Jefferson Healthcare

Jefferson County Public Hospital District No.2
Board of Commissioners Meeting

Due to the presence of multiple respiratory illness, Jefferson Healthcare is still highly encouraging practice of infection protocols. You may choose to attend this meeting virtually by accessing the below information or can attend in person in the Sheridan Conference Room at 915 Sheridan Street. Limited seating available.

Audio Only: dial Phone Conference Line: **(509) 598-2842**
When prompted, enter Conference ID number: **572 938 342#**

Microsoft Teams meeting: Join on your computer or mobile app.
This option will allow you to join the meeting live.
Click here to join the meeting

Regular Session Agenda
Wednesday, February 28, 2024

Call to Order:	2:00
Approve Agenda:	2:00
Methodology of Patient and Employee Satisfaction: Brandie Manuel, CPSO	2:00
Patient Story: Tina Toner, CNO	2:30
Public Comment:	2:45

Public comments are welcome orally, with a 3-minute limit, or may be submitted via email at commissioners@jeffersonhealthcare.org, or written and addressed to Commissioners at 834 Sheridan Street, Port Townsend, WA 98368. Written submissions must be received by 5:00 pm the day prior to the meeting.

Minutes: Action Requested 2:50

- January 24 Regular Session Meeting (pgs 3-6)
- February 07 Special Session Meeting (pgs 7-9)

Required Approvals: Action Requested 2:55

- Resolution 2024-03 Surplus Equipment (pgs 10-17)
- Resolution 2024-04 Canceled Warrants (pgs 18-19)
- January Warrants and Adjustments (pgs 20-25)
- Medical Staff Credentials/ Appointments/ Reappointments (pgs 26-27)
- Medical Staff Bylaws (pgs 28-75)
- Delineation of Privileges (pgs 76-78)

Financial Report: Tyler Freeman, CFO	3:00
Quality Report: Brandie Manuel, CPSO	3:15
Break:	3:30
Construction Report: Jake Davidson, COO	3:45

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 these tribal governments' sovereignty across the region.

Due to the presence of multiple respiratory illness, Jefferson Healthcare is still highly encouraging practice of infection protocols. You may choose to attend this meeting virtually by accessing the below information or can attend in person in the Sheridan Conference Room at 915 Sheridan Street. Limited seating available.

Administrative Report: Mike Glenn, CEO 4:00

Executive Session:

Executive session to discuss Performance of a Public Employee as allowed by RCW 42.30.110 (g)

-Action may be taken following Executive Session 4:15

Board Business: 4:25

- Meeting Evaluation

Conclude: 4:40

This Regular Session will be officially recorded. The times shown on the agenda are estimates only.

Due to the presence of multiple respiratory illness, Jefferson Healthcare is still highly encouraging practice of infection protocols. You may choose to attend this meeting virtually by accessing the below information or can attend in person in the Sheridan Conference Room at 915 Sheridan Street. Limited seating available.

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Click here to join the meeting

Jefferson County Public Hospital District No. 2
Board of Commissioners, Regular Session Minutes
Wednesday, January 24, 2024

Call to Order:

The meeting was called to order at 2:01 pm by Board Chair Buhler Rienstra. Commissioners in attendance included Commissioners Dressler, McComas, Kolff and Ready. Also, in attendance were Mike Glenn, CEO, Tyler Freeman, Chief Financial Officer, Jake Davidson, Chief Operating Officer, Molly Propst, Chief Human Resources Officer, Brandie Manuel, Chief Patient Safety and Quality Officer, Tina Toner, Chief Nursing Officer, Dunia Faulx, Chief Planning and Advocacy Officer, and Christina Avila, Executive Assistant. This meeting was officially audio recorded by Jefferson Healthcare.

Approve Agenda:

Commissioner Dressler made a motion to approve the agenda. Commissioner McComas seconded.

Commissioner Kolff made a motion to amend the agenda to include a resolution of the Jefferson County Public Hospital District #2 Board Regarding the Fundamental Human Rights of all People in Conflict Zones. Commissioner Ready seconded. Commissioner Dressler declined the motion to amend the agenda. Discussion ensued. Commissioner Kolff stated that his request is not a friendly amendment. Discussion ensued.
Action: Motion passed with three ayes.

Election of Officers:

Commissioner Dressler motioned to nominate Jill Buhler-Rienstra for Board Chair. Commissioner McComas seconded. Discussion ensued.
Action: Motion passed unanimously.

Commissioner Kolff motioned to nominate Marie for Board Secretary. Commissioner McComas seconded. Discussion ensued.

Action: Motion passed unanimously.

Patient Story:
Tina Toner, CNO shared a patient letter which included compliments from a patient guardian of vulnerable adults in Jefferson County for the Watership team, Leslie Brooks for her work with special needs patients, staff accommodating schedules if transportation is an issue, and Stacey in the Watership Clinic for assisting with a safe transfer from wheelchair to vehicle. Discussion ensued.

Public Comment:
Member of the public Doug Milholland shared concerns about weapons being sold to Israel from our state. Board Chair Buhler-Rienstra thanked Mr. Milholland for sharing his concerns.

Member of the public Daniel shared a request for Jefferson Healthcare to partner with Palestinian relief funds or Red Cross, or to provide supplies, surgery, and medical treatment, and provide staff when allowed. Board Chair Buhler-Rienstra thanked Daniel for his comment.

Member of the public Lori Bernstein shared her wishes that people did not get upset over the language in the proposed resolution that was added to the meeting agenda. Ms. Bernstein shared that she lost family in the Holocaust and read an article and shared that all access to health facilities is Gaza has been lost. Board Chair Buhler-Rienstra thanked Ms. Bernstein for her comment.

Minutes:
- December 20, 2023 Special Session Minutes

Commissioner Dressler made a motion to approve the December 20, 2023 Special Session Minutes. Commissioner McComas seconded. Commissioner Kolff abstained.
Action: Motion passed unanimously

Required Approvals: Action Requested
- Resolution 2024-01 December Cancelled Warrants
- Resolution 2024-02 January Cancelled Warrants
- December and January Warrants and Adjustments
- Medical Staff Credentials/Appointments/Reappointments

Commissioner Kolff made a motion to approve the Required Approvals. Commissioner Dressler seconded.
Action: Motion passed unanimously.

Financial Report:
Tyler Freeman, Chief Financial Officer, presented the November and December Financial Report. Discussion ensued.

Quality Report:
Brandie Manuel, Chief Patient Safety and Quality Officer, presented the January Quality Report, Including investing in our leadership team, investing in our medical staff, investing in our front line, Emergency Management Committee drills, culture of safety survey, care delivery awards, accreditation for Pulmonary Rehabilitation program and advanced hip/knee replacement, and 2024 focus areas. Discussion ensued.

Project Update: Jake Davidson, Chief Operating Officer provided a project update. Discussion ensued.

Administrative Report
Mike Glenn, Chief Executive Officer, and Dunia Faulx, Chief Planning and Advocacy Officer, presented the January Administrative report. Discussion ensued. Dunia requested a motion to approve the WSHA agenda.

Commissioner Kolff made a motion to approve the WSHA agenda. Commissioner Dressler seconded. Discussion ensued.

Commissioner Kolff made a motion to approve the WSHA agenda with charity care program update. Commissioner Dressler seconded. Discussion ensued.
Action: Motion passed unanimously.

CMO Report
Dr. Mattern provided a CMO report including respiratory illness trends, inpatient and outpatient visits, bylaw changes for Medical Executive Committee, telehealth provider updates, Palliative Care staff updates, and Epic upgrades. Discussion ensued.

Break
Commissioners recessed for break at 4:16 pm.
Commissioners reconvened from break at 4:25 pm.

Executive Session
Board Chair Buhler Rienstra announced that they will go into Executive Session for forty-five (45) minutes to discuss the Performance of a Public Employee as allowed by RCW 42.30.110 (g). Action is expected to be taken following the Executive Session.

Commissioners went into Executive Session at 4:25 pm.

Board Chair Buhler-Rienstra returned to regular session and announced they will go back into Executive Session for fifteen (15) minutes, until 5:30 pm.

Board Chair Buhler-Rienstra returned to regular session and announced they will go back into Executive Session for fifteen (15) minutes, until 5:45 pm.

Commissioners returned to regular session at 5:45 pm.
No public was present on the line.
No action was taken.

Board Business:

- Board of Health Report

Commissioner Kolff stated that he would save time for this meeting and not share a Board of Health report this month, but he will provide a double report next month.

Commissioner Kolff made a motion to approve the resolution of the Jefferson County Public Hospital District #2 Board Regarding the Fundamental Human Rights of all People in Conflict Zones. Commissioner Ready seconded. Discussion ensued.
Action: Two ayes, two nays. Commissioner Dressler abstained. Resolution failed due to a lack of majority. Discussion ensued.

Commissioner Kolff made a motion for the Board to authorize two board members to create an adjusted resolution to present to the Board at a later time. Commissioner McComas seconded. Commissioner McComas offered to assist Commissioner Kolff with the adjusted resolution.
Action: Four ayes. Commissioner Dressler abstained. Motion passed.

Meeting Evaluation:
Commissioners evaluated the meeting.

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

Meeting concluded at 6:07 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 Meeting

Sheridan Conference Room
915 Sheridan St., Port Townsend, WA 98368

Wednesday, February 7, 2024

Call to Order:
The meeting was called to order at 9:01 am by Board Chair Buhler Rienstra. Present in person were Commissioners Dressler, Kolff, McComas and Ready. Also, in attendance was Mike Glenn, CEO, Karma Bass, Via Healthcare Consulting, Linda Summers, Via Healthcare Consulting, and Christina Avila, Executive Assistant. This meeting was audio recorded by Commissioner Matt Ready.

Public Comment:
No public comment.

Work Session
Karma reviewed the agenda and objectives for the meeting including Meeting Content, Group Process, and Group Guidelines. Discussion ensued.

Linda reviewed the results of the Board Self-Assessment and interviews, including highest rated statements across all sections, lowest rated statements across all sections, interview identified strengths, and interview identified opportunities. Discussion ensued.

Karma provided a presentation about Using Generative Governance to Define the Scope of the Board's Role, including questions for engaging in generative discussions, how to "move upstream" to define the Board's role, and Discussion Questions. Discussion ensued.

Break:
Commissioners recessed for break at 10:25 am.
Commissioners reconvened from break at 10:30 am.

Patient Experience and Community Advocacy Presentation
Brandie Manuel, Chief Patient Safety and Quality Officer, shared an update on Patient Experience and Community Advocacy, including Outpatient Ambulatory Survey (AOS CAHPS), Patient Experience, Inpatient Experience (HCAHPS), Ambulatory Patient Experience 2023, 2023 Patient Experience and Community Advocate Highlights, 2023 Team Updates, 2024 Patient Experience & Community Advocacy Goals, 2024 Strategic Goals: Quality and Service Pillars, and 2024 Strategic Goals: People and Finance Pillars. Discussion ensued.

Break:
Commissioners recessed for lunch at 11:24 am.

Commissioners reconvened from lunch at 12:16 pm.

Work Session
Karma invited the Board to continue discussion surrounding Generative Governance. Discussion ensued.

