COVID-19 Notice

No in-person attendance will be allowed, pursuant to Governor Inslee's Proclamation 20-28.

All meeting attendees, including Board of Commissioners, staff and members of the public shall participate virtually. No physical meeting location will be provided.

To attend the meeting, dial Phone Conference Line: **(509) 598-2842**
When prompted, enter Conference ID number: **383682973#**

Regular Session Agenda
Wednesday, August 25, 2021

Call to Order:	2:00
Approve Agenda:	2:00
Board Governance Education:	2:01
• Review Community Health Improvement Plan Update (pg. 2-10)	
Education Topic:	2:15
• Pharmaceutical Update- Nell Allen, Pharmacy Technician Specialist	
• Home Health and Hospice Update- Tammy Tarsa, Executive Director, HHH	
Break:	3:15
Patient Story: Tina Toner, CNO	3:30
Minutes:	3:40
• July 28, 2021 Regular Session Minutes (pg. 11-13)	
• August 9, 2021 Special Session Minutes (pg. 14-16)	
Required Approvals: Action Requested	3:50
• July Warrants and Adjustments (pg. 17-22)	
• Medical Staff Credentials/ Appointments/ Reappointments (pg. 23-25	
• Medical Staff Policies (pg. 26-87)	
Quality Report: Brandie Manuel, CPSO	4:00
Financial Report: Tyler Freeman, CFO	4:15
Administrative Report: Mike Glenn, CEO	4:30
• Strategic Plan Update	
CMO Report: Dr. Joe Mattern, CMO	4:45
Board Business:	5:00
• Board of Health Report	
• Amendment to Superintendent Employment Agreement- Carryover of Paid Time Off	
Meeting Evaluation:	5:10
Conclude:	5:20

This Regular Session will be officially recorded.
Times shown in agenda are estimates only.

No Live Public Comment
In lieu of live comments, members of the public may comment on any agenda item or any other matter related to the District via a letter addressed to the Commissioners at 834 Sheridan Street, Port Townsend, Washington 98368, or via email to commissioners@jeffersonhealthcare.org.

Jefferson County Public Hospital District No. 2 Board of Commissioners acknowledge that Jefferson Healthcare is on the ancestral and contemporary homelands of the S'Klallam, Chemakum, Twana and other indigenous nations and we recognize the tribal governments sovereignty across the region.

BACKGROUND

CHIP is submitting this virtual Board update, rather than presenting in-person, due to schedule complications for John Nowak, who has been dealing with a family emergency. We appreciate the opportunity to share this information with the Jefferson Healthcare Board.

OVERALL CHIP UPDATE

CHIP is in a time of transition. As John moves to retire, CHIP's original support structure is being reviewed by the Health Department, Hospital and City. The final structure for CHIP's governance, lead role description and salary are unknown at this time. Lori remains committed to focusing on the grant-funded role of Behavioral Health Consortium (BHC) Project Director, productively serving CHIP's mission as convener, multiplier and amplifier of efforts that support the intersection of CHIP's community health improvement mission and the RCORP-Implementation Grant's specific, narrow focus band to improve access to Substance Use Disorder and Mental Health services. The RCORP-I grant's performance period ends August 2023. She looks forward to considering the next iteration of the CHIP lead role, once clarity emerges around the future governance, role description, and salary.

Currently CHIP's work is focused on two areas:

- The 2021 CHIP Update: John has been focused on the work of developing content for the 2021 CHIP update. He has been meeting for the past seven months with the three age-band teams that grew out of the Community Health Assessment (CHA) work completed in 2019. Lori has provided considerable support for this effort, since that time coincides with when John was re-assigned as the Interim IT/CI Director. The age bands are delineated by Youth, Working Age, and Senior groups. These groups have developed strategic frameworks that serve as a roadmap to improve the health of the community members in that age band.
- The BHC's efforts to improve access to SUD/MH services are supported by the $1M HRSA RCORP-Implementation grant CHIP was awarded in 2020. As Project Director, Lori leads monthly BHC meetings with the 10 Consortium agencies and stakeholders and a cadre of ad hoc team members that compose a broad-based team of decision-makers involved with the county's behavioral health system. Lori also facilitates multiple monthly subgroup meetings to advance action on the various strategic projects the BHC has committed to do with the RCORP-I grant's funding, and executes the significant quarterly reporting requirements for the grant.

CHIP AGE-BAND TEAM UPDATES

CHIP Youth Age Band Workgroup – (YAB)

The YAB team has been meeting every three weeks for the last seven months. In addition to the development of the framework, this team has been trying to develop some quick-hit solutions that will improve Adolescent Behavioral Health in our community. They have been reviewing the evidence-based solutions for reducing team suicide in our community. An example of this type of work is the effort to provide education to adults and teams called Mental Health First-Aid. This program is targeted to start in the fall.

We invite you to visit this link for the YAB meeting videos, notes and successive drafts of the strategic framework.

Team members include:

Kate Dean	Jefferson County BOCC
Kees Kolff	Jefferson Healthcare Commissioner
Cynthia Osterman	Benji Project
Denise Banker	Jefferson County Public Health
Apple Martine	Jefferson County Public Health
Jim Novelli	DBH
Ciela Meyer	OESD, Chimacum Schools
Jean Scarboro	Jumping Mouse
Trish Beathard	Brinnon Schools
Julie Canterbury	MCS Counseling

Dr Molly Parker	Jefferson Healthcare
Alexandra Murphy	Community Therapist
Jenny Vervynck	PTSD
Julie Canterbury	MCS Counseling
Dr Molly Parker	Jefferson Healthcare
Alexandra Murphy	Community Therapist
Anne Koomen	Jefferson Healthcare
John Nowak	Jefferson County CHIP
Lori Fleming	Jefferson County CHIP

CHIP Youth Age Band Group – (YAB) – Example of Strategic Framework

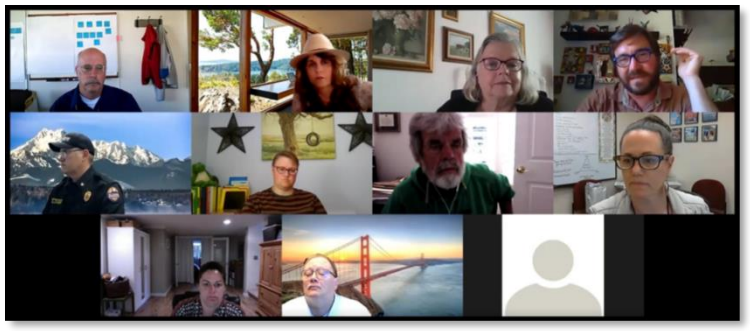
Youth Age Band Group - Strategic Framework Development - As of 06/01/2021

Goals:	Objectives:	Strategy:	Activities	Inputs
What are the objectives, if completed, going to lead to? What measurable goals has the workgroup decided on to make sure that it meets the purpose of the group? These should be SMART goals.	*How are we going to implement our workgroup goals? How are the deliverables from the strategy going to be maintained?*	*What types of things do we need to develop to help met our objectives? What deliverables will we have after we perform the activities?*	*What steps need to happen to make sure that we can complete the strategy?*	*What do we need to make the activities happen?*
Goal 1:	**Objective 1:**	**Strategy 1A:**	**1.A Activities**	**Inputs**
Implement a plan to reduce Jefferson County's adolescent suicide to 0% by…(?yeardate?)	Improve resources for Adolescent Behavioral Health Develop the above using specific language. Also, include Metric; Metric Data Source: Current State:	**1A.** Identify and execute a plan to improve the success of youth connecting and availing themselves of community, family and school services that support their improved mental health. Who owns this strategy and provides leadership/accountability?	**1A.1** Resource Map all agencies/organizations for relevant services. Perform gap analysis, determine actions to address shallow spots.	Develop Inputs
(Before this goal is finalized, re-work using the SMART format)			**1A.2** Develop a method to communicate Youth-related community effort updates between providers Develop Timeline and Who owns this activity and provides leadership/accountability?	Develop Inputs
Specific, Measurable Attainable, Realistic Time oriented			**1A.3** Design a process for better integration of services across community, family and school and improve how our kids are served by all. Develop Timeline and Who owns this activity and provides leadership/accountability?	Develop Inputs

20210603a_YABFramework.xlsx 6/1/2021 2:56 PM Page 1 of 3

CHIP Working Age Band Group – (WAG)

Because the issues for the working age members of our community were so closely aligned with work already going on at the Behavioral Health Consortium (BHC), this team was formed as a sub-team of that group. Team members have been particularly challenged by the fact that they only meet for 30 minutes monthly. Even with that pace the team has been able to complete a solid draft of the framework for this age band.



We invite you to visit this link for the Working Age Group meeting videos, notes and successive drafts of the strategic framework.

Team members include:

Sheriff Joe Nole	Jefferson County Sheriff
Jolene Kron	SBH-ASO
Peggy Webster	Affordable Housing
Chief Tim McKern	Quilcene Fire Dept
Milena Stott	Fletcher Group
Apple Martine	Community Health Exec Dir
Chief Bret Black	EJFR
Jim Novelli	DBH
Dunia Faulx	JHC
Patrick Johnson	NAMI
Greg Brotherton	Jefferson County Commissioner

CHIP Working Age Group – (WAG) – Example of Strategic Framework

Working Age Group - Strategic Framework Development - as of 8/12/2021

Goals:	Objectives:	Strategy:	Activities	Inputs	Resp
What are the objectives, if completed, going to lead to? What measurable goals has the workgroup decided on to make sure that it meets the purpose of the group? These should be SMART goals.	*How are we going to implement our workgroup goals? How are the deliverables from the strategy going to be maintained?*	*What types of things do we need to develop to help met our objectives? What deliverables will we have after we perform the activities?*	*What steps need to happen to make sure that we can complete the strategy?*	*What do we need to make the activities happen?*	
Goal 1:	**Objective 1:**	**Strategy 1A:**	**Activities**	**Inputs**	**Resp**
Improve Social Determinants of Health factors in Jefferson County. Increase housing capacity in Jefferson County by xx% by 2025 and reducing the percentage of residents below the poverty level by 2% by 2025 from 13% to 11%.	**Increase capacity of transitional supportive housing**	**Strategy 1A:** Coordinate with transitional housing providers to assist in the creation of additional capacity for transitional supportive housing. **Metric:** Increase work force housing units by 32 by 2024 **Data Source:** Housing Task Force **Current State:** Get numbers from Housing Task Force	**1A.1** t tranistional housing providers to identify (and pursue) grant and RFP opportunities	Identify individual to act as point of contact and coordination. Metrics: Need current state numbers from Housing Task force	
		Strategy 1B:	**Activities**	**Inputs**	**Resp**
		Strategy 1B: Coordinate with Pfeiffer House to support the current project to increase capacity at Pfeiffer House. Ensure that wrap around services are available to residents to support their needs. **Metric:** Capacity at Pfeiffer (Currently 2 young adults, to be increased to 10-12 young adults.) **Data Source:** Pfeiffer House	**1B.1** Collaborate with Pfeiffer House team to assess/articulate needs to increase capacity and support the development and execution an action plan.	Identify individual to act as point of contact and coordination. **Metrics:** Gather current state numbers from Pfeiffer House	Peggy Webster

CHIP Senior Age Band Workgroup

Because of the demographics of Jefferson County, this team has a particularly important task. Because Olympic Area Agency on Aging and Jefferson Healthcare have taken such active roles in this work historically, we had individual meetings with those groups to help refine the framework. As with the other teams we have a near final draft completed.

We invite you to visit this link for the Senior Age Group meeting videos, notes and successive drafts of the strategic framework.

Team members include:

Laura Cepoi	OAAA
Sheriff Joe Nole	Sheriff's office
Dunia Faulx	JHC
Mary Winters	Avamere Nursing Home
Nancy McGonagle	SHIBA
Jim Novelli	DBH
Kees Kolff	Jefferson County Commissioner
Heidi Eisenhour	County BOCC
Heather Freund	Dove House's (Vulnerable Adult Taskforce)
Miranda Nash	Transit
Sheriff Joe Nole	Jefferson County Sheriff
Jolene Kron	SBH-ASO

CHIP Senior Age Band – Example of Strategic Framework

Senior Age Band Workgroup - Strategic Framework Development - As of 8/11/2021

Goals:	Objectives:	Strategy:	Activities	Inputs	Resp
What are the objectives, if completed, going to lead to? What measurable goals has the workgroup decided on to make sure that it meets the purpose of the group? These should be SMART goals.	*How are we going to implement our workgroup goals? How are the deliverables from the strategy going to be maintained?*	*What types of things do we need to develop to help met our objectives? What deliverables will we have after we perform the activities?*	*What steps need to happen to make sure that we can complete the strategy?*	*What do we need to make the activities happen?*	*Who ensures strategy has resources and is accomplished?*
Goal 1 - Cont'd:	**Objective 2 - Cont'd:**	**Strategy 2B**	**Activities**	**Inputs**	**Resp**
Determine and address gaps in current system to support county seniors aging well Develop and implement a plan that supports county seniors to maintain the highest functional level possible by 2023	**Support existing plans that strengthen senior services** Take this out as a framework, mindful that AHT is working on this effort and we in this group that sit at that table are sensitized to represent Elder interests there.	~~**Strategy 2B:**~~ ~~Ensure Senior Housing is addressed in county housing planning process and action plan~~ ~~**Metric:** Homeless rate among seniors~~ ~~**Data Source:** OAAA survey?~~	~~**2B.1** Partner with existing agencies like the Affordable Housing committee to make sure the needs of Seniors are well represented.~~	~~Identify individual to act as point of contact and coordination.~~	~~Affordable Housing~~
		Strategy 2C	**Activities**	**Inputs**	**Resp**
		Strategy 2C: Work with Jefferson Transit to improve Senior Transportation access where gaps exist. **Metric:** JT will send out survey about senior ridership **Data Source:** Not Available **Current State:** does not exist	**2C.1** Create Survey for Elders to define their transportation needs **2C.2** Ensure Seniors are represented on Jefferson Transit Advisory Board.	Identify individual to act as point of contact and coordination.	Jefferson Transit

CHIP's November 25, 2020 Hospital Board Update highlighted receipt of HRSA's $1M RCORP-Implementation funding covering the performance period of September 2020 – August 2023.

FIRST YEAR PROGRESS UPDATES FOR BHC STRATEGIES DEVELOPED TO PURSUE RCORP-I FUNDING

- **Increase Integration of Behavioral Health Therapy Provider and MAT Prescription:** Underway: Discovery Behavioral Health (DBH) and Safe Harbor (SH) have collaborated to integrate DBH's MAT Perscription and SH's SUD Counseling services. They began integrating relevant clients in June 2021. In Development. Tracking JHC prescription/therapy integration.
- **Explore Crisis Stabilization Center Feasibility:** Not feasible at this time due to certification and regulation requirements that are antithetical to a local, sustainable mental health and Substance Use Disorder (SUD) Crisis Stabilization Facility. The BHC, with endorsement from HRSA's RCORP-I Tech Assistant Team, approved the projects below to move the county's behavioral health-related interactions to ever earlier interception points, ideally to reduce the number of County residents needing local crisis stabilization services.
- **Develop/maintain online/printed Resource Directory:** Completed. Resources linked here.
- **Improve Jail-to-Community service connection:** Underway. The Sheriff's office procured funding for a Residential Substance Abuse Treatment (RSAT) project that includes a Jail-to-Community Transition service component, managed by Believe in Recovery, a BHC Member.
- **Fund Recovery Café for peer network development and recovery/prevention environment:** Underway. $35k/Year funding is under contract for September 2020 – August 2023
- **Extend Harm Reduction Services into South County (SCHR):** In Development. Local stakeholder involvement is solid. Naloxone hosting/distribution logistic are awaiting clarity on JHC's Quilcene clinic staffing. Fortuitiously, CHIP's South County meeting table is also serving to connect Fire/Law Enforcement in conversations that have led to key positive brainstorming Next steps are underway to address the challenges presented by HB1310 and State v. Blake Decision, and how these agencies collaborate to deliver our residents timely connection to care and services needed. See SCHR meeting videos/meeting materials.
- **Execute communication/education/integration to address regional stigma**. Underway.
- **Coordinate and optimize navigator and care coordination services**: In Development.
- **Initiate collective case management for high utilizers of law enforcement/EMS services.** In Development. Next steps on bi-directional, closed loop communication systems are being considered by County players through an Olympic Communities of Health (OCH) Survey.
- **A new project:** Working with the Pfeiffer House to support wrap around services for 18-24 y.o. clients that are housed there. Funds saved from not hiring a grant coordinator for the grant's first year will fund the project, once defined, if approved by the BHC membership.

AGE BAND TEAMS – NEXT STEPS

Because John has been leading the efforts for the age band work and he is retiring, it is not clear who will support this work moving forward. Lori's work with the RCORP grant is a full-time commitment at this time. Until the question of on-going CHIP governance, role definition and salary is resolved, the work outlined in the strategic frameworks each Age Band has developed for the 2021 CHIP Update will be on hold.

When the plan for how CHIP will move forward is completed, we envision at this point that the three age-band teams will begin to meet again. Each workgroup will complete a quick review the frameworks they have developed, and make any changes needed. Then Plan will presented for approval by the appropriate governing body, and once approved, each group will begin the work of implementing the strategies and activities outlined in the approved 2021 CHIP Plan.

FINAL THOUGHTS

The work of CHIP has become recognized by many community leaders as an important part of the health of our community.

- The CHIP team has been effective at helping to integrate health efforts in our community and has often served as the convener, multiplier, and amplifier on important health issues.
- Over $1.3M in grant funding has been awarded to this community as a result of CHIP's efforts.
- CHIP's credibility is underscored by how City and County officials regularly turn to the CHIP team for consultation and implementation of health-related community programs.

We believe it is important for this work to continue, even in the face of this persistent pandemic. In fact, CHIP's work to support community health and social services in East Jefferson County might be more important than ever.

A FINAL NOTE FROM JOHN

On a final note, from John. As I depart Jefferson Healthcare after 42 years, I have had a chance to reflect on CHIP and its place in the community. It has been my pleasure to be involved with CHIP for the last eight years. I have learned how strong our community is and how many people there are that care about the health of our community and are willing to work to make it better. CHIP has become integral to those efforts and has helped to focus those efforts. I hope that work will continue.

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When prompted, enter Conference ID number: 383682973

Jefferson County Public Hospital District No.2
Board of Commissioners, Regular Session Minutes
Wednesday, July 28, 2021

Call to Order:
The meeting was called to order at 2:00pm by Board Chair Buhler Rienstra. Present by phone and video were Commissioners Dressler, Kolff, McComas and Ready. Also, in attendance by phone were Mike Glenn, CEO, Tyler Freeman, Chief Financial Officer, Jon French, Chief Legal Officer, Jake Davidson, Chief Ancillary & Specialty Services Officer, Caitlin Harrison, Chief Human Resources Officer, Dr. Joseph Mattern, Chief Medical Officer, and Alyssa Rodrigues, Administrative Assistant. This meeting was officially audio recorded by Jefferson Healthcare.

Approve Agenda:
Commissioner Dressler made a motion to approve the agenda. Commissioner McComas seconded.
Action: Motion passed unanimously

Board Governance Education
The Commissioners discussed upcoming Retreats.

Education Topic:
- Independent Auditors Report
    - Tom Dingus, CPA, Dingus, Zarecor & Associates PLLC

Tom Dingus provided the Independent Auditors Report.

Discussion ensued.

The Board recessed for break at 3:08pm.
The Board reconvened from break at 3:30pm

Team, Employee, Provider of the Quarter:
Caitlin Harrison, Chief Human Resources Officer announced the Employee of Quarter, Jeremiah Fountain, Provider of the Quarter, Kevin Hines, PA, Team of Quarter, Dietary and Leader of the Quarter, Jaimie Hoobler, RN.

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Minutes:

- June 15, 2021, Special Session Minutes
- June 17, 2021, Special Session Minutes
- June 23, 2021, Regular Session Minutes

Commissioner Kolff made a motion to approve the June 15, 2021, Special Session Minutes, June 17, 2021, Special Session Minutes, and June 23, 2021 Regular Session Minutes. Commissioner Dressler seconded.
Action: Motion passed unanimously.

Required Approvals: Action Requested

- June Warrants and Adjustments
- Medical Staff Credentials/Appointments/Reappointments
- Medical Staff Policies

Commissioner Dressler made a motion to approve the June Warrants and Adjustments, Medical Staff Credentials/ Appointments/ Reappointments, Medical Staff Policies. Commissioner Ready seconded.
Action: Motion passed unanimously.

Compliance Report:
Jon French, Chief Legal Officer presented the Compliance Report.

Discussion ensued.

Financial Report:
Tyler Freeman, CFO, presented the June Financial Report.

Discussion ensued.

Administrative Report
Mike Glenn, CEO, presented the July Administrative report which included updates on Vaccine, Volumes, Hospital Expansion Project, Campus Parking Modification, Mandatory Vaccines, and Recognition of Native Land.

Discussion ensued.

CMO Report
Dr. Joe Mattern, CMO, provided the CMO report which included updates on Hospital Bed Availability, Increase in COVID Cases, Employee Exposure, Nursing Hotline, Testing Program, and Vaccine Mandate

Discussion ensued.

