

MEDICAL STAFF POLICIES AND PROCEDURES

**VALLEY GENERAL HOSPITAL
MONROE, WASHINGTON**

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DEFINITIONS

As adopted by the Medical Staff Bylaws, the following definitions set forth shall pertain to policies and procedures:

“Allied Health Practitioner” (CRNA, ARNP, PA, PA-C, OD, PhD, RNFA) also known as Licensed Independent Practitioners is defined as an applicant such as, but not limited to, Certified Registered Nurse Anesthetist, Advanced Registered Nurse Practitioner, Physician Assistant, Physician Assistant-Certified, Optometrist, Psychologist, and Registered Nurse First Assistants, who have been granted appointment and privileges to the Allied Health Practitioner Staff of Valley General Hospital under the supervision and responsibility of a physician sponsor or Medical Staff member (if applicable), or, the Hospital, as designated at the time of approval.

“Board of Commissioners” or “Board” is defined as the elected Board of Commissioners of Snohomish County Public Hospital District No. 1.

“Chief Executive Officer” (“CEO”) is defined as the applicant appointed by the Board of Commissioners to act on its behalf in the overall management of Valley General Hospital. The CEO may appoint an Acting Administrator to serve in the CEO’s stead.

“Departments” mean the designated service provided by the medical staff and/or allied health practitioners of Valley General Hospital by areas of medical specialty.

“Disability” shall have the meaning set forth in the Americans with Disabilities Act VIII of these Bylaws.

“Ex Officio” means a member of a committee or body by virtue of an office or position held, with no voting rights unless otherwise expressly provided.

“Hospital” means Valley General Hospital, a general acute care hospital operated by Snohomish Public Hospital District No. 1.

“In Good Standing” means a member is currently not under suspension or serving with any limitation of clinical privileges or voting imposed by operation of these Bylaws, the rules and regulations or policy of the Medical Staff.

“Medical Director” means the Active Member of the Medical Staff appointed in accordance with Section 4.9 of these Bylaws.

“Medical Executive Committee” or “MEC” is defined as the group of medical staff members defined under Article VI of these Bylaws.

“Medical Staff” is defined as group of physicians, dentists, and podiatrists (MD, DO, DDS, DMD, DPM) who have been granted appointment and privileges to attend patients in the hospital by the Board of Commissioners.

“Member” is defined as any medical practitioner (MD, DO, DDS, DMD, DPM) appointed to, and maintaining membership in, any category of the Medical Staff in accordance with these Bylaws.

“Patient” is defined as any person undergoing diagnostic evaluation or receiving medical treatment at Valley General Hospital.

“Patient Contact” means the admission of a patient to the Hospital, the admission of a patient to the emergency room, the performance of outpatient surgery, assisting at surgery, or a consultation for a patient or documented participation in a patient’s care in either the Hospital or its emergency room.

“President” of the Medical Staff is defined as the individual elected by the Medical Staff of Valley General Hospital to act, along with the Medical Director, as the Medical Staff’s chief administrative officer.

“Proctoring, Proctored” means the act of designated monitoring of a Medical Staff member.

“Reasonable accommodation” when used in connection with a disability, shall have the meaning ascribed to it in the Americans with Disabilities Act.

Medical Staff Policies and Procedures As adopted by the Medical Staff Bylaws

The Medical Staff shall be organized by Administrative units according to medical specialty:

PRIMARY CARE DEPARTMENT

Addiction Medicine
Allergy and Immunology
Cardiology
Emergency Medicine
Family Medicine
Gastroenterology
Hematology & Oncology
Internal Medicine
Medical Oncology
Neurology
Nuclear Medicine

Optometry
Pediatrics
Physical Medicine and Rehab
Pulmonary/Critical Care
Psychiatry
Radiology

SURGERY DEPARTMENT

Anesthesiology
Colon & Rectal Surgery
Dermatology
General Surgery
Obstetrics and Gynecology
Ophthalmology
Oral & Maxillofacial Surgery
Orthopaedic Surgery
Otolaryngology
Pathology
Phlebology
Physical Medicine and Rehab
Plastic Surgery
Podiatry
Urology

At the time of the adoption of these policies and procedures, the above medical specialties exist at Valley General Hospital. From time to time, there may be addition, reduction or renaming of these specialties as approved by the medical staff and consistent with the Medical Staff Development Plan.

ARTICLE I: PRE-APPLICATION

- 1.1. PRE-APPLICATION: As a preliminary to the medical staff application process, a pre-application process shall be completed unless the applicant is joining an existing medical group. The pre-application form will be forwarded to the applicant. After the Medical Staff office receives the completed pre-application form, the form is assessed in accordance with the Medical Staff Development Plan, as set forth in Article II, Section 2.3.5. of the Policies and Procedures. A period of time not to exceed 30 days shall be given for completion and return of this form. If the applicant is aware that the form will not be completed and returned within 30 days, he or she may contact the Medical Staff office and request an extension of time in which to complete the pre-application, documenting reasons for requested extension and an intended date of application completion and return. Otherwise, it is assumed that the request for pre-application is no longer valid after 30 days.

The Medical Staff Office will determine if an extension is warranted.

- 1.1.1. Content: The content of the pre-application form may be supplemented and/or modified as appropriate, and shall include, but not be limited to informational requirements such as professional and personal contact information, education, training, relevant licensing and certification, malpractice history, and affiliations.

- 1.1.2. Pre-Application Form Review: When the pre-application form is received, the Medical Staff Coordinator will review it for content and completeness. If determined that the pre-application is complete and such expertise is needed in accordance to Article II, Section 2.3.5., the Medical Staff Coordinator shall forward the information to the Medical Executive Committee or its representative to inform them of the interested applicant.
- 1.1.3. Acceptance of Application. If the applicant is accepted as a candidate for the Medical Staff, the applicant will be notified and provided the primary application documents. If the applicant is not accepted as a candidate for the Medical Staff based on the completion of the pre-application form and eligibility requirements as set forth in Article II, Section 2.3, the Medical Staff Office shall notify the applicant of same.