Karma invited the Board to discuss the Agenda Approval process. Discussion ensued.

Break:
Commissioners recessed for break at 1:32 pm.
Commissioners reconvened from break at 1:42 pm.

Karma reviewed Leadership Development and Transition Planning, including questions to consider, Commissioner succession planning and leading practices for Boards in CEO succession planning. Discussion ensued.

Karma invited the Board to discuss Advocacy. Discussion ensued.

Break:
Commissioners recessed for break at 2:58 pm.
Commissioners reconvened from break at 3:08 pm.

Executive Session
Board Chair Buhler-Rienstra announced that they will go into Executive Session for thirty (30) minutes to discuss the Performance of a Public Employee as allowed by RCW 42.30.110 (g). Action is expected to be taken following the Executive Session.

Commissioners went into Executive Session at 3:10 pm.

The Board returned to regular session at 3:40 pm, and Board Chair Buhler-Rienstra announced that the Board will return to Executive Session for twenty (20) minutes, until 4:00.

Commissioners returned to regular session at 4:00.

Commissioner Dressler made a motion to approve a compensation increase for CEO Mike Glenn. The motion included an increase to Median Market Value plus 3% for a total base pay compensation to Three Hundred and Ninety-Six Thousand, Three-Hundred and Sixty-Three dollars and Fifty-Seven cents. Commissioner McComas seconded.

Action: Motion passed with four ayes and one opposed.

Work Session
Karma and the Board reviewed internal and external committees to be assigned. Discussion ensued.

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

Meeting concluded at 5:11 pm.

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

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

RESOLUTION 2024-03

A RESOLUTION TO DECLARE CERTAIN EQUIPMENT SURPLUS TO THE NEEDS OF JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2 AND TO AUTHORIZE THE DISPOSAL OF SAID EQUIPMENT

WHEREAS the item(s) of equipment enumerated below are obsolete and otherwise surplus to the District, and;

WHEREAS said equipment now represents an unnecessary cost to the District to retain and store it,

NOW, THEREFORE, BE IT RESOLVED THAT:

1) The following equipment be declared surplus to the needs of Jefferson County Public Hospital District No. 2 and will be disposed of in compliance with state law:

Description	**Asset #**	**Serial #**	**Model #**
Stryker OR Towers	13-00116 10-00039 13-00113 12-00054 10-00044 10-00043		
Surgery Bladder Scanner		06314483	BVI3000

APPROVED this 28th day of February 2024.

APPROVED BY THE COMMISSION:

Commission Chair Jill Buhler Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Bruce McComas: _____

Commissioner Kees Kolff: _____

Commissioner Matt Ready: _____

Jefferson County Public Hospital District #2

Surplus Equipment Form

Department: Surgical Services Date: 2.14.2024

Equipment to be declared surplus: Stryker OR towers/complete

Asset Number: highlight on attach Serial Number: See attached list.

Model Number: per attached

Justification for declaring surplus: (check all that apply)

- ☐ No longer supports current software
- ☑ End of life, useful life exhausted
- ☑ Not supported by original manufacturer, parts not available
- ☑ Cost of parts to repair exceeds cost of new equipment
- ☑ Technology outdated
- ☐ Removed or altered during remodeling process
- ☐ Other _____

Depreciated value: _____

CFO _____ _____

Department Director Signature Materials Director Signature

Recommended Disposition:

- ☐ Send to surplus storage until _____ if not pulled for service dispose in appropriate manner.
- ☐ Use as trade-in and return to vendor _____
- ☐ Send to recycler* _____
- ☐ Placed with third party reseller _____
- ☑ Send to ~~landfill~~* 3rd party Children of the Nations medical mission.

*If another party wishes to take equipment from District at no cost the CEO shall have discretion to allow this.

- ☐ Sell to _____

Approved by Commission on _____ Resolution # _____

O'Connell, Kelly

From: Freeman, Tyler
Sent: Wednesday, February 14, 2024 8:23 AM
To: Lawrence, Jay
Cc: O'Connell, Kelly; Lapp, Sandra
Subject: RE: Used Equipment

Dr. Lawrence,

That seems like a much better approach than trashing. Looping in Kelly and Sandy to go through the proper steps to surplus the equipment.

Thanks!
Tyler

From: Lawrence, Jay <jlawrence@jeffersonhealthcare.org>
Sent: Wednesday, February 14, 2024 6:57 AM
To: Freeman, Tyler <tfreeman@jeffersonhealthcare.org>
Subject: Used Equipment

Hello Tyler,
As you know we recently replaced our Olympus OR equipment with Stryker. The old laparoscopes, cameras, and processors were likely going to be thrown away. I've asked Robyn Wenz in the OR and I have asked him to hold on to that equipment to hopefully work on a plan to donate it to Children of the Nations for use in the mission site we visit in the D.R. They can provide a donation receipt if it would be helpful. This equipment would be a huge upgrade to the setup we used during our last trip.
Please let me know your thoughts.
Thank you,
Jay

O'Connell, Kelly

From: Patterson, Corey
Sent: Thursday, February 15, 2024 8:21 AM
To: O'Connell, Kelly
Subject: RE: Endo towers from OR

BIOMED ID#	Class	Model #	Serial #	Jefferson ID #	Date Pur
OR0124	INSUFFLATOR	PNEUMOSURE	121CE067	13-00116	2013
OR0031	COUPLER, SCOPE, CAMERA	PRECISION AC	15K027904	10-00039	2015
OR0128	LIGHT SOURCE	L9000	13A0611304	13-00113	2023
OR0127	COUPLER, SCOPE, CAMERA	PRECISION AC	15K027974	N/A	2015
OR0123	CART	240-099-011	130117AM012	N/A	2010
OR0097	LIGHT SOURCE	L9000	12E028274	12-00054	2012
OR0034	CART	240-099-011	100205AM010	10-00044	2010
OR0028	PROCESSOR, ELECTRONIC IMAGE	SDC ULTRA	10B021344	10-00043	2010
OR0032	LIGHT SOURCE	L9000	10B042614	N/A	2012
OR0093	INSUFFLATOR	INSUFFLATOR	1509CE0270	N/A	2010
OR0101	CART	240-099-011	130117AM012	N/A	2013

Thank you,

Corey Patterson
Supervisor, Biomedical Services
Jefferson Healthcare
834 Sheridan St.
Port Townsend, WA 98368
Phone: 1-360-385-2200 Ex:1440
cpatterson@jeffersonhealthcare.org
biomedstaff@jeffersonhealthcare.org

Schedule a meeting with me

From: O'Connell, Kelly <koconnell@jeffersonhealthcare.org>
Sent: Thursday, February 15, 2024 8:04 AM
To: Patterson, Corey <cpatterson@jeffersonhealthcare.org>
Subject: RE: Endo towers from OR

One last question...do you know year we purchased?

Jefferson County Public Hospital District #2
Surplus Equipment Form

Department: Surgery Date: 2/7/24

Equipment to be declared surplus: Bladder scanner

Asset Number: _____ Serial Number: 06314463

Model Number: BVI 3000

Justification for declaring surplus: (check all that apply)

- ☐ No longer supports current software
- ☑ End of life, useful life exhausted
- ☐ Not supported by original manufacturer, parts not available
- ☐ Cost of parts to repair exceeds cost of new equipment
- ☐ Technology outdated
- ☐ Removed or altered during remodeling process
- ☑ Other Biomed unable to calibrate

Depreciated value: _____

Department Director Signature

Materials Director Signature

Recommended Disposition:

- ☐ Send to surplus storage until _____ if not pulled for service dispose in appropriate manner.
- ☐ Use as trade-in and return to vendor _____
- ☐ Send to recycler* _____
- ☐ Placed with third party reseller _____
- ☐ Send to landfill* _____

*If another party wishes to take equipment from District at no cost the CEO shall have discretion to allow this.

- ☐ Sell to _____

Approved by Commission on _____ Resolution # _____

Jefferson Healthcare

Work Order BIOMED-130279

BIOMED
Printed 1/24/2024 - 2:10 PM

Maintenance Details

Requested By: Patterson, Corey on 1/24/2024 2:09:00 PM
Taken By: Patterson, Corey
Procedure: REMOVED FROM SERVICE (REMOVED FROM SERVICE)
Last PM: 1/24/2024

Target: 1/29/2024 (1) hr
Priority/Type: (3) CRITICAL TO SERVICE / Bio-Med
Supervisor: Patterson, Corey
Shop: 8435

JHC Bio Medical Assets
SURGICAL SERVICES (BIOMED)
PROBE, BLADDER SCANNER (OR0237)

Contact: Patterson, Corey
Phone: 1442

Reason: PROBE, BLADDER SCANNER (OR0237)

☐ Warranty ☐ Shutdown ☐ Lockout ☐ Attach ☐ Charge

Tasks

#	Description	Rating	Meas.	Initials	Failed	N/A	Complete
					☐	☐	☐
					☐	☐	☐
					☐	☐	☐

Labor

Labor	Account	Assigned	Work Date	Start	End	Reg Hrs	OT Hrs	Other Hrs
Patterson, Corey		1/24/2024 / 1						

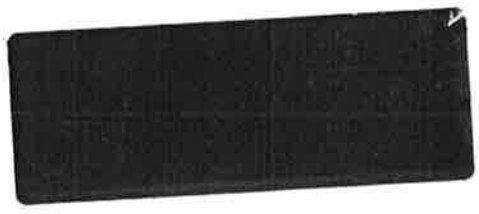
Parts/Tools

Barcode	Item	Location	Account	Est Qty	Actual Qty

Labor Report

Completed: _____ **Failure:** _____

Report:



VERATHON®

March 7, 2018

Re: BVI 3000 Updated Service and Support Dates

Dear valued Verathon customer,

Verathon introduced the BladderScan® BVI 3000 in 1998 and established itself as an integral part of patient care in healthcare facilities around the world. As Verathon continues to introduce new BladderScan products into the marketplace, we made the decision to implement a phased discontinuation of sales and support for the BladderScan BVI 3000 which was announced in August 2016.

Verathon is committed to providing the highest level of customer service and support while we help you determine the best plan for your BladderScan products. Please see below for updated end of service and support dates regarding your BladderScan BVI 3000.

Verathon will continue to honor any current warranty you have with your BVI 3000. Extended warranty sales will be offered with expiration dates not exceeding the end of service and support date.

Date	Program Activity
August 1, 2016	Discontinuation of BladderScan BVI 3000 announced
March 31, 2017	End new BladderScan BVI 3000 sales
December 31, 2019 Applies to units shipped before January 1, 2013 (serial numbers B3104335 and earlier, includes all numeric serial numbers)	End BladderScan BVI 3000 service and support End BladderScan BVI 3000 warranty repairs and replacements End BladderScan BVI 3000 non-warranty repairs and replacements
December 31, 2023 Applies to units shipped on or after January 1, 2013 (serial numbers B3104336 and later)	

For questions about this phased discontinuation communication, your specific comprehensive warranty plan, or for assistance in understanding available upgrade options, please contact your local Verathon representative or Customer Care at **1-800-331-2313** or email **Support@verathon.com**.

Once again, we appreciate your business and look forward to continuing to serve your needs in the future.