Board Business:

- Board of Health Report

Commissioner Kolff gave the Board of Health Report which included an introduction of Dr. Allison Berry as the new Public Health Officer for Jefferson and Clallam County. Dr. Locke will be Deputy Health Officer for Clallam and Jefferson County. He also explained Vicki Kirkpatrick as Director of Jefferson County Public Health has retired and is being replaced by Apple Martine.

Meeting Evaluation:

Commissioners evaluated the meeting.

Conclude:

Commissioner Dressler made a motion to conclude the meeting. Commissioner McComas seconded.
Action: Motion passed unanimously.

Meeting concluded at 5:26 pm.

Approved by the Commission:
Chair of Commission: Jill Buhler Rienstra _____
Secretary of Commission: Marie Dressler _____

Jefferson County Public Hospital District No.2
Board of Commissioners, Special Session Minutes
Monday, August 9, 2021
The Resort at Port Ludlow
One Heron Road, Port Ludlow, WA 98365

Call to Order:
The meeting was called to order at 9:33am by Board Chair Buhler Rienstra. Present were Commissioners Dressler, Kolff, McComas and Ready. Mike Glenn, CEO, and Alyssa Rodrigues, Administrative Assistant were also in attendance.

Welcome, Review Agenda
Mike Glenn, CEO, discussed the agenda.

Contemporary Issues Update
Mike Glenn, CEO, discussed contemporary issues which included various contracts and retention/sign on bonuses.

Discussion ensued.

Mr. Glenn discussed medical staff relations issues.

Discussion ensued.

Mr. Glenn discussed the importance of the role of East Jefferson Fire and Rescue in patient transports.

Discussion ensued.

Mr. Glenn discussed the Jefferson Healthcare Foundation. Discussion ensued.

Mr. Glenn discussed funding options for future hospital additions.

Discussion ensued.

Commissioners discussed a retreat in January with Karma Bass, Succession planning will be on the agenda.

Recognition of Native Land: Dunia Faulx, Director of Population Health and Care Transformation

Dunia Faulx, Director of Population Health and Care Transformation provided a presentation titled, JH Land Acknowledgement.

The Board discussed the following statement: "We acknowledge that Jefferson Healthcare is on the ancestral and contemporary homelands of the S'Klallam, Chemakum, Twana and other indigenous nations and we recognize the tribal governments sovereignty across the region."

Commissioners support the JH Land Acknowledgement statement being included on the Jefferson Healthcare website.

Discussion ensued around other ideas for the future.

Lunch:

Master Site Plan: Aaron Vallat, Construction and Planning Manager

Mike Glenn, CEO, introduced Aaron Vallat, Construction and Planning Manager. Mr. Vallat provided a presentation on the Master Site Plan.

Discussion ensued.

Mr. Vallat explained the difference between design-bid-build process and design- build.

Discussion ensued.

Patient Safety/Quality and Core Frameworks; Brandie Manuel, CPSO

- Malcolm Baldridge
- IHI- Whole System Quality

People: Brandie Manuel, CPSO

- Huron/Studor

Mr. Glenn introduced Brandie Manuel, Chief Patient Safety Officer. Ms. Manuel gave a presentation on Strategic Planning which included topics such as the Quality and Patient Safety Pillar Strategic Planning Team, Quality Planning Process, Aim Statement, Quality and Safety Priorities, Quality Pillar-Priorities, Transformational Goal,

Roadmap to Excellence, Main Frameworks: Baldridge/IHI/Huron, leadership survey: bottom three dimensions/top three dimensions, Quality/Control/Improvement,

Discussion ensued.

Ms. Manuel explained the idea of using IHI framework and supplementing it with Huron.

Discussion ensued around leadership development, governance involvement and commitment around frameworks.

Infection Control:
Commissioners discussed Governor Inslee's order on new Covid 19 mandates.

Discussion ensued.

Wrap Up:
Mr. Glenn and Commissioners wrapped up the meeting.

Conclude:
Commissioner Dressler made a motion to conclude the meeting. Commissioner McComas seconded.

Action: Motion passed unanimously.

Meeting concluded at 4:09pm.

Approved by the Commission:

Chair of Commission: Jill Buhler Rienstra _____

Secretary of Commission: Marie Dressler _____

Jefferson Healthcare

	July 2021 Actual	July 2021 Budget	Variance Favorable/ (Unfavorable)	%	July 2021 YTD	July 2021 Budget YTD	Variance Favorable/ (Unfavorable)	%	July 2020 YTD
Gross Revenue									
Inpatient Revenue	3,560,048	4,255,558	(695,510)	-16%	21,627,123	29,102,525	(7,475,402)	-26%	21,247,613
Outpatient Revenue	21,925,038	20,250,194	1,674,844	8%	151,725,736	138,485,196	13,240,540	10%	119,694,190
Total Gross Revenue	25,485,086	24,505,752	979,334	4%	173,352,858	167,587,720	5,765,138	3%	140,941,803
Revenue Adjustments									
Cost Adjustment Medicaid	2,233,770	2,644,398	410,629	16%	13,995,825	18,084,272	4,088,448	23%	11,562,359
Cost Adjustment Medicare	11,167,327	7,947,468	(3,219,859)	-41%	61,698,286	54,350,427	(7,347,859)	-14%	51,820,777
Charity Care	630,772	233,043	(397,729)	-171%	2,243,721	1,593,714	(650,007)	-41%	1,613,326
Contractual Allowances Other	(2,085,832)	1,872,869	3,958,702	211%	15,525,748	12,808,010	(2,717,738)	-21%	13,787,589
Administrative Adjustments	(7,323)	110,023	117,346	107%	279,917	752,415	472,498	63%	282,976
Allowance for Uncollectible Accounts	2,116,232	461,901	(1,654,331)	-358%	3,205,617	3,158,810	(46,808)	-1%	1,601,446
Total Revenue Adjustments	14,054,946	13,269,703	(785,243)	-6%	96,949,114	90,747,648	(6,201,466)	-7%	80,668,472
Net Patient Service Revenue	11,430,140	11,236,048	194,091	2%	76,403,744	76,840,072	(436,328)	-1%	60,273,330
Other Revenue									
340B Revenue	346,043	314,247	31,797	10%	2,248,218	2,149,041	99,177	5%	1,771,288
Other Operating Revenue	237,789	235,586	2,202	1%	2,536,282	1,611,105	925,177	57%	9,367,689
Total Operating Revenues	12,013,971	11,785,881	228,090	2%	81,188,245	80,600,219	588,026	1%	71,412,307
Operating Expenses									
Salaries And Wages	5,862,179	5,796,936	(65,243)	-1%	40,193,873	39,643,565	(550,308)	-1%	37,242,089
Employee Benefits	1,148,393	1,487,709	339,316	23%	9,364,021	10,174,012	809,991	8%	8,617,588
Professional Fees	183,510	133,343	(50,167)	-38%	1,137,901	911,897	(226,004)	-25%	1,612,069
Purchased Services	1,001,475	701,077	(300,397)	-43%	5,229,737	4,794,463	(435,274)	-9%	4,449,382
Supplies	2,573,603	2,188,327	(385,275)	-18%	16,111,845	14,965,335	(1,146,510)	-8%	13,698,166
Insurance	65,976	85,425	19,449	23%	609,013	584,198	(24,815)	-4%	449,114
Leases And Rentals	30,567	35,778	5,210	15%	187,168	244,673	57,505	24%	118,172
Depreciation And Amortization	490,285	537,192	46,907	9%	3,469,098	3,673,700	204,602	6%	3,578,799
Repairs And Maintenance	28,693	103,261	74,568	72%	380,726	706,173	325,447	46%	553,469
Utilities	107,147	98,536	(8,611)	-9%	731,537	673,858	(57,679)	-9%	696,723
Licenses And Taxes	17,843	64,054	46,212	72%	466,203	438,050	(28,153)	-6%	378,423
Other	156,123	199,859	43,736	22%	1,110,216	1,366,778	256,562	19%	1,107,159
Total Operating Expenses	11,665,793	11,431,499	(234,295)	-2%	78,991,338	78,176,702	(814,636)	-1%	72,501,151
Operating Income (Loss)	348,178	354,382	(6,204)	-2%	2,196,907	2,423,517	(226,610)	-9%	(1,088,844)
Non Operating Revenues (Expenses)									
Taxation For Maint Operations	23,101	23,798	(697)	-3%	161,706	162,746	(1,040)	-1%	154,736
Taxation For Debt Service	19,523	18,668	855	5%	260,040	127,665	132,375	104%	132,858
Investment Income	2,921	28,197	(25,276)	-90%	28,816	192,833	(164,017)	-85%	140,771
Interest Expense	(46,631)	(89,636)	43,005	48%	(619,496)	(612,993)	(6,503)	-1%	(623,454)
Bond Issuance Costs	-	-	-	0%	-	-	-	0%	0
Gain or (Loss) on Disposed Asset	-	-	-	0%	-	-	-	0%	-
Contributions	1,650	18,473	(16,823)	-91%	30,021	126,329	(96,308)	-76%	219,405
Total Non Operating Revenues (Ex	565	(500)	1,065	213%	(138,912)	(3,420)	(135,492)	-3962%	24,316
Change in Net Position (Loss)	348,743	353,882	(5,139)	-1%	2,057,995	2,420,097	(362,102)	-15%	(1,064,528)

Jefferson Healthcare

STATISTIC DESCRIPTION	JULY 2021 MO ACTUAL	MO BUDGET	% VARIANCE	YTD ACTUAL	YTD BUDGET	% VARIANCE	JULY 2020 MO ACTUAL	% VARIANCE	YTD ACTUAL	% VARIANCE
FTEs - TOTAL (AVG)	585.19	625.21	6%	604.37	625.21	3%	621.05	6%	599.67	-1%
FTEs - PRODUCTIVE (AVG)	512.47	559.80	8%	535.61	559.80	4%	546.40	6%	531.46	-1%
ADJUSTED PATIENT DAYS	2,759	2,233	24%	19,299	15,273	26%	1,962	41%	12,761	51%
ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	97	76	28%	518	517	0%	58	67%	409	21%
ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	290	331	-12%	1,871	2,261	-17%	244	19%	1,711	9%
SWING IP PATIENT DAYS (MIDNIGHT CENSUS)	-	23	-100%	95	157	-39%	11	-100%	119	-25%
PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION	387	430	-10%	2,484	2,935	-15%	313	24%	2,239	10%
BIRTHS	7	10	-30%	56	67	-16%	10	-30%	52	7%
SURGERY CASES (IN OR)	121	127	-5%	911	871	5%	118	3%	710	22%
SURGERY MINUTES (IN OR)	16,779	14,861	13%	118,433	101,628	17%	15,964	5%	90,491	24%
SPECIAL PROCEDURE CASES	64	77	-17%	515	529	-3%	63	2%	359	30%
LAB BILLABLE TESTS	22,001	21,570	2%	153,061	147,508	4%	20,517	7%	119,447	22%
BLOOD BANK UNITS MATCHED	-	48	-100%	-	327	-100%	38	-100%	292	0%
MRIs COMPLETED	191	238	-20%	1,448	1,626	-11%	184	4%	1,230	15%
CT SCANS COMPLETED	589	544	8%	3,813	3,717	3%	510	15%	3,011	21%
RADIOLOGY DIAGNOSTIC TESTS	1,673	1,583	6%	10,814	10,827	0%	1,580	6%	9,289	14%
ECHOs COMPLETED	115	138	-17%	1,114	944	18%	178	-35%	796	29%
ULTRASOUNDS COMPLETED	336	346	-3%	2,372	2,365	0%	305	10%	1,959	17%
MAMMOGRAPHYS COMPLETED	270	260	4%	1,856	1,778	4%	240	13%	1,333	28%
NUCLEAR MEDICINE TESTS	38	38	0%	344	261	32%	39	-3%	220	36%
TOTAL DIAGNOSTIC IMAGING TESTS	3,212	3,147	2%	21,761	21,518	1%	3,036	6%	17,838	18%
PHARMACY MEDS DISPENSED	19,937	24,451	-18%	136,934	167,216	-18%	20,204	-1%	126,352	8%
ANTI COAG VISITS	406	409	-1%	2,807	2,794	0%	456	-11%	2,562	9%
RESPIRATORY THERAPY PROCEDURES	2,592	3,727	-30%	18,623	25,487	-27%	2,455	6%	17,378	7%
PULMONARY REHAB RVUs	158	237	-33%	811	1,620	-50%	103	53%	849	-5%
PHYSICAL THERAPY RVUs	7,312	7,650	-4%	52,018	52,313	-1%	7,052	4%	41,364	20%
OCCUPATIONAL THERAPY RVUs	1,030	1,111	-7%	7,515	7,598	-1%	1,168	-12%	7,159	5%
SPEECH THERAPY RVUs	306	220	39%	2,027	1,508	34%	281	9%	1,437	29%
REHAB/PT/OT/ST RVUs	8,806	9,218	-4%	62,371	63,039	-1%	8,604	2%	50,809	19%
ER CENSUS	1,148	1,110	3%	6,676	7,588	-12%	1,003	14%	6,196	7%
EXPRESS CLINIC	1,008	830	21%	4,608	5,673	-19%	541	86%	4,151	10%
SOCO PATIENT VISITS	111	165	-33%	862	1,127	-24%	162	-31%	987	-15%
PORT LUDLOW PATIENT VISITS	637	662	-4%	4,435	4,530	-2%	586	9%	3,679	17%
SHERIDAN PATIENT VISITS	2,617	2,667	-2%	18,535	18,239	2%	2,384	10%	14,565	21%
DENTAL CLINIC	443	398	11%	2,725	2,723	0%	353	25%	1,620	41%
WATERSHIP CLINIC PATIENT VISITS	1,013	1,194	-15%	7,365	8,166	-10%	968	5%	6,114	17%
TOWNSEND PATIENT VISITS	562	554	1%	3,920	3,786	4%	619	-9%	3,682	6%
TOTAL RURAL HEALTH CLINIC VISITS	6,391	6,470	-1%	42,450	44,244	-4%	5,613	14%	34,798	18%
OFF-SITE LAB	515	-	0%	6,843	-	0%	1,177	-56%	2,752	60%
DISASTER CLINIC	-	-	0%	127	-	0%	176	-100%	1,086	-755%
TOTAL COVID RESPONSE	515	-	0%	6,970	-	0%	1,353	-62%	3,838	45%
CARDIOLOGY CLINIC VISITS	479	340	41%	3,322	2,323	43%	392	22%	2,171	35%
DERMATOLOGY CLINIC VISITS	561	561	0%	3,797	3,833	-1%	759	-26%	3,967	-4%
GEN SURG PATIENT VISITS	249	312	-20%	2,216	2,135	4%	326	-24%	1,580	29%
ONCOLOGY VISITS	561	594	-6%	3,816	4,064	-6%	581	-3%	3,489	9%
ORTHO PATIENT VISITS	668	729	-8%	4,876	4,987	-2%	734	-9%	4,386	10%
SLEEP CLINIC VISITS	103	142	-27%	600	971	-38%	165	-38%	1,079	-80%
UROLOGY VISITS	150	229	-34%	1,269	1,568	-19%	116	29%	1,057	17%
WOMENS CLINIC VISITS	294	276	7%	2,116	1,885	12%	155	90%	923	56%
WOUND CLINIC VISITS	277	277	0%	1,788	1,893	-6%	213	30%	1,461	18%
TOTAL SPECIALTY CLINIC VISITS	3,342	3,460	-3%	23,800	23,659	1%	3,441	-3%	20,113	15%
SLEEP CENTER SLEEP STUDIES	41	65	-37%	220	446	-51%	63	-35%	325	-48%
INFUSION CENTER VISITS	689	851	-19%	5,343	5,818	-8%	790	-13%	4,894	8%
SURGERY CENTER ENDOSCOPIES	74	79	-6%	535	540	-1%	85	-13%	397	26%
HOME HEALTH EPISODES	46	60	-23%	352	411	-14%	59	-22%	366	-4%
HOSPICE CENSUS/DAYS	1,006	749	34%	7,371	5,122	44%	1,109	-9%	7,382	0%
CARDIAC REHAB SESSIONS	81	85	-5%	446	581	-23%	65	25%	477	-7%
DIETARY TOTAL REVENUE	57,252	60,691	-6%	396,180	415,051	-5%	57,208	0%	448,973	-13%
MAT MGMT TOTAL ORDERS PROCESSED	1,663	2,207	-25%	12,132	15,091	-20%	1,973	-16%	13,547	-12%
EXERCISE FOR HEALTH PARTICIPANTS	-	290	-100%	-	1,981	-100%	-	0%	1,240	0%

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **JULY 2021 ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS, ADMINISTRATIVE, AND CHARITY CARE WRITE OFFS**

Submitted for your approval are the following:

	JULY	JULY YTD	JULY YTD BUDGET
Allowance for Uncollectible Accounts:	2,116,232.00	3,205,617.00	3,158,809.88
Charity Care:	630,772.35	2,243,720.50	1,593,713.57
Other Administrative Adjustments:	(7,323.11)	279,916.55	752,414.76
TOTAL FOR MONTH:	$2,739,681.24	$5,729,254.05	$5,504,938.21

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **JULY 2021 WARRANT SUMMARY**

The following items need to be approved at the next commission meeting:

General Fund Warrants & ACH Transfers	**$20,581,068.35**	(Provided under separate cover)
Allowance for Uncollectible Accounts / Charity	**$2,739,681.24**	(Attached)
Canceled Warrants	**$0.00**	(Attached)

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **JULY 2021 GENERAL FUND WARRANTS & ACH FUND TRANSFERS**

Submitted for your approval are the following warrants:

GENERAL FUND:

275592	**280823**	**$6,347,290.89**
ACH TRANSFERS		**$14,233,777.46**
		$20,581,068.35
YEAR-TO-DATE:		**$115,080,241.26**

Warrants are available for review if requested.

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **JULY 2021 WARRANT CANCELLATIONS**

State law requires you to pass a resolution canceling any warrants which are not presented to the Treasurer for payment within one year of issue.

DATE	WARRANT	AMOUNT

***Due to changes in County Software we are unable to confirm at this time.**

TOTAL:	**$ -**

FROM: **Medical Staff Services**
RE: **<u>08/24/2021 Medical Executive Committee appointments/reappointments for Board approval 08/25/2021</u>**

C-0241
§485.627(a) Standard: Governing Body or Responsible Individual
The CAH has a governing body or an individual that assumes full legal responsibility for determining, implementing and monitoring policies governing the CAH'S total operation and for ensuring that those policies are administered so as to provide quality health care in a safe environment.

Interpretive Guidelines §485.627(a)
It is the responsibility of the governing body (or responsible individual) to appoint, with the advice of the medical staff, the individual practitioners to the medical staff. After considering medical staff recommendations, and in accordance with established CAH medical staff criteria and State and Federal laws and regulations, the governing body (or responsible individual) decides whether or not to appoint new medical staff members or to continue current members of the medical staff.