ARTICLE II: MEDICAL STAFF APPLICATION

- 2.1. PURPOSE. This article shall establish the mechanism for appointment, reappointment, and for granting and renewing or revising hospital-specific clinical privileges for all Medical Staff members of Valley General Hospital.
- 2.2. GENERAL. All applications requested for Medical Staff appointment and clinical privileges shall be submitted either verbally or in writing from the department chairperson or its designee or from the existing group contracted service representatives upon request or upon review of pre-application form by the Medical Executive Committee. The pre-application form shall be reviewed according to the determined need of the applicant's services according to the Medical Staff Development Plan. The application process shall be designed to assure high quality patient care, and requires detailed documented data concerning the applicant's current licensure, specific training, experience, current competence, and ability to perform the privileges requested.
- 2.3. ELIGIBILITY. To be eligible for Medical Staff appointment the applicant:
 - 2.3.1. Must be a graduate of an accredited medical, osteopathy, dental, or podiatry school;
 - 2.3.2. Must be licensed by the State of Washington to practice medicine, dentistry, or podiatry;
 - 2.3.3. Must be a United States citizen, or a person with an appropriate visa;
 - 2.3.4. Must have proof of completing an approved residency or must have evidence of seven years of clinical service in an accredited hospital;
 - 2.3.5. Must have expertise that has been determined to be a need according to the Medical Staff Development Plan.
- 2.4. APPLICATION REQUIREMENTS. A complete application includes the signed "Washington Practitioner Application" including Valley General Hospital's attestation, delineated clinical privileges and agreement to abide forms with all requested data provided and the inclusion of a \$400 application fee for all initial applications and \$300 for reappointment applications. Practitioners employed by Valley General Hospital shall not be subject to application fees including members serving on the Medical Executive Committee.

The application fee may be fully refunded and/or waived to the applicant if the applicant becomes employed by Valley General Hospital or if the applicant is applying for

temporary privileges to provide care to a specific patient within a limited time or if the applicant voluntarily withdraws his/her application for appointment within 7 days of receipt, otherwise, the fee is non-refundable.

For all delinquent reappointment applications submitted, a late fee will be charged accordingly: 14 days - \$100; 15-30 days \$150; \$200 for more than 30 days.

- 2.5. SUBMISSION OF APPLICATION. The submission of the application signifies the applicant's:
- 2.5.1. Willingness to appear for interviews regarding the application;
 - 2.5.2. Authorization for Valley General Hospital representatives to consult the National Practitioner Data Bank, the Washington State Quality Assurance Board, and with other applicants and institutions and inspect all material records having information bearing on the applicant's experience, competence, character, ethics, and other qualifications for membership to the Medical Staff and to use and rely on such information;
 - 2.5.3. Release of Valley General Hospital and its representatives from any liability for their acts or omissions, performed in good faith without malice while evaluating and processing the applicant's credentials and application;
 - 2.5.4. Release from liability of all applicants and institutions that provide information to Valley General Hospital's representatives in good faith and without malice concerning the applicant's experience, competence, character, ethics, and other qualifications for Medical Staff appointment and clinical privileges, including otherwise privileged or confidential information;
 - 2.5.5. Authorization and consent for Valley General Hospital's and other representatives of Snohomish County Public Hospital District No. 1 to provide other hospitals, medical associations, and other organizations concerned with the member's performance and the quality and efficiency of patient care with any information the hospital may have concerning the applicant, and release of Valley General Hospital and the Hospital District and its representatives from liability for these actions provided that furnishing such information is done in good faith and without malice;
 - 2.5.6. Authorization and consent for Valley General Hospital's representatives to conduct a criminal history background check and utilize and rely on such information received.
 - 2.5.7. Pledge to provide continuous care for the applicant's patients and provide reassignment of patients if applicant or practitioner is unable to provide such care.
 - 2.5.8. Receipt and understanding of the Medical Staff Bylaws, Rules, and Regulations, Policies and Procedures, and agreement that the applicant's activities shall be governed and bound by these documents;
 - 2.5.9. Acceptance of the burden to produce for hospital staff and other physicians adequate information for a proper evaluation of the applicant's experience, competence, character, ethics, and other qualifications, and for resolving any doubts about such qualifications;
 - 2.5.10. Pledge to report notification of a professional liability action against the applicant

Those submitting an application for temporary privileges, proctoring, and locum tenens are included within those applicants whose application signifies the applicant's submission to the provisions above in this section.

- 2.6. ELEMENTS CONSIDERED IN APPLICATION. During the application review process, the following elements when applicable shall be considered for appointment, reappointment, and clinical privilege delineation. All elements shall be confirmed by primary source whenever reasonably possible. Other primary source elements may be used such as, but not limited to, the Educational Commission for Foreign Medical Graduates, American Medical Association profile, American Osteopathic Association profile, National Practitioner Data Bank, Medical Quality Assurance Commission, Office of the Inspector General, General Services Administration, and CertiFacts On-Line.
- 2.6.1. Applicant
- 2.6.1.1. A complete Washington Practitioner Application;
 - 2.6.1.2. A complete Valley General Hospital attestation and agreement to abide forms;
 - 2.6.1.3. A copy of current curriculum vitae;
 - 2.6.1.4. A 2X2 Photo ID;
 - 2.6.1.5. A copy of current and valid driver's license;
 - 2.6.1.6. Copy of current WA medical license and all previous licenses, DEA certificate or registration (if applicable). Pending challenges to any license or registration or voluntary/involuntary relinquishment of such licensure or registration;
 - 2.6.1.7. Query and Report from the National Practitioner Data Bank;
 - 2.6.1.8. Query and Report from the Office of Inspector General and General Services Administration;
 - 2.6.1.9. Current professional competence, performance, and experience;
 - 2.6.1.10. Quality assurance, quality improvement, and utilization review participation (if applicable);
 - 2.6.1.11. If the applicant has indicated s/he has a disability, an evaluation of reasonable accommodation necessary and appropriate for such applicant shall be made without discrimination based on a disability for which reasonable accommodation can be made and/or the American with Disabilities Act
 - 2.6.1.12. Health status (including drug/alcohol abuse);
 - 2.6.1.12.1. **Physical or Mental Impairment:** The applicant shall be free of or have under adequate control, any physical or mental health impairment that interferes with, or presents a reasonable probability of interfering with, the practitioner's ability to satisfy the qualifications for the physician's practice.
 - 2.6.1.12.2. **Substance/Chemical Abuse:** The applicant shall be free from abuse of any type of substance that may affect cognitive, motor or communication ability in a manner that interferes with, or present a reasonable probability of interfering with, the practitioner's ability to satisfy the qualifications required under this policy. In demonstrating satisfaction of the foregoing qualifications, a practitioner may, when suspicion or knowledge of a problem exists, be required to provide such

information or to obtain such examinations or tests as may reasonably be requested by any appropriate authorities of the medical staff or governing board and from such practitioner(s) as designated by said authority. In addition, a practitioner may be required to submit to on-the-spot testing on the basis of: physical manifestations on the job; or of suspicion based on recent performance; or as follow-up or concurrent monitoring to participation in a treatment program.