Sincerely,

Sven Powilleit
Director, Product Management & Strategic Marketing
Verathon Imaging and Scanning Solutions

BVI 3000
console and probe

Verathon Inc.
20001 North Creek Parkway
Bothell, WA 98011, USA

Toll-free: 800 331 2313
Main: 425 867 1348 Fax: 425 883 2896

verathon.com

0900-4737-01-86

Porter, Kristina

From: Patterson, Corey
Sent: Wednesday, February 7, 2024 10:46 AM
To: Porter, Kristina
Subject: Removed from service
Attachments: 1282_001.pdf

This has been removed from service. The MM ID Tag is blank.

Thank you,

Corey Patterson
Supervisor, Biomedical Services
Jefferson Healthcare
834 Sheridan St.
Port Townsend, WA 98368
Phone: 1-360-385-2200 Ex:1440
cpatterson@jeffersonhealthcare.org
biomedstaff@jeffersonhealthcare.org

Schedule a meeting with me

From: modularcopier@jeffersonhealthcare.org <modularcopier@jeffersonhealthcare.org>
Sent: Wednesday, February 7, 2024 10:39 AM
To: Patterson, Corey <cpatterson@jeffersonhealthcare.org>
Subject: 094676686

17

JEFFERSON COUNTY PUBLIC HOSPITAL DISTRICT NO. 2

RESOLUTION 2024-04

A RESOLUTION CANCELING CERTAIN WARRANTS IN
THE AMOUNT OF $19,425.31

WHEREAS warrants of any municipal corporation not presented within one year of their issue, or, that have been voided or replaced, shall be canceled by the passage of a resolution of the governing body;

NOW, THEREFORE BE IT RESOLVED THAT:

In order to comply with RCW 36.22.100, warrants indicated below in the total amount of $19,425.31 be canceled.

Date of Issue	Warrant #	Amount
01/31/2024	304616	2,475.71
01/31/2024	304485	1,594.20
01/31/2024	302725	464.77
01/31/2024	303756	119.85
01/31/2024	304571	13.36
01/31/2024	304774	354.00
01/31/2024	304787	535.74
01/31/2024	295931	99.32
01/31/2024	295936	1,319.53
01/31/2024	296129	776.57
01/31/2024	296130	229.27
01/31/2024	296270	345.04
01/31/2024	296271	1,200.38
01/31/2024	296407	0.01
01/31/2024	304922	2,474.39
01/31/2024	304921	2,474.39
01/31/2024	305039	2,474.39
01/31/2024	305040	2,474.39
Total		**$19,425.31**

APPROVED this 28th day of February 2024.

APPROVED BY THE COMMISSION:

Commission Chair Jill Buhler Rienstra: _____

Commission Secretary Marie Dressler: _____

Attest:

Commissioner Matt Ready: _____

Commissioner Kees Kolff: _____

Commissioner Bruce McComas: _____

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **January 2024 WARRANT SUMMARY**

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

General Fund Warrants & ACH Transfers	**$27,681,560.95**	(Provided under separate cover)
Allowance for Uncollectible Accounts / Charity	**$1,428,854.00**	(Attached)
Canceled Warrants	**19,425.31**	(Attached)

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **January 2024 GENERAL FUND WARRANTS & ACH FUND TRANSFERS**

Submitted for your approval are the following warrants:

GENERAL FUND:

303806 - 304491		**$6,259,240.21**
ACH TRANSFERS		**$21,422,320.74**
		$27,681,560.95
YEAR-TO-DATE:		**$27,681,560.95**

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: January 2024 ALLOWANCE FOR UNCOLLECTIBLE ACCOUNTS, ADMINISTRATIVE, AND CHARITY CARE WRITE OFFS

Submitted for your approval are the following:

	January	January YTD	January YTD BUDGET
Allowance for Uncollectible Accounts:	952,974.00	952,974.00	307,310.00
Charity Care:	322,636.00	322,636.00	290,602.00
Other Administrative Adjustments:	153,244.00	153,244.00	139,755.00
TOTAL FOR MONTH:	$1,428,854.00	1,428,854.00	$737,667.00

JEFFERSON HEALTHCARE
834 SHERIDAN AVENUE
PORT TOWNSEND, WA 98368

TO: **BOARD OF COMMISSIONERS**
FROM: **TYLER FREEMAN, CFO**
RE: **January 2024 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
1/31/2024	304616	FBO HOSPITAL DISTRICT #2	2475.71
1/31/2024	304485	FBO HOSPITAL DISTRICT #2	1594.2
1/31/2024	302725	FBO HOSPITAL DISTRICT #2	464.77
1/31/2024	303756	FBO HOSPITAL DISTRICT #2	119.85
1/31/2024	304571	FBO HOSPITAL DISTRICT #2	13.36
1/31/2024	304774	FBO HOSPITAL DISTRICT #2	354
1/31/2024	304787	FBO HOSPITAL DISTRICT #2	535.74
1/31/2024	295931	FBO HOSPITAL DISTRICT #2	99.32
1/31/2024	295936	FBO HOSPITAL DISTRICT #2	1319.53
1/31/2024	296129	FBO HOSPITAL DISTRICT #2	776.57
1/31/2024	296130	FBO HOSPITAL DISTRICT #2	229.27
1/31/2024	296270	FBO HOSPITAL DISTRICT #2	345.04
1/31/2024	296271	FBO HOSPITAL DISTRICT #2	1200.38

Jefferson Healthcare

	January 2024 Actual	January 2024 Budget	Variance Favorable/ (Unfavorable)	%	January 2024 YTD	January 2024 Budget YTD	Variance Favorable/ (Unfavorable)	%	January 2023 YTD
Gross Revenue									
Inpatient Revenue	3,981,621	3,721,745	259,876	7%	3,981,621	3,721,745	259,876	7%	43,914,759
Outpatient Revenue	29,329,282	29,253,285	75,997	0%	29,329,282	29,253,285	75,997	0%	320,074,623
Total Gross Revenue	33,310,903	32,975,030	335,873	1%	33,310,903	32,975,030	335,873	1%	363,989,382
Revenue Adjustments									
Cost Adjustment Medicaid	2,440,065	2,607,748	167,683	6%	2,440,065	2,607,748	167,683	6%	26,565,982
Cost Adjustment Medicare	11,934,584	11,836,686	(97,898)	-1%	11,934,584	11,836,686	(97,898)	-1%	138,824,816
Charity Care	332,636	290,602	(42,034)	-14%	332,636	290,602	(42,034)	-14%	3,495,078
Contractual Allowances Other	2,643,776	2,894,639	250,864	9%	2,643,776	2,894,639	250,864	9%	30,988,996
Administrative Adjustments	153,244	139,755	(13,489)	-10%	153,244	139,755	(13,489)	-10%	824,838
Allowance for Uncollectible Accounts	952,974	307,310	(645,664)	-210%	952,974	307,310	(645,664)	-210%	1,421,781
Total Revenue Adjustments	18,457,279	18,076,741	(380,538)	-2%	18,457,279	18,076,741	(380,538)	-2%	202,121,491
Net Patient Service Revenue	14,853,624	14,898,289	(44,665)	0%	14,853,624	14,898,289	(44,665)	0%	161,867,891
Other Revenue									
340B Revenue	262,759	505,503	(242,745)	-48%	262,759	505,503	(242,745)	-48%	3,533,416
Other Operating Revenue	258,665	428,596	(169,932)	-40%	258,665	428,596	(169,932)	-40%	3,203,921
Total Operating Revenues	15,375,047	15,832,389	(457,341)	-3%	15,375,047	15,832,389	(457,341)	-3%	168,605,228
Operating Expenses									
Salaries And Wages	7,733,771	7,585,544	(148,226)	-2%	7,733,771	7,585,544	(148,226)	-2%	78,776,532
Employee Benefits	1,778,594	1,747,688	(30,906)	-2%	1,778,594	1,747,688	(30,906)	-2%	17,721,497
Professional Fees	483,524	205,419	(278,104)	-135%	483,524	205,419	(278,104)	-135%	8,762,276
Purchased Services	1,051,237	1,302,296	251,059	19%	1,051,237	1,302,296	251,059	19%	11,908,554
Supplies	3,024,914	3,107,470	82,556	3%	3,024,914	3,107,470	82,556	3%	36,074,890
Insurance	145,698	152,618	6,920	5%	145,698	152,618	6,920	5%	1,631,953
Leases And Rentals	56,441	55,093	(1,348)	-2%	56,441	55,093	(1,348)	-2%	524,634
Depreciation And Amortization	424,053	437,672	13,619	3%	424,053	437,672	13,619	3%	5,166,355
Repairs And Maintenance	75,386	135,900	60,514	45%	75,386	135,900	60,514	45%	1,075,476
Utilities	142,716	136,899	(5,817)	-4%	142,716	136,899	(5,817)	-4%	1,396,638
Licenses And Taxes	99,589	88,315	(11,274)	-13%	99,589	88,315	(11,274)	-13%	1,099,550
Other	318,146	311,710	(6,437)	-2%	318,146	311,710	(6,437)	-2%	3,442,894
Total Operating Expenses	15,334,068	15,266,623	(67,444)	0%	15,334,068	15,266,623	(67,444)	0%	167,581,248
Operating Income (Loss)	40,980	565,765	(524,786)	-93%	40,980	565,765	(524,786)	-93%	1,023,980
Non Operating Revenues (Expenses)									
Taxation For Maint Operations	45,008	45,205	(197)	0%	45,008	45,205	(197)	0%	305,656
Taxation For Debt Service	-	-	-	0%	-	0	-	0%	225,948
Investment Income	458,027	207,344	250,683	121%	458,027	207,344	250,683	121%	1,879,475
Interest Expense	(582,297)	(417,744)	(164,553)	-39%	(582,297)	(417,744)	(164,553)	-39%	(1,083,620)
Bond Issuance Costs	-	(134,249)	134,249	100%	-	(134,249)	134,249	100%	1,574,900
Gain or (Loss) on Disposed Asset	-	-	-	0%	-	-	-	0%	162,317
Contributions	14,970	855,803	(840,833)	-98%	14,970	855,803	(840,833)	-98%	73,134
Total Non Operating Revenues (Expenses)	(64,291)	556,360	(620,651)	112%	(64,291)	556,360	(620,651)	112%	3,137,810
Change in Net Position (Loss)	(23,312)	1,122,125	(1,145,437)	-102%	(23,312)	1,122,125	(1,145,437)	-102%	4,161,790