Recommended provisional appointment to the active/courtesy/allied health/locum tenens staff:

1. Dr. Lise Labiche, MD - Teleneurology
2. Dr. Jonathan Dargo, MD – Telepsychiatry

Recommended re-appointment to the active medical staff with privileges as requested:

1. Dr. Catherine Mank, MD – Emergency
2. Dr. Katherine Biccum, DO – Primary Care
3. Dr. Robert Butterfield, MD – Primary Care
4. Dr. Paul Naumann, MD – Orthopedics
5. Dr. Gary Forbes, MD – Primary Care
6. Dr. Stephen Erickson, MD- Primary Care
7. Dr. Edward Eissmann, MD – Orthopedics
8. Dr. Kari Heistand, MD – Primary Care Behavior Health
9. Dr. Frank Magill, MD – Primary Care
10. Dr. Sarah Schmidt, MD – Primary Care

Recommended re-appointment to the courtesy medical staff with privileges as requested:

1. Dr. Arman Forouzannia, MD - Teleradiology
2. Dr. Joseph Freeburg, MD – Teleneurology
3. Dr. Mimi Lee, MD – Teleneurology
4. Dr. Kishan Patel, MD – Teleneurology
5. Dr. Andrew Rontal, MD - Teleneurology
6. Dr. Michael Squire, MD – Radia
7. Dr. Shaheen Umar, MD – Radia
8. Dr. Stephanie Cheng, MD – Radia
9. Dr. Benjamin Iles, DO – Radia
10. Dr. Mitchell Kok, MD – Radia
11. Dr. Ross Ondersma – Radia
12. Dr. Michael Peters – Radia
13. Dr. Jennifer McEvoy – Radia
14. Dr. Felix Nautsch, MD – Radia
15. Dr. Kenneth Hebert, MD – Radia

FROM: **Medical Staff Services**
RE: **08/24/2021 Medical Executive Committee appointments/reappointments for Board approval 08/25/2021**

C-0241
§485.627(a) Standard: Governing Body or Responsible Individual
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Recommended re-appointment to the allied health staff with privileges as requested:

1. Christine Doyle, ARNP – Primary Care
2. Gustavo Pena, CRNA- Surgery
3. Katie Ernst, ARNP – Dermatology
4. Sergei Pavlov, CRNA – Surgery
5. Jodi Sticker-Ivie, PA – Express Clinic

Recommended Temporary Privileges:

1. Shawnisa Francis, PA – Sleep Clinic

Recommended POCUS Privileges:
N/A

Medical Student Rotation:
N/A

Disaster Privileging
N/A

90-day provisional performance review completed successfully:

1. Isabel Liendo-Lira, DDS

Resignations:

1. John Murray, MD – Emergency
2. Thomas Kummet, MD – Oncology
3. Ryan Bergren, MD – Telepsychiatry
4. Christian Schmalz – Surgery

FROM: **Medical Staff Services**
RE: **<u>08/24/2021 Medical Executive Committee appointments/reappointments for Board approval 08/25/2021</u>**

C-0241
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Summary of Changes for Policy and Privilege Review

Policies

1. 90 Day Focused Professional Practice Review
    i. No Changes
2. Access to Provider Credentialing and Quality Files
    i. No Changes
3. Medical Staff Bylaws
    i. No Changes
4. Medical Staff Orientation
    i. No Changes
5. Medical Staff Rules and Regulations
    i. No Changes

Privileges

1. ARNP Sleep Medicine Privileges
    i. No Changes
2. General Dentistry
    i. No Changes

Origination: *05/2018*
Last Approved: *11/2020*
Last Revised: *03/2019*
Next Review: *11/2021*
Owner: *Allison Crispen: Director of Medical Staff Programs*
Policy Area: *Medical Staff Policies*
Standards & Regulations:
References:

90 Day Focused Professional Practice Review

Name: Department:

		Meets expected practice	Opportunity for improve-ment	Specific concerns
Patient Care	Provides compassionate, appropriate, and effective patient care for the treatment of health problems and the promotion of health.			
Medical Knowledge	Demonstrates knowledge about established and evolving biomedical, clinical, epidemiological and social behavioral sciences as well as the application of patient care.			
Technical Skills	Demonstrates strong hand-eye coordination, manual dexterity and proper use of surgical equipment and technique.			
Technology Skills	Demonstrates appropriate and knowledgeable use of EMR to ensure patient safety			
EHR Documentation	Demonstrates competence, appropriate documentation and utilization of EPIC. Timely completion of documentation.			
Practice based learning and improvement	Demonstrates the ability to investigate and evaluate patient care practices, appraises and assimilates scientific evidence to continuously improve patient care based on constant self-evaluation and life-long learning			
Interpersonal and Communication	Demonstrates interpersonal and communication skills that result in effective information exchange and collaboration with patients, their families and health professionals			

Skills				
Professionalism	Demonstrates a commitment to carrying out professional responsibilities, and adherence to ethical principles			
*** Below expectation performance (requires comments)**				

Recommendations:

_____ Resume routine evaluation process

_____ Extend evaluation period

_____ Recommend corrective action

_____

Reviewer signature Date

_____

Print Name

Attachments

No Attachments

Approval Signatures

Approver	Date
Allison Crispen: Director of Medical Staff Programs	11/2020

Origination:	*07/2014*
Last Approved:	*11/2020*
Last Revised:	*06/2019*
Next Review:	*11/2021*
Owner:	*Allison Crispen: Director of Medical Staff Programs*
Policy Area:	*Medical Staff Policies*
Standards & Regulations:	
References:	

Access to Provider Credentialing and Quality Files

POLICY/PURPOSE:

It is the policy of the Medical Staff of Jefferson Healthcare to maintain the confidentiality of all records, discussions and deliberations relating to credentialing, medical staff quality assessment and peer review committees. All practitioners have the right to access their credentialing quality data files upon request. Disclosure and/or access are as follows.

PROCEDURE:

Location and Security: All records shall be maintained under the care and custody of Jefferson Healthcare's Medical Staff Services Coordinator. Credentialing and peer review records must remain stored and locked in office and file cabinets except when in use for official business. Records stored electronically must have passwords and possess read/write control protections.

ACCESS TO RECORDS:

The following individuals may access credentialing and peer review records to the extent necessary to conduct official business and as described:

1. An individual practitioner may review his or her credentials and quality assessment file providing:
    - The practitioner will contact the Medical Staff Coordinator to make an appointment.
    - The Medical Staff Services Coordinator or officer of the medical staff is present during the file review.
    - The practitioner understands that he/she may not remove any items from the credentials file.
    - The practitioner understands that he/she may add an explanatory note or other document to the file and correct erroneous information.
    - The practitioner understands that he/she may not review confidential letters of reference received during the initial appointment or any subsequent reappointment.
    - Photocopying: The practitioner may photocopy items that he/she submitted as part of the application or reappointment process (i.e., application, diplomas, licenses, clinical performance reviews, etc.). The practitioner may not photocopy any other items unless express written permission is received from the Chief Executive Officer.

- For initial and reappointment application processes, the practitioner may receive status on his application upon request.

2. Medical Executive Committee member
3. Medical Staff Committee member conducting credentialing or peer review
4. A representative of the Governing Board
5. The Chief Executive Officer, Chief Medical Officer or designated Assistant Administrator
6. Medical Staff Services personnel for purposes of official medical staff committee business and routine filing of information
7. Consultants or attorneys engaged by Jefferson Healthcare or a Jefferson Healthcare credentialed provider
8. Representatives of regulatory or accreditation agencies

SUBPOENAS:

The hospital will refer all subpoenas pertaining to medical staff records to the Risk Manager and Medical Staff Services Coordinator, who shall consult with legal counsel regarding appropriate response and shall notify the involved practitioner and the Chief of Staff.

VERIFICATION OF INFORMATION:

Routine requests for verifications of affiliation and appointment, reappointment and privileges recommendations shall be released with an appropriate release of information form signed by the practitioner. Routine releases shall not be kept on file. Legal counsel will be obtained by Medical Staff Services Coordinator for release of adverse information and such release shall be documented.

DOCUMENTATION OF ACCESS:

Any person accessing credentialing or quality assessment files (other than Medical Staff Services Director/ personnel conducting routine medical staff file upkeep) shall sign and document the purpose and date of the access on the *Access and Released Information* form to be kept in the file.

REFERENCED DOCUMENTS:

NCQA, CR.1, Element B

Board approved: 6/7/2017; Board appr: 6/19/2019

Attachments

No Attachments

Approval Signatures

Approver	Date
Allison Crispen: Director of Medical Staff Programs	11/2020

Origination:	*10/2014*
Last Approved:	*01/2021*
Last Revised:	*02/2018*
Next Review:	*01/2022*
Owner:	*Allison Crispen: Director of Medical Staff Programs*
Policy Area:	*Medical Staff Policies*
Standards & Regulations:	
References:	

Medical Staff Bylaws

PREAMBLE:

PREAMBLE:

WHEREAS, Jefferson Healthcare in Port Townsend (hereinafter "the hospital") is owned and operated by Jefferson County Public Health Care District No. 2, Jefferson County, Washington ("the district"), a municipal corporation of the State of Washington; and WHEREAS, it is the purpose of the hospital to provide patient care and education, and WHEREAS, it is recognized that the Governing Board of Jefferson County Public Health Care District No. 2 (hereinafter the "Governing Board") has ultimate responsibility for the quality of medical care in the hospital and provided only by appropriately trained and licensed health care professionals. Therefore, the cooperative efforts of the Medical Staff, the Chief Executive Officer and the Governing Board

are necessary to fulfill the hospital's obligation to its patients. NOW, THEREFORE, the physicians practicing in Jefferson Healthcare hereby organize themselves into a Medical Staff in conformity with these Bylaws and the Rules and Regulations promulgated hereunder. Unless otherwise stated, Roberts' Rules of Order shall apply.

ARTICLE 1: NAME

The name of this organization shall be "the Medical Staff of Jefferson Healthcare, Port Townsend, Washington", hereinafter referred to as the "Medical Staff."

ARTICLE 2: PURPOSES

The purposes of this organization are:

- To insure that all patients admitted to or treated in any of the facilities, departments, or services of the hospital shall receive a uniform standard of quality care, treatment, and services.
- To assure that the composition of the medical staff meets the hospital and community needs.
- To assure that a member of the medical staff is available at all times to provide the hospital's services.
- To assure the highest level of professional performance of all practitioners authorized to practice in the hospital or any of the facilities of the hospital through appropriate delineation of each practitioner's hospital clinical privileges and /or position description/scope of practice through ongoing review and evaluation of each practitioner's performance.
- To provide an appropriate educational setting that will encourage maintenance of scientific standards and lead to continuous advancement in professional knowledge and skill.
- To develop and maintain rules and regulations and policies for self governance of the Medical Staff.
- To provide a forum for discussion of issues and for the development of working relations between the Governing Board and the Medical Staff.

ARTICLE 3: MEDICAL STAFF MEMBERSHIP

1. NATURE OF MEDICAL STAFF MEMBERSHIP: Membership on the Medical Staff of Jefferson Healthcare shall be extended only to physicians (M.D. or D.O.) and allied health staff (PAs, CRNAs and ARNPs) who meet the qualifications, standards and requirements set forth in Qualifications for Membership (3.2) of these Bylaws and in the Rules and Regulations of the Medical Staff. No practitioner, including those in medical-administrative positions by virtue of a contract of employment with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he/she is a member of the Medical Staff or has obtained temporary privileges in accordance with the procedures set forth in these Bylaws.
2. QUALIFICATIONS OF MEMBERSHIP/RESPONSIBILITIES:
3. Only Doctors of Medicine and Osteopathy and allied health staff licensed to practice in their respective fields in the State of Washington, who can document their background, education, training, experience, current technical and/or clinical competency and judgment, individual character, adherence to the ethics of their professions and ability to work with others, shall be qualified for membership on the Medical Staff. No physician shall be entitled to membership on the Medical Staff or to the exercise of particular clinical privileges in the hospital merely by virtue of licensure to practice medicine or osteopathy in this or any other state, membership in any professional organization, or having had similar membership or privileges at this institution in the past or current such membership or privileges elsewhere.
4. Acceptance of membership on the Medical Staff shall further evidence the member's agreement to strictly abide by the Principles of the Medical Ethics of the American Medical Association and American College

of Surgeons, as applicable, the rules, regulations, policies and procedures of the Medical Staff and Hospital and to work harmoniously with others.

5. No applicant shall be denied nor granted Medical Staff membership or clinical privileges on the basis of gender, race, creed, color or national origin, or on the basis of any other criterion lacking professional justification.
6. No applicant shall be discriminated against on the basis of disability. An applicant's specific needs/ accommodations required will be reviewed as necessary for each individual.
7. All Medical Staff members shall document their education, training, experience, current competence and certifications and shall perform within the privileges requested and duties of Medical Staff appointment.
8. Each physician on Active or Courtesy Staff, as a condition of hospital privileges, may be obligated to participate in emergency call in his/her area of specialty. If a problem arises with call in a particular area, the Executive Committee may mandate a call schedule for that specialty.
9. Each member of the Medical Staff agrees to provide for or arrange continuous care to and supervision over his/her hospitalized patients.
10. Applicant must have proof of clinical practice in their field in a hospital, at least two of the previous five years and a minimum of ten patients per year for whom they were the primary physician or surgeon (this criterion does not apply to radiology, pathology, anesthesiology).
11. Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties.
    - Current members of the medical staff (as of 7/2/08) not meeting this requirement shall have the requirement waived
    - Certification must occur within limits defined by specialty board.
    - Practitioner must maintain board certification.
    - Community providers may be members of the medical staff without privileges. **Board certification requirements apply to privileges only.**
12. Must have actively practiced in field for an average of at least 20 hours per week for 18 of the previous 24 months (or have completed a 12 month residency within the previous 18 months).
13. Applicant must submit evidence of CME related to privileges requested, excluding recent (within 3 years) residency graduates.
14. Applicant must have proof of ability to work in the United States, if not a citizen.
15. Applicant must not be excluded from Federal or State Programs including Medicare, Medicaid, etc.
16. CONDITIONS AND DURATION OF APPOINTMENT:
17. Initial appointments and reappointments to the Medical Staff shall be made by the Governing Board. The Board shall act on appointments, reappointments, or revocation of appointments only after there has been recommendation from the Medical Executive Committee through its committee structure.
18. Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been granted by the Governing Board, in accordance with these Bylaws.
19. All initial appointments and privileges shall be provisional for a period of one (1) year from the date of appointment by the Governing Board which may be extended to a period not to exceed two years from original date of appointment.

20. GOVERNING BOARD AUTHORITY TO LIMIT SERVICE
21. Hospital and Community Need and Ability to Accommodate: Any policies, plans and objectives formulated by the Governing Board concerning the hospital's current and projected patient care, teaching and research needs and the availability of required physical, financial and personnel resources may be considered in taking action on applications for staff appointment and reappointment and new or modified clinical privileges.
22. The granting or denial of clinical privileges for applicants and members of the Medical Staff will be based on professionally recognized standards of the Medical Staff and the Hospital and shall be uniformly applied. The Governing Board, where it finds that it is necessary or prudent may impose limitation on the number of practitioners to whom privileges are granted. Such limitations may be imposed through resolutions which have the effect of restricting the number of practitioners in a particular area or specialty through exclusive contracts or through any other appropriate device or means. The Governing Board is within its authority to manage the hospital facilities in the best interest of the community and quality patient care.
23. Applications for privileges will not be accepted for services not available at Jefferson Healthcare. Those granted temporary privileges as consultants may be exempt from this condition.
24. STAFF DUES AND ASSESSMENTS:
25. Annual Medical Staff dues and special assessments shall be set as recommended by the Executive Committee and adopted by a two thirds majority vote at a regular or special Medical Staff meeting. Special assessments may be charged only for purposes specifically approved by the Medical Staff at such meetings. The Medical Staff shall be notified of any contemplated change in Medical Staff dues or special assessments at a general meeting of the medical staff at which a vote on such proposed change is to be taken.
26. Annual dues and special assessments if any, shall be paid by all Medical Staff members and limited licensed independent practitioners who are privileged to provide patient care services in the hospital. Honorary Staff members are exempt from all dues and assessments.
27. Dues, if any, shall be payable annually. Special assessments shall be due and payable at of notification.
28. Failure to pay dues or assessments may result in suspension of medical staff membership. A member suspended for financial delinquency may be reinstated by the Executive Committee upon payment of the delinquent dues or assessments.
29. RELEASE OF INFORMATION AND LIABILITY:
    All applicants, as well as all members of the Medical Staff, consent to the release of information for any purpose set forth in these Bylaws as long as such release of information complies with all applicable laws, policies and procedures. All applicants as well as members of the Medical Staff also release from liability and agree to hold harmless any person or entity furnishing or releasing such information concerning his/her application or medical staff status. Members of the Medical Staff and any hospital representatives who are involved in credentialing or peer review activities are immune from liability. Applicants to the Medical staff shall sign a consent for the release of information and a hold harmless agreement in conformance with the purpose of this section.

ARTICLE 4: CATEGORIES OF THE MEDICAL STAFF

1. CATEGORIES:

There shall be five (5) categories of Medical Staff membership: Active, Courtesy, Honorary, Locum Tenens **and Refer and Follow.**

INITIAL EVALUATION: *During the first 90 days upon the initial granting of clinical privileges, all providers will have a minimum of three (3) evaluations completed using the Professional Evaluation Form. Review may consist of concurrent or retrospective reviews and or/proctoring. See policy: Provisional Evaluation Process.*

2. THE ACTIVE MEDICAL STAFF:
   The Active Medical Staff shall consist of physicians and allied health providers who meet the basic qualifications set forth in these bylaws and regularly have patient contacts at Jefferson Healthcare (including Jefferson Healthcare Clinics).
3. Prerogatives of Active Staff:
   The prerogatives of the active staff shall be to admit patients to the hospital; hold office in the medical staff organization and vote in medical staff meetings; serve on committees of the medical staff and vote in committee deliberations; exercise such privileges as have been granted to him/her by the Governing Board.
4. Responsibilities of the Active Staff:
   Responsibilities shall be to satisfy the requirements set forth for committees of which he/she is a member; actively participate in the patient care assessment and other quality assessment activities required of the staff; retain responsibility within his/her area of professional competence for the daily care and supervision of each patient in the hospital for whom he/she is providing services or arrange a suitable alternative for such care and supervision; participate in backup call for the Emergency Department to include acceptance of unassigned patients regardless of insurance coverage. Continuously comply with the bylaws and rules and regulations of the medical staff. Practitioner shall be required to attend any meeting for discussion of cases where he/she served as attending, if so requested. Failure to comply may result in initiation of disciplinary action. Should a member be absent from any meeting at which a case he/she attended is to be presented, it shall nevertheless be discussed unless the member is unavoidably absent and has requested a postponement be granted.
5. THE COURTESY MEDICAL STAFF:
   The Courtesy Medical Staff shall consist of practitioners who meet the basic qualifications set forth in these bylaws; regularly have patient contacts at Jefferson Healthcare but admit less than twenty (20) patients per year; are located close enough to the hospital to provide continuous care to their patients.
6. Prerogatives of the Courtesy Staff:
   Prerogatives shall be to admit patients to the hospital within the limitations and under the same conditions as specified for active staff members; exercise such clinical privileges as have been granted to him/her by the Governing Board; attend meetings of the medical staff and any medical staff or hospital educational program. Courtesy staff members shall not be eligible to vote or to hold office in this medical staff organization.
7. Responsibilities of Courtesy Staff Members:
   Shall be to retain responsibility within his/her area of professional competence for the daily care and supervision of each patient in the hospital for whom he/she is providing services or arrange a suitable alternative for such care and supervision; continuously comply with the bylaws and rules and regulations of the medical staff; practitioner shall be required to attend any meeting for discussion of cases where he/she served as attending, if so requested. Failure to comply may result in initiation of disciplinary action. Should a member be absent from any meeting at which a case he/she attended is to be presented, it shall

nevertheless be discussed unless the member is unavoidably absent and has requested a postponement be granted.

8. THE HONORARY MEDICAL STAFF:
   The Honorary Medical Staff shall consist of practitioners who are honored by emeritus positions. The Honorary Medical Staff shall be appointed by the Governing Board upon recommendation of the Executive Committee. These may be practitioners who have retired from active hospital practice or who are of outstanding reputation. Honorary Medical Staff members shall not be eligible to admit or provide clinical care to patients, to vote on medical staff issues or to hold Medical Staff Services Department; they shall be eligible for appointment by the Chief of Staff to Medical Staff to committees with voting privileges.
9. The LOCUM TENENS STAFF:
   A Locum tenens is a practitioner who is appointed to assist or temporarily fulfill the responsibilities of an active member of the medical staff within the same specialty. A practitioner applying for privileges in a locum tenens capacity shall meet the same qualifications and follow the same procedures required for all new applicants. An appropriately licensed practitioner of documented competency may be granted privileges for no more than **6 months**. Locum Tenens shall have no voting privileges.
10. TEMPORARY PRIVILEGES, CONSULTANTS, and VISITING PRACTITIONERS
    Circumstances:
    Temporary privileges may be granted in the following circumstances:
    a. New Applicants: To new applicants with a complete application as outlined in Article 6 that raises no concerns, after a favorable recommendation of the Medical Executive Committee while awaiting review and approval of the Medical Executive Committee and Governing Board.
       - additional requirements: no current or previously successful challenges to licensure or registration; no subjection to involuntary termination of medical staff membership at another organization; and no subjection to involuntary limitation, reduction, denial or loss of clinical privileges.

    b. Important Patient Care Need:
       - For the care of specific patients for whom the required expertise is not otherwise available (consultant/visiting practitioner). Temporary privileges granted in this circumstance shall not exceed the duration of the patient's hospitalization.
       - To a person serving as a locum tenens for a current member of the medical staff.

    c. Reappointment: When a current member of the medical staff has submitted a complete reappointment application that raises no concerns while awaiting review and approval of the medical executive committee and governing board.

       Hospital shall be provided at least fourty-five days advance notice of such planned locum tenens coverage. Such advance notice requirement may be waived in an emergency, as defined by the Chief of Staff.
11. Temporary Privileges Application and Review:
    The chief executive officer, or authorized designee and the chief governing officer on the recommendation of the chief of staff and the appropriate chief of service, may grant temporary privileges in accordance with the above provisions.
    General Conditions:
    - If granted temporary privileges, the practitioner shall act under the supervision of the chief of service

to which the practitioner has been assigned, and shall ensure that the chief of service, or the chief of service's designee, is kept closely informed as to his or her activities within the hospital.

- Requirements of consultation and reporting may be imposed by the Chief of Staff or designee.
- Temporary privileges shall not exceed 120 days.