- 2.6.1.13. Evidence of adverse action, such as pending challenges or voluntary/involuntary relinquishment of membership and/or privileges including but not limited to, sanctions or disciplinary actions taken against the applicant by any hospital or healthcare entity, professional associations/society, or specialty board regarding membership and/or privileges;
- 2.6.1.14. Cooperation with personnel, patients, and other medical staff members;
- 2.6.1.15. Professional Ethics;
- 2.6.1.16. Clinical judgment in the treatment of patients;
- 2.6.1.17. Conduct and professional attitude;
- 2.6.1.18. Equivalent peer review and recommendations;
- 2.6.1.19. Current Professional liability insurance coverage for at least \$1,000,000 per occurrence and \$3,000,000 aggregate limits with a carrier acceptable to the hospital;
- 2.6.1.20. Canceled or refused professional liability insurance coverage;
- 2.6.1.21. Lifetime Malpractice claims and lawsuits alleging medical injury or other conduct inappropriate to the practice of medicine;
- 2.6.1.22. TB Screening Form, or copy of TB test results done within the last 3 months prior to submission of application or a completed Declination Form and/or any other screening mandated by law or regulation or added by way of amendment to these policies; (this requirement is waived for those practitioners who do not provide "live" patient contact i.e., pathology)
- 2.6.1.23. All healthcare related employment/appointment history (work history);
- 2.6.1.24. Lifetime criminal history record;
 - 2.6.1.24.1. If the applicant is found to have had a criminal record, this applicant must provide any and all documents pertaining to his/her criminal actions including but not limited to a copy of a federal bureau of investigation (FBI) report sent directly to the medical staff office from the originating office. This information will be presented to the Medical Executive Committee and the committee shall determine whether the criminal action is such that the applicant should be allowed or not allowed to continue the credentialing process. The applicant is

informed of the Medical Executive Committee's decision on this;

- 2.6.2. Category of Medical Staff membership;
 - 2.6.3. Valley General Hospital's ability to provide adequate services for the applicant and the applicant's patients;
 - 2.6.4. Health care needs of the population served by Valley General Hospital;
 - 2.6.5. Valley General Hospital's current need for the expertise offered by the applicant.
- 2.7. REVIEW PROCESS. Each Medical Staff application for membership and clinical privileges shall be reviewed as follows:
- 2.7.1. Review by the Department Chairperson. Applications for initial appointment, reappointment, and clinical privileges shall be submitted to the chairperson upon completion. After receipt, the medical staff office shall review the application for completeness and verify accuracy of data provided. Reasonable efforts to ensure completeness and verification of the application shall generally be accomplished within 45 up to 180 days following receipt. If the application is deemed incomplete the applicant shall be notified by the Medical Staff Office and requested to submit necessary information to complete the application. No further action shall be taken in the review process until the application is complete.
 - 2.7.2. Review by the Medical Executive Committee and Board of Commissioners. The MEC shall review each application and make a recommendation to the Board of Commissioners. The MEC may defer action on an application if further information is requested. The applicant shall be notified and must comply with the request before the next scheduled meeting of the MEC, thus giving the applicant thirty (30) days to comply. If the applicant does not comply with the request, it is assumed that the applicant is no longer interested and shall be notified of the termination of the credentialing process. If the recommendation by the MEC is adverse, the applicant shall be notified and shall have the hearing and appeal rights set forth according to the Fair Hearing Plan.
 - 2.7.3. Final approval by Board of Commissioners. The Board of Commissioners shall have the final authority to grant the medical staff appointment and clinical privileges to the Medical Staff of Valley General Hospital. The Board of Commissioners may defer action on an application if further information is requested. The applicant shall be notified and must comply with the request before the next scheduled meeting of the Board of Commissioners, thus giving the applicant thirty (30) days to comply. If the applicant does not comply with the request, it is assumed that the applicant is no longer interested and shall be notified of the termination of the credentialing process. If the recommendation by the Board of Commissioners is adverse, the applicant shall be notified and shall have the hearing and appeal rights set forth according to the Fair Hearing Plan.

If the Board of Commissioners determine that it will decide a matter contrary to the recommendations of the MEC, the matter may be submitted to the Joint Conference Committee as noted in the Board bylaws for the final decision.

- 2.8. ENTITLEMENT. No applicant shall be automatically entitled to the Medical Staff appointment of Valley General Hospital or have the right to exercise his/her clinical privileges merely by virtue of the fact that they:
- 2.8.1. Have fulfilled eligibility requirements;
 - 2.8.2. Have practiced their profession in this state or any other state;
 - 2.8.3. Have been a member of any professional organization;
 - 2.8.4. Have been a member certified by any clinical board as approved by the American Board of Medical Specialties or American Osteopathic Association;
 - 2.8.5. Have been granted or maintained membership and/or clinical privileges at another institution or health care facility or group practice setting; or were previously a member of the medical staff of Valley General Hospital;
 - 2.8.6. Are/Were a member of a medical or professional faculty;
 - 2.8.7. Have been granted temporary privileges at this hospital;
 - 2.8.8. Have any combination as indicated above.

The Hospital will not discriminate in granting appointment, reappointment, and/or clinical privileges on the basis of age, gender, race, creed, color, or national origin.

ARTICLE III: INITIAL APPOINTMENT/12-MONTH PROVISIONAL STATUS

- 3.1. GENERAL. Initial appointment to the Medical Staff and granting of clinical privileges shall be reviewed after a full 12-month period, thus, placing the applicant under a provisional status from the initial approval date of the Board of Commissioners.
- 3.2. 12-MONTH PROVISIONAL REVIEW. During the provisional period, the member's performance will be reviewed and evaluated by the chairperson of the area in which s/he has been granted clinical privileges. A retrospective review of 5 cases will be performed whichever occurs last to confirm competence in privileges requested. If practitioner does not meet the 5 case criterion, MEC may review the need for privilege requested.

