of professional liability insurance which meets criteria established by the Board and must maintain continuity of coverage including prior acts coverage for claims made policies. Any change in professional liability carrier or status of coverage will be reported to the office of the Chief Medical Officer or designee immediately (within 10 working days).

5. Each practitioner must have documented evidence of compliance with Continuing Medical Education requirements established by the Washington Division of Professional Licensing and the Health System.
6. All practitioners shall reside and practice in sufficient proximity to the Campus to insure that any patient under the care and supervision of such practitioner will receive continuous care consistent with their expected needs, especially in the case of emergencies.

B. **Prerogatives:** Appointees to this category may:

1. Exercise Clinical Privileges approved by the Board without limitation, except as otherwise provided in the Medical Staff Rules and Regulations, or by specific restriction.

2. Vote on all matters presented at general and special meetings of the Medical Staff, and of the appropriate committee of which he/she is a member.

3. Hold office and sit on or be the chairperson of any committee, unless otherwise specified elsewhere in these Bylaws.

C. **Responsibilities:** Appointees to this category must:

1. Select the Campus at which their practice will be focused and at which they will vote.

2. Actively participate in recognized functions of the Medical Staff, including quality improvement and other monitoring activities, in monitoring initial appointees during their provisional period, and in discharging other staff functions as may be required by the Medical Executive Committee from time to time.

3. Participate in the emergency room and other specialty coverage programs unless exempted by the Medical Staff Operating Committee of their designated Campus or the Medical Executive Committee. This is further defined in the Rules and Regulations. Active Staff members are required to participate on a roster providing backup call for the Emergency Service and provide initial follow-up care for patients seen in the Emergency Service.

4. Fulfill the basic responsibilities of Medical Staff membership as set forth in Article I, Section 5 of these Bylaws.

**SECTION 2. THE AFFILIATE CATEGORY**

A. **Qualifications:** The Affiliate category is reserved for practitioners who do not meet the eligibility requirements for the Active category, and for those who do not seek Clinical Privileges. This category may also apply to practitioners who do not intend to admit and/or treat patients in the Hospital and Clinical Privileges shall not be offered.

B. **Prerogatives:** Appointees to this category may:

1. Attend educational meetings or committee meetings for educational purposes.

2. Not have voting rights or hold a Medical Staff office.
3. Review their own patient’s medical record but may not make any entries, write orders, record progress notes or request consultations.

C. Responsibilities: Appointees to this category must fulfill the basic responsibilities of Medical Staff membership as set forth in Article I, Section 5 of these Bylaws.

SECTION 3. THE HONORARY CATEGORY

Honorary category is awarded to those individuals the Medical Executive Committee wishes to honor. Such staff appointees are not eligible for Clinical Privileges and may not hold Medical Staff office, but may attend Medical Staff meetings in a non-voting capacity. Members in the Honorary category have no general Medical Staff obligations, except for any committee obligations, as applicable.

SECTION 4. APPOINTMENT

A. Procedure for Appointment: The procedure for appointment to the Medical Staff shall be that described in the Credentialing Manual as they may be established and amended by the Medical Executive Committee with the approval of the Board.

B. Applicant's Burden. The applicant shall have the burden of producing adequate information for a proper evaluation of such applicant’s competence, character, ethics, and other qualifications and of resolving any doubts about such qualifications. The applicant shall have the burden of providing evidence, if challenged, that all of the statements made and the information given on such applicant’s application are factual and true.

SECTION 5. REAPPOINTMENT

A. When Required. Reappointment to the Medical Staff shall be required on at least a biennial basis.

B. Factors to be Considered for Reappointment. Each recommendation concerning reappointment of a member to the Medical Staff shall be based upon:

1. The member’s professional ethics, competence, and clinical judgment in the treatment of patients as indicated by the member’s practice at the Health System, information obtained from other hospitals, health care facilities, and health plans, and updated information with respect to such member’s professional liability experience.

2. The member’s physical and mental capacity to treat patients.

3. The member’s compliance with the Bylaws and other Medical Staff documents.
4. The member’s use of the Health System’s facilities for such member’s patients, such member’s cooperation and relations with other practitioners and such member’s general attitude toward patients, the Health System and the public.

a. Procedure for Reappointment. The procedure for reappointment to the Medical Staff shall be that described in the Credentialing Manual as they may be established and amended by the Medical Executive Committee with the approval of the Board.

b. Member’s Burden. The member applying for reappointment shall have the burden of providing adequate information for a proper evaluation of such member’s competence, character, ethics, and other qualifications and of resolving any doubts about such qualifications. Such member shall have the burden of providing evidence, if challenged, that all of the statements made and the information given on such member’s application are factual and true.

SECTION 6. CLINICAL PRIVILEGES

A. Delineation and Scope of Clinical Privileges. The Clinical Privileges recommended to the Board shall be based upon the applicant’s education, training, experience, demonstrated competence and judgment, references and other relevant information.

B. Procedure for Assignment of Clinical Privileges. The procedure for assignment and modification of Clinical Privileges shall be that described in the Credentialing Manual as they are established and amended by the Medical Executive Committee with the approval of the Board.

C. Modification of Clinical Privileges. Any member of the Medical Staff who wishes to augment or otherwise modify such member’s Clinical Privileges may be granted such augmentation or modification upon such member’s demonstration that such member possesses the requisite training, skill, and experience necessary to competently exercise the Clinical Privileges sought. The procedure for modification of Clinical Privileges shall be that described in the Credentialing Manual as established and amended by the Medical Executive Committee with the approval of the Board.

D. Allied Health Professionals defined in the Credentials Manual as Categories I and II may care for patients in the hospital or ambulatory surgery setting in accordance with the scope of their professional license. The specific clinical privileges granted and degree of supervision required, if any, will be defined in the practitioner’s delineation of privileges and, in the case of PA-Cs, in the practice plan as well.

E. Each section of the organized Medical Staff will develop credentialing criteria for the granting of clinical privileges to Allied Health Professionals as defined in the Credentials Manual as Categories I, II and III whose clinical activities fall within the oversight of the Medical Staff. The credentialing criteria of classifications of Allied Health Professionals working within the Section must be approved by the Credentials Committee, Medical Executive Committee and Board of Directors initially and reviewed periodically to ensure the credentialing criteria and delineation of privileges are reflective of desired clinical practice in the hospital or ambulatory care setting.
F. Remote Provider and Virtual Health Services Privileges.

1. In order to meet patient care needs, the Health System or a Hospital may enter into agreements with practitioners, hospitals, or other health care entities to provide clinical services (including but not limited to interpretive and, diagnostic, or consultant services) through remote providers using virtual health services technology. In such instances, the individual practitioners must be granted appropriate Clinical Privileges by Health System, but they are not required to be members of the Medical Staff.

2. Specific Clinical Privileges for the diagnosis and treatment of patients at the Hospitals in this manner must be developed and delineated based upon commonly accepted quality standards.

3. If the agreement for Virtual Health Services is with an individual practitioner, the practitioner must be granted Clinical Privileges in the manner provided for in the Credentialing Manual for members of the Medical Staff.

4. If the agreement for Virtual Health Services is with a distant Medicare participating hospital, the Health System may accept the credentialing and privileging performed by the distant Medicare participating hospital as its own, provided that there is a written agreement between the Health System or a Hospital and the distant Medicare participating hospital, the distant hospital provides a copy of the Clinical Privileges held by each applicable practitioner, and the Health System shares with the distant hospital its performance review data of the practitioner.

5. If the agreement for virtual health services is with a distant virtual health services entity which is not a Medicare participating hospital, the Health System may accept the credentialing and privileging performed by the distant virtual health services entity if there is a written agreement specifying that the distant virtual health services entity will credential and privilege the Practitioner and furnish services according to, and in accordance with, all applicable Centers for Medicare & Medicaid Services conditions of participation applicable to the Health System, the virtual health services entity ensures that the practitioners will provide the remote services consistent with their education, training, and competence, and the Health System shares its performance review data of the relevant practitioners with the distant virtual health services entity.

6. In all cases, the practitioner must hold a license to practice in the State of Washington.

7. In all cases the Medical Executive Committee and the Board must approve the practitioner’s Clinical Privileges.

8. Temporary Privileges (granted in accordance with the Credentialing Manual) may be used if the Health System has a pressing clinical need that can be met by a Practitioner providing services via a virtual health services link.

G. Closed Panel, Exclusive and Semi-Exclusive Contracts

1. To promote quality care, patient safety, efficiency, adequate coverage, or
compliance with accreditation standards, the Health System or a Hospital may elect to close a service line or program as “closed panel” or enter into exclusive or semi-exclusive contracts with groups or individual practitioners to provide professional services in the service line or program on an exclusive basis.

2. Through a closed panel arrangement, the Health System or Hospital may close the service line or program and limit the grant and exercise of Clinical Privileges in the service line or program to those practitioners who meet certain objective qualifications or comply with objective requirements for accreditation or staffing under the closed panel requirements, as adopted and amended from time to time. Examples of a closed panel include Hospital programs that are seeking or have been awarded status as a “Center of Excellence” (“COE”) in accordance with nationally recognized standards, where the COE status requires that all practitioners meet certain objective qualifications (such as subspecialty board certification) or comply with objective COE requirements (such as documentation or response times).

3. To be eligible to apply for or exercise Clinical Privileges in a program or service line operated as a closed panel, a practitioner must continuously meet the objective qualifications and comply with the closed panel requirements. If a Medical Staff member fails to maintain the objective qualifications or to comply with the closed panel requirements, his/her ability to exercise Clinical Privileges in the closed panel will be automatically suspended until such time, if ever, as he/she comes into full compliance with the closed panel requirements.