12. Termination: Upon discovery of any information or the occurrence of any event which calls into question a practitioner's qualifications or ability to exercise any or all of the temporary privileges, the CEO may, after consultation with the Chief of Staff, terminate any or all of such practitioner's temporary privileges. Where life or wellbeing of a patient is determined to be endangered by continued treatment by the practitioner the termination may be effected by any person entitled to impose summary suspension as outlined in Article 10. In the event of such termination, the practitioner's patients then in the hospital, shall be assigned to another practitioner by the Chief of Staff.
13. Rights of Practitioner: A practitioner shall not be entitled to the procedural rights afforded By Article 9 (Corrective Action) because of inability to obtain temporary privileges or because of any termination or suspension of temporary privileges.
14. Information Required to Grant Temporary Privileges for important patient care needs as defined above:
    - Verification of current license in Washington State.
    - Verification of liability insurance coverage which must meet minimum requirements established by the Governing Board, Executive Committee and Medical Staff.
    - Evidence of current DEA registration, if applicable.
    - If applicable, evidence of Board Certification or eligibility.
    - Verification of education and training shall be confirmed by AMA/AOA profile. When applicable, the ECFMG will be queried.
    - Requesting criminal history information accordance with the Child/Adult Abuse Information Act (WSP).
    - The National Practitioner Data Bank shall be queried.
    - The OIG/SAM shall be queried for sanctions/exclusions.
    - The Noridian website(Medicare Part B carrier0 shall be queried for providers opting out (also at reappointment time and on an ongoing basis inbetween)
    - The hospital shall request from the last three facilities at which the practitioner had or has privileges, was associated or was employed the following information:
        - Any pending professional misconduct proceeding or any pending medical malpractice actions in this state or another state
        - Any judgment or settlement of a medical malpractice action and any finding of professional misconduct in his state or another state by a licensing or disciplinary board
        - Any information required to be reported by hospitals to the medical disciplinary board
    - Information regarding current clinical competence and ability to perform privileges requested, with or without accommodation, ethical character, ability to work cooperatively with others
    - At least two peer recommendations from practitioners not newly associated with or about to become partners with the applicant, who have knowledge of the applicant's medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills,

professionalism, ethical character, and ability to work cooperatively with others.

- List of privileges requested (may be a copy of privileges granted at another hospital).
- Curriculum vitae.
- Agreement to abide by the Medical Staff Bylaws and Rules and Regulations, Policies and Procedures and Jefferson Healthcare Bylaws and Policies and Procedures.

15. REFER AND FOLLOW PRIVILEGES: These privileges allow the practitioner only to refer patients to the hospital. The provider may follow the patient's progress but attending physicians at the hospital provide the necessary care.

    Prerogative of Refer and Follow Staff:

    - Refer patient to hospitalist for admission
    - Visit and follow his/her patient while in the hospital
    - May submit office information as it applies for historical charting only
    - Access the medical record both remotely and at the hospital in a read-only function
    - Communicate with the attending physician
    - *Attend* meetings of the General Medical Staff

    Limitations of Refer and Follow Staff:

    - Write orders
    - Do evaluations on any patient at the Hospital
    - Vote on matters presented at meetings
    - Hold office at any level in the staff organization or be chairman of any committee or serve on MEC
    - Provide emergency room coverage
    - Serve on committees of the hospital

16. EMERGENCY PRIVILEGES: For the purposes of this section, an emergency is defined as a condition in which life or limb is in immediate danger and any delay in administering treatment would add to the danger. In the case of an emergency, any practitioner, to the degree permitted by his/her license and regardless of staff status or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save a patient from permanent and serious harm.
17. TEMPORARY PRIVILEGES DURING A DISASTER: The CEO, upon recommendation of the Chief of staff or authorized designee(s) may grant emergency privileges in a disaster for which the Emergency Management Plan has been activated and the hospital is unable to handle the immediate needs of patients. Privileges will be granted in accordance with the medical staff policy: *Credentialing Physicians and Allied Health Professionals in the Event of a Disaster*. The medical staff and governing board shall make a decision within 72 hours related to the continuation of the disaster privileges initially granted. These privileges will automatically expire when the disaster situation no longer exists or by action of the CEO, Chief of Staff or authorized designee(s). Termination of these privileges will not give rise to a fair hearing or review.
18. RESIDENTS: Residents may participate in patient care activities at Jefferson Healthcare in accordance with Medical Staff Policy*, Residents*, providing:

    - Jefferson Healthcare has an affiliation agreement with the residency program.

- Resident is enrolled in an accredited residency program.
- All residency program requirements are met.

19. CHANGE OF STATUS: Any member desiring to change his/her status may apply to the Medical Executive Committee who shall make recommendation to the Governing Board for their action.
20. LEAVE OF ABSENCE: Leave of absence shall be defined as a leave of six months and may not exceed two years from the time of last credentialing. A practitioner may obtain a leave of absence from the medical staff by submitting written notice to the Chief of Staff and the CEO. Such notice must state the commencement date and estimated termination date for the leave. Practitioners returning from leave of absence will be subject to the normal reappointment process unless exempted by the Executive Committee. At least forty-five (45) days prior to termination date of the leave, the practitioner may request reinstatement of privileges by submitting a request to the Medical Staff Services Department. This notice must be accompanied by a written statement of relevant activities during the leave. Such request shall be forwarded to the medical staff which shall make recommendation to the Governing Board concerning the reinstatement of the member's privileges. Final determination regarding reinstatement of privileges shall rest with the Governing Board. An adverse decision by the Governing Board with respect to reinstatement or privileges shall entitle the affected practitioner to a hearing as outlined in the Fair Hearing Plan. Failure to request reinstatement and/or provide a satisfactory statement of activities during the leave shall result in automatic termination of staff membership and privileges without the right of hearing or appellate review. A request for staff membership subsequently received from practitioner so terminated shall be submitted and processed in the manner specified for initial applications.

ARTICLE 5: NATIONAL PRACTITIONER DATA BANK and MEDICAL QUALITY ASSURANCE COMMISSION (MQAC)

1. DUTY TO REPORT: Jefferson Healthcare must report the following certain adverse actions that have been taken against the clinical privileges of a provider (physician, dentist, podiatrist, psychologist, PA-C, ARNP). Jefferson Healthcare reporting is compliant with State and National reporting requirements.

   A professional review action based on the practitioner's professional competence or professional conduct that adversely affects his/her clinical privileges for a period of more than thirty (30) days (actions to include reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges).

   Acceptance of the surrender or restriction of clinical privileges while the practitioner is under investigation, or in return for not conducting an investigation by the Medical Staff/Hospital relating to possible professional incompetence or improper professional conduct.

   The adverse action must be reported to the NPDB and the MQAC within 15 days from the date the adverse action was taken or clinical privileges were voluntarily surrendered. The Report Verification Document received from the NPDB must be submitted to the appropriate State Licensing Board.
2. NOT REPORTABLE: The following actions are not based on competence or professional conduct and are not reportable to the NPDB or MQAC:
   - Suspension of a physician's clinical privileges or medical staff membership due to a failure to complete medical records on time, if the action has not compromised patient care.

- Denial of clinical privileges or medical staff membership because of the lack of need for the practitioner's services.
- Suspension, denial or non-renewal of clinical privileges or staff membership due to a failure to obtain or maintain a specified level of professional liability insurance.
- Denial of clinical membership or staff membership due to a failure to comply with threshold eligibility requirements, such as board certification, geographic requirements.
- Reduction or non-renewal of privileges due to the physician's failure to meet new threshold requirements (i.e., board certification) or lapse in requirement (i.e., Advanced Cardiac Life Support Certificate).
- Reduction or non-renewal of privileges due to the medical staff's Credentialing requirements, such as physician's failure to admit a minimum number of patients to the hospital.
- Voluntary admission to an impairment program.

3. QUERY RESPONSIBILITY: Jefferson Healthcare must query the National Practitioner Data Bank in the following situations:
   - When clinical privileges are initially granted.
   - At the time of renewal of privileges (no longer than two years).
   - When a new privilege is requested.
4. RESPONSIBILITY TO PHYSICIAN: Medical Staff Services personnel shall notify the physician when information is reported to the National Practitioner Data Bank or the Medical Quality Assurance Commission.

ARTICLE 6: INITIAL APPOINTMENT PROCEDURES

1. REQUEST FOR APPLICATION:

   An application for staff appointment must be submitted by the applicant in writing and on the hospital approved form and must be dated within 90 days of receipt. Any applicable fees shall accompany the application. The application will be processed according to the Medical Staff *Initial Appointment policy*.
2. APPLICATION CONTENT: Every application must furnish complete information as outlined in the current Medical Staff *Initial Appointment* policy and shall include at least the following:
3. Staff category and specific clinical privileges requested: The applicant must submit any reasonable evidence of current ability to perform privileges requested safely and competently.
4. Medical school and post-graduate training including the name and address of each institution, degrees granted, program completed, dates attended and for all post-graduate training, names of practitioners responsible for monitoring the applicant's performance.
5. All past and currently valid medical and other professional licensures or certifications, Drug Enforcement Administration (DEA) Controlled Substances Registration, if applicable.
6. Specialty or subspecialty board certification, recertification or current qualification status to sit for the examination.
7. Any physical or mental condition including alcohol or drug dependencies that may affect the applicant's

ability to perform privileges requested and duties of medical staff appointment.

8. Professional liability insurance coverage and information on professional liability history and experience (claims, suits, judgments and settlements made, concluded and pending in this state or another state including the names of present and past insurance carriers (5 years). Copy of current liability policy face sheet must accompany the application.
9. Any proceedings initiated, pending or completed involving allegations or findings of professional medical misconduct in this state or another state.
10. Any proceedings initiated, pending or completed involving denial, revocation, suspension, reduction, limitation, probation or non-renewal of any of the following whether voluntary or involuntary : licensing or certificate to practice any profession in a state or country; drug enforcement administration or other controlled substances registration; membership or fellowship in local, state or national professional organizations; faculty membership at any medical or other professional school; appointment or employment status, prerogatives or clinical privileges at any other hospital, facility or organization including health plans; limitation, cancellation, imposition of surcharge on professional liability insurance.
11. Any instances in which the applicant did not renew, terminated, restricted, limited, withdrew or failed to proceed with an application for any of the elements listed in 6.1.2.8 above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action.
12. Location of offices; names and addresses of other practitioners with whom the applicant is or was associated and inclusive dates of such association; names and addresses of any hospital or facility where the applicant has or had any association, employment, privileges or practice with dates of each affiliation, status held and general scope of clinical privileges.
13. Any current felony criminal charges pending against the applicant and any past charges including their resolution.
14. Peer and/or Faculty Recommendations: References to include the names of at least two professional references, not newly associated or about to become partners with the applicant in professional practice or personally related to the applicant who have personal knowledge of the applicant's current medical/ clinical knowledge, technical/clinical skills, clinical, judgment, interpersonal skills, communication skills, professionalism, character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters upon request from hospital or medical staff authorities. The named individuals must have acquired the requisite knowledge through recent observation (within last 24 months) of the applicant's professional performance over a reasonable period of time. At least one must be from a colleague in the applicant's specialty not formerly, currently or about to become associated with the applicant in practice, and at least one must have had organizational responsibility for the applicant's performance.
15. Data from professional practice review by an organization(s) that currently privileges the applicant (when available).
16. Statements summarizing the scope and extent of the authorization, confidentiality, immunity and release provisions of the medical staff bylaws.
17. A non-refundable application fee of $100.00.
18. EFFECT OF APPLICATION: The applicant must sign the application and in so doing:
19. Attests to the correctness and completeness of all information furnished and acknowledges that any material misstatement in or omission from the application constitutes grounds for denial of appointment or for automatic revocation of staff membership and clinical privileges. For purposes of this paragraph,

"material" means that the misstated or omitted information was important to evaluation of the application and may have resulted in a different application being taken or recommendation being made by the applicable medical staff or board authorities. A practitioner who is denied appointment to the staff or whose membership and privileges are removed pursuant to this paragraph is entitled to the procedural rights afforded in the Fair Hearing Plan for the sole purposes of determining the materiality of the misstatement or omission.

20. Signifies a willingness to appear for interview in connection with the application.
21. Agrees to abide by the terms of the bylaws and related manuals and policy manuals of the medical staff and those of the hospital if granted appointment and/or clinical privileges and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether or not appointment and/or privileges are granted;
22. Agrees to maintain an ethical practice and to provide for continuity of care to patients;
23. Agrees to notify immediately the Chief of Staff and CEO of any change made or proposed in the status of the applicant's license, professional license to practice, DEA or other controlled substances registration, professional liability insurance coverage, membership or clinical privileges at other institutions and on the status of current or initiation of new professional liability claims, receipt of quality concerns letters from Quality Improvement Organization (QIO)or the Medicare reviewing agency and upon initiation of sanction proceedings;
24. Authorizes and consents to hospital representatives consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to their inspecting all records and documents that may be material to such an evaluation; and
25. Releases from any liability all those who in substantial good faith review, act on or provide information regarding the applicant's background, experience, clinical competence, professional ethics, utilization practice patterns, character, health status and other qualifications for staff appointment and clinical privileges.
26. PROCESSING THE APPLICATION:
    A separate credentials and quality assessment file is established and maintained for each applicant and appointee to the Medical Staff. The credentials file shall contain, but not be limited to the completed application, primary source verifications, references, general correspondence, privileges, attestation and release of information, quality assessments, results of performance improvement activities, evaluations, results of peer review, reappointment information and CME documentation.
27. Applicants Burden: The applicant has the burden of producing adequate information for proper evaluation of his/her experience, education, training, current competence, relevant practitioner specific data as compared to aggregate data (when available) and morbidity and mortality data (when available) , ability to work cooperatively with others and health status; of resolving any doubts about any of the qualifications required; and of satisfying any requests for information or clarification (including health examination) made by appropriate staff or board authorities.
28. Verification of Information: Verification shall be carried out as outlined in the current Medical Staff Policy *Initial Appointments.* Verifications are obtained from primary sources (the originating source) whenever possible and shall include but not be limited to:
    - An American Medical Association Physician Masterfile shall be obtained. The profile is primary source verification of medical school graduation, (Educational Commission for Foreign Medical Graduates ECFMG for foreign graduates) and residency.

- The American Board of Medical Specialties shall be verification of Board Certification.
- The American Osteopathic Association of Physician Database shall be verification of osteopathic education.
- The American Osteopathic Association Council on Postdoctoral Training and Osteopathic Specialty Board Certification shall be verification of Osteopathic Board Certification
- The American Academy of Physician Assistants profile shall be verification of Physician Assistant Education.
- The National Commission of Certification of Physician Assistants shall be verification of Physician Assistant Certification.
- Sending a copy of the list of clinical privileges requested by the applicant to relevant residency and fellowship training programs (when program completion is less than three years ago) with a request for specific information regarding training, experience and competence in exercising each of the privileges requested.
- Requesting from any hospital with or at which the practitioner has or had privileges, was associated, or was employed, the following information:
  - any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state
  - any judgment or settlement of a medical malpractice action and any finding of professional misconduct in this state or another state by a licensing or disciplinary board
  - any information required to be reported by hospitals to the medical disciplinary board
- The National Practitioner Data Bank will be queried.
- Complete Licensure History: Requesting from all present and past licensing authorities all information maintained regarding the practitioner.
- Additionally, Washington State license and licenses held in other states are verified at initial appointment, at reappointment or renewal or revisions of clinical privileges, and at the time of expiration of the license.
- Requesting criminal history information in accordance with the Child/Adult Abuse Information Act (WSP).
- The Office of the Inspector General's list of excluded individuals from government sponsored programs shall be queried.
- The General Services Administration (GSA) Excluded Participants List System shall be queried (EPLS).
- Present and past liability insurance carriers will be queried (at least 5 years)
- The hospital will verify that the practitioner requesting appointment and privileges is the same practitioner identified in the credentialing documents by viewing a current picture hospital ID card or a valid picture ID issued by a state of federal agency (drivers license, passport).

29. Medical Staff Input: The name of each applicant and a brief summary of the applicant's credentials shall be communicated to the medical staff. Any staff member may submit in writing to the Chief of Staff or to the Credentials Committee, a written statement containing relevant information regarding an applicant's qualifications for membership or the privileges requested. Any member may request or may be requested to confer with the committee or the Chief of Staff to discuss the statement.

30. Clinical Evaluation: The applicable Chief(s) of Service and Vice Chief of Staff shall review the initial application and supporting documents and make a recommendation to the Medical Executive Committee. The Chief of Staff or his designee, together with another representative of the medical staff designated by the Chief of Staff (or together with the CEO), may conduct an interview with the applicant. This interview shall follow a protocol that involves at minimum: a detailed oral description by the applicant of the formal training and experience to date; specific review of each clinical privilege being requested and the application evidence supportive thereof; analysis of clinical cases by the applicant with discussion of how the applicant would approach diagnosing and/or resolving the problem presented. A report of the interview should be prepared. If further information is required, the interviewers may defer this report but generally not for more than 30 days except for good cause. In case of a deferral, the interviewers must notify the Chief of Staff and the applicant in writing of the deferral and the grounds. This report is transmitted to the Credentials Committee.

31. The Department Chair and Medical Staff Services Coordinator shall review the application, results of verifications and interviews and any other relevant information made available to or requested by it. Decisions on membership and granting of privileges include criteria that are directly related to the quality of patient care, treatment and services. The Chair or his/her representative shall promptly notify the applicant of any gaps in or any other problems in obtaining the information required. This shall be by special notice and shall indicate the nature of the information the applicant is to provide and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date shall be deemed a voluntary withdrawal of the application. Recommendations shall be submitted to the Executive Committee.

32. Action by the Medical Executive Committee: The Executive Committee shall review the recommendation of the Department Chair and the supporting documentation and either endorse or reject that recommendation.

33. Favorable Recommendation: A favorable recommendation by the Executive Committee shall be forwarded to the Governing Board for action.

34. Unfavorable Recommendations: Unfavorable recommendations of the Medical Executive Committee are forwarded to the CEO who shall implement the Fair Hearing Plan. The applicant is then entitled, upon proper and timely request, to the procedures outlined in that plan. For purposes of this part, an unfavorable recommendation by the committee is as defined in Article 12.

35. Action by the Governing Board: As part of any of its actions outlined below, the Governing Board may at its discretion conduct an interview with an applicant or designate one or more individuals to do so on its behalf. If as part of its deliberations the Governing Board determines that it requires further information, it may defer action for no more than 30 days. The Governing Board shall notify the applicant and the Chief of Staff in writing of the deferral and of the grounds. If an applicant is to provide additional information, the notice to the applicant must state the information needed and must include the time frame for response. This notice must be sent by registered mail, return receipt requested. Failure to respond in a satisfactory manner within the time frames specified shall be deemed a voluntary withdrawal of the application.

36. Action on Favorable Executive Committee Recommendation: The Governing Board may adopt or reject in whole or in part a favorable recommendation or refer the recommendation back to the Executive Committee for further consideration. If the Executive Committee's subsequent recommendation is unfavorable to the applicant, it shall be processed as provided in Article 12.

37. Definition of Unfavorable Governing Board Action: Unfavorable action" by the Governing Board is as defined in 12.5 of these bylaws. If the Governing Board takes unfavorable action, the applicant is entitled to the procedural rights in the Fair Hearing Plan. The applicant is not entitled to the procedural rights in

the Fair Hearing Plan until and unless the Governing Board takes unfavorable action.

38. On Unfavorable Medical Staff Recommendation: In case of an unfavorable Medical Staff recommendation, the Governing Board takes final action in the matter.

ARTICLE 7: CLINICAL PRIVILEGES

1. Exercise of Privileges: All individuals who are permitted by these Bylaws to provide patient care services independently in the hospital shall have delineated clinical privileges. Special requirements for consultation may be required. Practitioners must provide care (consistent with their delineated privileges) or arrange for continuous medical care for their patients in the hospital. Practitioners shall obtain appropriate consultation or refer the cases to another qualified practitioner when appropriate or when required by the rules or other policies of staff or hospital.

2. Basis for Privileges Determinations:
   Criteria for clinical privileges shall be developed by the medical staff and approved by the Governing Board. This criteria will be considered in the decision to grant, limit or deny a requested privilege. Clinical privileges shall be granted in accordance with prior and continuing education and training and/or prior and current experience, practice patterns, current ability to perform privileges requested and demonstrated competence and judgment to provide quality and appropriate patient care in an efficient manner as documented and verified in each practitioner's credentials file. Jefferson Healthcare through the Executive Committee and Governing Board, shall consistently determine the resources necessary for each requested privilege. When new technology, procedures and privileges are proposed, Hospital resources including sufficient space, equipment, staffing and financial resources will be considered. *See policy, New or Additional Privileges/ Procedures*, The geographic location of the practitioner in terms of personal availability to provide timely coverage for patients, the availability of qualified medical coverage in the event of absence, and an adequate level of professional liability insurance will be considered. Where appropriate, a review of the records of patients treated in other hospitals may also serve as the basis for privilege determinations.

   In the event privileging criteria is unrelated to quality of care, treatment, and services or professional competence, the medical staff will evaluate the impact of resulting decisions on quality of care, treatment and services.

   The basis for privilege determinations for current staff members in connection with reappraisal, including conclusion of the provisional period or with a requested change in privileges may also include observed clinical performance, documented results of quality review, utilization management and professional liability prevention program activities and in the case of additional privileges requested, evidence of appropriate training, experience and competence supportive of the request.