In the event the practitioner's practice evaluation review reflects significant unresolved quality assurance matters at time of review for provisional advancement, the MEC may, on a case by case basis recommend a specific appointment period for the sole purpose of resolving quality assurance issues.

- 3.3. ACTION. Upon review of the completed 12-month provisional review clinical activity, the chairperson may recommend ONE of the following:
- 3.3.1. Advancement to full privileges to end on the last day of the member's initial approval month following the 12-month provisional status, at which time, the member shall be eligible for reappointment. If approved, all reappointments shall be reviewed in no more than two years (24 months), with reappointment effective on the last day of the respective member's approval month;
 - 3.3.2. Reappointment with a subsequent 6-month or 12-month provisional status on a case by case basis. This provisional review shall be at the discretion of the chairperson. There shall be no limit to the number of provisional reviews;
 - 3.3.3. Reappointment with suspension of certain clinical privileges to be reviewed as specified by chairperson, with documents accompanying such appointment for justification; or
 - 3.3.4. Complete revocation of appointment with documentation of justification.

All initial appointments, provisional review, and/or clinical privileges shall be presented to the Medical Executive Committee for review and recommendations to the Board of Commissioners for final approval.

ARTICLE IV: REAPPOINTMENT

- 4.1. GENERAL. The reappointment period shall end 24 months after appointment, on the last day of the same month as the Board of Commissioners approval of the member's initial appointment.
- 4.2. TERM OF APPOINTMENT. Appointments/Reappointments shall be reviewed in no more than 2 years (24 months), with reappointment effective on the last day of the member's initial approval month.

A retrospective review of cases will be performed as indicated per privilege criteria to confirm competence in any new privileges requested. If practitioner does not meet the case criterion, MEC may review the need for additional privilege requested. Otherwise, all cases are peer reviewed according to specialty indicators which will be part of the practitioners' practice evaluation for reappointment assessment.

In the event the practitioner's practice evaluation review reflects significant unresolved quality assurance matters at time of review for provisional or reappointment advancement, the MEC may, on a case by case basis recommend a specific appointment period for the sole purpose of resolving quality assurance issues.

- 4.3. CRITERIA FOR REAPPOINTMENT. Recommendations for reappointment and clinical privileges delineation shall be based on the following criteria as set forth in Article II, Section 2.6 through 2.6.5. and shall also include the following:
 - 4.3.1. Attendance at Medical Staff committees and meetings;
 - 4.3.2. Continuing medical education;
 - 4.3.3. Accuracy, timeliness, and completion of medical records;
 - 4.3.4. Compliance with policies and procedures of Valley General Hospital;
 - 4.3.5. Utilization of Resources;
- 4.4. APPLICATION FOR REAPPOINTMENT. Between four to six months prior to expiration of the reappointment period, the medical staff coordinator shall send the reappointment application for the member to complete. The member shall return the completed application to the Medical Staff Office within 30 days from the date the forms were sent or as specified on the cover letter. Information requested (from the applicant) includes:
 - 4.4.1. Requested change in clinical privileges and justification;
 - 4.4.2. Documentation of satisfactory completion of the minimum requirements for continuing medical education activities;
 - 4.4.3. If the medical staff member has indicated s/he has a disability, an evaluation of reasonable accommodations shall be made without discrimination;
 - 4.4.4. Current WA medical license, DEA or CDS certification/registration (if applicable). Pending challenges to any licensure or registration;
 - 4.4.5. Canceled or refused professional liability insurance coverage;
 - 4.4.6. Health status (including drug/alcohol abuse);
 - 4.4.7. Completed TB screening form, or copy of TB results done within 3 months prior to expiration of reappointment or completed declination form; (this

- requirement is waived for those practitioners who do not provide "live" patient contact)
- 4.4.8. Malpractice history (claims and lawsuits) alleging medical injury or other inappropriate medical practice conduct within the last 2 years;
 - 4.4.9. Information concerning the member's admitting practices;
 - 4.4.10. Any and all other information bearing on the practitioner's medical practice and privileges such as have not been previously reported i.e., changes in criminal history;
- 4.5. The medical staff coordinator shall request reports from, including but not limited to, the National Practitioner Data Bank, Medical Quality Assurance Commission, Office of Inspector General, General Services Administration, Washington Physicians Health Program, and from other internal/external agencies and/or department which relates to practitioners' clinical practice as the chairperson deems related to the reappointment application.
- 4.6. It is the applicant's sole responsibility to submit the completed application within a reasonable time as requested by the Medical Staff Office. The member shall submit the completed application with requested documents to the Medical Staff Office who shall immediately process the application for the chairperson. The chairperson shall submit a recommendation regarding reappointment to the Medical Executive Committee.
- 4.7. In the event the medical staff office failed to provide the practitioner his or her reappointment application timely, the practitioner is given an extension for 30 days which will be granted by the Medical Executive Committee on a case by case basis. If the member fails to submit his or her reappointment application, s/he shall submit a request in writing to the Medical Executive Committee for an extension of time to complete the reappointment application.
- 4.8. ACTION. All reappointments shall be presented to the Medical Executive Committee for review and recommendations to the Board of Commissioners for final approval.

ARTICLE V: CLINICAL PRIVILEGES

- 5.1. GENERAL. Members of the Medical Staff shall seek clinical privileges through the appointment/reappointment process. During the appointment/reappointment process, privileges requested shall be reviewed in no more than two years (24 months), with privileges effective on the last day of the member's approval month.
- 5.2. Each member shall be entitled to exercise only those clinical privileges specifically granted. Specific privileges requested must conform to the hospital's ability to provide the services. Each chairperson shall have the responsibility to continually monitor and assure that all members with clinical privileges within the respective service shall provide only those services within the scope of privileges granted. The Medical Executive Committee shall have responsibility to assure the maintenance of quality patient care by all applicants with clinical privileges within and across clinical services and among all Medical Staff members. The Medical Executive Committee shall conduct this responsibility through the quality assurance program.
- 5.3. Unless otherwise limited, all members of the Active or Courtesy Medical Staff are granted clinical privileges to:

- 5.3.1. Admit patients and treat inpatients and outpatients;
 - 5.3.2. Order diagnostic and therapeutic services within the scope of their clinical privileges
 - 5.3.3. Write orders and progress notes in the patient's medical record;
 - 5.3.4. Request consultation;
 - 5.3.5. Provide consultation within the scope of their clinical privileges;
 - 5.3.6. Render any care without regard to delineation of privileges in a life-threatening emergency.
- 5.4. Every patient is under the care of the Active or Courtesy Medical Staff member of Valley General Hospital and no Active or Courtesy Medical Staff member may delegate the care of any patient to any practitioner who is not a member of the Active or Courtesy Medical Staff of the hospital.
- 5.5. All clinical privileges shall be presented to the Medical Executive Committee for review and recommendations to the Board of Commissioners for final approval.