Jefferson Healthcare

STATISTIC DESCRIPTION	JANUARY 2024 MO ACTUAL	MO BUDGET	% VARIANCE	YTD ACTUAL	YTD BUDGET	% VARIANCE	JANUARY 2023 MO ACTUAL	% VARIANCE	YTD ACTUAL	% VARIANCE
FTEs - TOTAL (AVG)	673	696	3%	673	696	3%	598	-13%	598	-13%
FTEs - PRODUCTIVE (AVG)	592	619	4%	592	619	4%	553	-7%	553	-7%
ADJUSTED PATIENT DAYS	3,517	3,041	16%	3,517	3,041	16%	3,583	-2%	3,583	-2%
ICU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	86	88	-2%	86	88	-2%	84	2%	84	2%
ACU PATIENT DAYS (IP + OBSERVATION, MIDNIGHT CENSUS)	385	296	30%	385	296	30%	320	20%	320	17%
SWING IP PATIENT DAYS (MIDNIGHT CENSUS)	14	25	-44%	14	25	-44%	-	100%	-	100%
PATIENT DAYS (ACU, ICU, SWING), INCLUDES OBSERVATION	485	409	19%	485	409	19%	404	20%	404	17%
BIRTHS	4	7	-43%	4	7	-43%	5	-20%	5	-25%
SURGERY CASES (IN OR)	134	134	0%	134	134	0%	137	-2%	137	-2%
SURGERY MINUTES (IN OR)	19,681	18,117	9%	19,681	18,117	9%	18,784	5%	18,784	5%
SPECIAL PROCEDURE CASES	101	88	15%	101	88	15%	73	38%	73	28%
LAB BILLABLE TESTS	23,604	21,933	8%	23,604	21,933	8%	22,099	7%	22,099	6%
BLOOD BANK UNITS MATCHED	44	45	-2%	44	45	-2%	39	13%	39	11%
MRIs COMPLETED	233	243	-4%	233	243	-4%	217	7%	217	7%
CT SCANS COMPLETED	679	651	4%	679	651	4%	617	10%	617	9%
RADIOLOGY-DEXA	96	129	-26%	96	129	-26%	160	-40%	160	-67%
X-RAYS COMPLETED	1,855	1,868	-1%	1,855	1,868	-1%	1,766	5%	1,766	5%
ECHOs COMPLETED	194	192	1%	194	192	1%	201	-3%	201	-4%
ULTRASOUNDS COMPLETED	372	370	1%	372	370	1%	335	11%	335	10%
MAMMOGRAPHYS COMPLETED	240	321	-25%	240	321	-25%	301	-20%	301	-25%
NUCLEAR MEDICINE TESTS	35	35	0%	35	35	0%	43	-19%	43	-23%
TOTAL DIAGNOSTIC IMAGING TESTS	3,704	3,809	-3%	3,704	3,809	-3%	3,640	2%	3,640	2%
PHARMACY MEDS DISPENSED	23,214	23,476	-1%	23,214	23,476	-1%	21,559	8%	21,559	7%
ANTI COAG VISITS	332	366	-9%	332	366	-9%	382	-13%	382	-15%
RESPIRATORY THERAPY PROCEDURES	3,709	2,934	26%	3,709	2,934	26%	2,732	36%	2,732	26%
PULMONARY REHAB	76	109	-30%	76	109	-30%	60	27%	60	21%
CARDIAC REHAB SESSIONS	133	203	-34%	133	203	-34%	186	-28%	186	-40%
PHYSICAL THERAPY	6,512	6,943	-6%	6,512	6,943	-6%	6,021	8%	6,021	8%
OCCUPATIONAL THERAPY	896	1,276	-30%	896	1,276	-30%	1,471	-39%	1,471	-64%
SPEECH THERAPY	216	289	-25%	216	289	-25%	205	5%	205	5%
REHAB/PT/OT/ST	7,833	8,820	-11%	7,833	8,820	-11%	7,943	-1%	7,943	-1%
ER CENSUS	1,134	1,244	-9%	1,134	1,244	-9%	1,066	6%	1,066	6%
EXPRESS CLINIC	1,077	1,163	-7%	1,077	1,163	-7%	1,046	3%	1,046	3%
SOCO PATIENT VISITS	182	228	-20%	182	228	-20%	77	136%	77	58%
PORT LUDLOW PATIENT VISITS	750	766	-2%	750	766	-2%	630	19%	630	16%
SHERIDAN PATIENT VISITS	3,149	2,829	11%	3,149	2,829	11%	2,864	10%	2,864	9%
DENTAL CLINIC	454	493	-8%	454	493	-8%	454	0%	454	0%
WATERSHIP CLINIC PATIENT VISITS	1,182	1,288	-8%	1,182	1,288	-8%	1,192	-1%	1,192	-1%
TOWNSEND PATIENT VISITS	565	537	5%	565	537	5%	536	5%	536	5%
TOTAL RURAL HEALTH CLINIC VISITS	7,359	7,304	1%	7,359	7,304	1%	6,799	8%	6,799	8%
CARDIOLOGY CLINIC VISITS	562	630	-11%	562	630	-11%	483	16%	483	14%
DERMATOLOGY CLINIC VISITS	717	759	-6%	717	759	-6%	692	4%	692	3%
GEN SURG PATIENT VISITS	373	343	9%	373	343	9%	303	23%	303	19%
ONCOLOGY VISITS	409	682	-40%	409	682	-40%	550	-26%	550	-34%
ORTHO PATIENT VISITS	676	633	7%	676	633	7%	583	16%	583	14%
SLEEP CLINIC VISITS	205	197	4%	205	197	4%	182	13%	182	11%
UROLOGY VISITS	259	212	22%	259	212	22%	253	2%	253	2%
OB/GYN CLINIC VISITS	345	332	4%	345	332	4%	349	-1%	349	-1%
WOUND CLINIC VISITS	112	187	-40%	112	187	-40%	131	-15%	131	-17%
HANDS/PLASTICS	214	212	1%	214	212	1%	262	-18%	262	-22%
TOTAL SPECIALTY CLINIC VISITS	3,872	4,187	-8%	3,872	4,187	-8%	3,788	2%	3,788	2%
SLEEP CENTER SLEEP STUDIES	48	58	-17%	48	58	-17%	53	-9%	53	-10%
INFUSION CENTER VISITS	767	908	-16%	767	908	-16%	937	-18%	937	-22%
SURGERY CENTER ENDOSCOPIES	75	76	-1%	75	76	-1%	63	19%	63	16%
HOME HEALTH EPISODES	94	77	22%	94	77	22%	70	34%	70	26%
HOSPICE CENSUS/DAYS	904	1,178	-23%	904	1,178	-23%	1,059	-15%	1,059	-17%
DIETARY MEALS SERVED	6,508	9,828	-34%	6,508	9,828	-34%	10,225	-36%	10,225	-57%
MAT MGMT TOTAL ORDERS PROCESSED	1,856	1,706	9%	1,856	1,706	9%	1,467	27%	1,467	21%

FROM: Medical Staff Services
RE: 02/20/2024 Medical Executive Committee appointments/reappointments for Board approval 02/28/2024

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. Wilford, Boone, ARNP - Oncology
2. McGruder, Jr., Robert, ARNP - Cardiology/Stress Tests
3. Kundra, Ajay, MD - Oncology –
4. Lee, Ashley, MD - Skagit Radiology

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

1. Mendez-Escobar, Ivan, MD - Hospitalist
2. Vasilyuk, Pavel, DDS - General Dentistry

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

1. Atwal, Sarabjit, MD - Teleneurology - Providence
2. Jordan, James, MD - Teleneurology - Providence
3. Evans, Jamie, MD - Psychiatry - Array
4. Koch, Lisa, MD - Clinical Pathology - NW Pathology
5. Lord, Teresa, MD - Medical Oncology -Eagle
6. Pabbathi, Haritha, MD - Medical Oncology -Eagle
7. Ahmed, Tarig, MD - Medical Oncology -Eagle

Recommended re-appointment to the allied health staff with privileges as requested:

1. N/A

Recommended Temporary Privileges:

1. N/A

Recommended POCUS Privileges:

1. N/A

Medical Student Rotation:

1. N/A

FROM: Medical Staff Services
RE: 02/20/2024 Medical Executive Committee appointments/reappointments for Board approval 02/28/2024

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Disaster Privileging

1. N/A

90-day provisional performance review completed successfully:

1. N/A

Resignations:

1. Schwartz, Chrystal, DO - Family Medicine - Termed 12/31/23
2. Walz, Elizabeth, MD -Teleneurology - Providence - 12/31/23
3. Calhoun, Shannon, DO - Teleradiology, RealRad - 12/31/23 - WA Med Lic not renewed
4. Sayles, Kathleen, FNP – Oncology - Termed 1/31/24
5. Moll, Steven, DO - Family Medicine - Effective 2/7/24
6. Roschmann, Alfred, MD - Telerad/Diagnostic Radiology - effective 1/15/24

Policy and Privilege Review
Policies

1. N/A

Privileges

1. Psychology Privileges PhD or PsyD (NEW)

Status Draft PolicyStat ID 14556656

Origination	N/A	Owner	Tesha Davidson: Manager, Medical Staff Programs
Last Approved	N/A	Policy Area	Medical Staff Policies
Last Revised	N/A		
Next Review	N/A		

REVISED Medical Staff Bylaws

PREAMBLE:

Whereas, Jefferson Healthcare is owned and operated by Jefferson County Public Hospital District No. 2, located in 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 Pubic Hospital District No. 2 (hereinafter the "Governing Board") has ultimate authority and responsibility for the quality of medical care in the hospital and provided only be 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 and advance practice providers (APPs) 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.

DEFINITIONS

Advance Practice Providers (APPs): Refers to members of the medical staff who are licensed in the state of Washington as an Advance Practice Registered Nurse, Physician Assistant, or Certified Registered Nurse Anesthetist (CRNA).

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 and responsibilities 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 consistent and high 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

NATURE OF MEDICAL STAFF MEMBERSHIP:

Membership on the Medical Staff of Jefferson Healthcare shall be extended only to physicians, dentists, and advanced practice providers who continuously meet the qualifications, standards and requirements set forth in Qualifications for Membership 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 at Jefferson Healthcare, 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.

QUALIFICATIONS OF MEMBERSHIP/ RESPONSIBILITIES:

1. Only physicians, podiatrists, dentists, and advanced practice providers 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 license 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.
2. 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.

3. 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.
4. 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.
5. 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.
6. 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.
7. Each member of the Medical Staff, or APP, agrees to provide or arrange for continuous care to his/her patients within standards appropriate to their specialty.
8. 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.
9. Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties.
    - Members of the medical staff appointed prior to 7/2/08 who do not meet this requirement shall have the requirement waived
    - Certification must occur within limits defined by specialty board.
    - Practitioner must maintain board certification.
10. Must have actively practiced in field for the previous 24 months (or have completed a 12-month residency within the previous 18 months).
    a. Exceptions may be considered by MEC, based on the circumstances, according to the re-entry to practice policy.
11. Applicant must submit evidence of CME related to privileges requested, excluding recent (within 3 years) residency graduates.
12. Applicant must have proof of ability to work in the United States, if not a citizen.
13. Applicant must not be excluded from Federal or State Programs including Medicare, Medicaid, etc.

ADVANCED PRACTICE PROVIDERS:

The Governing Board shall determine the categories of eligible advanced practice providers.

Only advanced practice providers 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 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.

1. Members of the Advanced Practice Providers Staff must have a current state license, registration or certification and be in good standing with their registration/licensing/certifying bodies.
2. They may serve on committees and vote for/nomiate Medical Staff Officers.
3. 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.
4. 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 Advance Practice Providers 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 professionals privileges.
5. All Advance Practice Providers shall be subject to the current hospital policies and procedures specific to Advanced Practice Providers.
    a. Physician Assistants function under the direction of the supervising physician.
6. 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.
7. 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 Advance Practice Providers' appointment or privileges, scope of service or position description at this or any other hospital.
8. Anesthesia Services (provided by CRNAs) shall function under the direction of the board-certified Chief of Surgical Services.