3. Definition of Privileges:
   The medical staff must define in writing the operative, invasive and other special procedures; the conditions and the problems that fall within its clinical area, including different levels of severity or complexity and different age groupings, when appropriate; and the requisite training, experience or other qualifications required. These definitions must be incorporated into instruments used for the requesting and granting of privileges and must be approved by the Executive Committee and the Governing Board. The definitions and delineating instruments must be periodically reviewed and revised as necessary to reflect new procedures, instrumentation, treatment modalities and like advances or changes. When definitions and delineating instruments are revised by additions or deletions or the adoption of new forms,

all staff members holding affected privileges in the hospital must, as appropriate to the circumstances complete the new forms, request and be processed for privileges added or comply with any privileges deleted.

4. Procedure for Delineating Privileges Requests:
   Each application for appointment and reappointment to the medical staff must contain a request for the specific privileges desired by the applicant or staff member. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments. The privilege granting or denial criteria are consistently applied for each requesting practitioner.
5. Processing Requests:
   All requests for clinical privileges, except those for temporary privileges are processed according to the procedures outlined for the initial appointment and reappointment processes as applicable. Requests for temporary privileges are processed as outlined in Article 4.5.
6. Privileges in Emergency Situations:
   In case of an emergency which serious permanent harm or aggravation of injury or disease is imminent or in which the life of the patient is in immediate danger and any delay in administering treatment could add to that danger, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm to the degree permitted by the practitioner's license but regardless of staff category or privileges. A practitioner providing services in an emergency situation that are outside the practitioner's usual scope of privileges is obligated to summon all consultative assistance available as deemed necessary and to arrange for appropriate follow-up care.
7. Experimental, Untried or Unproven Procedures, Treatment Modalities or Instrumentation:
   Experimental drugs, procedures or other therapies or tests may be administered or performed only after the approval of the protocols involved by the institutional review board. Any experimental or other untried or unproven procedure, treatment, modality or instrumentation may be performed or used only after the regular Credentialing process has been completed and the privilege to perform or use said procedure/ treatment modality/instrumentation has been granted to the individual practitioner. For the purposes of this paragraph, an untried or unproven procedure, treatment, modality, instrumentation is one that is not generalizable from an established procedure, treatment, modality or instrumentation in terms of involving the same or similar skills, the same or similar instrumentation and technique, the same or similar complications or the same or similar expected physical outcome for the patient as the established procedure, treatment, modality or instrumentation.
8. Notification of privileges:
   The practitioner shall be notified in writing regarding the approval or denial of any privileges within the parameters of the Appointment, Reappointment or Fair Hearing Sections of these Bylaws.
9. The final decision to grant, deny, revise, or revoke privileges(s) shall be disseminated and made available to medical staff, hospital staff, and to regulatory agencies when required by law.
10. Location of privileges:
    Approved privileges are kept in the individual practitioner's file in Medical Staff Services, the Operating Room, Emergency Department, Acute Care Unit Nurses Station and on the Intranet accessible to all hospital employees.

ARTICLE 8: REAPPOINTMENT PROCEDURES

Reappointment to the medical staff and the granting, renewal or revision of clinical privileges is completed no longer than every two years. The Credentials Committee shall make recommendations to the Executive

Committee which shall then forward its recommendations to the Governing Board (see Medical Staff Policy, *Reappointment* for detailed reappointment procedures).

ARTICLE 9: CORRECTIVE ACTION OTHER THAN SUMMARY OR AUTOMATIC SUSPENSION

1. Criteria for Initiation: Whenever the activity or professional conduct of any practitioner may be detrimental to patient safety or to the delivery of appropriate patient care; disruptive to hospital operations; in violation of these bylaws, the Rules and Regulations, or other hospital policies; or otherwise fails to meet the qualifications or requirements for Medical Staff appointment and/or privileges as provided in these bylaws, an evaluation of circumstances relating to such practitioner may be requested by an officer of the Medical Staff, any standing committee or subcommittee of the medical staff or chairman thereof, the CEO or the Governing Board.
2. Requests and Notices: All requests for corrective action shall be made to the Executive Committee and shall be supported by reference to specific grounds for the request. The Chief of Staff shall promptly notify the CEO of all requests for special investigative action received by the committee and shall continue to keep the CEO fully informed of all action taken in connection therewith. After the Executive Committee action initiating the special investigative action, the Chief of Staff shall mail to the practitioner written notice of the investigation and the general nature of the concerns leading to the investigation.
3. Investigation: The Chief of Staff shall take summary action on the request in accordance with Article 10 (Summary Suspension), determine that the request has no basis, or direct that investigation concerning the grounds for the request be undertaken. This investigation process is not a "hearing" as that term is used in the Fair Hearing Plan. It may include a conference with the practitioner involved, with the individual or group making the request, and with other individuals who may have knowledge of the events involved. A written report of the investigation must be made. Those conducting the investigation may at any time within their discretion, and shall at the request of the Governing Board or its designee, terminate the investigative process and proceed with action as provided below. The investigating group or individual shall have the full resources of the medical staff and the hospital as well as the authority to use outside consultants as deemed necessary. As part of the investigation, the investigating group or individual may for good cause require the practitioner involved to procure an impartial physical or mental evaluation within a specified time and pursuant to the guidelines set forth below. Failure without good cause to obtain the evaluation pursuant to said guidelines shall result in immediate suspension of medical staff appointment and all clinical privileges until such time as the evaluation is obtained, the results are reported to the investigating group or individual, and the board takes final action. The practitioner(s) who will conduct the examination shall be named by the investigating group or individual. Fees for an evaluation shall be paid by the hospital. All reports shall be forwarded to the chief of staff.
4. Committee Action: As soon as practicable after the conclusion of the investigative process, if any, and after receipt of the report of the investigation, but in any event within three months after receipt of the request for corrective action, the Chief of Staff and at least two other medical staff members shall act upon such request. Their action may include without limitation any one or combination of the following:
5. Recommending rejection of the request for corrective action.
6. Recommending a verbal warning or formal letter of reprimand.
7. Recommending individual medical/psychiatric treatment.

8. Recommending a probationary period of prescribed duration with retrospective review of cases and/or other review of professional behavior but without special requirements of prior or concurrent consultation or direct supervision.
9. Recommending suspension of appointment prerogatives that do not affect clinical privileges.
10. Recommending an individually imposed requirement of prior or concurrent consultation or direct supervision.
11. Recommending a limitation on the practitioner's right to admit patients.
12. Recommending reduction, suspension or revocation of all or any part of the clinical privileges granted.
13. Recommending suspension or revocation of staff appointment.
14. Procedural Rights: An unfavorable recommendation is defined as one which restricts, suspends or revokes clinical privileges or staff appointment. Such a recommendation entitles the practitioner upon timely and proper request, to the procedural rights outlined in the Fair Hearing Plan.

ARTICLE 10: SUMMARY SUSPENSION

1. Criteria for Initiation: Either the Chief of Staff, the Chief Executive Officer, or their respective designated representatives or the Governing Board has the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of a practitioner where the failure to take such action may result in an imminent danger to the health or safety of any individual. A summary suspension is effective immediately upon imposition and the person or group imposing the suspension is to follow it up promptly by giving special written notice of the suspension to the practitioner. A suspended practitioner's patients then in the hospital must be assigned to another practitioner by the Chief of Staff, considering the wishes of the patient where feasible in choosing a substitute practitioner.
2. Committee Action: As soon as possible, but in any event within 14 days after a summary suspension is imposed, a committee of the Chief of Staff and at least three other medical staff members convenes to review and consider the action taken. It may recommend modification, continuation or termination of the terms of the suspension. A recommendation to continue the suspension or to take any other unfavorable action as defined in Article 12 entitles the practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan. A recommendation to terminate the suspension or to modify it to a lesser sanction not triggering procedural rights is transmitted immediately, together with the supporting documentation, to the Governing Board and the procedure in Section 6.4.8 is followed. The terms of the summary suspension as originally imposed remain in effect pending final decision by the board.

ARTICLE 11: AUTOMATIC SUSPENSION

1. Criteria and Initiation: Whenever a practitioner's license to practice or when controlled substances certificate/registration is, restricted or suspended, when sanctions are imposed, when official disciplinary action is taken by the Board of Medical Examiners or by another hospital, or when put on probation, the practitioner must immediately report it to the Chief of Staff and the CEO. Failure to do so shall be considered an immediate resignation of staff appointment and clinical privileges. The practitioner's privileges are immediately limited to conform to such suspension, restriction, or probation.
2. Committee Deliberation: As soon as practicable after
    1. notification by the practitioner of sanction;
    2. after a practitioner's license is suspended, restricted or placed on probation;

3. after the practitioner's DEA number is revoked, restricted, suspended or made probationary, or
4. notification of disciplinary action taken by the Board of Medical Examiners or another hospital, the Chief of Staff shall convene a committee to review and consider the facts under which such action was taken. The committee may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation. Thereafter, the procedure in 9.3 is followed but only with respect to any additional corrective action recommended by the committee or taken by the Governing Board.

3. Drug Enforcement Agency (DEA): A practitioner whose DEA registration is revoked, suspended, limited or voluntarily relinquished is thereby immediately and automatically divested of his/her right to prescribe medications covered by such registration. As soon as reasonably possible after such automatic suspension, the Executive Committee shall convene to review and consider the facts under which the DEA registration was revoked, limited or suspended or relinquished. The Executive Committee may then take such further corrective action as is appropriate based upon the facts disclosed in its investigation.
4. Incomplete Medical Records: A limited suspension, effective until medical records are completed, will be imposed automatically for failure to complete medical records within thirty (30) days. After the third and each subsequent suspension within any twelve (12) month period for failure to complete or prepare records, the staff member may be completely suspended from appointment and from the exercise of any clinical privilege for an additional thirty (30) days beyond the date all records are completed.
5. Non-renewal of License, DEA, or Insurance: When a member's license, DEA or insurance has expired due to non-renewal, privileges and membership shall automatically be suspended as of the date of such expiration and shall remain suspended until proof of renewal is received. Notice of the suspension and subsequent reinstatement shall be provided to the involved practitioner, the CEO, Chief of Staff, Chief of Service, Hospital Department Directors, and involved practitioner.

   AUTOMATIC TERMINATION OF PRIVILEGES AND MEMBERSHIP: The following terminations are automatic and do not afford the practitioner any hearing rights:

   - Licensure: revocation of license in the State of Washington
   - Medicare/Medicaid participations: Exclusion from participation in Medicare or Medicaid.
6. Temporary Suspension: In those areas where specific certification is required as a condition of privileges, such privileges shall be suspended upon expiration of such certification unless documentation of certification or recertification has been received in the Medical Staff Services Department. These privileges shall be reactivated upon receipt of such documentation.

ARTICLE 12: DEFINITION OF UNFAVORABLE RECOMMENDATION/ACTION, EXHAUSTION OF REMEDIES; REAPPLICATIONS

1. Recommendations/Action Giving Rise to Hearing Rights: Unfavorable Recommendations or Actions: Subject to the exceptions set forth in 12.3 below, the following actions or recommended actions, if deemed unfavorable under part 12.2 below, entitle the practitioner to a hearing upon timely and proper request:
2. Denial of initial staff appointment.
3. Denial of reappointment; suspension of appointment provided that summary suspension entitles the

practitioner to request a hearing only as specified in Article 10.

4. Revocation of appointment.
5. Denial of requested appointment to or advancement in staff category.
6. Special limitation of the right to admit patients.
7. Denial or restriction of requested clinical privileges.
8. Reduction in clinical privileges.
9. Suspension of clinical privileges, provided that summary suspension entitles the practitioner to request a hearing only as specified in 11 below.
10. Revocation of clinical privileges. Individual application of or individual changes in mandatory consultation or supervision requirement.
11. Summary suspension of appointment or clinical privileges provided that the recommendation of the committee or action by the Governing Board under Article 9 is to continue the suspension or to take other action which would entitle the practitioner to request a hearing under this part.
12. When Deemed Unfavorable: Except as provided below, any action or recommended action listed in 2 (above) is deemed unfavorable to the practitioner only when it has been recommended by the medical staff committee or taken by the Governing Board under circumstances where no prior right to request a hearing existed.
13. Exceptions to Hearing Rights: Certain actions or recommended actions notwithstanding any provision in the Fair Hearing Plan, the medical staff bylaws, or any other official policy or procedure manuals to the contrary, the following actions or recommended actions do not entitle the practitioner to a hearing:
14. The issuance of a verbal warning or formal letter or reprimand.
15. The imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period.
16. The imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation.
17. The removal of a practitioner from a medico-administrative office within the hospital unless a contract or employment arrangement provides otherwise.
18. Any other action or recommended action not listed in 12.1.1 above.
19. Other Situations: An action or recommended action listed in 12.1.1 above does not entitle the practitioner to request a hearing when it is voluntarily imposed or accepted by the practitioner; automatic pursuant to Article 9 or taken or recommended with respect to temporary privileges.
20. Exhaustion of Administrative Remedies: Every applicant to and member of the medical staff agrees that, when corrective action is initiated or taken pursuant to Article 9 or when an unfavorable action or recommended action as defined in 9.1 is proposed or made, the applicant or staff member will exhaust the administrative remedies afforded in the various medical staff bylaws and in The Fair Hearing Plan prior to pursuing any other remedy.
21. Reapplication After Unfavorable Credentials Decision: Except as otherwise provided in the medical staff bylaws or as determined by the medical staff in light of exceptional circumstances, an applicant or staff member who has received a final unfavorable decision or who has voluntarily resigned or accepted a condition regarding limitation of or restriction on, or withdrawn an application for appointment, staff category, clinical assignment or clinical privileges is not eligible to reapply to the medical staff or for the

applicable category or privileges for a period of 24 months from the date of the notice of the final unfavorable decision or the effective date of the resignation, or application withdrawal. Any such reapplication is processed in accordance with procedures set forth in the section regarding processing the application in these bylaws. The applicant or staff member must submit such additional information as the applicable authorities of the staff and the Governing Board may reasonably require in demonstration that the basis of the earlier unfavorable action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.

ARTICLE 13: CONFIDENTIALITY, IMMUNITY AND RELEASE

1. For the purposes of this part only, the following definitions shall apply:
2. Good Faith shall mean having an honest purpose or intent and being free from intention to defraud.
3. Malice shall mean the dissemination of a known falsehood or of information with a reckless disregard for whether or not it is true or false.
4. Practitioner shall mean a staff member or applicant.
5. Representative shall mean the Governing Board of the hospital and any member or committee thereof; the Chief of Staff or designee(s); registered nurses and other employees of the hospital; the medical staff and any member, officer or committee thereof; and any individual authorized by any of the foregoing to perform specific information gatherings, analysis, use or disseminating functions.
6. Third parties shall mean both individuals and organizations providing information to any representative.
7. Authorizations and Conditions: By submitting an application for staff appointment or reappointment or by applying for or exercising clinical privileges, a practitioner:
8. Authorizes representatives of the hospital to solicit, provide and act upon information bearing on his/her professional ability, utilization practices and other qualifications.
9. Agrees to be bound by the provisions of this part and to waive all legal claims against any representative who acts in accordance with the provisions of this part and acknowledges that the provisions of this part are express conditions to his application for or acceptance of staff appointments and the continuation of such appointment and to his exercise of clinical privileges at the hospital.
10. Acknowledges that the provisions of this section are express conditions to this application for, or acceptance of, medical staff appointment or privileges, or his/her exercise of privileges at the hospital.
11. Confidentiality of Information: Information with respect to any practitioner submitted, collected or prepared by any representative of this or any other health care facility or organization or medical staff for the purpose of achieving and maintaining appropriate patient care, shall to the fullest extent permitted by law, be confidential and shall not be disseminated to anyone other than a representative, or used in any way except as provided herein. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall not become part of any particular patient's file or of the general hospital records.
12. Immunity from Liability:
13. For Action Taken: No representative of the hospital or medical staff shall be liable in any judicial proceeding for damages or other relief for any action taken or statement or recommendation made within the scope of his/her duties as a representative if such representative acts in good faith and without malice.

14. For Providing Information: No representative and no third party shall be liable in any judicial proceeding for damages or other relief by reason of providing information, including otherwise privileged or confidential information, to a representative or to any other health care facility or organization of health professionals concerning said practitioner, provided that such representative or third party acts in substantial good faith, or unless such information is false and such representative or third party knew it was false.
15. Activities and Information Covered:
16. Activities: The confidentiality and immunity provided by this part applied to all information or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to: applications for appointment or clinical privileges; periodic reappraisals for reappointment or clinical privileges; corrective or disciplinary actions; hearings and appellate reviews; quality review program activities; utilization review and management activities; claims reviews; profiles and profile analysis; professional liability prevention program activities; and other hospital, committee or staff activities related to monitoring and maintaining quality and efficient patient care and appropriate professional conduct.
17. Information: The information referred to in this part may relate to a practitioner's professional licensure or certification, education, training, clinical ability, judgment, utilization practices, character, physical or mental health, emotional stability, professional ethics or any other matter that might directly or indirectly affect the quality or efficiency of patient care provided in the hospital.
18. Releases: Each practitioner shall upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this part, subject to such requirements, including those of good faith, as may be applicable under relevant Washington law. Execution of such releases is not a prerequisite to the effectiveness of this part. Failure to execute such releases shall result in an application for appointment, reappointment or clinical privileges being deemed incomplete and voluntarily withdrawn, and it will not be further processed. Failure to execute such releases in connection with conclusion of the provisional period shall be deemed a voluntary resignation of staff membership or particular clinical privileges as appropriate to the context. Failure to execute such releases in connection with a disciplinary or corrective action shall result in a presumption that the facts or circumstances that are the subject matter or the particular releases reflect adversely on the practitioner involved. This presumption will stand unless the practitioner presents verifiable facts to the contrary.
19. Cumulative Effect and Severability: Provisions in the medical staff bylaws, in application forms relating to authorizations, confidentiality of information and immunities from liability are in addition to other protections provided by relevant Washington state and federal law and not in limitation thereof. A finding by a court of law or administrative agency with proper jurisdiction that all or any portion of any such provision is not enforceable shall not affect the legality or enforceability of the remainder of such provision or of any other provision.

ARTICLE 14: FAIR HEARING PLAN

1. DEFINITIONS. The following definitions apply to the provisions of this Fair Hearing Plan:
2. Days: Any calendar day, including Saturday, Sunday and official Hospital holidays.
3. Deadline: If the deadline falls on a Saturday, Sunday or official hospital holiday, then the deadline is for the next regular day.
4. Executive Committee: Known as the "Committee" throughout, it is the controlling body that shall appoint and oversee the hearing panel.