ARTICLE VI: TEMPORARY PRIVILEGES AND LEAVE OF ABSENCE

- 6.1. TEMPORARY PRIVILEGES. No applicant who has not substantially completed the appointment/reappointment process may practice medicine at Valley General Hospital except when the applicant has been granted temporary privileges.
- 6.1.1. GENERAL. There are three types of temporary privileges:
- 6.1.1.1. CARE OF SPECIFIC PATIENT. This temporary privilege is specified only for a care of a specific patient, which can be granted for a period as requested by the medical staff member but no more than 90 days. Privileges shall be granted only after receipt and verification of the following:
 - 6.1.1.1.1. A written request from the medical staff member addressed to the Chief of Staff for the practitioner's expertise need to assist or cover for the care of a specific patient.
 - 6.1.1.1.2. A copy of current curriculum vitae;
 - 6.1.1.1.3. Copy of current and valid driver's license;
 - 6.1.1.1.4. Copy of current WA medical license;
 - 6.1.1.1.5. Copy of current DEA certificate or registration;
 - 6.1.1.1.6. Copy of current Professional liability certificate;
 - 6.1.1.1.7. Letter of good standing from primary hospital affiliation with Active clinical privileges;
 - 6.1.1.1.8. Two equivalent peer reference recommendation letter of clinical competence for the specified requested clinical privileges;
 - 6.1.1.1.9. Signed attestation and agreement to abide form;
 - 6.1.1.1.10. Signed disclosure statement for criminal history background check;
 - 6.1.1.1.10.1. If the applicant is found to have had a criminal record, this applicant is required to provide any and all documents pertaining to his or her criminal actions including but not limited to a copy of a federal

bureau of investigation (FBI) report sent directly to the medical staff office from the originating office. This information will be presented to the President of the Medical Staff and the Chief Executive Officer/Designee who shall determine whether the applicant should be allowed to continue the credentialing process. The applicant shall be informed of the decision.

6.1.1.1.11. Query and Report from National Practitioner Data Bank, Office of the Inspector General, and General Services Administration;

6.1.1.2. LOCUM TENENS. This temporary privilege is only granted for a period of 90 days with only one extension of no more than 90 days within one calendar year. Privileges shall be granted only after receipt and verification of the following:

6.1.1.2.1. A complete Washington Practitioner application;

6.1.1.2.2. Completion of Valley General Hospital attestation and agreement to abide forms;

6.1.1.2.3. A copy of current curriculum vitae;

6.1.1.2.4. Copy of current and valid driver's license;

6.1.1.2.5. Copy of current WA medical license;

6.1.1.2.6. Copy of current DEA certificate or registration;

6.1.1.2.7. Copy of current Professional liability certificate;

6.1.1.2.8. Letter of good standing from primary hospital affiliation with Active clinical privileges;

6.1.1.2.9. Two equivalent peer reference recommendation letters of clinical competence for the specified requested clinical privileges;

6.1.1.2.10. Signed disclosure statement for criminal history background check;

6.1.1.2.10.1. If the applicant is found to have had a criminal record, the applicant is required to provide any and all documents pertaining to his or her criminal actions including but not limited to a copy of a federal bureau of investigation (FBI) report sent directly to the medical staff office from the originating office. This information will be presented to the President of the Medical Staff and the Chief Executive Officer/Designee who shall determine whether the applicant should be allowed to continue the

credentialing process. The applicant shall be informed of the decision.

6.1.1.2.11. Query and Report from National Practitioner Data Bank, Office of the Inspector General, and General Services Administration;

6.1.1.2.12. Receipt of \$400 application fee

6.1.1.2.12.1. In the event the applicant decides to apply for Active or Courtesy privileges during the locum tenens period, the practitioner's processing fee will be waived or reimbursed.

6.1.1.3. PENDING OF APPLICATION. This temporary privilege shall only be granted for a period of 90 days with only one extension of no more than 90 days and only after receipt and verification of elements as indicated in Article 2.6. through 2.6.5. of this document. Temporary privileges during pendency of application shall be granted by the Chief Executive Officer or Designee and President of the Medical Staff or MEC Designee for the following circumstances:

6.1.1.3.1. Immediate need for coverage for the particular specialty for which the practitioner practices;

6.1.1.3.2. The member is on leave of absence.

6.1.2. REVIEW PROCESS. Each Medical Staff application for temporary privileges shall be reviewed accordingly:

6.1.2.1. Review by the President or Designee of the Medical Staff. All completed and verified applications for all temporary privileges shall be submitted to the President of the Medical Staff for recommendation of temporary privileges to the Chief Executive Officer or Designee for a limited period of time. The President shall provide an appropriate recommendation based on the applicant's licensure, training, experience, and current competence. If the application is deemed incomplete, the applicant shall be notified by the Medical Staff Office to submit necessary information to complete the application. No further action shall be taken in the review process until the application is complete.

6.1.2.2. Review by the Chief Executive Officer or Designee. Upon review and recommendation by the President or Designee of the Medical Staff, the application is forwarded to the Chief Executive Officer or its Designee. If the application is deemed incomplete, the applicant shall be notified by the Medical Staff Office to submit necessary information to complete the application. If the application is found to be complete, a recommendation for temporary privileges shall be granted for a limited period of time.