4. The Health System or Hospital may enter into a contract with group or individual practitioners to provide professional services in a service line or program on an exclusive or semi-exclusive basis. “Semi-exclusive” contracts may be used to arrange for more than one group or individual provider to be the exclusive providers of professional services in a service line or program.

5. To be eligible to apply for or exercise Clinical Privileges in a service line or program operated under an exclusive or semi-exclusive contract, the practitioner must be and remain a member, employee, or subcontractor of the group or person that holds the exclusive or semi-exclusive contract for a service line or program. If a Medical Staff member fails to maintain his/her status as a member, employee, or subcontractor of the group or person that holds the exclusive or semi-exclusive contract for a service line or program, his/her ability to exercise Clinical Privileges in the service line or program will be automatically suspended until such time, if ever, as his/her affiliation with the group or person that holds the exclusive or semi-exclusive contract is reinstated.

SECTION 7. DISASTER MANAGEMENT

In the event of a disaster, Emergency Management Disaster Plans and Procedures are implemented (Refer to #504.00, 504.20, 504.60 and 504.70).

The Chief Medical Officer or designee has authority for Medical Staff activities when the plan is implemented. If the emergency situation requires, this authority includes changing or overruling
the orders of primary physicians, discharging patients to other facilities (or other locations) and whatever else may be medically required in his/her professional opinion.

ARTICLE III. OFFICERS

SECTION 1. OFFICERS OF THE MEDICAL STAFF

The officers of the Medical Staff shall be:

A. President of the Medical Staff
B. A Vice President from each Campus
C. A Vice President-elect from each Campus

SECTION 2. QUALIFICATIONS FOR MEDICAL STAFF LEADERS

Only those Active Staff appointees who satisfy the following criteria shall be eligible to serve as Medical Staff officers, clinical section chiefs, assistant clinical section chiefs and committee chairpersons:

A. Those who have been appointed and remain in good standing on the Active Medical Staff of the Health System throughout their term of office.
B. Those who have no pending adverse recommendations concerning staff appointment or Clinical Privileges.
C. Those who have demonstrated involvement in maintaining quality medical care at the Hospital.
D. Those who are not presently serving as a Medical Staff or corporate officer, department chief or committee chairperson at another hospital, and shall not so serve during the term of office.
E. Those who have constructively participated in Medical Staff affairs, including peer review activities.
F. Those who are willing to discharge faithfully the duties and responsibilities of the position to which the individual is selected, elected or appointed.
G. Those who are knowledgeable concerning the duties of the office.

All Medical Staff officers, clinical section chiefs and committee chairpersons must possess at least the above qualifications and maintain such qualifications during their term of office.
SECTION 3. SELECTION OF OFFICERS OF THE MEDICAL STAFF

Selection of the officers of the Medical Staff shall be arranged by the Medical Staff Office in such a manner that a Vice President-elect shall be selected each year from each Campus.

A. Vice Presidents and Vice President-elects: Nominations for the Vice President-elect shall be made by the Medical Staff Operating Committee of each Campus in accordance with Article V, Section I of these Bylaws. The Vice President-elects in their second year shall automatically become the Vice Presidents.

B. President of the Medical Staff: The members of the Medical Executive Committee will select a President of the Medical Staff from their own membership to serve a two (2) year term. Such selection shall be made at the first Medical Executive Committee meeting after the start of the Medical Staff year.

SECTION 4. TERM OF OFFICE

All officers of the Medical Staff shall serve a two (2) year term (one year as a Vice President and one year as the Vice President-elect). The President of the Medical Staff may, in some cases, serve a three (3) year term; one year as a Vice President or Vice President-elect and two (2) years as the President of the Medical Staff. Officers shall take office on the first day of the Medical Staff year.

SECTION 5. VACANCIES IN OFFICE

Vacancies in office during the Medical Staff year shall be filled by the Medical Staff Operating Committee of the Campus from which the vacancy developed.

SECTION 6. DUTIES OF OFFICERS

A. President of the Medical Staff – The President of the Medical Staff shall serve as chair of the Medical Executive Committee and will fulfill those duties specified in the Organizational Manual.

B. Vice Chair – In the absence of the President of the Medical Staff, a Vice Chair elected by the Medical Executive Committee from among its members shall assume all the duties and have the authority of the President of the Medical Staff. Each member shall perform such further duties to assist the President of the Medical Staff as the President of the Medical Staff may from time to time request.

SECTION 7. REMOVAL FROM OFFICE

The Medical Staff may remove from office any officer by petition of twenty-five (25) percent of the Active Staff members and a subsequent two-thirds (2/3) majority of ballots cast by the Active Staff and returned within fourteen (14) days of mailing. Removal shall be for failure to conduct those
responsibilities assigned within these Bylaws or other policies and procedures of the Medical Staff.

SECTION 8. CLINICAL SECTION CHIEFS

A. Selection: Clinical Section Chiefs for those Clinical Sections of the Medical Staff set forth in Article II of the Medical Staff Organizational Manual, shall be selected in accordance with Article II, C.2. of the Medical Staff Organizational Manual. Any such selected Clinical Section Chief must meet the qualifications for Medical Staff leaders set forth in Article III, Section 2 of these Bylaws.

B. Duties: The duties and responsibilities of the Clinical Section Chiefs at each Campus may include the following:

Clinically related activities of the Clinical Section;

1. Administratively related activities of the Clinical Section, unless otherwise provided by the relevant Hospital;

2. Continuing surveillance of the professional performance of all individuals in the Clinical Section who have delineated Clinical Privileges;

3. Recommending to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Clinical Section;

4. Recommending Clinical Privileges for each member of the Clinical Section;

5. Assessing and recommending to the relevant Hospital or Health System authority off-site sources for needed patient care, treatment, and services not provided by the Clinical Section or the Hospital;

6. The integration of the Clinical Section into the primary functions of the Hospital;

7. The coordination and integration of interdepartmental and intradepartmental services;

8. The development and implementation of policies and procedures that guide and support the provision of care, treatment, and services;

9. The recommendation for a sufficient number of qualified and competent persons to provide care, treatment, and services;

10. The determination of the qualifications and competence of Clinical Section or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

11. The continuous assessment and improvement of the quality of care, treatment, and services;

12. The maintenance of quality control programs, as appropriate;
13. The orientation and continuing education of all persons in the Clinical Section;

14. Recommendations for space and other resources needed by the Clinical Section; and

15. Compliance with state and federal laws regarding the practice of medicine; including without limitation, the prohibitions against fee splitting, and the anti-referral and anti-kickback statutes.

ARTICLE IV. COMMITTEES

SECTION 1. DESIGNATION AND SUBSTITUTION

There shall be a Medical Executive Committee and Credentials Committee and such other standing and special committees of the staff responsible to the Medical Executive Committee as may from time to time be necessary and desirable to perform the staff functions listed in these Bylaws. Those functions requiring participation of, rather than direct oversight by, the staff may be discharged by the Medical Staff representation on such Health System committees as are established to perform such functions.

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to the Medical Executive Committee, but a standing or special committee has been formed to perform the function, the committee so formed shall act in accordance with the authority delegated to it by the Medical Executive Committee. All such committee actions are subject to review by the Medical Executive Committee.

SECTION 2. MEDICAL EXECUTIVE COMMITTEE

A. Composition:

The Medical Executive Committee may include members and other practitioners and individuals determined by the Medical Staff. The Medical Executive Committee shall consist of the following voting members: President of the Medical Staff and Vice President, Vice President-elect and two members at large from each Campus. The Chairs of the Credentials, Bylaws and Peer Review Committees shall be ex-officio members without vote. The Chair may appoint another Committee member to attend as his/her delegate. The Chief Executive Officer (or his/her designee), Hospital President(s), Associate Chief Medical Officers and Chief Medical Officer shall be ex-officio members without vote. The President of the Medical Staff shall serve as the chair of the Medical Executive Committee.

B. Selection and Removal of Medical Executive Committee Members:

Nominations for the members of the Medical Executive Committee shall be made by the Medical Staff Operating Committee of each Campus in accordance with Article V, Section I of these Bylaws. Members of the Medical Executive Committee may be removed from
the Medical Executive Committee in accordance with Article III, Section 7 of these Bylaws. All members of the Medical Executive Committee shall serve a two (2) year term, except in some instances, the President of the Medical Staff may serve on the Medical Executive Committee for three (3) years, as described in Article III, Section 4 of these Bylaws.

C. Function and Duties:

The Medical Executive Committee shall hold executive function and shall act on behalf of the Medical Staff between meetings of the Medical Staff at each Campus. The duties and the authority of the Medical Executive Committee shall be to:

1. Receive or act upon reports and recommendations concerning patient care quality and appropriateness reviews, evaluation and monitoring functions and the discharge of their delegated administrative responsibilities. Recommend to the Board-specific programs and systems to implement these functions. This shall include but not be limited to receiving reports and recommendations from the Franciscan Quality Council.

2. Coordinate the activities and policies adopted by the Board

3. Submit recommendations (with or without comment) to the Board concerning all matters relating to appointments, reappointments, staff category, Clinical Privileges and corrective action.

4. Be Accountable to the Board for the overall quality and efficiency of patient care in the Health System.

5. Take reasonable steps to encourage professionally ethical conduct and competent clinical performance on the part of Medical Staff appointees including initiating investigations and initiating and pursuing corrective action, when warranted.