5. Board of Governors: known as the "Board" throughout, it shall appoint and oversee the Appellate Review Body and any Hearing panels associated with its decisions.
6. Hearing Panel: Committee of practitioners appointed under this plan to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.
7. Appellate Review Body: Means the group of board members designated under this Plan to hear a request for appellate review properly filed and pursued by a Practitioner.
8. Unfavorable Action: It includes the following: denial of initial staff appointment or reappointment, denial or restriction of clinical privileges, suspension, or revocation of some or all medical staff membership, revocation of appointment, reduction in staff category or reduction in clinical privileges, individual application of or individual changes in mandatory consultation or supervision requirement,
9. Presiding Officer: The use of a hearing officer to preside at the evidentiary hearing is optional and is to be determined by the CEO after consultation with the Chairperson of the Board and the Chief of Staff, as appropriate. A hearing officer may or may not be an attorney at law, but must be experienced in and recognized for conducting hearings (e.g. arbitration, mediation, or other non-judicial dispute resolution matters).
10. INITIATION OF HEARING, NOTICE, AND WAIVER
11. Qualifying Event: Any event that qualifies as an unfavorable action as defined in 14.1.7 that is properly and timely pursued.
12. Notice of Unfavorable Action: The Chief Executive Officer shall, within fifteen (15) days of receiving written notice of an unfavorable action as defined under 14.1.7 of this plan, give the practitioner special notice thereof. The notice shall include:
13. Statement that a Professional review action has been proposed to be taken against the physician.
14. The reason for the proposed action in a concise statement including the alleged acts or omissions, a list of the specific or representative patient or patients, and/or the other reasons forming the basis for the unfavorable action.
15. A summary of the rights in the hearing plan along with a copy of the Fair Hearing Plan.
16. The right to request a hearing on the proposed action within fifteen (15) days of receipt of the notice.
17. State that failure to properly request a hearing within fifteen (15) days constitutes a waiver of right to a hearing and appellate review on the matter(s).
18. State that any unfavorable action can be modified by the Board and that a more severe action would renew the right to request a hearing after the special combined council appointed under 12.2.4.2.
19. Request for a Hearing: The practitioner shall have fifteen (15) days after receiving the above notice to deliver a written request for a hearing, in person or by mail, to the Chief Executive Officer.
20. Waiver by Failure to Request a Hearing: A practitioner who fails to request a hearing within the time and manner specified in 14.2.3 above, waives his/her right to any hearing or appellate review. Such waiver shall be effective only against the actions outlined in the notice given under 14.2.2. The effect of a waiver is as follows:
21. After Unfavorable Action by the Board: A waiver constitutes acceptance of the action, which immediately becomes the final decision in the matter.
22. After unfavorable recommendation by the Medical Executive Committee: A waiver constitutes acceptance of the recommended action which becomes effective immediately and remains so pending the final

decision of the Board. If the governing board keeps the original decision, then it is a waiver as outlined in

23. If the board changes the outcome, then there will be a new right of appeal.
24. HEARING PREREQUISITES:
25. Receipt of Request Notice for Hearing: Upon receiving a timely and proper request for a hearing, the Chief Executive officer shall notify the Chief of Staff or Chairperson of the Governing Board, depending on which body's action gave rise to the hearing rights, and shall schedule a hearing.
26. Notice of Time and Place for Hearing: The CEO shall send the practitioner special notice of the hearing, including the time, place and date thereof. The special notice of hearing shall also include the names of the witnesses who, as far as currently reasonably known, will give testimony or evidence in support of the party whose action gave rise to the hearing rights. The hearing shall not be less than thirty (30) days nor more than sixty (60) days from the date of the special notice of the hearing; provided however that a hearing for a practitioner who is under suspension then in effect may be held sooner than thirty (30) days from the date of the special notice of the hearing. The hearing may be scheduled or continued beyond sixty (60) days by agreement or by motion upon showing of good cause.
27. Appointment of Hearing Panel: The Chief Executive Officer shall appoint a hearing panel composed of three (3) members selected from qualified nominees submitted by the Chief of Staff or the chairperson of the Board, depending on which body's action or recommended action gave rise to the hearing requirements. The CEO shall appoint a chairperson of the hearing panel.
28. Eligibility for Hearing Panel: The following members are eligible for nomination or appointment to membership:
29. Members of the medical staff except for any such member who:
30. Initiated the request for corrective action, made any complaint or report associated with this corrective action.
31. Was a member of any committee, panel or other group which conducted interviews, heard testimony, considered evidence or undertook any action, which gave rise to this hearing;
32. Is in direct economic competition with the practitioner involved.
33. Has another conflict of interest in which the provider has a direct, personal interest in the outcome of the hearing such that, in the opinion of the CEO, puts the provider impartiality in doubt.
34. Persons not members of the medical staff who:
35. Are not and have not within the preceding five (5) years been employees, members of the board, consultants or legal counsel to the hospital;
36. Have no spouse, parent or children who are employees, members of the medical staff, members of the board, consultant or legal counsel to the hospital,
37. Are not in direct economic competition with the practitioner involved, and
38. Do not have another conflict of interest in which the individual has a direct, personal interest in the outcome of the hearing such that, in the opinion of the CEO, puts his/her impartiality in doubt.
39. An individual shall not be disqualified from serving on a hearing panel merely because he/she has heard of the case, has knowledge of the facts involved, or what he/she supposes the facts to be.
40. List of Witnesses: At least fifteen (15) days prior to the scheduled date for commencement of the hearing, the practitioner who requested the hearing shall give to the party whose action gave rise to the hearing rights, by special notice, a list of the names of the individuals who, as are then reasonably known, will

give testimony or evidence in support of the practitioner at the hearing. At the same time and by special notice, the CEO shall update the list of names provided to the practitioner with the special notice of the hearing under

41. of this Plan. Each list shall be amended as soon as reasonable when addition when additional witnesses are identified. If a witness is not disclosed, the hearing panel shall determine the action to be taken following 14.4.11.
42. HEARING PROCEDURE
43. Personal Presence: The personal presence of the practitioner is required throughout the hearing, unless excused for any specified time, in writing, by the hearing panel. The presence of legal counsel or other representative does not constitute the personal presence of the practitioner. Failure to comply, without good cause, to be present throughout the hearing without permission shall be deemed a forfeiture of the right to a hearing.
44. Presiding Officer: The hearing officer shall be the presiding officer. The presiding officer shall maintain decorum, insure compliance with procedure, assist in preparation of the report and recommendation, and assure that all participants have reasonable opportunity to present relevant evidence. The hearing officer shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence. The presiding officer shall not act as a prosecuting officer or as an advocate to any party to the hearing. They shall not be entitled to vote.
45. Practitioner Representation: The practitioner may be accompanied and assisted at the hearing by an attorney, or by any other representative.
46. Committee/Board Representation: The Board or Committee who took the unfavorable action subject to the hearing shall appoint a representative for the hearing.
47. Rights of Parties: All rights shall be exercised so as to permit the hearing to proceed efficiently and expeditiously. The hearing officer shall direct any request by a party and develop the procedure to satisfy the rights of all parties. Each party shall have the following rights:
48. Challenge Members: The parties shall have the right to petition the presiding officer for removal of a chair member up to fifteen (15) days before the proceeding. Rulings shall be made by the presiding officer. In the event of a removal, the CEO shall appoint a new member upon notice from the presiding officer.
49. Call, examine, cross-examine, and impeach any witnesses on any relevant matter,
50. Introduce exhibits and evidence as provided in 12.4.6;
51. Rebut any evidence;
52. Request a copy of the proceeding record or transcript in accordance with 12.4.7;
53. Call the practitioner to testify on his/her own behalf, or at the bequest of any party subject to cross-examination; and
54. Submit a written statement at the close of the hearing.
55. Admission of Evidence: The hearing need not be conducted strictly according to the rules of evidence or examination of witnesses. At the discretion of the presiding officer, any relevant matter upon which responsible persons customarily rely in the conduct of serious affairs may be considered, regardless of the admissibility of such evidence in a court of law. Exhibits admitted into evidence before the hearing panel shall be identified as the presiding officer may direct.
56. Hearing Record: A record of the hearing shall be kept. The presiding officer shall determine whether this

shall be done by use of a court reporter or audio tape recording of the proceeding. If the practitioner requests a transcript of the hearing record, he/she shall bear the cost of transcription. Any testimony given requires the taking of an oath administered by the hearing panel.

57. Memorandum to the Panel: Each party shall be entitled prior to, during, or after the hearing, to submit memoranda concerning any issue of law or fact. Those memoranda, if any, must be presented to the presiding officer, the panel, and to the opposing party.
58. Panel Examination: The hearing panel may ask questions of the witnesses, call additional witnesses, or request documentary evidence if it deems it appropriate.
59. Burden of Proof: The practitioner shall have the burden of proving that the committee or Board's decision was an abuse of discretion.
60. Admission of Witnesses Not Listed: The hearing panel may permit a witness who has not been listed in accordance with 14.3.5 to testify if it finds that the failure to list such witness was justified by exceptional circumstances, that failure did not prejudice the party entitled to receive such list, and that the testimony of such witness will assist the hearing panel in making its report.
61. Presence of Hearing Panel Members and Vote: A majority of the hearing panel must be present throughout the hearing and deliberations. If a panel member is absent from any part of the hearing or deliberations, the presiding officer, at his/her discretion, may rule that such member may not participate further in the hearing or deliberations or in the decision of the hearing panel.
62. Recess and Adjournment: The presiding officer may recess and reconvene the proceeding for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, without special notice and with such written or oral notice as she/he deems appropriate. Upon conclusion of the presentation or oral statements, if allowed, the hearing shall be adjourned.
63. Deliberation: The review body shall then, at a time convenient to itself within fifteen (15) days, conduct its deliberation outside the presence of the parties. No record of the deliberation process will be produced or available to any party involved. presiding officer does not deliberate with the panel, but may assist in drafting the report and recommendation.
64. Document Storage: After the conclusion of the deliberation of the panel, the records, evidence, and exhibits shall be transported to the Medical Staff Services office for safekeeping as official records and minutes of the medical staff. They shall be available for review by any party during normal office hours, excluding holidays.
65. HEARING PANEL REPORT AND FURTHER ACTION:
66. Hearing Panel Report: Within fifteen (15) days after the deliberation of the panel, the hearing panel shall make a written report of the procedure, its findings, reasons, and recommendations with such reference to the hearing record and other documentation considered as it deems appropriate. The report shall be promptly forwarded to the Committee or Board, depending upon the origin of the original action. At the same time the practitioner shall be given a copy of the report by special notice.
67. Action on Hearing Panel Report: Within Fifteen (15) days after receiving the hearing panel report, the Committee or Board, depending on which body's unfavorable action occasioned the hearing, shall consider the report and affirm, modify, or reverse its previous action. It shall transmit its decision, together with the hearing panel report to the CEO.
68. Board Decision: If the Board was the origin of the action, then its review of the hearing panel will be final. The provider shall have the right to one appeal from the Board's decision under the appellate review board procedure outlined in 14.6.

69. Medical Executive Committee: They shall review the action and forward their decision on to the provider and the Board. The Board may affirm, modify or reverse the decision of the Committee within (15) days. The physician shall have a right to a single appeal from the decision of the Committee after any revisions have been made by the Board.
70. The practitioner shall be sent special notice of the decision within fifteen 15 days of the decision.
71. INITIATION AND PREREQUISITES OF APPELLATE REVIEW
72. Request for Appellate Review: A practitioner shall have fifteen (15) days after receiving special notice of an unfavorable decision pursuant to 14.5.3 of this Plan to file a written request for an appellate review. The request must be delivered to the CEO by special notice.
73. Waiver by Failure to Request Appellate Review: A practitioner who fails to request an appellate review within the time and in the manner specified in 12.6.1 of this Plan shall be deemed to have waived any right to a review.
74. Notice of Time and Place for Appellate Review: The CEO shall deliver a timely and proper request for appellate review to the Chairperson of the Board. As soon as practicable, said Chairperson shall schedule an appellate review to commence not less than thirty (30) days nor more than sixty (60) days after the CEO received the request; provided, however, that an appellate review for a practitioner who is under a suspension then in effect shall be held as soon as the arrangements for it may be reasonably made, but not later than thirty (30) days after the CEO received the request. The hearing may be scheduled or continued beyond sixty (60) days by agreement or by motion upon showing of good cause. At least seven (7) days prior to the appellate review, the CEO shall send the practitioner special notice of the time, place and date of the review.
75. Appellate Review Body: The Chairperson of the Board shall appoint an appellate review body, composed of not less than four (4) persons.
76. The review body members may or may not be members of the Board of Governors and may be other reputable persons provided that the proposed panel members be impartial, not in direct economic competition with the practitioner involved, or have any other conflict of interest in which the individual has a direct, personal interest in the outcome of the hearing such that, in the opinion of the Chairperson, puts the panel member's impartiality in doubt.
77. First member: The Chairperson of the Board shall designate a non-voting Chairperson of the review body.
78. Second and Third Member: the Board and the practitioner each shall pick one (1) voting member to comprise the second and third member.
79. Fourth Member: The Board and the practitioner must mutually agree on the fourth member.
80. APPELLATE REVIEW PROCEDURE
81. Nature of Proceedings: The proceedings by the review body are a review based on the hearing record, the hearing panel's report, all subsequent decisions and actions, the written arguments, if any, provided below and any other material that may be presented and accepted. The presiding officer shall direct that the hearing record and documentation consider be available at the appellate review for use by any party. The review body shall determine whether the foregoing evidence demonstrates that the practitioner has met the burden of proof as required under 14.4.10 of this Plan.
82. Presiding Officer: The chairperson of the appellate review body is the presiding officer. The chairperson shall determine the order of the procedure during the review, make all required rulings, and maintain decorum.

83. Written Statements: The practitioner may submit a written statement detailing the findings of complaint, conclusions, and procedural matters with which the practitioner disagrees and reasons for such disagreement. The statement shall be submitted to the CEO at least ten (10) days prior to the scheduled date of the review. The CEO shall provide a copy of the practitioner's statement to the appellate review body and to the body to which the unfavorable action occasioned the review. A similar statement may be submitted by the Board or Committee, and if submitted, the CEO shall provide a copy to the practitioner and to the appellate review body at least seven (7) days prior to the scheduled date of the appellate review.

84. Personal Appearance and Oral Statement: The appellate review body, at its discretion, may allow the parties or their representatives to personally appear and make oral statements. Any party or representative appearing shall be required to answer questions put by any appellate review member. Any appearance shall be handled in the same manner as provided in 14.4.3 of this Plan.

85. Consideration of New or Additional Matters: New or additional matters or evidence not raised or presented during the original hearing or in the hearing report and not otherwise reflected in the record may be introduced at the appellate review only at the discretion of the review body, only if the party requesting consideration of the new or additional matter or evidence demonstrates that it could not have been discovered with due diligence in time for the initial hearing, and the matter directly bears upon the issue before the board. The requesting party shall provide, through the CEO, a written, substantive description of the matter or evidence to the appellate review body and the other party prior to its being introduced to such appellate review. Any such new or additional matters or evidence shall be subject to the same right of cross-examination, impeachment, and rebuttal provided at the hearing pursuant to 14.4.5. of this Plan.

86. Powers: The appellate review body has all of the powers granted to the hearing panel, and any additional powers that are reasonably appropriate to or necessary for discharge of its responsibilities.

87. Presence of Hearing Panel Members and Vote: A majority of the appellate review panel must be present throughout the hearing and deliberations. If a panel member is absent from any part of the hearing or deliberations, the Chairperson of the review, at his/her discretion, may rule that such member may not participate further in the hearing or deliberations or in the decision of the appellate review.

88. Recess and Adjournment: The Chairperson may recess and reconvene the proceeding for the convenience of the participants or for the purpose of obtaining new or additional evidence or consultation, without special notice and with such written or oral notice as she/he deems appropriate. Upon conclusion of the presentation or oral statements, if allowed, the appellate review shall be adjourned.

89. Review Body report and Recommendation: Within fifteen (15) days after adjournment pursuant to

90. above, the review body shall prepare its report and conclusion and transmit the same to the Board and CEO, as provided below.

91. Final Decision by the Board: Within thirty (30) days after receiving the review body's report, the Board shall take final action on the matter. The CEO shall send notice of each action taken herein to the Chief of Staff for transmittal to the appropriate staff authorities and to the practitioner. The notice to the practitioner shall include a statement of the basis of the decision.

92. Release from Liability: By requesting a hearing or appellate review under this plan, a practitioner agrees to release from liability all representatives of Jefferson Healthcare and its Medical Staff for their acts performed in good faith and without malice.

ARTICLE 15: ALLIED HEALTH

PROFESSIONALS

The Governing Board shall determine the categories of eligible allied health professionals. Only allied health professionals holding a license, certificate, or other legal credentials required by state law, who document their education, training, experience, background, demonstrated ability, current clinical competence, and health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the hospital; and are determined, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others, shall be eligible to provide specified services in the hospital.

The Medical Staff shall credential Podiatrists, Advanced Registered Nurse Practitioners, Certified Registered Nurse Anesthetists, Psychologists and Physicians' Assistants-Certified in general, according to Bylaws and Policies for Appointment and Reappointment and Privileges.

1. Members of the Allied Health Professional Staff must have a current state license, registration or certification and be in good standing with their registration/licensing/certifying bodies. They may serve on committees and vote for/nominate Medical Staff Officers.
2. Specific privileges, scope of practice or position descriptions shall be recommended by the Department Chair and approved by the Executive Committee and Medical Staff and granted by the Governing Board. Review and renewal of privileges, scope of practice/position descriptions shall in general be conducted as provided for in current medical staff policies and procedures specific to reappointment of the medical staff. Consultants from outside the hospital with expertise in the type of patient care provided by Allied Health Professionals may be called at the discretion of the Medical Staff Committee(s) involved when the results of the Committee's deliberations may result in an adverse recommendation regarding the health professional's privileges.
3. All Allied Health Professionals shall be subject to the current hospital policies and procedures specific to Allied Health Professionals. Fair Hearings shall only be provided to those entitled by current law. Practitioners may request a hearing with the Executive Committee concerning any adverse action.
4. No practitioner shall be automatically entitled to appointment or to the exercise of privileges or scope of practice/position description merely because they are licensed to practice in this or any other state; are certified by any board or certifying agency; or have had or presently have Allied Health Professional appointment or privileges, scope of service or position description at this or any other hospital.
5. Anesthesia Services (provided by CRNAs) shall function under the direction of the board certified Chief of Surgical Services.

ARTICLE 16: CLINICAL SERVICES

1. The Medical Staff shall be divided into five major services: Ambulatory Services, Emergency Medicine, Medicine, Obstetrics and Surgery. Pediatrics, and Diagnostic Services shall be subsections of Medicine and Anesthesiology shall be a subsection of Surgery.

   Chiefs of service must be members of the Active Medical Staff. Chiefs of Ambulatory Services, Emergency Medicine, and Medicine, shall be appointed by the hospital administration with input and affirmation from the Medical Executive Committee. Chiefs of Obstetrics and Surgery shall be elected by majority vote of members of their service. The term of office of each shall be two (2) years with the Chief of Obstetrics elected in even years and the Chief of Surgery in odd years. The Subsection heads shall be

appointed by the Chief of Staff with concurrence of the Executive Committee.

2. Duties of the Chief of each Major Service:
    - Shall have general supervision over the clinical work falling within his/her service including:
    - Shall recommend to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department;
    - Shall evaluate and make appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department;
    - Reviewing professional performance of practitioners with clinical privileges in his/her service and initiate corrective action when appropriate and report to Medical Executive Committee as required.
    - Serve as a member of the Medical Executive Committee.
    - Assure implementation of actions taken by the Medical Executive Committee and the Governing Board.
    - Assure enforcement of the hospital district and medical staff bylaws, rules and regulations and policies within the service.
3. The following duties may be delegated to a physician in his/her service:
    - Conduct initial phase of patient care review with service committee.
    - Assure administration of the service through cooperation with the nursing service and the hospital administration in matters affecting patient care, including standing orders, personnel, supplies, special regulations and techniques.
    - Preside as chair of committee meetings as delegated.
    - Perform other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff, the Executive Committee or the Governing Board.

ARTICLE 17: STRUCTURE

1. OFFICERS:
   Officers must be members of the Active Medical Staff at the time of their nomination and election and must have maintained this status for a period of not less than two years. Failure to maintain such status shall immediately create a vacancy in the office involved.
    - Officers shall be the Chief of Staff and Vice Chief of Staff; The Chief of Staff and the Vice Chief of Staff shall be elected by majority ballot before the end of the expiring term, approved by the Governing Board and shall hold office for two years or until a successor is elected.
    - The Vice Chief of Staff shall succeed the Chief of Staff, if the Chief of Staff's position is vacated during the term.
    - Vacancies occurring in the office of the Chief of Staff or Vice Chief of Staff within the term shall be filled by election at a special meeting or mail ballot of the medical staff.
2. Compensation:
   The Chief of Staff and Vice Chief of Staff shall receive financial compensation as determined by the hospital administration and governing board.
3. Chief of Staff Duties:
    - To call and preside at all meetings of the medical executive committee and medical staff. Shall be a

member ex-officio of all medical staff committees.

- To provide general medical direction of the hospital's health care activities and consultation for and medical staff supervision of the health care staff.
- To act in coordination and cooperation with the administration in all matters of mutual concern within the hospital and in coordinating the activities and concerns of the hospital administration and of the nursing and other hospital services with those of the medical staff.
- Be accountable to the Governing Board in conjunction with the medical staff for the uniform quality and efficiency of patient care, treatment and services and performance within the hospital and for the effectiveness of the quality assessment and other quality functions delegated to the staff.
- Be responsible for enforcement of medical staff bylaws, rules and regulations and policies; for implementation of sanctions where indicated and for medical staff compliance with procedural safeguards in instances where corrective action has been requested or suspension has been imposed affecting a practitioner.
- Communicate and represent the opinions, policies, concerns, needs and grievances of the medical staff to the governing board, the administrator and other officials of the staff.
- Appoint committee members to all standing and special medical staff committees.
- Assist in development and implementation of methods and education, utilization of resources, concurrent monitoring, quality assessment and other areas as deemed appropriate.
- Serve as spokesman for the medical staff in its external professional and public relations.
- Perform all other duties required of the position under these Bylaws and the rules and regulations and policies and procedures of the medical staff and facility.

4. Vice Chief of Staff Duties:
   - In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all of the duties of the Chief of Staff and shall have the authority of the position.
   - Shall perform such duties of supervision as may be assigned to him/her by the Chief of Staff.
   - Shall serve as a member of the Executive Committee
   - Shall perform such additional duties as may be assigned to him/her by the Chief of Staff or the Governing Board.
   - Shall perform credentials reviews for appointments, reappointments and privileges and shall forward such recommendation to the medical executive committee.
   - Shall serve as liaison for infection control.
5. Recall of Officers and/or Chiefs of Service:
   Recall of an officer or Chief of Service of the Medical Staff may be initiated for conduct detrimental to the interest of the practice of medicine in the Hospital, or if such officer is suffering from a physical or mental impairment that renders him/her incapable of fulfilling the duties of his/her office. Except as otherwise provided, recall may be initiated by a majority vote of the Executive Committee or shall be initiated by a petition signed by at least one-third (1/3) of the members of the Medical Staff eligible to vote, or majority of each major service's members. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds (2/3) vote of the Medical Staff members eligible to vote.
6. Nominating and Election of Officers:

In August of each year, an email from the Medical Staff Office will go out to all active medical staff asking for nomination or volunteering for the position of Vice-Chief of Staff. To qualify for Vice-Chief the physician must have served in a leadership position at JHC for at least one full term.If no nominations from active staff have been submitted, the nominating committee which shall consist of three members to include the immediate Chief of Staff will present candidates to the Medical Executive Committee at their September or October meeting. Such slate of candidates shall include at least one nominee for each office in which a vacancy exists. Election shall be conducted by ballot the end of October. Only members of the active medical staff shall be eligible to vote. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

7. MEDICAL STAFF FUNCTIONS

The medical staff is actively involved in the measurement, assessment and improvement of the following:

- Use of information about adverse privileging decisions for any practitioner privileged through the medical staff process.
- Use of medications and medication policies and practices
- Use of blood and blood components
- Operative and other procedures, including tissue review
- Appropriateness of clinical practice patterns
- Utilization review activities
- Infection control and prevention
- Medical Records review
- Quality Management System
- Reports and recommendations of these activities shall be forwarded to the Governing Board

The Medical Staff shall:

- Monitor and evaluate care provided in and participate in development of clinical policy for special care areas such as intensive or critical care units, patient care support, radiology, laboratory, anesthesia and emergency, outpatient, home care and other ambulatory care services. The Medical Staff is responsible for oversight of all ancillary staff.
- Provide continuing education responsive to evaluation and quality assessment findings, new developments and other perceived needs.
- Develop, plan or participate in such planning, programs of continuing education designed to keep the
- medical staff informed of new developments in medicine.
- Develop programs for continuing education which are responsive to the results of the medical staff quality assessment program, medical staff requests and hospital quality assessment.
- Maintain a permanent record of educational activities, specifically including the relationship to findings of quality assessment activities.
- Require that patient records are complete, timely, legible and clinically pertinent.
- Direct staff organizational activities including staff bylaws review and revision, staff officer and committee nominations, liaison with the board and hospital administration and review and maintenance of hospital licensure.