6.2. LEAVE OF ABSENCE AND RETURNS TO STAFF.

6.2.1. A medical staff member may request a leave of absence of no more than six months. The Medical Executive Committee shall grant or deny requests for leave of absence. During the leave of absence, unless otherwise specified, the member shall continue to be a Medical Staff member with full clinical

privileges as granted by the Board of Commissioners. If the time for reappointment occurs during the leave of absence, the member shall not be required to go through the reappointment process until his/her return from leave of absence.

- 6.2.2. Any previous member who wishes to return to the staff after leaving the staff for a period of less than one year and who are eligible for Medical Staff appointment are not required to follow the procedure for initial staff appointment. They shall follow the procedure for reappointment, with appropriate modifications to ensure the disclosure of complete information concerning their practice and activities during the period when they were not on the Medical Staff of Valley General Hospital. Any previous member who wishes to return to the staff after having left the hospital for more than a year **must** complete the initial appointment process.

6.2.2.1. If the applicant cannot meet the eligibility criteria, the Medical Executive Committee upon the recommendation of the department chairperson may recommend the appointment and privileges of the applicant as Proctored Staff under Article VII, provided that the applicant satisfies all of the requirements of Section 7.2 except Section 7.2.6.

ARTICLE VII: PROCTORED STAFF

- 7.1. GENERAL. This article shall be undertaken in good faith by involved parties on a case by case basis as determined and approved by the Board of Commissioners according to state, federal, local, and hospital regulations.
- 7.1.1. To allow applicants for training and supervision.
- 7.1.2. To accommodate the diverse needs of the Medical Staff such as fluctuations in medical technology, and development of new procedures.
- 7.1.3. To allow applicants to meet qualification criteria for privileges if applicant has been out of the clinical setting for six months or more.
- 7.1.4. To allow applicants for further training and supervision as recommended by MEC based from professional practice evaluation assessments.
- 7.2. REQUIREMENTS. Applicants for proctored positions on the Medical Staff must satisfy all requirements set forth below, in addition to applicable stipulations in the Bylaws, Policies and Procedures, and rules and Regulations of the Hospital, and requirements set forth in federal, state, and local laws and regulations.
- 7.2.1. The applicant must have received a D.O., MD, DDS, DMD, or DPM, or equivalent degree from an accredited school or institution;
- 7.2.2. The applicant must have a current WA license;
- 7.2.3. The applicant must have completed at least 2 years of an accredited residency program and have begun the third year of training;
- 7.2.4. The applicant must have a current DEA or CDS certificate or registration;
- 7.2.5. The applicant must maintain a proof of professional liability coverage for proctored practice with a minimum of \$1 million per incident and \$3 million per aggregate;
- 7.2.6. The applicant must provide a (3) peer references who can attest to his/her clinical competency which includes, but not limited to, the Program Residency Director and 2 other professional reference with the concurrent specialty;

- 7.2.7. The applicant must provide a current copy of his/her curriculum vitae which shall outline his/her education, research projects, any related clinical activities, work history, and areas of practice interest;
- 7.3. LETTER OF INTENT CONCERNING PROCTORED STAFF. The department chairperson shall forward a letter of intent regarding the proctoring relationship in detail which must accompany the application for review and recommendation during the credentialing review process. The letter shall include:
 - 7.3.1. The need/reason for acceptance of the applicant to be proctored;
 - 7.3.2. The specialty and practice characteristics of the applicant;
 - 7.3.3. The Medical Staff member(s) who has/have agreed to proctor the applicant;
 - 7.3.4. The extent of the proctoring process for each applicant;
 - 7.3.5. The length of time which shall not exceed six-month; of the proctoring period. However, if needed, an extension for proctoring may be requested for an additional six month period;
 - 7.3.6. Any other requirements as directed by the MEC, Proctoring Medical Staff member, Hospital Administration and Board of Commissioners;
 - 7.3.7. The letter must contain the signatures of both the proctored staff and the proctoring Medical Staff member;
- 7.4. DUTIES OF PROCTORING A MEDICAL STAFF MEMBER. The Medical Staff member designated to proctor the applicant shall adhere to the following minimum guidelines:
 - 7.4.1. The proctor will review, approve, and sign all admitted patients;
 - 7.4.2. The proctor will review, approve, and sign for all diagnoses;
 - 7.4.3. The proctor will review and sign all documents related to patient care such as history and physical, progress notes, medication and treatment orders, operative reports (if applicable), surgery notes (if applicable);
 - 7.4.4. The proctor will review, approve, and sign for all referrals of care outside the scope of care provided by the proctored staff member;
 - 7.4.5. The proctor will review, approve, and sign for all consultations obtained during the course of the patient's care;
 - 7.4.6. The proctor will review and sign each case file at the conclusion of treatment, noting any deviations in Standards of Care, and reporting same to the appropriate chairperson and/or Medical Executive Committee;
 - 7.4.7. The proctor will attest to agreement to these guidelines and other stipulations of the proctoring process;
 - 7.4.8. The proctor shall agree to assure full liability for the actions of the proctored staff member during the proctoring period.
 - 7.4.9. The proctor shall agree to additional guidelines as may be required by case law, MEC, Proctoring Physician(s), Board of Commissioners and/or Hospital Administration.
 - 7.4.10. The proctor shall agree to maintain proof of Professional Liability coverage for Proctoring Practice, with minimum coverage limits of \$1 million per incident and \$3 million per aggregate.
- 7.5. DUTIES OF PROCTORED STAFF MEMBER. The proctored staff member shall agree to comply with those stipulations outlined in this article, Medical Staff Bylaws, Rules and Regulations, Policies and Procedures of Valley General Hospital during the course of his/her proctoring period. In addition:
 - 7.5.1. The proctored staff member shall not be a voting member of any committees or meetings as instituted in the hospital;

- 7.5.2. The proctored staff member shall not be eligible to hold office positions in any committees or meetings as instituted in the hospital;
 - 7.5.3. The proctored staff member shall not admit patients in the hospital without the acceptance of the designated proctoring medical staff member;
 - 7.5.4. The proctored staff member will routinely report his or her related clinical activities to his/her proctor;
 - 7.5.5. The proctored staff member shall not be permitted to perform any procedures nor provide care without the authorization and approval of the proctoring medical staff member;
 - 7.5.6. The proctored staff member shall not be permitted to admit any patients under his/her care;
 - 7.5.7. The proctored staff member shall attest to agreement to these duties and limitations and other stipulations of the Proctoring process.
- 7.6. REVIEW PROCESS. The Board of Commissioners shall grant the final approval upon review and recommendation by the chairperson and Medical Executive Committee. The application for proctored staff shall accompany a letter of intent from the designated proctoring Medical Staff member indicating the proctoring relationship in detail.