CONDITIONS AND DURATION OF APPOINTMENT:

1. 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 the Credentials Committee.
2. 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.
3. 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.

GOVERNING BOARD AUTHORITY TO LIMIT SERVICE:

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.

1. 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.
2. 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.

STAFF DUES AND ASSESSMENTS:

1. 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.
2. 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.
3. Dues, if any, shall be payable annually. Special assessments shall be due and payable at of notification.
4. 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.

RELEASE OF INFORMATION AND LIABILITY:

1. 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.
2. All applicants, as well as members of the Medical Staff, 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.

3. Members of the Medical Staff and any hospital representatives who are involved in credentialing or peer review activities are immune from liability.
4. 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

CATEGORIES:

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

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other provision in these Bylaws and the Policies & Procedures and Rules & Regulations of the Hospital.

Active Medical Staff

The Active Medical Staff shall consist of physicians and advanced practice providers who meet the basic qualifications set forth in these bylaws and regularly have patient contacts at Jefferson Healthcare (including Jefferson Healthcare Clinics). Part time medical staff will generally be appointed to the active medical staff.

Prerogatives and Responsibilities of Active Staff:

A. Unless otherwise provided in these Bylaws, Policies and Procedures, or Rules and Regulations, the prerogatives of the active staff shall be to:
    1. Provide healthcare services to patients at Jefferson Healthcare, consistent with his/her privileges.
    2. Hold office in the Medical Staff and in his or her assigned Department(s), Section(s), and Committee(s).
    3. Vote on all matters presented at regular and special meetings of the Medical Staff and of the Department, Section, and Committees of which he or she is a member;
    4. Serve on committees of the medical staff and vote in committee deliberations;
    5. Exercise such privileges as have been granted to him/her by the Governing Board.

B. Responsibilities of the Active Staff include the following:
    1. Satisfy the requirements set forth for committees of which he/she is a member;
    2. Actively participate in the patient care assessment and other quality assessment activities required of the staff;
    3. Retain responsibility within his/her area of professional competence for the daily

care and supervision of each patient in the organization for whom he/she is providing services or arrange a suitable alternative for such care and supervision;

4. Participate in call coverage specific to your specialty, as specified by the Chief of Service.
5. Participate in emergency deployment in the event of a declaration of a state of emergency, at the request of Incident Command.
6. Continuously comply with the bylaws and rules and regulations of the medical staff.
7. Practitioner shall reply promptly and completely to information requests made by medical staff committees.
    a. Failure to comply may result in initiation of disciplinary action.
    b. 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.

Courtesy Medical Staff

Are members of good standing of the Active Medical Staff of another hospital which is accredited by the Joint Commission ("TJC") or Det Norske Veritas ("DNV"), Washington State Department of Heath or other acceptable and nationally recognized credentialing organization; actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital in fulfilling its obligations related to patient care, including, but not limited to, emergency care and back-up coverage, peer review, quality evaluation and related monitoring activities required of and by the Medical Staff, actively participate and regularly cooperate with the Medical Staff in supervising APPs and proctoring other Members and APPs; and discharging such other functions as may be required from time to time.

The Courtesy Medical Staff shall consist of practitioners who meet the basic qualifications set forth in these bylaws; provide direct medical care for a limited number of patients or shifts per year or to those who provide care via telemedicine at Jefferson Healthcare. Courtesy staff may provide direct patient care.

Per diem medical staff will be considered Courtesy Medical Staff unless otherwise specified.

A. Courtesy medical staff members who work per diem may be asked to provide a credentialing attestation every six months.

Prerogatives and Responsibilities of the Courtesy Staff

A. Prerogatives shall be to:
    1. Admit patients to or provide professional services for the hospital within the limitations and under the same conditions as specified for active staff members;
    2. Exercise such clinical privileges as have been granted to him/her by the Governing Board;
    3. ***Courtesy staff members shall not be eligible to vote or to hold office in this medical staff organization.***

B. Responsibilities of Courtesy Staff Members:

1. 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;
2. Continuously comply with the bylaws and rules and regulations of the medical staff;
3. Practitioner shall be required to attend any meeting for discussion of cases where he/she served as attending, if so requested.
    a. Failure to comply may result in initiation of disciplinary action.
    b. 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.

Honorary Medical Staff

Honorary status shall be conferred upon Physicians who do not actively practice at the Hospital but who are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health or medical sciences, or their previous long.-standing service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct.

Honorary Medical Staff members shall not be eligible to admit patients to the Hospital, provide clinical care to patients in the hospital, exercise clinical care to patients in the hospital, or to vote or hold office in the Medical Staff, but serve and vote on committees at the discretion of the MEC.

A. The Honorary Medical Staff shall consist of practitioners who are honored by emeritus positions.
B. The Honorary Medical Staff shall be appointed by the Governing Board upon recommendation of the Executive Committee.
C. These may be practitioners who have retired from active hospital practice or who are of outstanding reputation.
D. 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.
E. They shall be eligible for appointment by the Chief of Staff to Medical Staff to committees with voting privileges.

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.

Locum Tenens Staff members shall not be eligible to admit patients to the Hospital, provide clinical care to patients in the hospital, exercise clinical care to patients in the hospital, or to vote or hold office in the Medical Staff.

A. 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.

B. An appropriately licensed practitioner of documented competency may be granted privileges for no more than **6 months**.

C. Locum Tenens shall have no voting privileges.

D. 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.

Affiliate Medical Staff Members

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.

A. **Prerogative of Affiliate Staff:**

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

B. **Affiliate Staff shall not:**

1. Write orders
2. Do evaluations on any patient at the Hospital
3. Vote on matters presented at meetings
4. Hold office at any level in the staff organization or Chair any committee or serve on MEC
5. Provide emergency room coverage
6. Serve on committees of the hospital

Temporary Privileges, Consultants, and Visiting Practitioners

A. Temporary privileges may be granted in the following circumstances:

1. **New Applicants:** To new applicants with a complete application as outlined in Article 4 that raises no concerns, after a favorable recommendation by the Credentials Committee, while awaiting review and approval of the Medical Executive Committee and Governing Board. The Applicant is appropriately licensed.

    a. **Additional requirements:** applicant may not have 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.

2. **Important Patient Care Need:**
    a. 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.
    b. To a person serving as a locum tenens for a current member of the medical staff.
3. **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.

B. Temporary Privileges Application and Review:
The chief executive officer, or authorized designee and the chief governing officer on the recommendation of the Credentials Committee or Chief of Staff, may grant temporary privileges in accordance with the above provisions.

C. General Conditions:
1. 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 organization.
2. Requirements of consultation and reporting may be imposed by the Chief of Staff or designee.
3. Temporary privileges shall not exceed 120 days.

D. 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.
1. 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.
    a. 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.

E. 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.

F. Information Required to Grant Temporary Privileges for important patient care needs as defined above:
1. Verification of current license in Washington State.
2. Verification of liability insurance coverage which must meet minimum requirements established by the Governing Board, Executive Committee and Medical Staff.
3. Evidence of current DEA registration, if applicable.

4. If applicable, evidence of Board Certification or eligibility.
5. Verification of education and training shall be confirmed by AMA/AOA profile. When applicable, the ECFMG will be queried.
6. Requesting criminal history information in accordance with the Child/Adult Abuse Information Act (WSP).
7. The National Practitioner Data Bank shall be queried.
8. The OIG/SAM shall be queried for sanctions/exclusions.
9. The Fiscal Intermediary/Noridian (Medicare Part B carrier) shall be queried for providers opting out (also at reappointment time and on an ongoing basis inbetween)
10. 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:
    a. Any pending professional misconduct proceeding or any pending medical malpractice actions in this state or another state
    b. 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
    c. Any information required to be reported by hospitals to the medical disciplinary board
11. Information regarding current clinical competence and ability to perform privileges requested, with or without accommodation, ethical character, ability to work cooperatively with others
12. 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.
13. List of privileges requested (may be a copy of privileges granted at another hospital).
14. Curriculum vitae.
15. Agreement to abide by the Medical Staff Bylaws and Rules and Regulations, Policies and Procedures and Jefferson Healthcare Bylaws and Policies and Procedures.

DISASTER PRIVILEGES

For the purposes of this section, an emergency is defined as a state or nationally declared state of emergency.

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.

Temporary Privileges During a Disaster

A. The CEO, upon recommendation of the Chief of staff or authorized designee(s) may grant emergency privileges in a state or national declaration of emergency, for which the Emergency Management Plan has been activated, and the hospital is unable to handle the immediate needs of patients.

B. Privileges will be granted in accordance with the medical staff Disaster Credentialing: Medical Staff and Allied Health Professionals policy.

C. The medical staff and governing board shall make a decision within 72 hours related to the continuation of the disaster privileges initially granted.

1. 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).
2. Termination of these privileges will not give rise to a fair hearing or review.

RESIDENTS

A. Residents may participate in patient care activities at Jefferson Healthcare in accordance with Medical Staff Policy, *Residents and Medical Student Agreement and Scope of Practice*, providing that:

1. Jefferson Healthcare has an affiliation agreement with the residency program.
2. Resident is enrolled in an accredited residency program.
3. All residency program requirements are met.

B. Residents and students are not members of the medical staff.

CHANGE OF STATUS

Any member desiring to change his/her status may apply to the Medical Executive Committee (MEC), who shall make recommendations to the Governing Board for their action.

A. **LEAVE OF ABSENCE:** Leave of absence shall be defined as a leave of absence lasting thirty days, and may not exceed two years from the time of last credentialing.

1. A practitioner may obtain a leave of absence from the medical staff by submitting written notice to the Chief of Staff and the CEO.
2. Such notice must state the commencement date and estimated termination date for the leave.
3. Practitioners returning from leave of absence will be subject to the normal reappointment process unless exempted by the Executive Committee.
4. At least fifteen (15) 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.
    a. This notice must be accompanied by a written statement of relevant activities during the leave.

b. The Credentials Committee will evaluate the request for reinstatement and the Attestation Questionnaire at its next scheduled meeting and forward its recommendation to the MEC for review.

    i. The Credentials Committee may recommend and the Board may impose requirements of further education, i.e., a refresher course, or reinstatement of specific clinical privileges on a provisional basis, as appropriate to the circumstances.

    ii. The MEC will evaluate the request at its next scheduled meeting, and forward its recommendation to the Board for the final decision.

c. Final determination regarding reinstatement of privileges shall rest with the Governing Board.

    i. 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.

d. The requester will be notified within five (5) business days of the Board's decision.