- Conduct annual review of bylaws, rules and regulations, policies and procedures of the medical staff.
- Develop, review and revise and implement clinical policies for services in conjunction with physician's assistant(s) and/or nurse practitioner(s).
- Submit recommendations to the medical staff and the governing board for changes in these documents.
- Act upon all bylaws issues referred by the board, medical staff, chief of staff, administrator or committee of the medical staff.
- Review medical staff and hospital policies, rules and regulations relating to medical records documentation; including medical record completion, forms, formats, etc. and ensure that such policies are current and reflect standard practice.
- Coordinate care, treatment and services among the practitioners and staff involved in a patient's care treatment and services.
- Participate regularly in the review of medical records, clinical orders and medical services, including adequacy and quality of care provided, in conjunction with physician assistant(s) and/or nurse practitioner(s).
- Participate in fire and other disaster planning, in long range planning of hospital growth and development and for provision of services required to meet the needs of the community.
- Participate in development and periodic review of written plans for activities and procedures to be followed in the event of an internal or external disaster.
- Participate in disaster drills as appropriate.
- Participate in the hospital infection control process.
- Oversee quality of Jefferson Healthcare Services.

8. Committees: See *Medical Staff Committee Charters*
9. Liaison Physicians : See policy *Liaison Physician*s
10. Joint Conference Committee:
    - The Joint Conference Committee shall be a standing committee composed of the Chief of Staff, the Vice Chief of Staff, the CEO and a representative member of the Governing Board.
    - The committee shall conduct itself as a forum for the discussion of matters of hospital policy and practice, especially those pertaining to efficient and effective patient care and shall participate in corrective action in the manner provided in these bylaws.
    - The committee shall meet on an as needed basis. A permanent record shall be kept of the proceedings and actions.
11. EXECUTIVE COMMITTEE
12. Membership:
    The Executive Committee of the Medical Staff shall be a standing committee and shall consist of the officers of the medical staff, the Chief of Ambulatory Care, Chief of Emergency Medicine, Chief of Medicine, Chief of Obstetrics, Chief of Surgery, Chief Medical Information Officer, and subsection chairs as deemed appropriate. The Chief Executive Officer and/or his/her designee, the Chief Operating Officer and the Chief Nursing/Quality Officer shall be ex-officio members of this committee, without voting privileges. Others may be invited to attend.

13. Purpose:
    The purpose of the Executive Committee shall be to consider and act upon all business prior to presentation to the Medical Staff. All actions taken by the Executive Committee shall be reported to the medical staff. Actions of the Executive Committee may be altered by majority vote of the Medical Staff.
14. Duties:
    In the absence of the Chief of Staff, other elected members of the Executive Committee shall assume all of the Chief of Staff's duties when necessary. The line of authority shall be (1) Vice Chief of Staff; (2) Chief of Medicine; (3) Chief of Surgery.
15. Responsibilities:
    The Medical Executive Committee shall:
    - Act for the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.
    - Receive and act upon the reports and recommendations of medical staff and multidisciplinary committees and of assigned activity groups. (Executive Committee actions shall be reported directly to the Governing Board and to the Medical Staff).
    - Implement the approved policies of the Medical Staff.
    - Review and make recommendations to the Governing Board regarding all matters relating to appointments and reappointments, clinical privileges and any corrective actions, staff categorization, organization structure, and major service assignments.
    - Be responsible to the Governing Board for recommendations regarding the overall medical care rendered by the Medical Staff to patients in the hospital.
    - Initiate and pursue corrective action when warranted, and as allowed by these Bylaws.
    - Inform the Medical Staff of State standards and recommendations and take appropriate action to obtain hospital accreditation.
    - Serve as a liaison between the Medical Staff, the CEO and the Governing Board.
    - Recommend action to the CEO on medical practice matters of a medico-administrative nature.
    - Make recommendations on hospital matters (for example, long-range planning) to the Governing Board.
    - Promote professionally ethical conduct and competent clinical performance on the part of members, including initiation of and participation in Medical Staff corrective review measures as provided by these Bylaws.
    - Appoint physicians to fill any vacancies on the Executive Committee (appointments effective until the next regularly scheduled election).
    - Role of Chief Medical Officer: Should the CMO or CMIO hold a position on the Medical Executive Committee, they shall recuse themselves from voting.
16. Meetings:
    The Executive Committee shall meet at least nine times per year. Additional meetings may be called by the Chief of Staff or his/her designee if pending business warrants. A permanent record shall be kept of committee minutes. Minutes of all meetings shall be prepared and a copy of such shall be approved by the attendees and made available to the Medical Executive Committee and Medical Staff. A permanent file of the meetings shall be maintained and is available in the Medical Staff Office.

ARTICLE 18: GENERAL MEDICAL STAFF MEETING

1. ANNUAL MEETING:
   The annual meeting of the Medical Staff shall be held in October. At the annual meeting, the retiring officers and committees may make such reports as may be desirable and the officers and Chiefs of Service with expiring terms shall be elected.
2. REGULAR MEETINGS AND ATTENDANCE:
   There shall be at least four (4) general medical staff meetings per year. Written notice stating the agenda, place, day and hour shall be posted, emailed to all medical staff members entitled to be present not less than 2 weeks before the meeting. There are no quorum requirements for general medical staff meetings. Those members present at the start of the meeting shall constitute a quorum for conducting business.
3. ATTENDANCE: Active Medical Staff members must attend one meeting per year.
4. QUORUM: A quorum is considered to be those active and provisional active physicians present. There shall be no voting by proxy.
5. SPECIAL MEETINGS: Special meetings of the Medical Staff may be called at any time by the Chief of Staff and shall be called at the request of any three (3) members of the Medical Staff. The Chief of Staff shall designate the time, place and purpose of any special meeting which shall be held within fifteen (15) days after receiving any such written request. Written notice stating the place, day, hour and purpose of any special Jefferson Healthcare Medical Staff Bylaws meeting of the medical staff shall be delivered either personally or by mail to each member of the active staff and provisional staff not less than three (3) nor more than ten (10) days before the date of such meeting by or at the direction of the Chief of Staff. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his/her address as it appears on the records of the hospital. Notice may also be sent to members of the courtesy medical staff who have so requested. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

ARTICLE 19: PEER REVIEW (PROFESSIONAL PRACTICE EXCELLENCE COMMITTEE)

1. PURPOSE:
   The JHC medical staff is responsible for ensuring that patients admitted or treated at JHC receive care at a level of quality and efficiency that is consistent with generally accepted standards attainable within the hospital's means and circumstances. It is the policy of the hospital to support a fair, timely and objective process performed by the medical staff to evaluate and measure competence and professional conduct of practitioners holding privileges at Jefferson Healthcare and where necessary, improve performance.
2. COMMITTEE STRUCTURE:
   The Professional Practice Excellence Committee shall be a multidisciplinary committee comprised of physicians, nurse practitioners and physician assistants from the following services: Surgical Services, Internal Medicine/Pediatric Services, Family Medicine/Obstetrics Services, Hospital Medicine and Emergency Services, and other members as appointed by the Professional Practice Excellence Committee. The Director of Patient Safety/Quality shall attend as a non-voting member of the committee.
3. DUTIES:
   The Professional Practice Excellence Committee shall be responsible for assessing the quality

performance of medical staff members and practitioners holding privileges. Such responsibilities shall include the following:

- Investigating medical care rendered in order to determine whether accepted standard of care has been met, and, when appropriate, making recommendations for corrective action to the appropriate Service Committee.
- Identifying for review through the following non-inclusive sources: Outcome indicators, issues identified by members of the patient care team, cases identified by Risk Management and/or patient advocates, issues referred by any medical staff member or committee, practitioner self-referral.
- Providing written documentation of the findings, conclusions (including the underlying rationale), and recommendations to the practitioner under review and to the appropriate Service Committee.
- Reporting systems problems or potential issues with nursing care to the Hospital Performance Improvement Committee via Quality Director.
- Reporting monthly to Medical Executive Committee.

Frequency of meetings: Monthly or as determined otherwise.

ARTICLE 20: RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations and policies and procedures as may be necessary to implement more specifically the general principles found within these bylaws subject to the approval of the Governing Board. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital. Such rules and regulations shall be a part of these bylaws, except that they may be amended or repealed by majority vote of the active medical staff by mail ballot or at the annual or special meeting. Such changes shall become effective when approved by the Governing Board.

ARTICLE 21: AMENDMENTS

These Bylaws may be amended by the active Medical Staff provided there has been previous notification of the proposed change 30 days before said vote whether by mail ballot or meeting.

ARTICLE 22: ADOPTION

Adoption of the bylaws and such revisions shall require a two-thirds (2/3) vote of active members present at meeting or majority vote by mail ballot. Amendments shall be effective when approved by the Governing Board. Once approved, the Governing Board shall comply with the medical staff bylaws. Neither the medical staff nor the Governing Board may unilaterally amend the bylaws, rules and regulations.

Approvals:

MEC: 10/23/07, 3/24/09, 4/08/09, 10/21/11, 9/3/2013, 8/26/2014
Medical Staff: 3/11/08, 4/14/09- refer back to MEC, 7/22/09, 10/21/11,
Governing Board: 4/8/08, 8/5/09, 11/2/11, 10/2/2013, 9/3/2014

Referenced Documents:

Reference Type	Title	Notes

Attachments

No Attachments

Approval Signatures

Approver	Date
Allison Crispen: Director of Medical Staff Programs	01/2021

Origination:	*07/2010*
Last Approved:	*01/2021*
Last Revised:	*12/2019*
Next Review:	*01/2022*
Owner:	*Allison Crispen: Director of Medical Staff Programs*
Policy Area:	*Medical Staff Policies*
Standards & Regulations:	
References:	

Medical Staff Orientation

POLICY:

Every newly appointed Medical Staff provider will complete an orientation. This orientation, designed to help promote and build a positive relationship with the provider, will be a personal, interactive orientation overseen by and including Medical Staff leadership, Hospital leadership, Medical Staff Services and other key personnel within the hospital. As a tool to assist in orienting the Medical Staff provider, a resource manual has been developed and will be presented and reviewed at the time of orientation.

Providers working from a remote site (tele-radiology, tele-stroke) shall have full orientation requirements waived, however, essential elements of Jefferson Healthcare and medical staff protocols, and guidelines appropriate to the services shall be communicated to the provider.

Providers who require EPIC access will receive training by the Clinical Informatics Department before their first Jefferson Healthcare assignment or shift.

PURPOSE:

To ensure that all newly appointed Medical Staff Providers are oriented to Jefferson Healthcare and Medical Staff leadership, contribute to patient safety and to relay pertinent clinical, operational and regulatory information and expectations.

PROCEDURE:

1. Mission, Vision and Values
2. Patient Rights and Responsibilities
3. Patient Safety, Quality, Facility Accreditation, Restraint Use
4. Infection Control
5. Medical Staff Officers and Committees
6. Phone Directory
7. Organizational Chart
8. Bylaws, Rules and Regulations
9. Health Information Management, and HIPAA
10. CME and Tumor Board Information, PolicyStat Instructions

11. Conduct Expectations
12. Provisional Evaluation Process
13. Peer Review

RECORD REQUIRED:

Jefferson Healthcare Orientation Manual; Medical Staff On boarding (attached)

Attachments

Medical Staff Onboarding Guide

Approval Signatures

Approver	Date
Allison Crispen: Director of Medical Staff Programs	01/2021

Origination:	*08/2014*
Last Approved:	*03/2021*
Last Revised:	*10/2015*
Next Review:	*03/2022*
Owner:	*Allison Crispen: Director of Medical Staff Programs*
Policy Area:	*Medical Staff Policies*
Standards & Regulations:	
References:	

Medical Staff Rules and Regulations

ADMISSION AND TREATMENT OF PATIENTS:

1. A patient may be admitted to the hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the hospital.
2. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated and recorded. In the case of an emergency such statement shall be recorded as soon as possible.
3. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the completeness and accuracy of the medical record, for the necessary special instructions, and the transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, the responsible physician will personally contact the other staff member and the patient and, if they concur, a note indicating the transfer of responsibility shall be documented.
4. Podiatric or Dental staff shall, before scheduling patients for surgery, ensure that patient has consulted with his/her usual physician. A physician shall be responsible for providing history and physical examination for the admission. Podiatrist or Dentist shall furnish information and examination regarding aspect of care which he/she provides, shall write orders and sign them, document operative report if applicable and shall provide other documentation as required under rules and policies of the hospital. Dentists/ Podiatrists shall be held jointly responsible, with the attending physician of their patients, for the care of the patients during hospitalization, and shall be responsible to the Chief of Surgery.
5. The admitting practitioner shall be responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatsoever.
6. Admissions to the ACU/ICU: If any question as to the validity of admission to, or discharge from, the ACU/ICU should arise, that decision is to be made through consultation with the hospitalist or the patient's specialist. If disagreement remains the issue shall be **referred for secondary review (see Utilization Review Plan)**.
7. In the event of a hospital death, the deceased shall be pronounced according to hospital policy. An appropriate entry shall be made in the medical record of the deceased.
8. Staff members shall identify possible organ/tissue donor. Designees of the organ and tissue donation agencies will discuss donation with the families.

9. Patients may be treated only after a written consent to treatment is signed by the patient or the patient's guardian as indicated below*:*

It is the policy of Jefferson Healthcare (JHC) to oversee the patient's right to be involved in all aspects of their care including obtaining a general consent for services and informed consent for more specific treatment and surgical procedures. It is also the policy of JHC to protect those with reduced capacity to consent. The purpose of this policy is to outline the procedures in obtaining consent and substituted consent.

INFORMED CONSENT DEFINED:

Consent is the dialogue between the healthcare provider and patient in which information is exchanged about the health care services or treatment being recommended.

RCW 7.70.060 establishes the necessary elements that must be included in a written consent which, when signed by the patient or patient's legal representative if the patient is not competent, constitutes evidence that the patient (or representative) gave informed consent. These elements include:

- The nature and character of the proposed treatment and procedures to be performed
- The anticipated results of the proposed treatment and procedures
- The recognized possible alternative forms of treatment
- The recognized serious possible risks, complications, and anticipated benefits involved in the proposed treatment and the recognized possible alternative forms of treatment, including non-treatment

The following procedures require documented evidence of informed consent in the medical record. The procedures listed are not necessarily all inclusive.

a. *Surgical procedure*
b. *Endoscopic procedure;*
c. *Anesthesia*
d. *Procedures involving invasion of body cavity*
e. *Insertion of central venous or pulmonary artery catheters*
f. *Pacemaker insertion*
g. *Lumbar puncture*
h. *Cardioversion*
i. *Transfusion of blood/blood products*
j. *Procedures involving significant radiation exposure*
k. *Chemotherapy*

WHO CAN CONSENT:

In most cases, the patient is the only person authorized to give consent as long as competent. Persons listed on the hierarchy of consent may not provide consent for a competent patient except as outlined in #2 below. In cases where the patient is unable to sign the consent but is capable of making the decision, a witnessed verbal consent shall be obtained and witnessed by two persons.

Informed consent for healthcare for a patient who is not competent, as defined in RCW 11.88.010(1)(e), consent may be obtained from a person authorized to consent on behalf of such patient in order of priority:

1. The appointed guardian of the patient, if any
2. The individual, if any, to whom the patient has given a durable power of attorney that encompasses the authority to make health care decisions.
3. The patient's spouse or the patient's registered domestic partner.
4. Children of the patient who are at least eighteen years of age.
5. Parents of the patient.
6. Adult brothers and sisters of the patient.

See also *Treatment of Minor and Their Protected Health Information*

RESPONSIBILITY FOR OBTAINING CONSENT:

General Consent:

A general consent for treatment must be completed and signed at the time of admission. This authorizes the hospital to perform routine hospital services, diagnostic procedures and nonsurgical medical treatment. If for any reason this is not accomplished, the responsibility for obtaining a signed and dated general consent form will rest with the house supervisor.

Informed Consent:

For treatment which requires specific consent (such as blood transfusion and surgical procedures) the treating physician is responsible for explaining medical treatment and procedures to the patient, sign/date the surgeon's attestation, and obtaining a properly filled out and executed consent form **and sign the surgeon's attestation**.

Additionally, it is recommended that the physician enter a note in the hospital medical record indicating that a discussion was held with the patient and an informed consent was obtained. The signed form is only a written verification of the understanding between the patient and the physician. The physician should also document the completion of the informed consent process in the patient's medical record.

It is the responsibility of hospital personnel to determine the presence of an appropriate consent form. The nurse or other hospital staff caring for the patient at the time of the treatment or procedure is responsible to see that the appropriate special consent forms have been obtained by the physician and are in the patient's medical record before treatment is undertaken. Hospital personnel should report to their supervisor any case in which it appears a patient has unanswered questions about the treatment or procedures they are about to undergo or are uncertain about proceeding.

INFORMED CONSENT FORM:

In accordance with the Medical Conditions of Participation, Jefferson Healthcare's consent form documentation will include at least the following:

- Name of patient, and when appropriate, patient's legal guardian;
- Name of hospital;
- Name of procedure(s);
- Name of practitioner(s) performing the procedure(s) or important aspects of the procedure(s) (Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue,

implanting devices, altering tissues: this includes assistants)
- Signature of patient or legal guardian;
- Date and time consent is obtained;
- Statement that procedure including anticipated benefits, material risks and alternative therapies was explained to patient or guardian;
- Signature of professional person witnessing the consent; and
- Name/signature of person who explained the procedure to the patient or guardian.

The responsible practitioner must disclose to the patient any information necessary to enable the patient to evaluate a proposed medical or surgical procedure before submitting to it. Should patient decline to receive such information, this shall be documented. Informed consent requires that a patient have a full understanding of that to which he or she has consented. An authorization from a patient who does not understand what he/she is consenting to is not informed consent. Patients must be given sufficient information to allow them to make intelligent choices from among the alternative courses of available treatment for their specific ailments.

The responsible practitioner must provide as much information about treatment options as is necessary based on a patient's personal understanding of the practitioner's explanation of the risks of treatment and the probable consequences of the treatment.

Informed consent means the patient or patient representative is given (in a language or means of communication he/she understands) the information needed in order to consent to a procedure or treatment.

An informed consent would include at least: an explanation of the nature and purpose of the proposed procedures, risks and consequences of the procedures, risks and prognosis if no treatment is rendered, the probability that the proposed procedure will be successful, and alternative methods of treatment (if any) and their associated risks and benefits.

Informed consent includes that the patient is informed as to who will actually perform surgical interventions that are planned. When practitioners other than the primary surgeon will perform important parts of the surgical procedures, even when under the primary surgeon's supervision, the patient must be informed of who these other practitioners are, as well as, what important tasks each will carry out.

Consent to extension or modification of the specific medical treatment authorized can be implied, if this is not a radical departure from the treatment initially contemplated and understood by the patient. Consent may also be implied if there is an emergency. Otherwise, a new special consent should be obtained (RCW 7.70.050(4).

If this question arises in the course of an operation, and the extension or modification is a radical departure, or is an additional unrelated operation, and the extension or modification is merely desirable – as opposed to **necessary**, as an unforeseen emergency – there is no implied consent.

When a patient has specifically prohibited certain treatment, it should not be performed without consent.

WITNESS:

Witness to informed consent must be a medical professional. The witness is attesting to the patient or authorized representative's signature. Model practice would include the physician restating to the witness in the patient's presence, elements of the informed consent or by having the patient state back to the witness their understanding of the elements of the informed consent.