ARTICLE VIII: DISRUPTIVE CONDUCT

It shall be the policy of Valley General Hospital that all individuals be treated courteously, respectfully, and with dignity. To that end, the medical staff and the Board of Commissioners require that all licensed independent practitioners conduct themselves in a professional and cooperative manner in Valley General Hospital.

- 8.1 **POLICY:** The purpose of the policy set forth in this section is to ensure quality care by promoting a safe, cooperative and professional healthcare environment and to prevent or eliminate conduct which disrupts the operation of the hospital, affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for hospital employees, patients, or other individuals.
- 8.2 **DEFINITION:** Unacceptable or unprofessional conduct as defined by WA RCW 18.130.180, which is disruptive may include but is not limited to:
- 8.2.1 Rude, vulgar or abusive conduct toward, or in the presence of, patients, nurses, other hospital employees, other practitioners or visitors.
 - 8.2.2 Inappropriate comments spoken, or written, in patient records or other official documents attacking or impugning the quality of care in the hospital, other practitioners, Valley General Hospital personnel, or hospital policy.
 - 8.2.3 Non-constructive criticism addressed to its recipient in a way as to intimidate, belittle or to impute stupidity or incompetence.
 - 8.2.4 Deliberate destruction or stealing of hospital property, including falsification or alteration of medical records.
 - 8.2.5 Disrupting hospital case management, committee, or peer review functions.
 - 8.2.6 Disrupting hospital personnel's ability to perform their assigned functions.
 - 8.2.7 Engaging in discrimination or harassment of any individual including but not limited to another medical staff member, hospital employees, patients, other practitioners, or visitors at the hospital as further described on the basis of age, marital status, gender, race, religion, creed, national origin, the presence of any sensory, mental, or physical disability or any other protected classification.

- 8.2.7.1 Harassment is defined as:
 - 8.2.7.1.1 Any harassment based on age, marital status, gender, race, religion, creed, national origin, and disability or other legally protected classification
 - 8.2.7.1.2 Any verbal, written, or physical conduct which has the purpose of unreasonably interfering with individual work performance and/or creating an intimidating, hostile, and offensive working environment.
 - 8.2.7.1.3 Verbal, written, physical and other conduct whereby submission to and/or rejection of such conduct are explicitly or implicitly used as a basis for hiring, promotion, performance evaluation, and termination.
- 8.2.7.2 Sexual harassment is defined as unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work) and visual harassment (such as the display of derogatory cartoons, drawings, or posters), when:
 - 8.2.7.2.1 Submission to such conducts are explicitly or implicitly made a term or condition of employment or working relationship;
 - 8.2.7.2.2 Submission to or rejection of such conduct by an individual is used as the basis of employment decisions affecting such individual or working relationship; or
 - 8.2.7.2.3 Such conduct has the purpose or effect or interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.
- 8.2.7.3 Examples of Harassment
 - 8.2.7.3.1 Prohibited harassment includes comments, slurs, jokes, innuendoes, cartoons, pranks, physical harassment, and related behavior, such as is substantive in nature and which are derogatory on the basis of the individual's age, marital status, gender, race, religion, creed, national origin, disability, or other protected classification.
 - 8.2.7.3.2 Sexual harassment includes unwelcome behaviors, which persist after communication to the individual that such behaviors are unwelcome. Such behavior may include sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature.
 - 8.2.7.3.3 Any of the above conduct, or other offensive conduct, directed at individuals because of their race, national origin, religion, creed, disability, age, military, or any legally-protected status is also prohibited.
- 8.2.7.4 Determination of Harassment

8.2.7.4.1 Determination of what constitutes harassment in a given uncomfortable or unsolicited situation shall be the standard of a reasonably prudent person under such circumstances.

8.3 **COMPLAINT PROCEDURE.** If an individual has experienced or witnessed harassment at Valley General Hospital, the individual should utilize the complaint procedure.

All complaints of harassment will be investigated promptly and impartially in as confidential a manner as reasonably possible. Practitioners are required to cooperate in any investigation. Retaliation against any individual for filing a complaint or participating in an investigation is strictly prohibited.

8.3.1 Complaints shall be filed on Quantros or a written complaint may be provided and documented as follows:

8.3.1.1 Names of all parties involved

8.3.1.2 Date, time, and circumstances surrounding the situation

8.3.1.3 A description of the conduct limited to factual, objective language

8.3.1.4 Any known consequences of the conduct

8.3.1.5 Any witnesses to the event

8.4 **INVESTIGATION:** Upon receipt of a report regarding disruptive conduct, the President/Designee of the Medical Staff, the Medical Director/Designee, and Chief Executive Officer/Designee shall review the matter and decide if further investigation is warranted.

Reports which are not found to be credible or of merit, with concurrence of the above parties, may be dismissed. Others involved in the investigation may include department and committee chairpersons.

8.5 **INTERVENTION AND ACTIONS:** May include the following:

8.5.1 A meritorious report, after reasonable investigation, will warrant a discussion with the individual. Any of the parties listed in Section 8.4 of this policy may be chosen to conduct this meeting, which shall be collegial in nature and designed to help the individual, and the hospital to rectify the situation. It should be stressed to the individual that such behavior is unacceptable.

8.5.2 If it appears that the initial intervention was unsuccessful, and a pattern of conduct is developing or persisting, the President of the Medical Staff, and the Medical Director/Designee, and Chief Executive Officer/Designee shall meet with the individual and again stress that the behavior shall cease, and that more formal action may be taken to stop it. A letter shall be sent to the individual stating what is required, and the Medical Executive Committee of the Medical Staff shall be notified.

8.5.3 There is no requirement of progressive discipline and any one incident may be grounds for referral to the Medical Executive Committee for corrective action, pursuant to the medical staff's policy on appointment and reappointment, and/or the medical staff bylaws, and rules and regulations. Summary suspension, as outlined in the medical staff bylaws, may be appropriate during the investigation.

Any summary suspension beyond thirty (30) days, or upon recommendation by the Medical Executive Committee for corrective action that would

adversely effect the practitioner's privileges, shall entitle him/her to the hearing and appeal process outlined in the Fair Hearing Plan.