5. 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.
6. 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. 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).

    b. 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 professional competence or professional conduct.

    c. 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:
    a. 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.
    b. Denial of clinical privileges or medical staff membership because of the lack of need for the practitioner's services.
    c. 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.
    d. Denial of clinical membership or staff membership due to a failure to comply with threshold eligibility requirements, such as board certification, geographic requirements.
    e. 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).
    f. 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.
    g. Voluntary admission to an impairment program.
3. QUERY RESPONSIBILITY: Jefferson Healthcare must query the National Practitioner Data Bank in the following situations:
    a. When clinical privileges are initially granted.
    b. At the time of renewal of privileges (no longer than two years).
    c. 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

REQUEST FOR APPLICATION

A. 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.
B. Any applicable fees shall accompany the application as determined by the Medical Executive Committee.
C. The application will be processed according to the Medical Staff Initial Appointment policy.

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:

1. Staff category and specific clinical privileges requested
    a. The applicant must submit any reasonable evidence of current ability to perform privileges requested safely and competently.
2. 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.
3. All past and currently valid medical and other professional licenses or certifications, Drug Enforcement Administration (DEA) Controlled Substances Registration, if applicable.
4. Specialty or subspecialty board certification, recertification or current qualification status to sit for the examination.
5. 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.
6. 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.
7. Any proceedings initiated, pending or completed involving allegations or findings of professional medical misconduct in this state or another state.
8. 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:
    a. 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;
    b. 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.
9. 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 6.2.8 above in order to foreclose or terminate actual or possible investigation or disciplinary or adverse action.
10. 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.
11. Any current felony criminal charges pending against the applicant and any past charges including their resolution.

12. 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.
    a. 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.
    b. 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 should have had organizational responsibility for the applicant's performance.
13. Data from professional practice review by an organization(s) that currently privileges the applicant (when available).
14. Statements summarizing the scope and extent of the authorization, confidentiality, immunity and release provisions of the medical staff bylaws.

EFFECT OF APPLICATION:

The applicant must sign the application and in so doing:

1. 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.
    a. 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.
    b. 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.
2. Signifies a willingness to appear for interview in connection with the application.
3. Agrees to abide by the terms of the Medical Staff Bylaws, Medical Staff policies or procedures, 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;
4. Agrees to maintain an ethical practice and to provide for continuity of care to patients;
5. 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;

6. 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
7. 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.

PROCESSING THE APPLICATION:

A separate credentials and quality 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 reappointment information, CME documentation and release of information.

1. 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.
2. 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:
    a. An American Medical Association Physician Master file 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.
    b. Board Certification:
        i. The American Board of Medical Specialties shall be verification of Board Certification.
        ii. The American Osteopathic Association of Physician Database shall be verification of osteopathic education.
        iii. The American Osteopathic Association Council on Postdoctoral Training and Osteopathic Specialty Board Certification shall be verification of Osteopathic Board Certification
        iv. The American Academy of Physician Assistants profile shall be verification of Physician Assistant Education.

v. The National Commission of Certification of Physician Assistants shall be verification of Physician Assistant Certification.

c. 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.

d. Affiliation information, at any organization where the practitioner has or had privileges, was associated, or was employed, that includes the following information:

i. any pending professional medical misconduct proceedings or any pending medical malpractice actions in this state or another state

ii. 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

iii. any information required to be reported by hospitals to the medical disciplinary board

e. The National Practitioner Data Bank will be queried.

f. Complete Licensure History: Requesting from all present and past licensing authorities all information maintained regarding the practitioner.

g. 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.

h. Requesting criminal history information in accordance with the Child/Adult Abuse Information Act (WSP).

i. The Office of the Inspector General's list of excluded individuals from government sponsored programs shall be queried.

j. The General Services Administration (GSA) Excluded Participants List System shall be queried (EPLS).

k. Present and past liability insurance carriers will be queried (at least 5 years)

l. 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).

3. Medical Staff Input: The name of each applicant and a brief summary of the applicant's credentials shall be communicated to the Credentials Committee.

a. Any staff member may submit in writing to the Chief of Staff or to the Credentials Committee, a written statement or relevant information regarding an applicant's qualifications for membership or the privileges requested.

4. Clinical Evaluation: The applicable Section Chair or designee shall review the initial application and supporting documents and make a recommendation to the Medical Executive Committee.

a. The Chief of Staff or 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.

b. 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.

c. 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.

d. 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.

5. The Section Chair and Medical Staff Services personnel shall review the application, including the results of verifications and interviews and any other relevant information made available to or requested by it.

    a. Decisions on membership and granting of privileges include criteria that are directly related to the quality of patient care, treatment and services.

    b. The Chair or his/her representative shall promptly notify the applicant of any gaps in or any other problems in obtaining the information required.

        i. 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.

    c. Failure, without good cause, to respond in a satisfactory manner by that date shall be deemed a voluntary withdrawal of the application.

    d. Recommendations shall be submitted to the Executive Committee.

6. Action by the Medical Executive Committee: The Executive Committee shall review the recommendation of the Section Chair, Credentials Committee, and the supporting documentation and either endorse or reject that recommendation.

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

8. Unfavorable Recommendations: Unfavorable recommendations of the Medical Executive Committee are forwarded to the CEO who will notify the applicant of his or her rights regarding a Fair Hearing.

    a. 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 9.

9. 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.

    a. The Governing Board shall notify the applicant and the Chief of Staff in writing of the

deferral and of the grounds.

b. 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.

    i. This notice must be sent by registered mail, return receipt requested.

c. Failure to respond in a satisfactory manner within the time frames specified shall be deemed a voluntary withdrawal of the application.

10. 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.
11. Definition of Unfavorable Governing Board Action: "Unfavorable action" by the Governing Board is as defined in 9.4.3 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.
12. On Unfavorable Medical Staff Recommendation: In case of an unfavorable Medical Staff recommendation, the Governing Board takes final action in the matter.

Initial Appointment Evaluation - Focused Professional Practice Evaluation (FPPE):

1. 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.
2. Review may consist of concurrent or retrospective reviews and or/proctoring. ***See policy: Provisional Evaluation Process.***

ARTICLE 7: CLINICAL PRIVILEGES

Exercise of Privileges

All individuals who are permitted by these Bylaws to provide patient care services independently shall have delineated clinical privileges. Special requirements for consultation may be required.

1. Practitioners must provide care (consistent with their delineated privileges) or arrange for continuous medical care for their patients.
    a. Practitioners shall obtain appropriate consultation or refer the cases to another qualified practitioner when appropriate or when required by the rules or other policies.

Basis for Privileges Determinations

1. Criteria for clinical privileges shall be developed by the medical staff and approved by the Governing Board.

a. This criteria will be considered in the decision to grant, limit or deny a requested privilege.

2. 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.
3. Jefferson Healthcare, through the Executive Committee and Governing Board, shall consistently determine the resources necessary for each requested privilege.
    a. 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*
4. 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.
5. Where appropriate, a review of the records of patients treated in other hospitals may also serve as the basis for privilege determinations.
6. 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.
7. 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.

Definition of Privileges

1. 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.
2. 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.
3. The definitions and delineating documents must be periodically reviewed and revised as necessary to reflect new procedures, instrumentation, treatment modalities and like advances or changes.
    a. 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.

Procedure for Delineating Privileges Requests

1. 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.
2. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments.
3. The privilege granting or denial criteria are consistently applied for each requesting practitioner.

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.

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.

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, when available, as defined by the MEC and Jefferson Healthcare Administration.

1. 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.
    a. 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.

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.

1. 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.

Communication of approved privileges

Approved privileges are kept in the individual practitioner's file in Medical Staff Services, 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

Criteria for Initiation

The Medical Staff will monitor and investigate any allegation of:

- Deviations from the standard of care, failure to provide quality medical care, or significant medical error
- Professional conduct that is or may be detrimental to safe, high quality care
- Violations of these Bylaws, Rules and Regulations, or other hospital policies
- Failure to meet the qualifications and requirements for appointment to the Medical Staff for the specific privileges granted

The medical staff does not investigate complaints directly from patients of the general public unless supported by any of the persons identified under 'Requests and Notices' below.

Allegations involving employed Medical Staff that involve disruptive behavior, harassment, work attendance, productivity, or violation of non-clinical policy will be referred to administration. The Medical Staff will work in collaboration with administration to investigate and address behavior issues.

Requests and Notices:

Requests for investigation may be made by any member of the Medical Staff, Administrator, or Clinical Supervisor by written notification to the Chief of Staff, the chair of the PPEC, or through other hospital quality reporting mechanisms.

Safety and provider care or conduct concerns that may warrant summary suspension in accordance with Article 10 will be brought immediately to the Chief of Staff (or if unavailable, the next MEC officer in the line of succession as described in Article 16).

After the Executive Committee action initiating the investion, 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.

Investigation:

1. The Chief of Staff shall evaluate the request, in accordance with Article 10 (Summary Suspension), and either determine that the request has no basis, or direct that investigation concerning the grounds for the request be undertaken.
    a. Initial investigation by the Chief of Staff, or other MEC members is not a “hearing”, as that term is used in the Fair Hearing Plan.
    b. If the Chief of Staff or designee determines that summary suspension is not required, the matter will be referred to PPEC or appropriate medical staff committee for further investigation and deliberation.
        i. 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.
        ii. 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.
2. A written report of the investigation must be made.
3. 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.
    a. 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.
    b. 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.
    c. All reports shall be forwarded to the chief of staff.
4. The PPEC or other investigative committee shall forward the results of the investigation and any recommendation for corrective action to MEC. This evaluation shall not exceed three months from the date that corrective action was requested.

Committee Recommendation:

1. Upon completion of the investigation, the MEC, or the Chief of Staff and at least two other medical staff officers shall review the investigation findings and recommend appropriate action.
    a. In the event that the investigation is ongoing, this will be reported to the MEC who may extend the due date, not to exceed thirty (30) days.
    b. The Chief of Staff is required to send a written update to the physician or advance

practice provider with an explanation and outline of the expected completion date.

2. Their action may include without limitation any one, *or combination*, of the following:
    a. Recommending rejection of the request for corrective action.
    b. Recommending a verbal warning or formal letter of reprimand.
    c. Recommending individual medical/psychiatric treatment.
    d. 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.
    e. Recommending suspension of appointment prerogatives that do not affect clinical privileges.
    f. Recommending an individually imposed requirement of prior or concurrent consultation or direct supervision.
    g. Recommending a limitation on the practitioner's right to admit patients.
    h. Recommending reduction, suspension or revocation of all or any part of the clinical privileges granted.
    i. Recommending suspension or revocation of staff appointment.
3. 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.
4. MEC may accept, modify, or reject the recommendations made by those conducting the investigation, and is empowered to require corrective action of any member of the medical staff.
    a. An unfavorable recommendation (as defined in Article 9), when approved by MEC, entitles the affected provider to the Fair Hearing Plan process described in Article 14

ARTICLE 10: SUMMARY SUSPENSION

Criteria for Initiation

1. Either the Chief of Staff, the Chief Executive Officer, or the Board of Directors has the authority to summarily suspend Medical Staff membership status, or all or any portion of clinical privileges when failure to do so may result in an imminent danger to the health or safety of any individual.
    a. If the Chief of Staff is not immediately available, this authority may pass to the next MEC officer in succession as outlined in Article 16.
    b. If the Chief Executive Officer is not immediately available, this authority may pass to the Administrator On Call.
    c. 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.

d. 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 shall convene to review and consider the action taken. It may recommend modification, continuation, or termination of the terms of the suspension.
    a. A recommendation to continue the suspension or to take any other unfavorable action as defined in Article 9 entitles the practitioner, upon timely and proper request, to the procedural rights contained in the Fair Hearing Plan.
    b. 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 Article 9.
3. The terms of the summary suspension as originally imposed remain in effect pending final decision by the Board.