6. Make recommendations on medical administrative and Health System management matters.

7. Keep the Medical Staff informed concerning the licensure and accreditation status of each individual Campus.

8. As consistent with the mission and philosophy, the Medical Executive Committee will participate in identifying community health needs and in setting Health System goals and implementing programs to meet those needs.

9. Represent and act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws.

10. Formulate Medical Staff Rules, Policies and Procedures.

In addition to those duties and responsibilities of the Medical Executive Committee set forth herein, the Medical Staff may delegate the Medical Executive Committee to act on the Medical Staff’s behalf on certain matters by a two-thirds (2/3) vote of the members of the Active Staff. The members of the Active Staff may also remove the Medical Executive Committee’s delegated authority upon a two-thirds (2/3) vote.
D. Meetings:

The Medical Executive Committee shall meet at least ten (10) times per year and maintain a permanent record of its proceedings and actions.

SECTION 3. CREDENTIALS COMMITTEE

There shall be a Credentials Committee established by the Medical Executive Committee.

A. Composition:

1. This committee shall consist of three (3) members from each Campus appointed by the Medical Staff Operating Committee of that Campus.

2. The Chair of the Credentials Committee shall be appointed by the President of the Medical Staff and shall serve as an additional member.

3. Members will serve for a period of two (2) years and may be reappointed.

4. The Associate Chief Medical Officers and the Chief Medical Officer will serve as ex-officio members, without vote.

B. Duties:

1. The Credentials Committee will develop professional criteria for Clinical Privileges for all practitioners in the Health System.

2. The Credentials Committee will make recommendations to the Medical Executive Committee regarding all applications for Medical Staff and Allied Health Professionals appointment, reappointment and privilege requests.

3. The Credentials Committee will provide each campus Medical Staff Operating Committee with a list of site specific Medical Staff and Allied Health Professional appointments, reappointments and privilege requests.

4. Records will be maintained of all committee activities and shall be confidential.

5. The Credentials Committee will meet at least six (6) times a year.

6. The Credentials Committee may direct the creation of a Special Procedures Review Subcommittee to address the definition of procedure specific privileging criteria for new or unusual treatments.

SECTION 4. MEDICAL STAFF WELL-BEING COMMITTEE (see Policy #30.0)

There shall be a Medical Staff Well-Being Committee established by the Medical Executive Committee. CHI Franciscan complies with and honors the Americans with Disabilities Act in all well-being and impairment proceedings.
A. **Purpose:**

1. The purpose of the Medical Staff Well-Being Committee shall be to ensure the quality of care and patient safety by promoting the competence of the Medical Staff and by attempting to resolve matters relating to Medical Staff Members’ health, well-being or impairment prior to the evolution of such difficulties into significant patient care problems.

2. A further purpose is to function as an investigative body in response to properly submitted reports related to the health, well-being or impairment of the Medical Staff.

3. With respect to matters involving individual Medical Staff Members, the Committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential.

4. If, as a result of a formal investigation, the findings suggest that the impairment of a Medical Staff Member may pose a risk of harm to the Hospital patients (or prospective hospital patients), then those findings shall result in referral to the Chief Medical Officer or designee and President of the Medical Staff for appropriate corrective action.

5. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

B. **Composition:**

1. The Committee shall be composed of no fewer than three (3) and no more than five (5) active medical staff members selected by the President of the Medical Staff.

2. The Committee may add, as they deem appropriate, additional members – such as a mental health provider or a practitioner in the same specialty field as the practitioner being discussed – needed to address the issues of a specific case.

3. Members will serve for a period of two (2) years and may be reappointed.

4. The Associate Chief Medical Officers and the Chief Medical Officer will serve as an ex-officio member, without vote.

C. **Meetings:**

1. The Committee shall meet at the beginning of its two (2) year term to familiarize its members with its purpose, function and processes. The prior term’s chairman, with assistance as appropriate by the Chief Medical Officer or designee and/or the President of the Medical Staff, will provide this briefing.

2. At its initial meeting, the members will elect a chairman who will be the contact person for the committee.

3. The Committee shall meet on an as-needed basis and shall operate as a component of the Hospital’s Quality/Risk Management Program. It shall maintain
only such records of its proceedings as it deems advisable, but shall report on its activities on a routine basis to the Medical Executive Committee.

SECTION 5: PEER REVIEW COMMITTEE

There shall be a Medical Staff Peer Review Committee established by the Medical Executive Committee. See Peer Review Policy #50.0.

A. Composition:

1. The Peer Review Committee shall consist of at least six (6) established leaders representing a broad variety of specialists across the system with representation from each Campus.

2. The Chair shall be appointed by the President of the Medical Staff.

3. Membership will be reviewed and approved by the Medical Executive Committee.

4. Members will serve for a period of two (2) years and may be reappointed.

5. The Medical Staff President, Medical Staff President Elect, Medical Staff Vice Presidents, Associate Chief Medical Officers and the Chief Medical Officer may serve as an ex-officio member, without vote.

B. Duties:

1. Establish, maintain and ensure a consistent, timely, defensible, balanced, useful and ongoing peer review process.

2. Review data derived from the peer review process to identify and address organizational trends and physician specific issues.

3. Determine if the peer review process is operating as it should and take appropriate or necessary action to ensure that the process meets the above criteria.

4. Whenever corrective action is taken or requested, the Peer Review Committee shall investigate charges, compile a detailed report and make a recommendation to the Medical Executive Committee.

5. Function on an ad hoc basis to review individual, potentially problematic cases and/or providers.

C. Meetings:

The Peer Review Committee shall meet on an ad hoc basis, as needed, but at least one time per year.
SECTION 6: FRANCISCAN QUALITY COUNCIL

The Franciscan Quality Council (FQC) is a regularly constituted committee of the Health System that reports to the Medical Executive Committee. It is the responsibility of the medical staff to monitor and lead improvement of the quality of care for the Health System. The FQC may report on behalf of the medical staff to the Medical Executive Committee. See Quality and Safety Plan, Policy #395.

A. Composition:

1. This committee shall consist of: a physician Chair, a Chief Nursing Officer Co-Chair, one (1) member from each Campus appointed by the Medical Staff Operating Committee of that Campus; a representative from the Franciscan Inpatient Team and a representative from the Quality and Value Committee of the Board of Directors.

2. The physician Chair shall be appointed by the President of the Medical Staff.

3. The Chief Medical Officer, Associate Chief Medical Officers, Chief Nursing Officer, Vice President Informatics and Operations, Health System Quality Director, Performance Excellence Director and other Health System administrators will serve as members.

B. Duties:

1. Health System has established the FQC as its central, regularly constituted quality improvement committee.

2. Oversee the Health System’s coordinated Quality and Safety Plan and responsible for monitoring results, recognizing successes, and overseeing the design and maintenance of the Quality and Safety Plan. See Quality and Safety Plan, Policy #395.

3. Review and evaluate the overall quality of health care services rendered to patients by members of the clinical and support services within the Interdisciplinary Teams (IDTs).

4. Define and prioritize Health System’s quality and safety improvement efforts and activities utilizing strategic goals, institutional performance data and trends, and benchmark data.

5. Oversee and monitor the effectiveness of patient safety, clinical quality, patient satisfaction and care coordination performance improvement activities of each of the clinical services within the Interdisciplinary Teams (IDTs).

6. Coordinate the acquisition of performance improvement information and interface with appropriate hospital committees and departments of the Health System to improve organizational performance.

7. Oversee compliance with quality-related statutory and regulatory requirements.
C. **Meetings:**

   The FQC shall meet at least quarterly and maintain a permanent record of its proceedings and actions.

**SECTION 7: STAFF FUNCTIONS**

The function of the Medical Staff shall be implemented in accord with these Bylaws, the current Organizational Manual and/or by resolution of the Medical Executive Committee. This can be accomplished through assignment of functions to staff committees, staff officers or other officials or to interdisciplinary Health System Committees. These functions are to:

A. Monitor and evaluate care provided in and develop clinical policy for special care areas, such as intensive or coronary care units; patient care support services, such as emergency, outpatient, home care and other ambulatory care services;

B. Conduct and/or coordinate quality and appropriateness and improvement activities, including invasive procedures, blood usage, drug usage reviews, medical record and other reviews;

C. Conduct and/or coordinate utilization review activities;

D. Conduct and/or coordinate credentials investigations regarding Medical Staff membership and granting of Clinical Privileges and specified services;

E. Provide continuing education opportunities responsive to quality assessment/improvement activities, new developments and other perceived needs, and supervise the Health System’s professional library services;

F. Develop and maintain surveillance over drug utilization policies and practices;

G. Investigate and monitor nosocomial infections by working with the Health System’s infection control program;

H. Participate in planning for response to fire and other disasters, for the Health System’s growth and development, and for the provision of services required to meet the needs of the community;

I. Direct organizational activities of the Medical Staff including review and revision of the Medical Staff Bylaws, Medical Staff officer and committee nominations, liaison of the Medical Staff Committee with Health System administration, and review and assist in achieving Health System accreditation;

J. Coordinate the care provided by members of the Medical Staff with the care provided by the nursing service and with the activities of other Health System patient care and administrative services; and

K. Assess and recommend off-site sources for needed patient care, treatment and services not provided by the Health System.
ARTICLE V. CAMPUS ORGANIZATION

SECTION 1. ORGANIZATION OF CAMPUSES

The Medical Staff will be organized into five Campuses which are located at St. Anthony Hospital, St. Clare Hospital, St. Elizabeth Hospital, St. Francis Hospital and St. Joseph Medical Center.

A. Medical Staff Operating Committee

1. Each Campus will establish a Medical Staff Operating Committee. The Vice President will chair the committee and serve as an officer of the Medical Staff on the Medical Executive Committee.