WHEN PATIENT MAY UNDERGO TREATMENT/ SURGERY WITHOUT CONSENT:

When the patient is in immediate need of medical treatment but is unable to give consent because of a physical or mental impairment medical treatment or surgery treatment can be instituted under these circumstances once it is determined that: a) a delay in treatment would be life threatening or cause the patient serious harm; b) no close family member or surrogate is available to give consent on behalf of the patient; and c) the physician has no evidence that would suggest that the patient would oppose the treatment. The physician shall document in the medical record the emergency circumstances under which the medical treatment or surgery without consent was rendered.

LENGTH OF TIME CONSENT IS VALID:

Ordinarily, a consent is only valid for a reasonable time unless or until it is revoked. A good measure for the reasonable period of time that a consent form is valid is considered to be 30 days. In general, a consent should not be considered valid after discharge from the hospitalization for which the consent was given, unless it was clearly for continuing treatment. The patient can revoke consent at any time, either orally or in writing.

NUMBER OF COPIES; DISPOSITION OF FORMS:

One copy of each consent form, release or other document which is utilized for a patient, should after execution, be attached to and become a part of the patient's permanent medical record. One copy of each specific consent form should also be delivered to the patient or the patient's personal representative at the time it is signed.

(Refer to form: "*Special Consent To Operation, Post-Operative Care, Medical Treatment, Anesthesia or other Procedure")*

CONSULTATION:

1. Except in the case of emergency situations requiring immediate cesarean, the attending physician shall confer by phone with another physician with obstetric privileges prior to performing a first Cesarean section. The nature of this conversation shall be documented in the medical record.
2. In major surgical cases in which the patient is not a good risk, and in all cases in which the diagnosis is obscure or where there is doubt as to the best therapeutic measures to be utilized, consultation is appropriate.
3. Judgment as to when to obtain consultation rests with the physician responsible for the care of the patient. However, it is the duty of the Medical staff through the Chief of Service and the Executive committee to see that members of the staff obtain consultation in an appropriate and timely manner.
4. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to the operation.

ORDERS:

1. Medication orders shall be written/entered electronically, dated, timed and signed and shall include dosage, frequency, mode of administration and duration.
2. Orders shall also be written/entered electronically for consultations, diagnostic (i.e. laboratory and diagnostic imaging, nuclear medicine) and therapeutic procedures (i.e. respiratory therapy, rehabilitation therapy), and to convey other special instructions (ordering home health, AMA, transfer, etc).
3. All orders for treatment shall be in writing/entered electronically, dated, timed and signed.
4. Orders written by individuals who are not Medical Staff/Allied Health Professional Staff members (such as, practitioners serving clinical rotations, etc.) shall be authenticated by the responsible Medical Staff member.
5. Duly licensed providers may order outpatient services (such as, Home Health/Hospice and Medication Infusion) without authentication by a member of the medical staff.
6. **Orders by Allied Health Professionals**: Orders by ARNP's, CRNA's and PA-C's with clinical privileges do not require authentication by signature of a physician (see medical staff policy entitled Role and Practice of the Certified Physician Assistant and Advanced Registered Nurse Practitioner).
7. *Computerized Physician Order Entry Policy:*

Order entry in EPIC is to be completed by provider with the two exceptions that are intended to support timely and best care of the patient.

PROCEDURE:

Providers can give VERBAL orders to be read back and entered into EPIC by the RN during the following **two** scenarios:

1. Inability for provider to use EPIC
2. Urgent clinical situation

The understanding is that situations in which a provider is "unable to access EPIC" will be variable and should be assessed on an individual basis with the continued focus on patient safety.

Examples of "**Unable to access EPIC**":

- Provider is in a procedure with another patient(i.e. surgery/procedure)
- Provider is on call and outside of hospital/clinic

Verbal orders will be managed the following way:

- When RN makes the call to the provider with update or to get an order, **the RN will have the patient's EPIC chart OPEN and will enter the order all the way through the signing process before hanging up the phone.** This will prevent having to call the provider back for clarification, etc. due to system alerts.
- The provider may NOT ask a non-licensed employee to enter orders at any time (i.e. HUC or CNA).
- When provider calls the RN in a non-emergent setting, especially during the daytime, the expectation is that the provider will be asked to enter their own orders into EPIC, unless there are other "unable to access EPIC" conditions.

MEDICAL RECORDS:

The attending physician shall be responsible for preparation of a complete and legible medical record for each patient. Content shall be pertinent and current and shall include, where appropriate: identification data; complete history and physical examination; consultations; clinical laboratory, radiology and other special reports; provisional diagnosis; medical or surgical treatment; operative reports; anesthesiology records; pathological findings; progress notes; final diagnosis; discharge summary; and autopsy report, when performed.

History and Physical Policy:

A. **Documentation Requirements:**

1. The history and physical must be performed and documented within 30 days prior to a scheduled admission[1] or within twenty-four (24) hours after an unscheduled admission.
2. At the time of admission, or at the time of the physician's first visit, but no longer than 24 hours after admission, all charts should include a brief handwritten or current office note. This note will include the diagnosis, reason for admission, indications for any planned procedure, relevant assessment of the patient's condition and plan for therapeutics and diagnostics. There does not need to be a handwritten note, if the dictated history and physical has already been transcribed and placed in the chart.
   - An HP completed within 30 days prior to admission or registration shall include an entry in the medical record documenting an examination for any change in the patient's current medical condition completed by a doctor of medicine or osteopathy.
   - This examination and update of the patient's current medical condition shall be completed and placed in the medical record within twenty four (24) hours after admission or registration, but prior to surgery or other procedure requiring anesthesia services.
   - *The handwritten note is **not** in lieu of a dictated history and physical, except as included in 6. Obstetrical Record*

B. **History and Physical Requirements by Patient Status:**

1. **Inpatient, Same Day Surgery and Observation Charts**:
   To include chief complaint, details of the present illness, relevant past medical history, relevant social history, relevant family history, summary of psychosocial needs as appropriate, relevant review of body systems, relevant physical exam, allergies, medications, and impression/plan or conclusion.
   - A preoperative history and physical (either dictated or written) shall be on chart prior to performance of a surgical procedure. If history and physical is not recorded before the time scheduled for procedure, the operation shall be canceled or postponed, unless the attending surgeon documents on the record that such delay would be detrimental to the patient. All cases which are canceled due to absence of history and physical shall be reported to Surgical Services Committee.
   - For inpatients the record shall contain identification data and consent forms, chief complaint, present illness, inventory of systems, past history, pertinent or relevant social history, family history, and a physical examination.
   - Special reports such as consultations and medical laboratory and x-ray reports shall also be included. Provisional diagnosis, medical or surgical treatment, operative reports, pathological

findings, progress notes, and final diagnosis should be part of the record. A condition on discharge and a discharge summary as well as post-mortem reports, when applicable.

2. **Recurring Patients, Medical Short Stay Procedures or Treatment (i.e., IV medications, chemo):**
    a. Initial visit for the recurring, Medical Short Stay patient: The following options are available:
        1. Complete H&P; or
        2. *Completion of the Medical Short Stay H&P form.*
        3. *Office notes that contain all elements of an H&P, as referenced above in Section B1*
    b. Following the initial visit, for recurring medical outpatients: Entries are required at least every four (4) weeks, or prior to the next treatment if the treatment is longer than four (4) weeks apart.
3. Diagnostic Procedures (i.e.lab, cath flushes, radiology, physical therapy): No history and physical required.
4. Emergent/Stat Treatment: At the time of admission, the patient's diagnosis must be documented. A progress note, Short Stay Form or office notes that contain all elements of an H&P, as referenced above in Section B1, need to be provided within twenty-four hours.
5. Procedural Sedation (moderate/conscious sedation): Refer to policy for documentation requirements.
6. The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's Office record transmitted to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and subsequent changes in physical findings. Un-established patients will need a full history and physical.
7. Emergency Department:
    - Chief Complaint
    - History of Present Illness (HPI)
    - Review of Systems (ROS)
    - Past, Family, and or Social History (PFSH)
    - Medication list
    - Physical Examination
    - Description of any procedures performed and course of care and treatment
    - Final Impression
    - Discharge Disposition
    - Discharge Condition
    - Follow-up Up/Discharge Instructions

C. **Readmission:**
When a patient is readmitted within 30 days for the same problem, an interval history and physical exam may be completed. A copy of the previous history and physical must be inserted in the chart and the interval note must reflect any subsequent changes in the patient.

D. **Who Can Perform the History and Physical:**

A history and physical examination may be performed by physicians, oral and maxillofacial surgeons, and

specified allied health professionals.

1. It is expected that the operating surgeon will be the admitting physician under normal circumstances for scheduled procedures. If the admitting physician is not the operating surgeon, the surgeon must provide a pre-operative consultation which shall be documented in the medical record.
2. Dentists may perform a history and physical related to dentistry.
3. Podiatrists may perform a pre-operative history and physical examination independently on their patients of surgical risk ASA Category I or II. The podiatrist is responsible for arranging an additional H&P by a MD, DO, ARNP or PA for podiatric patients with risk greater than ASA category II. *Please refer to History and Physical policy for ASA I/II definition.*
4. Advanced Practice Registered Nurses and Physicians Assistants may perform a history and physical. Co-signature by sponsoring physician is required.
5. Residents may perform a history and physical. Co-signature by sponsoring physician is required.

E. **Format:**

Format of H&P's may vary while addressing all necessary data elements. Patient identification, including first and last name with either the date of birth or medical records number, is an essential element of any history and physical report.

- Admission is defined as patient registration in any inpatient, observation, same day surgery, or short-stay hospital service.
- Pertinent, legible progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.
- Progress notes shall be written at least daily on hospitalized patients. Following surgery, a progress note shall be written immediately describing the operative findings, surgical procedure and condition of the patient.
- All clinical entries in the patient's medical record shall be accurately timed, dated, and authenticated. Dictated information may be electronically authenticated, written documentation must be signed.
- Symbols and abbreviations that appear in the *Unapproved Abbreviations* policy may not be used.
- Final diagnoses shall be recorded in full, dated and signed by the responsible practitioner at the time of discharge. There shall be no abbreviations in the final diagnoses. Physician attestation shall be reviewed and authenticated prior to hospital billing.
- All medical records of patients who expire within the hospital shall have a mortality summary. Content shall be sufficient to validate the diagnosis and warrant treatment and end result.
- Any medical record incomplete 15 days after the discharge of the patient shall be considered delinquent. The first notice of such delinquency shall be made at 15 days. A second notice shall be given at 25 days. If such records are not completed by the 30th day the physician will be restricted from all new admissions to the hospital but may continue to render professional care to patients already in the hospital until their discharge.

TREATMENT OF EMERGENCY PATIENTS:

When a patient presents to the Emergency Department, the Emergency Department physician or designee, will perform the medical screening exam. If it is felt that the patient needs to be admitted to the hospital, the

hospitalist or specialist on an emergency call schedule will be contacted. In pregnant patients, the medical screening exam will be performed by the Emergency Department physician or by the obstetric nurse in consultation with a staff physician with obstetrical privileges. Provider will be called to see patient if the following symptoms are present:

- Category III FHR tracing or Category II evolving into a Category III.
- Cord prolapse
- Breech presentation
- Absence of FHTs (suspected intrauterine demise)
- Eclamptic seizures
- Imminent delivery
- Frank vaginal bleeding in pregnancy

Each member of the staff who is not available in the immediate vicinity shall name a member of the medical staff who is available in the area who may be called to attend his patients in an emergency or until he/she arrives. In case of failure to name such associate, the chairman of the department concerned, the chief executive officer of the hospital or the chief of staff shall have authority to call any member of the active staff.

Unassigned Patients: After completion of the medical screening exam, if it is felt that the patient needs to be admitted to the hospital, the hospitalist or specialist on call will be contacted. Should this physician or call group not be available, the administrator on call will be contacted.

Emergency Call Schedules - Participation Requirement:

1. Physician members of the hospital medical staff with admitting privileges may be required to serve on emergency department call rotation (including rotation for unassigned patients) as determined appropriate by the Executive Committee and hospital needs**.** Exceptions are the following:
    1. Physicians over 60 years of age with ten (10) years of Active Staff tenure.
    2. Any other requests for opting out will be taken to MEC for consideration.
2. Call must be prospective by individual physician name.
3. Call schedules for clinics shall include coverage for Jefferson Healthcare primary care clinics.
   Call schedules for Hospital and Emergency Department coverage shall include
    - General Surgery
    - Orthopedic Surgery
    - Obstetrics
    - Anesthesia
    - Hospitalist group
4. The on-call physician is to present to the Emergency Department within 30 minutes of request **or** at the clinical discretion of the ED provider the outgoing call from the Emergency Department, unless extenuating circumstances exist in which the Emergency Department would be notified of delay. Surgical/ anesthesia personnel (surgeons, CRNAs, OB surgeons) are required to present at the site **within 20 minutes of request**.
5. It shall be the responsibility of the practitioner on call to respond to the Emergency Department when medically urgent; to be physically present in the Emergency Department as outlined in #4 above; to arrange alternate coverage if necessary and notify appropriate contacts (Emergency Department and House Supervisor).

Surgical Services Policy:

- The practitioner responsible for the patient records the provisional diagnosis in the record prior to the operative or other high risk procedure.
- When Surgery is performed there is a pre-operative and post-operative note by the anesthetist.
- For History and Physical refer to H&P policy in this document. In case of an emergency, when a complete history and physical can not be documented prior to surgery, a brief admission note is necessary. The note should include at a minimum, critical information about the patient's condition including pulmonary status, cardiovascular status and vital signs.
- An operative note is documented within 24 hours of surgery and contains date and times of operation, name and identification number of patient, names of surgeons and assistants or other practitioners who performed surgical tasks*, pre-operative and post-operative diagnoses, type of anesthesia, names of specific procedures performed, description of operation, techniques, findings, and tissues removed, or altered, prosthetic devices, grafts, tissues, transplants or devices implanted, if any, specimen(s) removed, complications, if any, estimated blood loss, condition at conclusion of procedure.
  - *surgeons or practitioner's name(s) and a description of the specific significant surgical tasks that were conducted by practitioner otter than the primary surgeon/practitioner (opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting device(s), altering tissues)
- Progress Note: An operative or other high-risk procedure progress note is entered in the medical record immediately after the procedure, if the full operative/high risk operative/procedure report cannot be entered into the record immediately after the operation/procedure.
- Elective surgery (including after hour requests) shall be scheduled with the supervisor of the surgery department at least 24 hours in advance. Only emergency surgery may be done on Saturdays, Sundays and holidays.
- All operations shall begin at the scheduled time. If the operating surgeon is more than 15 minutes late, the case may be postponed until the next convenient time on the schedule. Postponement of cases will be reported to the Chief of Surgery and the Medical Executive Committee.
- Surgical procedures require informed consent (*see Informed Consent above*).

Referenced Documents

Reference Type	Title	Notes

Attachments

No Attachments

Approval Signatures

Approver	Date
Allison Crispen: Director of Medical Staff Programs	03/2021

Origination:	*05/2018*
Last Approved:	*11/2019*
Last Revised:	*11/2019*
Next Review:	*11/2021*
Owner:	*Allison Crispen: Director of Medical Staff Programs*
Policy Area:	*Medical Staff Delineation of Privileges*
Standards & Regulations:	
References:	

ARNP Sleep Medicine Privileges

Independent Allied Health Professional – Scope of Practice

Primary Practice Area: Sleep Medicine ARNP

To be eligible to request ARNP Sleep Medicine Privileges, the following minimum threshold criteria must be met:

Basic education: Advance Registered Nurse Practitioner

Minimum formal training:

- Master's degree in nursing from accredited college or university if training was completed after January 1, 1995, or certified by a board approved national certification program prior to December 31, 1994 and recognized by another state board of nursing for advanced practice prior to December 31, 1994.
- If the applicant has neither specialty certification nor at least two years of clinical experience, the specialty department shall submit a formal training and evaluation plan to the Credentials Committee/MEC prior to the granting of initial privileges. At minimum, the practitioner is required to work alongside a specialty trained physician until a recommendation for independent practice is made during formal review at 3 months, 6 months and/or 1 year of work.

Credentials:

- Current Washington State advanced registered nurse practitioner license
- Current Washington State registered nurse license
- Valid DEA registration for ordering medications and prescriptions
- Certification by American Nurses Credentialing Center (ANCC) or AANP
- Current BLS certification (ACLS supersedes BLS for care of adult patient)

Privileges include assessment, evaluation, and management of outpatients presenting for sleep disorders.

- Evaluate patients with sleep related complaints under sponsoring physician supervision.
- Complete history and physical – present all patients to sponsoring physician.
- Initiate treatment as directed by sponsoring physician

- Provide patient education on pathophysiology of different sleep disorders and mechanism of treatment.

Reappointment Criteria:

- Documented clinical activity within the scope of privileges without significant variations identified.
- Continuing education related to applicant's primary practice area is required.

Medical Records:

In accordance with standard work policies and procedures, the ARNP will document all care provided.

Orders:

Diagnostic tests, medications (including Schedule II-V controlled substance with appropriate DEA registration), and other patient treatments may be ordered by the ARNP and treated as a physician's orders.

Diagnostics specific to sleep medicine include: polysomnography, manual CPAP/Bi-level titration study, multiple sleep latency tests and similar studies.

May order pulmonary function tests, overnight pulse oximetry and chest x-rays as indicated.

Privileges:

Privileges include assessment, evaluation, and management of outpatients presenting for sleep disorders.

- Perform and document complete, system-focused, or symptom-specific physical examination
- Assess the need for and perform additional screening and diagnostic testing, based on initial assessment findings
- Prioritize data collection
- Manage diagnostic tests through ordering and interpretation
- Formulate differential diagnoses by priority
- Prescribe appropriate pharmacologic and non-pharmacologic treatment modalities
- Utilize evidence-based, approved practice protocols in planning and implementing care
- Initiate appropriate referrals and consultations
- Provide specialty specific consultation services upon request and within specialty scope of practice
- Facilitate the patient's transition between and within health care settings, such as admitting, transferring, and discharging patients
- Identify patient and family needs regarding preventative care, disease entity, medications, dietary restrictions and other therapeutic forms

The checklist details privileges and tasks/duties that can be done independently, when they need to check with the physician and when they must do the task only with a physician present.

	Procedure	On Own	With Physician	With Physician Present
	Assessment	X		
	Prescriptive Authority for all drugs	X		
	Write Orders	X		
	Care of Patients with non-urgent conditions	X		
	Transfer of Outpatients to Emergency Dept	X		
	Lab Test and Study Interpretation	X		

Hospital-Based Privileges

ARNPs providing inpatient care are required to have a physician supervisor who is a member of the Active Medical Staff with inpatient privileges. Privileges in the Hospital shall be exercised only under the supervision of the physician. The sponsoring physician or designee shall review care provided by the ARNP on a continuous basis and for admitted patients, shall countersign the admitting history and physical and the discharge summary.

CoP: § 485.631(c)(3) Whenever a patient is admitted to the CAH by a nurse practitioner, physician assistant, or clinical nurse specialist, a doctor of medicine or osteopathy on the staff of the CAH is notified of the admission.

Provider Attestation

I have crossed out any procedures that I do not currently perform or request. I understand that in applying for these privileges, I am bound by the applicable Bylaws and/or policies of the Hospital and Medical Staff. I hereby stipulate that I meet the threshold criteria for the requested privileges.

Provider Signature _____

Date _____

Sponsoring Physician (if applicable) Signature: _____ Date: _____

Governing Board Approval Date:_____

Delineation of Privileges reviewed by Credentials Committee: August, 2019; Governing Board Approval: October 23, 2019

Attachments

No Attachments

Approval Signatures

Approver	Date
Brandie Manuel: Chief Patient Care Officer	11/2019

Current Status: *Active* **PolicyStat ID:** *10120797*

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Owner:	*Allison Crispen: Director of Medical Staff Programs*
Policy Area:	*Medical Staff Delineation of Privileges*
Standards & Regulations:	
References:	

General Dentistry

General Dentistry Privileges

To be eligible to request privileges the following minimum threshold criteria must be met:

Basic education: Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD)

Formal training and experience at initial appointment:

Successful completion of an American Dental Association-Approved school of dentistry accredited by the Commission of Dental Accreditation (CODA) and board certification in adult and pediatric dentistry.

Clinical Experience (initial) Applicants for initial appointment must be able to demonstrate active dental practice in the past 24 months or successful completion of accredited training program in the past 12 months.

Clinical Experience (reappointment) Current demonstrated competency and adequate volume of experience with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluations and outcomes. Evidence of current ability to perform privileges as requested is required of all applicants for renewal of privileges.

Providers must be BLS certified.

Requesting: **GENERAL DENTISTRY** Core Privileges:

Consult, evaluate oral health needs, diagnose, and provide general dental diagnostic, preventive, and therapeutic oral healthcare to patients of all ages to correct or treat various routine conditions of the oral cavity and dentition.

I request the privileges checked above and attest that I have met the requirements for these privileges. I have crossed out any procedures that I do not currently perform or request. I understand that by making this request I am bound by the applicable bylaws, policies and procedures of the hospital and the Medical Staff and hereby stipulate that I meet the threshold criteria for each privilege requested.

Dentist Signature Print Name Date

Governing Board Approval date: _____

Attachments

No Attachments

Approval Signatures

Approver	Date
Allison Crispen: Director of Medical Staff Programs	07/2021