ARTICLE 11: AUTOMATIC SUSPENSION

Criteria and Initiation

1. A practitioner must immediately report any of the following actions to the Chief of Staff and the CEO. Failure to do so shall be considered an immediate resignation of medical staff appointment and clinical privileges:
    a. Whenever a practitioner's license to practice is restricted or suspended
    b. When controlled substances certificate/registration is restricted or suspended
    c. When sanctions are imposed
    d. When official disciplinary action is taken by the Board of Medical Examiners, or by another hospital
    e. When put on probation
2. 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.
    a. 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.
        i. The Executive Committee may then take such further corrective action as is appropriate based upon the facts disclosed in its investigation.
3. 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, in accordance with the Delinquent Medical Records Policy.
    a. 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.

4. 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.
    a. 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.
5. Licensure: revocation of license in the State of Washington
6. Medicare/Medicaid participations: Exclusion from participation in Medicare or Medicaid.

Committee Deliberation

1. Pursuant to *Article 11: Criteria and Initiation*, as soon as practicable after any of the following:
    a. notification by the practitioner of sanction;
    b. after a practitioner's license is suspended, restricted or placed on probation;
    c. after the practitioner's DEA number is revoked, restricted, suspended or made probationary, or
    d. notification of disciplinary action taken by the Board of Medical Examiners or another hospital,
2. The Chief of Staff shall convene a committee to review and consider the facts under which such action was taken.
3. The committee may then recommend such further corrective action as is appropriate to the facts disclosed in the investigation.
    a. Thereafter, the procedure in Article 9 is followed but only with respect to any additional corrective action recommended by the committee or taken by the Governing Board.

Automatic Termination of Privileges and Membership

The following terminations are automatic and do not afford the practitioner any hearing rights:

1. 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.
    a. These privileges shall be reactivated upon receipt of such documentation.

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

1. Recommendations/Action Giving Rise to Hearing Rights: Subject to the exceptions set forth below, the following actions or recommended actions, if deemed unfavorable, entitle the practitioner to a hearing upon timely and proper request:
    a. Denial of initial staff appointment.
    b. Denial of reappointment; suspension of appointment provided that summary suspension entitles the practitioner to request a hearing.
    c. Revocation of appointment.
    d. Denial of requested appointment to or advancement in staff category.
    e. Special limitation of the right to admit patients.
    f. Denial or restriction of requested clinical privileges.
    g. Reduction in clinical privileges.
    h. Suspension of clinical privileges, provided that summary suspension entitles the practitioner to request a hearing only as specified below.
    i. Revocation of clinical privileges. Individual application of or individual changes in mandatory consultation or supervision requirement.
    j. Summary suspension of appointment or clinical privileges provided that the recommendation of the committee or action by the Governing Board under Article 10 is to continue the suspension or to take other action which would entitle the practitioner to request a hearing under this part.
2. Adverse Action: Except as provided below, any action or recommended action listed in Section 1 (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.
3. 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:
    a. The issuance of a verbal warning or formal letter or reprimand.
    b. The imposition of a monitoring or consultation requirement as a condition attached to the exercise of clinical privileges during a provisional period.
    c. The imposition of a probationary period involving review of cases but with no requirement either for direct, concurrent supervision or for mandatory consultation.
    d. The removal of a practitioner from a medico-administrative office within the hospital unless a contract or employment arrangement provides otherwise.
    e. Any other action or recommended action not listed in Article 12 above.

f. Other Situations: An action or recommended action listed above does not entitle the practitioner to request a hearing when it is voluntarily accepted by the practitioner; automatic pursuant to Article 11 or taken or recommended with respect to temporary privileges.

4. 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 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.
5. Reapplication After Adverse Action/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 adverse action/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.
    a. 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.
        i. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be further processed.
    b. Any such reapplication is processed in accordance with procedures set forth in the section regarding processing the application in these bylaws.

ARTICLE 13: CONFIDENTIALITY, IMMUNITY AND RELEASE

DEFINITIONS:

For the purposes of this part only, the following definitions shall apply:

- Good Faith shall mean having an honest purpose or intent and being free from intention to defraud.
- 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.
- Practitioner shall mean a medical staff member or applicant.
- 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.
- Third parties shall mean both individuals and organizations providing information to any representative.

Authorizations and Conditions:

By submitting an application for staff appointment or reappointment or by applying for or exercising clinical privileges, a practitioner:

1. Authorizes representatives of the hospital to solicit, provide and act upon information bearing on his/her professional ability, utilization practices and other qualifications.
2. 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.
3. 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.
4. 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.

Immunity from Liability

1. 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.
2. 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.

Activities and Information Covered

1. 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.

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.

Releases:

1. 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.
    a. Execution of such releases is not a prerequisite to the effectiveness of this part.
    b. 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.
    c. 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.
    d. 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.
    e. This presumption will stand unless the practitioner presents verifiable facts to the contrary.
2. 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.
        i. 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

DEFINITIONS

The following definitions apply to the provisions of this Fair Hearing Plan:

- Days: Any calendar day, including Saturday, Sunday and official Hospital holidays.
- Deadline: If the deadline falls on a Saturday, Sunday or official Hospital holiday, then the deadline is for the next regular day.
- Executive Committee: Known as the "Committee" throughout, it is the controlling body that shall appoint and oversee the hearing panel.
- 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.
- Hearing Panel: Committee of practitioners appointed under this plan to hear a request for an evidentiary hearing properly filed and pursued by a practitioner.
- 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.
- Adverse Action: 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,
- 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).

INITIATION OF HEARING, NOTICE, AND WAIVER

1. Qualifying Event: Any event that qualifies as an unfavorable action as defined in Article 9 that is properly and timely pursued.
2. Notice of Adverse Action: The Chief Executive Officer shall, within fifteen (15) days of receiving written notice of an unfavorable action, shall give the practitioner special notice thereof. The notice shall include:
    1. Statement that a Professional review action has been proposed to be taken against the physician.
    2. 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.
    3. A summary of the rights in the hearing plan along with a copy of the Fair Hearing Plan.
    4. The right to request a hearing on the proposed action within fifteen (15) days of receipt of the notice.

a. 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).

5. 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.

3. 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.
4. Waiver by Failure to Request a Hearing: A practitioner who fails to request a hearing within the time and manner, waives his/her right to any hearing or appellate review. Such waiver shall be effective only against the actions outlined in the notice given. The effect of a waiver is as follows:
    1. After Adverse Action 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.
    2. After Adverse Action by the Board: A waiver constitutes acceptance of the action, which immediately becomes the final decision in the matter.
        a. If the board changes the outcome, then there will be a new right of appeal.

HEARING PREREQUISITES:

1. 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.
2. 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.
    a. The special notice of hearing shall also include notice of exhibits, in addition to 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.
    b. 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.
        i. The hearing may be scheduled or continued beyond sixty (60) days by agreement or by motion upon showing of good cause.
3. 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.

4. Eligibility for Hearing Panel: The following members are eligible for nomination or appointment to membership:
5. Members of the medical staff except for any such member who:
    a. Initiated the request for corrective action, made any complaint or report associated with this corrective action.
    b. 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;
    c. Is in direct economic competition with the practitioner involved.
    d. 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.
6. 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.
    a. 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 this Plan.
    b. 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 *Article 14: Hearing Procedure (11)*.

HEARING PROCEDURE

1. 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.
    a. The presence of legal counsel or other representative does not constitute the personal presence of the practitioner.
    b. 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.
2. Presiding Officer: The hearing officer shall be the presiding officer. The presiding officer shall maintain decorum, ensure compliance with procedure, assist in preparation of the report and recommendation, and assure that all participants have reasonable opportunity to present relevant evidence.
    a. The hearing Presiding Officer shall determine the order of procedure during the hearing and make all rulings on matters of procedure and the admissibility of evidence.
    b. The Presiding Officer shall not act as a prosecuting officer or as an advocate to any party to the hearing.
    c. The Presiding Officer shall not be entitled to vote.
3. Practitioner Representation: The practitioner may be accompanied and assisted at the hearing

by an attorney, or by any other representative.

4. Committee/Board Representation: The Board or Committee who took the unfavorable action subject to the hearing shall appoint a representative for the hearing. In addition, the Board or Committee may be represented by an attorney.
5. Rights of Parties: All rights shall be exercised so as to permit the hearing to proceed efficiently and expeditiously.
    a. 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:
        i. 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.
            a. 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.
    b. Call, examine, cross-examine, and impeach any witnesses on any relevant matter,
    c. Introduce exhibits and evidence;
    d. Rebut any evidence;
    e. Request a copy of the proceeding record or transcript;
    f. Call the practitioner to testify on his/her own behalf, or at the bequest of any party subject to cross-examination.
6. Admission of Evidence: The hearing need not be conducted strictly according to the rules of evidence or examination of witnesses.
    a. 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.
    b. Exhibits admitted into evidence before the hearing panel shall be identified as the presiding officer may direct.
7. Hearing Record: A record of the hearing shall be kept.
    a. The presiding officer shall determine whether this shall be done by use of a court reporter or audio tape recording of the proceeding.
    b. If the practitioner requests a transcript of the hearing record, he/she shall bear the cost of transcription.
    c. Any testimony given requires the taking of an oath administered by the hearing panel.
8. 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.
    a. Those memoranda, if any, must be presented to the presiding officer, the panel, and to the opposing party.
9. Panel Examination: The hearing panel may ask questions of the witnesses, call additional

witnesses, or request documentary evidence if it deems it appropriate.

10. Burden of Proof: The practitioner shall have the burden of proving that the committee or Board's decision was an abuse of discretion.
11. Admission of Witnesses Not Listed: The hearing panel may permit a witness who has not been listed 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.
12. Presence of Hearing Panel Members and Vote: A majority of the hearing panel must be present throughout the hearing and deliberations.
    a. 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.
13. 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.
14. 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.
15. 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.

HEARING PANEL REPORT AND FURTHER ACTION

1. 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.
2. 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.
3. 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 the *Appellate Review Procedure*.
4. 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.

a. 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.

5. The practitioner shall be sent special notice of the decision within fifteen 15 days of the decision.

INITIATION AND PREREQUISITES OF APPELLATE REVIEW

1. Request for Appellate Review: A practitioner shall have fifteen (15) days after receiving special notice of an adverse decision pursuant to file a written request for an appellate review. The request must be delivered to the CEO by special notice.
2. Waiver by Failure to Request Appellate Review: A practitioner who fails to request an appellate review within the time and in the manner specified above shall be deemed to have waived any right to a review.
3. 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.
    a. 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.
    b. 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.
4. Appellate Review Body: The Chairperson of the Board shall appoint an appellate review body, composed of not less than four (4) persons.
5. 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.
6. First member: The Chairperson of the Board shall designate a non-voting Chairperson of the review body.
7. Second and Third Member: the Board and the practitioner each shall pick one (1) voting member to comprise the second and third member.
8. Fourth Member: The Board and the practitioner must mutually agree on the fourth member.