2. **Composition:** Medical Staff Operating Committees shall consist of the four (4) Medical Executive Committee representatives (Vice President, Vice President Elect and two members-at-large), all Campus Section Chiefs and other invited clinical representatives. The Hospital President and Chief Medical Officer or designee will serve as ex-officio members without vote. The Vice President shall serve as the chairperson of the Medical Staff Operating Committee.

3. **Selection:** Nominations for Vice President-elect and an at-large members of each Campus Medical Staff Operating Committee shall be made by a committee composed of the current Vice President and two immediate past chairpersons of each Campus’s Medical Staff Operating Committee willing and able to serve. Additional nominations may be made for each Campus by submitting a petition signed by either ten percent (10%) of or twenty (whichever is less) Primary Medical Staff members of that Campus. The Medical Staff Operating Committee will make the final selection from those nominated.

4. **Structure:** The Medical Staff Operating Committee will be responsible for organizing its Campus for purposes of providing medical administrative services, assisting in the monitoring and improvement of patient care and otherwise fulfilling the responsibilities delegated to it by the Medical Executive Committee.

5. **Meetings:** Each Medical Staff Operating Committee will meet at least quarterly.

B. Utilization Management Committee

There shall be a Utilization Management (UM) Committee for each acute care hospital established by the Medical Staff Operating Committee as delineated in the Utilization Management Plan.

1. **Composition:**
a) This committee shall consist of at least two (2) members of the active medical staff at each Campus and will include the Medical Director(s) of the Hospitalist Teams, or appropriate designee(s).

b) Medical Staff committee members shall be appointed by the Medical Staff Operating Committee of that Campus.

c) An active member of the Medical Staff will chair the Utilization Management Committee and shall be appointed by the Medical Staff Vice President.

d) The remaining members will be comprised of appropriate representatives of the following institutional departments:
   i. Administration, Care Management, Patient Access, HIM
   ii. Others: Compliance, Clinical Effectiveness, Transfer Center as identified on an ad hoc basis
   iii. Medical Directors or health care practitioners may be consulted from time to time as necessary for determination of medical necessity in their specialty areas

2. Objectives:

   The objective of this committee is to review services furnished by the institution and by members of the medical staff to patients, and to govern its operation by delivering the Right Care at the Right Place and Right Pace/Time.

3. Duties

   a) To ensure that all patients receive the Right Care:
      i. Consistent with the patient’s documented/communicated condition, differential diagnosis, and actual diagnosis and reflects the resources required to provide high quality care
      ii. Using professionally recognized standards of healthcare, clinical guidelines, and established utilization processes

   b) To ensure that all patients are cared for at the Right Place:
      i. By appropriate outpatient care for patients not requiring hospitalization
      ii. By appropriate hospitalization of patients who require hospitalization as inpatients or observation
      iii. By transition to the appropriate level of care as soon as their condition no longer requires hospitalization at an acute care hospital

   c) To ensure that all patients are cared for at the Right Pace/Time
      i. Through the efficient use of hospital facilities and services as well as community health care resources
      ii. By transition to the appropriate next level of care including that discharge to outpatient care and outpatient facilities (SNF, Rehab, Hospice, etc,) occurs at the earliest, clinically appropriate time
SECTION 2. OPTIONAL SECTIONS

Other than the Medical Staff Operating Committee, any group of physicians may organize themselves into a clinical section. Any clinical section, if organized, will not be required to hold regularly scheduled meetings. Attendance will not be required unless the clinical section chairperson calls a special meeting to discuss a particular issue. (Such special meetings must be preceded by at least two (2) weeks prior notification for those expected to attend.) Any clinical section will select a member to act as chief of that clinical section. Clinical sections may also select a member to serve in the capacity of assistant chief.

Clinical sections may perform any of the following activities:

A. Continuing education.
B. Grand rounds.
C. Discussion of clinical policy.
D. Discussion of equipment needs.
E. Development of clinical recommendations for clinical section chief, Medical Staff Operating Committee or Medical Executive Committee.
F. Participation in the development of criteria for Clinical Privileges.
G. Discussion of a specific issue at the request of a clinical section chief, Medical Staff Operating Committee or the Medical Executive Committee.

Except in extraordinary circumstances, no minutes or reports reflecting the activities of clinical sections will be required. Only when clinical sections are making formal recommendations to the Medical Staff Operating Committee will a report be required from the clinical section chief documenting their position.

NOTE: Clinical section meetings will ordinarily not be staffed by representatives of the Medical Staff Office. Attendance will not be required.

ARTICLE VI. CORRECTIVE ACTION

SECTION 1. DEFINITION

The term "corrective action" includes reducing, restricting, suspending, revoking, denying or failing to renew Clinical Privileges or membership on the Medical Staff. Certain adverse actions are excluded from the proceedings afforded under this Article. These include:

A. Adverse actions of any kind with respect to temporary or emergency Clinical Privileges.
B. Termination of Staff membership or Clinical Privileges resulting from or pursuant to a contractual provision with the practitioner.
C. Summary suspension, pending review findings (Section 2).

D. Termination of application/reapplication processing due to failure on the part of applicant to respond to time schedules as outlined in Articles I & II of the Credentialing Manual.

E. Any adverse action involving Allied Health Professionals.

F. The rejection of an application and termination of processing of said application.

G. The automatic suspension or relinquishment of Medical Staff membership or Clinical Privileges as set forth in the Credentials Manual.

SECTION 2. SUMMARY SUSPENSION

A. Imposition

1. Whenever action must be taken immediately, because of any potential danger to the health of any individual, including to, patients, other members of the Medical Staff, the Health System, or its personnel, and immediate action is required to protect such individual, then the Chief Executive Officer and the President of the Medical Staff or their designated representative shall have the authority to suspend all or any portion of the Clinical Privileges of the practitioner.

2. Such summary suspension shall become effective immediately upon imposition.

B. Purpose of Summary Suspension

1. Summary suspension is limited to no more than fourteen (14) days, during which time an investigation is conducted to determine the need for professional review action.

2. The Peer Review Committee will be convened to review the reasons for summary suspension and make a recommendation to the Medical Executive Committee regarding the need for professional review action.

3. In no case shall a summary suspension exceed a time period of fourteen (14) continuous days unless the Chief Executive Officer and the President of the Medical Staff, or their designated representative, determine that failure to continue a summary suspension may result in serious breach of good patient care.

C. Medical Executive Committee Action

1. The Medical Executive Committee may recommend modification, continuance, or termination of the terms of the summary suspension.

2. If, as a result of such hearing, the Medical Executive Committee does not recommend immediate termination of the summary suspension, the affected practitioner shall be entitled to notice and opportunity for a panel review hearing and the appellate procedure as provided for under Articles VII and VIII.
3. The summary suspension as sustained or modified by the Medical Executive Committee shall remain in effect pending review and final determination as provided for under Articles VII and VIII.

D. Patient Care

Immediately upon the imposition of a summary suspension, the Chief Medical Officer or his/her designee shall have responsibility for identifying appropriate Campus medical coverage for the patients of the suspended practitioner still in the Hospital at the time of such suspension. The wishes of the patients shall be considered in the selection of such an alternative practitioner.

SECTION 3. AUTOMATIC SUSPENSION OR RELINQUISHMENT

A. Delinquent Medical Records

1. See Policy “Completion and Filing Medical Records” of the Medical Staff Rules and Regulations (Article III, Section 9).

2. In the event that any practitioner practices while suspended for delinquent medical records, the Chief Medical Officer or designee may request corrective action from the Medical Executive Committee pursuant to Article VI.

3. This automatic relinquishment shall be in effect until all records are completed.

B. State or Federal Action

1. Action by the relevant Washington State Department of Health Medical professional agency, revoking or suspending a practitioner’s license or other authoritative body having the authority to interrupt or terminate practice shall cause automatic suspension or relinquishment of all of the practitioner’s Hospital privileges.

2. Current members of the Medical or Allied Health Professional Staffs who are excluded from a federally funded health care program shall cause automatic suspension or resignation from the Medical Staff.

C. Felony Conviction

Upon conviction of a felony in any U.S. court of law, the practitioner’s staff privileges will be automatically terminated. The practitioner may request appropriate preapplication forms for Medical Staff membership upon removal of any restraints against medical practice by the court. The “Limitation on Reapplication for Membership” shall apply (Credentialing Manual, Article III).

D. Professional Liability Insurance

Receipt of notice of cancellation of professional liability insurance or failure to provide the Hospital with satisfactory evidence of current and continuous professional liability insurance which meets the criteria established by the Board shall be cause for automatic relinquishment of Medical Staff Privileges. Automatic relinquishment for professional
liability insurance shall remain in effect until the practitioner has supplied the Medical Staff Office with evidence of current and continuous professional liability insurance meeting such criteria (see Article II, Section 1, A4).

E. Late or Incomplete Reappointment Applications

1. Failure to return the reappointment application in sufficient time (less than three weeks) to process prior to the current expiration of privileges, shall be cause for automatic relinquishment of Medical Staff Privileges.

2. Automatic relinquishment shall remain in effect until such time as the review, evaluation and approval by the Board has occurred.

F. Removal of Medical Records

Unauthorized removal or alteration of medical records from the Hospital shall be cause for automatic suspension of Medical Staff privileges. This suspension shall be in effect until such medical records are returned to the Hospital (see Rules and Regulations, Article III, Section 8C).

G. Closed Panel, Exclusive or Semi-Exclusive Contract

1. If the Health System or Hospital elects to operate a service line or program as a closed panel and the practitioner does not meet the objective qualifications and requirements for the closed panel, (i) the practitioner is not eligible to apply or reapply for Clinical Privileges in the service line or program, and (ii) if the practitioner has Clinical Privileges in the closed panel, the practitioner’s right to exercise the Clinical Privileges is automatically suspended until such time, if ever, as the practitioner fully satisfies the objective qualifications and cures any past deficit in the objective requirements of the closed panel.

2. If a Health System or Hospital elects to operate a service line or program under an exclusive or semi-exclusive contract and the practitioner is not a member, employee, or subcontractor of the group or person that holds the exclusive or semi-exclusive contract, (i) the practitioner is not eligible to apply or reapply for Clinical Privileges in the service line or program, and (ii) the practitioner’s right to exercise Clinical Privileges is automatically suspended until his/her affiliation with the group or person what holds the exclusive or semi-exclusive contract is fully reinstated.

H. Rights of the Practitioner

1. A practitioner subject to suspension or relinquishment of Clinical Privileges pursuant to this Article VI, Section 3, Paragraph A-G, shall not be entitled to any of the procedural rights of Article VII, subject to an investigation by the Medical Executive Committee into the veracity of underlying facts leading to automatic suspension or relinquishment.

2. The Chief Executive Officer or the Chief Medical Officer acting on behalf of the Chief Executive Officer will so notify the practitioner, in writing by certified mail, return receipt requested, of any such automatic suspension or relinquishment.
I. Patient Care

Immediately upon automatic suspension or relinquishment, the Chief Medical Officer or his/her designee shall have responsibility for identifying appropriate medical coverage for the patients of the practitioner still in the Hospital at the time of such suspension or relinquishment. The wishes of the patients shall be considered in the selection of such an alternative practitioner.

SECTION 4. REQUEST FOR CORRECTIVE ACTION

A. Corrective action may be requested whenever the competence or professionally ethical conduct as defined and described by the practitioner's professional organization, either within or outside the Hospital, of any practitioner with Clinical Privileges:

1. Affects or could affect adversely the health or welfare of a patient or patients or staff; or

2. Is considered to be lower than the established standards; or

3. Is considered to be contrary to the Bylaws, rules and regulations, policies and procedures of the Hospital or the Medical Staff; or

4. Is considered to be disruptive to the operations of the Hospital such that the quality or efficiency of patient care is or is likely to be affected.

B. The initiation of Corrective action against such practitioner may be requested by:

1. Any Hospital Staff member through his/her Vice President, or the Chief Medical Officer or designee, or

2. Any Medical Staff member through any officer of the Medical Staff; or

3. The President of the Medical Staff or designee; or

4. The Chief Executive Officer, or designee, e.g. Chief Medical Officer; or

5. The Board.

C. All requests for corrective action shall be in writing and supported by reference to the specific activities or conduct which constitute the grounds for the request. Such requests will be presented to the Medical Executive Committee by the Medical Staff officer, the Chief Medical Officer, the Chief Executive Officer or the Board representative to the Medical Executive Committee. The President of the Medical Staff shall promptly notify the Chief Executive Officer (CEO) in writing of all requests.
SECTION 5. FAIR HEARING & DUE PROCESS PROCEDURE

A. Fact Finding

1. Whenever corrective action is requested, the chairperson of the Medical Executive Committee shall convene the Peer Review Committee to investigate charges.

2. Should the charge or charges deal with a practitioner’s professional conduct or competency, at least one (1) member of the Peer Review Committee shall have expert knowledge in the area of practice in question. If the Peer Review Committee does not have the expert knowledge needed, such a practitioner may be requested from the Medical Staff to assist the Peer Review Committee. No member of the Peer Review Committee may be related to, in practice with, or in direct economic competition with the practitioner. If it is not possible to appoint a Medical Staff member with expert knowledge who is not related to, in practice with, or in direct economic competition with the practitioner, professional consultation from outside the organization, not in direct economic competition with the practitioner, may be requested to assist the Peer Review Committee. In this case, no member of the Peer Review Committee need have expert knowledge.

3. The Peer Review Committee shall make its report in writing to the Medical Executive Committee within thirty (30) days of its appointment, if possible. The report will include a recommendation for response to the request for corrective action.

B. Preliminary Findings

1. Should the report from the Peer Review Committee contain a recommendation for corrective action which could involve a reduction, restriction, suspension, revocation, denial or failure to renew Clinical Privileges or membership on the Medical Staff, the practitioner shall be permitted to make an appearance before the Medical Executive Committee and the Peer Review Committee prior to its taking action on such a request.

2. The practitioner shall be encouraged to present any relevant data, information or opinion, but this appearance shall not constitute a formal hearing, shall be preliminary in nature, and none of the procedural rules provided in these Bylaws with respect to hearing shall apply thereto.

3. A record of such appearance and the practitioner’s presentation, if any, shall be made by the Medical Executive Committee and a copy shall be provided to the practitioner involved.

C. Medical Executive Committee

1. The practitioner may appear and present his/her data, information or opinion at the Medical Executive Committee.

2. The action of the Medical Executive Committee on a request for corrective action may be, but is not limited to:

   a. Reject or modify the request for corrective action;
b. Issue a warning, a letter of admonition, or a letter of reprimand;
c. Impose terms of probation or a requirement for consultation;
d. Recommend additional training;
e. Recommend reduction, suspension or revocation of Clinical Privileges;
f. Recommend that an already imposed summary suspension of Clinical Privileges be terminated, modified or sustained; or
g. Recommend that the practitioner’s Staff membership be suspended or revoked.

3. If the recommendation of the Medical Executive Committee is favorable to the practitioner, the Chief Executive Officer, the appropriate Campus Vice President, and the concerned practitioner shall be notified in writing.

4. Recommendation unfavorable to the practitioner shall be provided to the practitioner, in writing, in accordance with the provisions of Article VII. Such recommendation shall also be provided to the appropriate Campus Vice President, and the procedures for a review under Article VII and appeal to the Board-under Article VIII shall apply.

D. Chief Executive Officer

All requests for corrective action and any recommendation by the Medical Executive Committee relating thereto shall be promptly forwarded to the Chief Executive Officer. Such recommendation shall be in writing. The Medical Executive Committee shall continue to keep the Chief Medical Officer fully informed of all action taken in connection therewith.

ARTICLE VII. PANEL REVIEW HEARING

SECTION 1. RIGHT TO HEARING

A. Should action taken by the Medical Executive Committee adversely affect the practitioner’s appointment to, or status as, a member of the Medical Staff, or his/her exercise of Clinical Privileges, the practitioner shall accept and abide by this decision or he/she may request a Panel Review Hearing to contest the action.

B. Any Active Medical Staff member has a right to a hearing/appeal pursuant to the Hospital’s fair hearing plan in the event any of the following actions are taken or recommended:

1. Denial of Staff reappointment;
2. Revocation of Staff appointment;
3. Denial or restriction of requested Clinical Privileges;

4. Reduction in Clinical Privileges;

5. Revocation of Clinical Privileges;

6. Individual application of, or individual changes in, mandatory concurring consultation requirement; and

7. Suspension of Staff appointment or Clinical Privileges if such suspension is for more than fourteen (14) days or if the suspension has been extended as provided under the Fair Hearing Process.

SECTION 2. NOTICE BY CHIEF EXECUTIVE OFFICER

A. The Chief Executive Officer shall be responsible for giving prompt written notice, by certified mail with return receipt requested, of an adverse recommendation to any affected practitioner who is entitled to a hearing under these Bylaws.

B. Such written notice shall state:

1. That an adverse recommendation or decision has been proposed to be taken against the practitioner;

2. Reasons for the proposed adverse recommendation or decision;

3. That the practitioner has the right to request, within thirty (30) days following the date of receipt of such notice, a hearing on the proposed action;

4. That any request for the hearing shall be in writing by certified mail with return receipt requested; and

5. A summary of the practitioner’s rights in the hearing as delineated in Section 7 of this Article VII.

SECTION 3. WAIVER OF RIGHTS FOR HEARING

A. Refusal on behalf of the practitioner to accept written notice from the Chief Executive Officer shall constitute the practitioner’s receipt and waiver of his/her right to the Panel Review Hearing proceedings of Article VII and appellate review proceedings of Article VIII.

B. The failure of a practitioner to request a hearing to which he/she is entitled by these Bylaws within the time and in the manner herein provided shall be deemed a waiver of his/her right to such hearing and to any further review to which he/she might otherwise have been entitled on the matter.

C. When the waived hearing relates to an adverse recommendation of the Medical Executive Committee of the Medical Staff, the recommendation or decision shall thereupon become and remain effective against the practitioner pending the Board’s decision on the matter.
The Chief Executive Officer shall promptly notify the affected practitioner of his/her status by certified mail, return receipt requested.

SECTION 4. NOTICE OF PANEL REVIEW HEARING

A. If a Panel Review Hearing is requested in a timely manner as provided for under Section 2B of this Article VII, the Chief Executive Officer shall send a notice to the practitioner, by certified mail, return receipt requested.

B. Such notice shall set forth the following information:

1. The place, time and date, of the hearing. The date shall not be less than thirty (30) days nor more than ninety (90) days after the date of receipt of the request for a hearing;

2. A list of the witnesses (if any) expected to testify at the hearing on behalf of the ad-hoc committee;

3. A concise statement of reasons for the adverse recommendation;

4. A summary of the practitioner's rights in the hearing as delineated in Section 7 of this Article VII.

SECTION 5. COMPOSITION OF HEARING REVIEW PANEL

A. Members

1. When a Panel Review Hearing is to be conducted, the members of the hearing committee shall be composed of at least three (3) members of the Active Medical Staff, who:

   a) Have not had previous connection with the case under appeal;

   b) Are not related to, in practice with, or in direct economic competition with the practitioner involved; and

   c) Are appointed by the President of the Medical Staff.