APPELLATE REVIEW PROCEDURE

1. 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.

a. The presiding officer shall direct that the hearing record and documentation consider be available at the appellate review for use by any party.

b. The review body shall determine whether the foregoing evidence demonstrates that the practitioner has met the burden of proof as required under *Article 14: Hearing Procedure (10)* of this Plan.

2. 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.
3. 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.
    a. The statement shall be submitted to the CEO at least ten (10) days prior to the scheduled date of the review.
        i. 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.
    b. 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.
4. 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 *Article 14: Hearing Procedure (3)* of this Plan.
5. 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.
    a. 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.
    b. 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.
6. 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.
7. 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.

8. 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.
9. Review Body report and Recommendation: Within fifteen (15) days after adjournment pursuant to above, the review body shall prepare its report and conclusion and transmit the same to the Board and CEO, as provided below.
10. 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.
    a. 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.
11. 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: MEDICAL STAFF SECTIONS

1. The Medical Staff shall be divided into six major sections, with specific services divided among them, as defined by the MEC:
    - Ambulatory Medicine, Primary Care
        - Includes outpatient pediatrics
    - Ambulatory Medicine, Specialty Services
    - Emergency Medicine
    - Hospital-Based Medicine
    - Obstetrics
        - Includes inpatient neonatal care
    - Surgery
        - Anesthesia services (provided by CRNAs) shall function under the direction of the board-certified Chair of Surgical Services
2. Duties of the Chair of each Major Section:
    - 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.
4. Section Chair(s) must be physicians on the Active Medical Staff.

ARTICLE 16: STRUCTURE AND COMMITTEES

OFFICERS:

Officers must be physicians and 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 of the Medical Staff will consist of the Chief of Staff, Credentials Chair, PPEC Chair.

- The 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 Chief of Staff shall appoint the Chair of PPEC and the Chair of the Credentials Committee, either of whom shall succeed the Chief of Staff, if the Chief of Staff is vacated during the term.
- Vacancies occurring in the office of the Chief of Staff within the term shall be filled by election at a special meeting or by ballot of the medical staff.

Recall of Officers and/or Section Chairs:

1. Recall of an officer or Service Chair 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.

2. 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.
3. 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.

NOMINATION OF OFFICERS AND SECTION CHAIRS

1. The Medical Staff Office will contact active medical staff members to request nominations for open positions.
    a. 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.
2. Section Chairs are nominated by MEC with input, but no vote, from the CEO, and are elected by voting members of the Department.
    a. Elections shall be conducted by secret ballot, and only members of the active medical staff shall be eligible to vote.
3. A nominee shall be elected upon receiving a majority of the valid votes cast.
    a. 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.

Committees: See *Medical Staff Committee Charters*

The following are committees of the medical staff, and members shall be approved by MEC.

1. Medical Executive Committee (MEC)
2. Professional Practice Excellence Committee (PPEC), described in Article 19
    1. Peer Review
    2. Ongoing Quality Assessment
3. Credentials Committee
4. Pharmacy and Therapeutics
5. Infection Control and Prevention
6. Joint Conference Committee
    a. The Joint Conference Committee shall be a standing committee composed of the Chief of Staff, the CEO or CMO and a representative member of the Governing Board.
    b. 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.
    c. The committee shall meet on an as needed basis. A permanent record shall be kept of the proceedings and actions.

7. Institutional Review Board: In the even that medical research is proposed at Jefferson Healthcare, the CEO and Chief of Staff may appoint members to serve as a local Institutional Review Board (IRB).
    a. The purpose of this committee is to review the proposed research protocol and any external IRB findings to determine that the proposal meets current ethical principles, protects the rights and welfare of research participants, and is appropriate to take place at Jefferson Healthcare.
        i. When convened, the IRB will report its recommendations to the MEC and CEO for final approval.
    b. No human subject research may be carried out at Jefferson Healthcare until this approval process has been completed.
8. The Chief of Staff may appoint or disband ad-hoc committees and nominate members to such committees as organizational needs may require.

MEDICAL EXECUTIVE COMMITTEE

1. Membership:
    1. The Executive Committee of the Medical Staff shall be a standing committee and shall consist of the Officers of the Medical Staff, Section Chairs and the Chief Medical Officer.
        a. Any member holding more than one role shall have only one vote.
        b. Each Section shall have a single vote, including those who have a shared Chair role.
    2. The Chief Executive Officer and other members of administration as required, shall be ex-officio members of this committee, without voting privileges. Others may be invited to attend, and do not hold voting privileges.
2. 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.
3. Duties:
   In the absence of the Chief of Staff, another member of the MEC shall assume all of the Chief of Staff's duties when necessary. The line of authority shall be (1) Chair of PPEC; (2) Chair of Credentials Committee.
4. 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 regulatory requirements and take appropriate action to maintain hospital accreditations.
- 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).

5. 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 through the Medical Staff Office.
- A quorum is defined as at least one Officer and a total of five voting members.

ARTICLE 17: FUNCTIONS

THE MEDICAL STAFF FUNCTIONS

1. 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.

2. Provide continuing education responsive to evaluation and quality assessment findings, new developments and other perceived needs.
3. Develop, plan or participate in such planning, programs of continuing education designed to keep the medical staff informed of new developments in medicine.
4. 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.
5. Maintain a permanent record of activities, specifically including the relationship to findings of quality assessment activities.
6. Require that patient records are complete, timely, legible and clinically pertinent.
7. 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.
8. Conduct annual review of bylaws, rules and regulations, policies and procedures of the medical staff.
9. Develop, review and revise and implement clinical policies for services in conjunction with physician's assistant(s) and/or nurse practitioner(s).
10. Submit recommendations to the medical staff and the governing board for changes in these documents.
11. Act upon all bylaws issues referred by the board, medical staff, chief of staff, administrator or committee of the medical staff.
12. 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.
13. Coordinate care, treatment and services among the practitioners and staff involved in a patient's care treatment and services.
14. Participate regularly in the review of medical records, clinical orders and medical services, including adequacy and quality of care provided.
15. 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.
16. 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.
17. Participate in the hospital infection prevention and control processes.
18. Oversee quality of services provided by the Jefferson Healthcare Medical Staff.

Medical Staff Quality Assessment

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

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.

ARTICLE 18: GENERAL MEDICAL STAFF MEETING

A. ANNUAL MEETING:
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.

B. REGULAR MEETINGS AND ATTENDANCE:

There shall be at least four (4) general medical staff meetings per year.

1. Written notice stating the agenda, place, day and hour shall be posted to the Medical Staff SharePoint page and distributed to all medical staff members entitled to be present not less than 2 weeks before the meeting.
2. There are no quorum requirements for general medical staff meetings.
    a. Those members present at the start of the meeting shall constitute a quorum for conducting business.
    b. There shall be no voting by proxy.

C. ATTENDANCE: Active Medical Staff members must attend one meeting per year.

D. 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.

1. 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.
2. Written notice stating the place, day, hour and purpose of any special Jefferson Healthcare Medical Staff Bylaws meeting of the medical staff shall be sent 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.
3. Notice may also be sent to members of the courtesy medical staff who have so requested.
4. 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)

Purpose:

To review the care provided by the Medical Staff, offer feedback and opportunities for improvement when identified, and recommend corrective actions when necessary.

Committee Structure:

The Professional Practice Excellence Committee shall be a multidisciplinary committee comprised of physicians, nurse practitioners and/or physician assistant from the following services: Surgical Services, Primary Care, Obstetrics Services, Hospital Medicine and Emergency Services, and other members as appointed by the Professional Practice Excellence Committee.

The Credentials Committee shall report to the Peer Review Committee.

The Chief Patient Safety and Quality Officer, Medical Staff Manager, and/or Coordinator, shall attend as non-voting member(s) of the committee.

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 Chief of Service.
- Reporting systems problems or potential issues with nursing care to the Executive Quality Committee as needed.
- Reporting monthly to Medical Executive Committee.

Frequency of Meetings:

The committee shall meet 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, and embody the level of practice that is to be required of each member of the Active Medical Staff.

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 meeting, ballot, or electronic voting.

ARTICLE 22: ADOPTION

Adoption of the bylaws and such revisions shall require a majority vote of active members present at meeting, or by ballot/electronic voting.

- Two-thirds majority vote is required to approve amendments to the Medical Staff Bylaws.

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

Approval Signatures

Step Description	Approver	Date

Jefferson Healthcare
Delineation of Privileges
Psychology PhD. and PsyD

To be eligible to request core privileges in psychology, the following minimum threshold criteria must be met:

Basic Education:

- Successful completion of a doctorate degree in psychology (PhD or PsyD) from a program accredited by the American Psychological Association; AND
- One year of formal postdoctoral fellowship in clinical psychology; OR
- Two years of supervised postdoctoral work.

Certification:

- Maintenance of Washington State licensure
- Board Certification by the American Board of Professional Psychology (ABPP) or Board Eligible

Initial requirements:
Applicant must provide documentation of provision of psychology services to at least 15 patients representative of the scope and complexity of the privileges requested during the previous year (waived for applicants who completed training during the previous year.

Clinical Experience (Reappointment): Applicant must provide documentation of provision of clinical services to a representative sample of patients within the scope and complexity of the privileges requested during the previous 24 months.

☐ Core Privileges in Psychology

Description: Work directly with patients, as well as groups (families, patients of similar psychopathology), using a wide range of assessment and intervention methods to promote mental health and to alleviate discomfort and maladjustment.
Includes the assessment, diagnosis and treatment for mental, physical, emotional, and behavioral disorders using psychological testing and mental status examination for patients aged 18 and older.

Special Privileges:

Please select below which privileges you are requesting

☐ Biofeedback
Requirements: Documentation of graduate or post graduate experience or practicing with supervision.

☐ Hypnosis
Requirements: Documentation of graduate or post graduate experience or practicing with supervision.

☐ Interpretation of psychometric testing (MMPI)

Requirements: Documentation or demonstration of graduate and post- graduate supervised experience.

☐ Administration and interpretation of neuropsychological testing

Requirements: One-year pre- or post-doctoral internship or fellowship in neuropsychology (and documentation of assessments)
Documentation of a minimum of 25 assessments within the past 24- months.

☐ Children ages 0-9 years: Assess, diagnose, and treat cognitive, emotional and behavioral disorders using standard psychological testing and mental status examination

Requirements:

1. At least one year of graduate and post- graduate supervised experience and/or
2. 24 months of commensurate documented clinical activity
3. Documentation of cases or procedures will be required. Please attach case and/or procedural logs to your privilege delineation form.

☐ Children and Adolescents ages 10 to 17 years: Assess, diagnose, and treat cognitive, emotional, and behavioral disorders using standard psychological testing and mental status examination.

Requirements:

1. At least one year of graduate and post- graduate supervised experience and/or
2. 24 months of commensurate documented clinical activity
3. Documentation of cases or procedures will be required. Please attach case and/or procedural logs to your privilege delineation form.

TO BE COMPLETED BY APPLICANT:

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.

Signature Date

Board Approval Date