2. The practitioners shall be advised of the individuals selected and be given the opportunity to object if there are legitimate basis for objections, such as bias or direct economic competition.

3. There shall be at least two alternative members appointed from the Active Medical Staff.

4. The Chief Executive Officer and the Chief Medical Officer or designee may attend, but may not vote. They shall not participate in deliberations.

5. Practitioner review of panel:
a) The practitioner, upon learning of the composition of the review panel, shall be entitled to two (2) preemptory challenges.

b) Any challenged member will be dismissed from the panel and an alternate member(s) be impaneled in order of selection by lot.

6. Each member of the review panel is required to represent in writing to the President of the Medical Staff that he/she is not in actual or potential direct economic competition with the affected practitioner.

7. After the final composition of the review panel is determined, the review panel shall choose its chairperson.

B. Hearing Officer

The President of the Medical Staff shall designate as a Hearing Officer an individual with demonstrated competence to lead such a hearing, and who is not related to, in practice with, or in direct economic competition with the practitioner. The Hearing Officer may be an attorney at law, but may not be the legal counsel for the Hospital. Reasonable justification for determining a proposed Hearing Officer to be unacceptable must be provided to the Medical Executive Committee who shall have sole authority to render a decision on the matter.

SECTION 6. CONDUCT OF PANEL REVIEW HEARING

A. Attendance

1. A majority of the review panel members and the Hearing Officer shall be present when the hearing takes place.

2. No review panel member may vote by proxy and no review panel member may vote unless he/she was present during the entire hearing.

B. Record of Hearing

The Hearing Panel shall maintain a record of the hearing by a stenographic reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the Hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual’s expense. Oral evidence shall be taken only on oath or affirmation administered by any person designated by such body and entitled to notarize documents in this State.

C. Postponement

Postponement of the hearing by either side beyond the time set forth in these Bylaws shall be made only with the approval of the review panel or the Hearing Officer. Granting of such postponement shall only be for good cause shown as determined by the review panel.
D. Hearing Officer’s Duties

In addition to any other duties conferred by this Article, the Hearing Officer shall:

1. Preside over the hearing;
2. Be without vote;
3. Determine the order of procedure;
4. Act to assure that all participants in the hearing have a reasonable opportunity to present relevant oral and documentary evidence; and
5. Act to assure that all participants maintain decorum.

E. Proceedings

1. The hearing need not be conducted strictly according to rules of law relating to the examination of witnesses or presentation of evidence.

2. Any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs shall be considered, regardless of the existence of any common law or statutory rules which might make evidence inadmissible over objection in a civil or criminal action except for statutory privilege.

3. The hearing shall be limited to the action and reasons for it stated in the notice of adverse action. No information reasonably considered relevant to his/her defense by the practitioner can be excluded.

4. Both the practitioner for whom the hearing is being held and the committee whose adverse recommendation prompted the hearing shall, prior to or during the hearing, be entitled to submit memoranda concerning any issue of procedure or of fact and such memoranda shall become part of the hearing record.

5. Participants in the hearing shall be informed of the matters to be officially noticed in the record of the hearing.

6. Both the affected practitioner and the committee whose adverse recommendation prompted the hearing shall have the following rights:

   a) Call and examine witnesses;
   b) Introduce written evidence;
   c) Cross-examine any witnesses on any matter relevant to the issue of the hearing;
   d) Rebut any evidence;
   e) Submit a written statement at the close of the hearing; and
   f) Reasonable argument by the practitioner or representative.
7. If the practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

F. Discovery:

1. There is no right to discovery in connection with the hearing. However, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties that such documents shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing:

   a) Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at the individual's expense;

   b) Reports of experts relied upon by the Medical Executive Committee or the;

   c) Paraphrased copies of relevant committee or other meeting minutes (such provision does not constitute a waiver of the State peer review protection statute);

   d) Copies of any other documents relied upon by the Medical Executive Committee or the Board; and

   e) Other relevant information that is not unduly burdensome to produce.

2. Prior to the hearing, on dates set by the Presiding Officer or agreed upon by counsel for both sides, each party shall provide the other party with a list of proposed exhibits and witnesses. All objections to documents or witnesses to the extent then reasonably known, shall be submitted in writing in advance of the hearing. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

3. Prior to the hearing, on dates set by the Presiding Officer, the individual requesting the hearing shall, upon specific request, provide the Medical Executive Committee (or the Board) copies of any expert report or other documents relied upon by the individual.

4. Neither the affected individual, nor his/her attorney, nor any other person on behalf of the affected individual, shall contact Hospital employees appearing on the Hospital’s witness list concerning the subject matter of the hearing, unless specifically agreed upon by Hospital counsel. Such agreement shall not be unreasonably withheld. Final decision rests with the Hearing Officer.

G. Pre-Hearing Conference:

The Hearing Officer may require counsel for the individual and for the Hospital’s Medical Executive Committee (or the Board) to participate in a pre-hearing conference for purposes of resolving all procedural questions in advance of the hearing. The Presiding Officer may specifically require that:

1. All documentary evidence to be submitted by the parties be presented at this conference; any objections to the documents shall be made at that time and the Presiding Officer shall resolve such objections;
2. Evidence unrelated to the reasons for the unfavorable recommendation or unrelated to the individual's qualifications for appointment or the relevant Clinical Privileges be excluded subject to Subsection E, 3., above;

3. The names of all witnesses and a brief statement of their anticipated testimony be submitted if not previously provided;

4. The time granted to each witness’ testimony and cross-examination be agreed upon, or determined by the Presiding Officer, in advance; and

5. Witnesses and documentation not provided and agreed upon in advance of the hearing may be excluded from the hearing.

H. Medical Executive Committee Representation. The Medical Executive Committee, when its action has prompted the hearing, shall appoint one of its members or some other Medical Staff member to represent it at the hearing, to present the facts in support of its adverse recommendation, and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision.

I. Board Representation. The Board, when its action has prompted the hearing, shall designate someone to represent it at the hearing, to present the facts in support of its adverse decision, and to examine witnesses. It shall be the obligation of such representative to present appropriate evidence in support of the adverse recommendation or decision.

J. Legal Representation. The affected practitioner, the Medical Executive Committee or the Board may be represented by an attorney subject to reasonable regulation by the Hearing Officer at any phase of the hearing. Each party must notify the other of the attorney's name, address and telephone number not less than ten (10) days prior to the scheduled hearing or appellate review.

K. Recess. The review panel may, without special notice, recess the hearing and reconvene the same for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation. No such recess or combination of recesses shall exceed fourteen (14) days in length unless the practitioner expressly so consents in writing.

L. Conclusion.

1. Upon conclusion of the presentation of oral and written evidence, the hearing shall be closed.

2. As soon thereafter as possible, the review panel shall conduct its deliberations outside the presence of the practitioner or any other non-panel members.

3. A majority vote of the review panel shall be needed to affirm, modify or reverse the decision.

4. The report of the panel shall not reflect the number of votes for or against the practitioner.
M. Report to the Medical Executive Committee.
   1. Within fourteen (14) days after final adjournment of the hearing, the review panel,
      represented by its chair, shall make a written report and recommendation and shall
      forward the same together with the hearing record and all other documentation to
      the Medical Executive Committee.
   2. The report may recommend confirmation, modification, or rejection of the original
      adverse recommendation or decision of the Medical Executive Committee and
      shall state the reason(s) for the recommendation.

SECTION 7. RIGHTS AND OBLIGATIONS OF THE AFFECTED PRACTITIONER

A. Hearing Record. The practitioner involved shall have the right to have a record made of
   the proceedings, copies of which may be obtained by the practitioner upon payment of
   any reasonable charges associated with the preparation thereof.

B. Presence of the Affected Practitioner.
   1. The personal presence of the practitioner for whom the hearing has been
      scheduled shall be required.
   2. A practitioner who fails without good cause, as determined by the review panel, to
      appear and proceed at such hearing shall be deemed to have:
      a) Waived his/her rights as provided in Section 3 of Article VII of these Bylaws,
         and
      b) Accepted the adverse recommendation or decision involved.
   3. The same shall thereupon become and remain in effect as provided in said Section
      3C of Article VII, and the practitioner shall be given notice required therein.

C. Representation.
   1. The affected practitioner shall be entitled to be accompanied at the hearing by:
      a) Member of the Medical Staff in good standing; or
      b) A member of his/her local professional society; or
      c) His/Her attorney, who may act in an advisory capacity only.
   2. If a practitioner elects to be advised by an attorney, he/she shall be responsible for
      payment of all of his/her attorney’s fees no matter the outcome of the hearing.

D. Submission of Memorandum. The practitioner for whom the hearing is being held shall,
   prior to or during the hearing, be entitled to submit memoranda concerning any issue of
   procedure or of fact and such memoranda shall become part of the hearing record.
E. Rebuttal

1. The practitioner shall be responsible for supporting his/her challenge to the adverse recommendation or decision by presenting relevant evidence as rebuttal.

2. If the practitioner does not testify in his/her own behalf, he/she may be called and examined as if under cross-examination.

SECTION 8. FINAL RECOMMENDATION BY THE MEDICAL EXECUTIVE COMMITTEE

A. The Medical Executive Committee shall, within fifteen (15) days, review the report and recommendations of the review panel and prepare a written report and a list of their recommendations.

B. The Medical Executive Committee’s report may recommend:

1. Confirmation; or

2. Modification; or

3. Rejection of the original adverse recommendation or decision.

C. The Chief Executive Officer shall promptly forward a copy of the review panel’s report and the recommendations of the Medical Executive Committee to the practitioner by certified mail, return receipt requested, and to the Board. The practitioner shall also be made aware of the basis for the Medical Executive Committee’s recommendations.

ARTICLE VIII. APPELLATE REVIEW

SECTION 1. RIGHT TO HEARING

Should the Medical Executive Committee’s final recommendation adversely affect the practitioner’s appointment, status or Clinical Privileges, he/she may request an appellate review hearing by the Board.

A. Request for Appellate Review. Within ten (10) days after a practitioner receives notice of an adverse recommendation or decision by a hearing panel as provided above, he/she may request a review by the Board. Such request shall be in writing to the Board, delivered through the Chief Executive Officer by certified mail, return receipt requested.

B. Waiver of Appellate Review. If such review is not requested within ten (10) days, the practitioner shall be deemed to have waived his/her right to the same, and to have accepted such adverse recommendation or decision, and the same shall become effective immediately, unless it is already effective, as provided in Article VII, Section 3 of these Bylaws.

C. Notice
1. Within thirty (30) days of receipt of such request, the Board shall schedule a date, time and place for an appellate review to be held.

2. The practitioner shall be notified through the Chief Executive Officer by certified mail, return receipt requested of the place, time and date of review, such date to be at least thirty (30) days but not more than ninety (90) days after receipt of the request for a review.

SECTION 2. RIGHTS OF THE PRACTITIONER

The practitioner shall be entitled to all rights listed in Article VII, Section 7, as well as the following:

A. Access to Documentation. The practitioner shall have access to the report and record of the ad-hoc hearing committee and all other material, favorable or unfavorable, that was considered in making the adverse recommendation or decision against him/her.

B. Written Statement

1. He/She shall be entitled to submit a written statement in his/her own behalf, in which those factual and procedural matters with which he/she disagrees, and his/her reasons for such disagreement, shall be specified.

2. This written statement may cover any matters raised at any step in the procedure to which the appeal is related, and legal counsel may assist in its preparation.

3. Such written statement shall be submitted to the Board or to the duly appointed appellate review committee (Article X, Section 3, A below), through the Chief Executive Officer by certified mail, return receipt requested, at least five (5) days prior to the scheduled date for the appellate review.

4. A similar statement may be submitted by the Medical Executive Committee of the Medical Staff or by the chairman of the review panel. If submitted, the Chief Executive Officer shall provide a copy thereof to the practitioner at least five (5) days prior to the date of review by the Board--by certified mail, return receipt requested.

SECTION 3. COMPOSITION OF APPELLATE REVIEW COMMITTEE

A. The Board Appellate Review Committee shall be appointed by the Chairman of the Board and shall consist of at least three (3) individuals appointed by the Board-(including at least one (1) physician). The Hospital Chief Executive Officer and the Chief Medical Officer or Associate Chief Medical Officers may be members, but may not participate in deliberations and may not vote.

B. No Medical Staff member or representative of the Board shall be a person who is related to, in practice with, or in direct economic competition with the practitioner or who has instigated or participated in earlier proceedings in the case.
C. One (1) member of the Appellate Review Committee shall be selected by the Committee to act as chair and shall, with the advice of the Appellate Review Committee, make all necessary rulings.

SECTION 4. CONDUCT OF REVIEW

A. Review.

1. The review shall be conducted by a majority of the Appellate Review Committee.

2. The Appellate Review Committee shall review the record created in the proceedings, and shall consider any written statements submitted pursuant to Article VIII, Section 2, subparagraph B.

B. Oral Argument.

1. The affected practitioner or his/her attorney shall be permitted to speak briefly against the adverse recommendation or decision and shall answer questions put to him/her by any member of the review body.

2. The Medical Executive Committee shall also be represented by an individual who had participated in the Panel Review Hearing and who shall be permitted to speak in favor of the adverse recommendation or decision and who shall answer questions put to him/her by any member of the review body.

C. New Information. New or additional matters not raised during the original hearing or in the panel review report, or otherwise reflected in the record, shall only be introduced in writing to the Appellate Review Committee under unusual circumstances, and the Committee thereof appointed to conduct the appellate review shall in its sole discretion determine whether such new matters shall be accepted.

D. Referral of Matter

1. Should the review conducted by the Appellate Review Committee modify or reverse the prior decision, it may refer the matter back to the Medical Executive Committee of the Medical Staff for further review and recommendation within thirty (30) days.

2. Such referral may include a request that the Medical Executive Committee arrange for a further hearing to resolve specified disputed issues.

E. Conclusion

The appellate review shall not be deemed to be concluded until all of the procedural steps provided in this Article VIII have been completed or waived.

F. Final Recommendation

1. Within ten (10) days after adjournment, the Appellate Review Committee shall make a written report, including its recommendations. The written report together
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with the Appellate Review Committee’s recommendations and all documentation will be forwarded to the Board.

2. The Chief Executive Officer shall send the practitioner a copy of the report and recommendations by certified mail, return receipt requested.

SECTION 5. FINAL DECISION BY THE BOARD

A. Within ten (10) days after the conclusion of the review, the Board shall:

1. Confirm;
2. Modify; or
3. Deny the recommendation from the Appellate Review Committee.

B. The Board shall send notice of the matter to the Chief Executive Officer who shall send notice thereof to the Medical Executive Committee and to the affected practitioner by certified mail, return receipt requested.

C. Notwithstanding any other provisions of these Bylaws, no practitioner shall be entitled as his/her right to more than one panel review hearing and one review by the Board on any matter.

SECTION 6. PROTECTION FROM LIABILITY

In matters related to hearing and appellate review, all Medical Staff members and other practitioners, and all appropriate Hospital personnel, including members of the Board and Hospital management shall act pursuant to the same rights, privileges, immunities, and authority of Article X, of these Bylaws, and such rights, privileges and immunities as provided under applicable State and/or Federal law.

ARTICLE IX. ACTION BY DESIGNEE

A. Chief Executive Officer

Whenever any action is required to be taken by the Chief Executive Officer of the Hospital, the Chief Executive Officer may designate another person to act in his/her place, and the acts of such designee shall have the same force and effect as if performed by the Chief Executive Officer.

B. Board
Whenever any action is required to be taken by the Board, the Board may designate a committee of the Board to act in its place, and the act of such committee shall have the same force and effect as if performed by the Board.

ARTICLE X. CONFIDENTIALITY OF INFORMATION AND IMMUNITY FROM LIABILITY

The following shall be express conditions to any practitioner’s application for Medical Staff membership and to an application for, or exercise of, Clinical Privileges at this Hospital:

A. The confidentiality of all matters relating to Medical Staff membership, credentialing, quality assurance, and risk management activities is maintained by all committees and staff involved and is protected to the fullest extent of the law.

B. Any act, communication, report, recommendation, or disclosure, with respect to any such practitioner, performed or made in good faith and without malice and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, shall be privileged to the fullest extent permitted by law.

C. Such privileges shall extend to members of the Hospital’s Medical Staff and of its Board, its other practitioners, its Chief Executive Officer and his/her representatives, and to third parties, who supply information to any of the foregoing authorized to receive, release, or act upon the same. For the purpose of this Article X, the term “third parties” means both individuals and organizations from whom information has been requested by an authorized representative of the Board or of the Medical Staff.

D. There shall be, to the fullest extent permitted by law, immunity from civil liability arising out of any such act, communication, report, recommendation, or disclosure, made in substantial good faith, even where the information involved would otherwise be deemed privileged (see RCW 70.41.200(2) and amendments thereto).

E. Such immunity shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with this or any other health care institution’s activities related, but not limited to:

1. Applications for appointment or Clinical Privileges,
2. Periodic reappraisals for reappointment or Clinical Privileges,
3. Corrective action, including summary suspension,
4. Hearing and appellate reviews,
5. Medical care evaluations,
6. Utilization reviews, and
7. Other Hospital, clinical section, service or committee activities related to quality patient care and intra-professional conduct.
F. The acts, communications, reports, recommendations and disclosures referred to in this Article X may relate to a practitioner’s professional qualifications, clinical competency, character, mental or emotional stability, physical condition, ethics, or any other matter that might directly or indirectly have an effect on patient care.

G. Upon request of the Hospital, each practitioner shall execute a release from liability for individuals and organizations specified in Paragraph C above, for the functions carried out under these Bylaws, subject to requirements of substantial good faith, absence of malice, and the exercise of reasonable effort and due care.

H. The consents, authorizations, releases, rights, privileges and immunities provided in the Credentialing Manual of these Bylaws for the protection of this Hospital's practitioners, other appropriate Hospital officials and personnel and third parties, in connection with applications for initial appointment and reappointment, shall also be fully applicable to the activities and procedures covered by this Article X.

ARTICLE XI. MEDICAL STAFF MEETINGS

SECTION 1. ANNUAL MEDICAL STAFF MEETINGS

A. An annual meeting of the Medical Staff shall be held during the first quarter of each Medical Staff year. Written notice of the meeting shall be sent to all Medical Staff members and conspicuously posted. The agenda of the meeting may include reports on review and evaluation of the work done in clinical sections, the conduct of other Medical Staff business, and educational topics.

B. The primary objective of the meetings shall be to report on the activities of the Medical Staff and to conduct other business as may be on the agenda. Written minutes of all meetings shall be prepared and recorded.

SECTION 2. SPECIAL MEETINGS

A. The President of the Medical Staff may call a special meeting of the Medical Staff at any time. The President of the Medical Staff shall call a special meeting within twenty (20) days after receipt of a written request therefore signed by not less than ten percent (10%) of the Active Medical Staff, or upon a resolution by the Medical Executive Committee. Such a request or resolution shall state the purpose of the meeting. The President of the Medical Staff shall designate the time and place of any special meeting. Medical Staff meetings may also be called in accordance with Article I, Section 6, Paragraph C.

B. Written or printed notice stating the time, place and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Active Medical Staff at least seven (7) days before the date of such meeting. The attendance of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.
SECTION 3. REGULAR MEETINGS

When a meeting is called under Article XI, Section 2, A, B, committees may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

SECTION 4. QUORUM

A. Medical Staff Meetings: Those present and voting.

B. Medical Executive Committee and Medical Staff Operating Committee Meetings: Fifty percent (50%) of the voting members of the Committee.

C. Other Meetings: Those present and voting.

SECTION 5. ATTENDANCE REQUIREMENTS

Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance will not be used by the Credentials Committee in evaluating physicians, dentists, and podiatrists at the time of reappointment.

Medical Executive Committee and Credentials Committee Meetings: Members of the Medical Executive Committee and Credentials Committee shall attend at least fifty percent (50%) of the meetings held.

SECTION 6. PARTICIPATION BY CHIEF EXECUTIVE OFFICER

The Chief Executive Officer and any representative assigned by the Chief Executive Officer may attend any committee or clinical section meetings of the Medical Staff.

SECTION 7. ROBERT’S RULES OF ORDERS

The latest edition of ROBERT’S RULES OF ORDERS shall prevail at all meetings of the Medical Staff, Medical Executive Committee, Medical Staff Operating Committee and Credentials Committee.

SECTION 8. NOTICE OF MEETINGS

Written notice stating the place, day and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the committee or clinical section not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.
SECTION 9. ACTION OF COMMITTEE

The action of a majority of its members present at a meeting at which a quorum is present shall be the action of a committee.

SECTION 10. RIGHTS OF EX-OFFICIO MEMBERS

Except as otherwise provided in these Bylaws, persons serving as ex-officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

SECTION 11. MINUTES

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and motions passed or failed. The minutes shall be signed by the presiding officer and copies thereof shall be submitted to the Medical Executive Committee. Each committee shall maintain a permanent file of the minutes of each meeting.

ARTICLE XII. REVIEW, REVISION, ADOPTION AND AMENDMENT

SECTION 1. MEDICAL STAFF RESPONSIBILITY

The Medical Staff shall have the responsibility to formulate, review annually, adopt and recommend to the Board, Medical Staff Bylaws and amendments thereto, which shall be effective when approved by the Board. Such responsibility shall be exercised in good faith and in a responsible and timely manner. This applies as well to the review, adoption and amendment of the related rules, policies and manuals developed to implement various sections of these Bylaws.

SECTION 2. METHODS OF ADOPTION AND AMENDMENT

All proposed amendments to the Bylaws or the policies and manuals incorporated into these Bylaws, as set forth in Article XII, Section 3 below, whether originated by the Medical Executive Committee, another standing committee or by a member of the Active category of the Medical Staff, must be reviewed and discussed by the Medical Executive, except as set forth below. All such amendment(s) shall be approved by the Board or its authorized agent prior to becoming effective.

A. Bylaws. Amendments to the Bylaws may be recommended to the Board:

1. Following approval by a majority of the members of the Active Staff who choose to vote on the amendments proposed by the Medical Executive Committee. Proposed amendments to the Bylaws shall be distributed to the Active Staff by the
Medical Executive Committee and members of the Active Staff shall have twenty-one (21) days to review the proposed amendments and to vote on the proposed amendments by either written or electronic ballot. There shall not be a minimum requirement for the number of members of the Active Staff required to submit a ballot in order for the proposed amendments to be approved.

2. By the members of the Active Staff upon a petition signed by a majority of the members of the Active Staff, provided that prior to going to the Board for approval, the proposed amendments are presented to the Medical Executive Committee for review and comment. Such a petition shall be deemed to evidence sufficient support and approval of the proposed amendments by the members of the Active Staff such that the petition shall take the place of a formal vote on the amendment by members of the Active Staff prior to presenting the proposed amendments to the Board for approval.

3. By the Medical Executive Committee, provided that such amendments are technical amendments to the Bylaws in the Medical Executive Committee’s judgment. Technical amendments shall include legal modifications or clarifications; reorganization or renumbering of sections; or corrections of punctuation, spelling or other errors of grammar or expression.

B. Medical Staff Rules, Regulations, Policies and Manuals. Amendments to the Medical Staff Rules, Regulations, Policies and Manuals may be recommended to the Board:

1. By the Medical Executive Committee after a majority vote, provided that if the proposed amendment(s) are to the Rules and Regulations, the amendment(s) are first distributed to the members of the Medical Staff for review and comment at least twenty-one (21) days prior to a Medical Executive Committee vote. Amendments to the Medical Staff Policies and Manuals (that are not the Rules and Regulations) must be promptly communicated to the members of the Medical Staff following their adoption.

2. By the members of the Active Staff upon a petition signed by a majority of the members of the Active Staff, provided that the proposed amendment is first presented to the Medical Executive Committee for review and comment. Such a petition shall be deemed to evidence sufficient support and approval of the proposed amendments by the members of the Active Staff such that the petition shall take the place of a formal vote on the amendment by members of the Active Staff prior to presenting the proposed amendments to the Board for approval.

C. Urgent Amendment to the Rules and Regulations. In cases of a documented need for an urgent amendment to the Rules and Regulations in order to comply with a law or regulation, the Medical Executive Committee may provisionally adopt such an amendment and forward it to the Board for approval and immediate implementation without prior notification of the Active Staff. The Active Staff will then be immediately notified by the Medical Executive Committee of the provisionally adopted and approved Rule and Regulation. The Active Staff shall then have the opportunity for retrospective review of and comment on the provisional amendment. The Active Staff may, by a petition signed by at least two-thirds (2/3) of the Active staff members require that the amendment be reconsidered; provided, however, the approved amendment shall remain effective until such time as a superseding amendment meeting the requirements of the law or regulation has been approved.
SECTION 3. RELATED POLICIES AND MANUALS

The Medical Executive Committee will recommend to the Board rules and regulations, a credentials policy, an organizational manual and such other rules as are necessary to further define the general policies contained in these Bylaws (the “Policies and Manuals”). Upon adoption by the Board, these Policies and Manuals will be incorporated by reference and become part of these Bylaws, and such Policies and Manuals shall be amended in accordance with Article XII, Section 2.B. hereof.

A. Rules and Regulations

**Purpose:** The Medical Staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to the approval of the Board.

1. The Rules and Regulations are subordinate to the Bylaws.

2. The Rules and Regulations of the Medical Staff set forth guidelines for the proper conduct of the Medical Staff.

3. The Rules and Regulations of the Medical Staff shall be appended and be a part of these Bylaws.

B. Credentialing Manual

**Purpose:** The Credentialing Manual delineates specific procedures and mechanisms for the preapplication, application, reappointment processes, and for the delineation and granting of Clinical Privileges.

1. The Credentialing Manual is subject to the approval of the Board.

2. The Credentialing Manual shall be appended to and be a part of these Bylaws.

C. Organizational Manual

**Purpose:** The Organizational Manual describes the Medical Staff structure.

1. The Organizational Manual contains the specifications relating to the structure, function and interaction of the Medical Staff and its committees. These are subject to the approval of the Board.

2. The Organizational Manual of the Medical Staff shall be appended to and is a part of these Bylaws.

D. Credentialing Guidelines for Dependent Allied Health Professionals

**Purpose:** The credentialing Guidelines for Dependent Allied Health Professionals establish the relationship of the dependent Allied Health Professionals to the Hospital and other practitioners.
1. Criteria for classification of dependent Allied Health Professionals are identified.

2. The process for the appointment, reappointment and granting of Clinical Privileges is defined.

3. The requirement for and the role of physician sponsors are identified.

4. The Guidelines for Dependent Allied Health Professionals of the Medical Staff shall be appended to and is a part of these Bylaws.

ARTICLE XIII. BYLAWS REVIEW

A Medical Staff Bylaws Committee shall be convened at least annually for the purpose of reviewing and, as felt appropriate by the committee, recommending amendments to the Bylaws or any of the supporting documents identified above.

A. The Bylaws Committee shall be appointed by the President of the Medical Staff and approved by majority vote of the Medical Executive Committee.

B. The Bylaws Committee shall consist of five (5) members in good standing of the Active Medical Staff, one of whom shall be a past President of the Medical Staff.

C. The Chief Medical Officer and a representative of the Health System administration shall serve on the Bylaws Committee, without vote.

D. The Bylaws Committee shall choose a chairperson from among its voting members.

E. The Bylaws Committee may request consultative support from other Medical Staff members, the Hospital staff, or outside sources, including legal advice, as it deems necessary. Such consultants will serve without vote.

F. The Bylaws Committee will be appointed in February of every odd numbered year, and shall report to the Medical Executive Committee by May of that year.

G. A recording secretary and technical support will be provided by the Hospital.

ARTICLE XIX. ADOPTION

These Bylaws, together with the appended Rules and Regulations, Credentialing Manual, Organizational Manual, and Guidelines for Dependent Allied Health Professionals, after adoption shall replace any previous Bylaws, Rules and Regulations and shall become effective when approved by the Board.

ADOPTED by the Active Medical Staff on April 10, 1996.

APPROVED by the Board on May 31, 1996.