- 8.5.4 At any time, the matter may be referred to the Physician Well-Being Committee.

All meetings with the practitioner shall be documented, including any rebuttal, and such records shall be kept in a separate file by the Chief Executive Officer/Designee. Any final actions, as defined in the medical staff bylaws, rules and regulations, will be placed within the practitioner's credentials file.

Any restriction imposed on healthcare practitioners' privileges based on unprofessional conduct shall be reported within 15 days from day of restriction.

ARTICLE IX: PHYSICIAN WELL-BEING COMMITTEE POLICY AND PROCEDURE

- 9.1. **POLICY:** Members of the Medical Staff and Allied Health have the responsibility to their patients, colleagues, and the Hospital to provide care in accordance with expected community standards. Staff members must be able to work in a drug free environment and must themselves be free from the effects of any performance-impairing substance, behavior or physical condition.

It shall be the responsibility of every medical staff and allied health practitioner to report any physical/behavior/health condition to the medical staff office if and when condition exists.

If practitioner reports that s/he is enrolled with the Washington Physicians Health Program (WPHP) structure the medical staff office shall be given release for information to request compliance reports quarterly from the program until condition has been reported resolved by the program. WPHP program shall supercede this policy for practitioner's compliance purposes in relation to the physician well-being committee.

- 9.1.1. **Physician Well-Being Committee Duties.** The Physician Well Being Committee ("PWBC") is a standing committee of the Medical Staff and Allied Health whose following duties shall be:
- 9.1.1.1. to evaluate the competency of and qualifications of practitioners referred to it with respect to possible impairment of their ability to practice with reasonable skill and safety to patients;
 - 9.1.1.2. to encourage practitioners treatment and rehabilitation, and to promote wellness; and
 - 9.1.1.3. to educate the Medical Staff and Allied Health practitioners and Hospital community regarding the problem of the impaired practitioner.

The activities of the committee will be kept confidential to the extent permitted by law.

- 9.1.2. **Definition of Impairment**
The American Medical Association defines an impaired practitioner as "one who is unable to practice medicine with reasonable skill and safety to

patients because of physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol." Any medical staff/ allied health member with the unauthorized presence of drugs or alcohol in his or her body for non-medical reasons is prohibited in the workplace at Valley General Hospital.

9.2. PROCEDURE

9.2.1. Investigation and Evaluation

9.2.1.1. **Report.** Reports of suspected practitioner impairment may be received from any source, and should be written, signed, dated, and forwarded on a timely basis to the PWBC for investigation and evaluation. In the case of a report of suspected acute impairment, an expedited procedure will be followed (see Section 3 below). "Impairment" may include:

- 9.2.1.1.1. impairment due to mental, emotional or physical problems;
- 9.2.1.1.2. impairment due to alcohol or other drug use or abuse; or
- 9.2.1.1.3. impairment due to behavioral problems.

9.2.1.2. **Confidentiality of Sources.** The sources of allegations of impairment will usually remain confidential. Where the PWBC finds no basis for the allegation, it will specifically evaluate the nature of the accusation with regard to the accuser's good faith and keep a confidential record of the accusation. Where the PWBC does find impairment and where the practitioner contests this finding or the actions taken by the Medical Executive Committee based upon the finding, the identity of the accuser shall be made known to the practitioner, but only in the course of an appeal according to the Fair Hearing Plan as applicable.

9.2.1.3. **Investigation.** Upon receipt of a referral or an allegation of impairment, the Chair of the PWBC will assign one of the members to investigate. The assigned member may not be a partner or direct competitor of the accused practitioner or have any other potential conflict of interest. The scope and methods of investigation and evaluation will necessarily be determined on a case-by-case basis. The Washington Physicians Health Program (WPHP) may be consulted to assist with the investigation at any point. The Investigator may privately interview the accuser.

After investigation, the member will make a preliminary written report to the full PWBC addressing the following:

- 9.2.1.3.1. The nature and source of the report or allegations of impairment.
- 9.2.1.3.2. The explanation of the practitioner accused of impairment regarding his/her behavior.
- 9.2.1.3.3. Results of private inquiries made of others who may be knowledgeable including the practitioner's partners or co-workers.
- 9.2.1.3.4. The results of blood or urine testing. The PWBC investigator may request or offer such testing to the

accused practitioner. Such testing will be done at a site and laboratory designated by the PWBC and following approved chain of custody procedures. The practitioner shall have the right to refuse testing but this will be reported to the full PWBC, and Medical Executive Committee as appropriate.

9.2.1.3.5. Results of any physical or mental health testing. The investigator may perform or ask another physician to perform such examinations. The practitioner has the right to refuse such examinations but, again, this fact will be reported to the full PWBC, and Medical Executive Committee as appropriate.

The full PWBC will receive the written report of its investigator for evaluation. The PWBC may make further inquiries of the practitioner or others. The PWBC may also consider prior reports regarding the practitioner and actions which were taken as a result of those prior reports. The PWBC may request an outside evaluation with the consent of the practitioner.. Finally, of course, the practitioner shall have the right to submit any information he or she wishes the PWBC to consider, including the right to make an oral presentation.

All costs of initial blood and urine testing will be borne by the Hospital. Costs for any additional outside evaluation shall be borne by the practitioner, unless the PWBC decides otherwise.

9.2.2. **Reporting and Recommendation.** Once the PWBC has completed its investigation and evaluation, it will prepare a final written report with its findings for the practitioner's file. A summary of the final report will also be sent to the referring officer or body of the medical staff and/or allied health (Medical Executive Committee, Department Chair, President).

Where the PWBC finds evidence of impairment, the final report will be sent to the Medical Executive Committee with recommendations regarding limitations to be imposed upon the practitioner's staff status and/or privileges. Specifically, the report will include the results of efforts by the PWBC to get the practitioner to recognize the problem and agree to participate in treatment and monitoring. Where the practitioner has come to an agreement with the PWBC, the report will explain the agreed upon treatment and monitoring program. The PWBC has no independent authority regarding a practitioner's status or privileges.

In the event that the PWBC makes a finding that there is current and ongoing impairment, it will notify the appropriate officer of the Medical Staff and/or Allied Health or Department Chair for possible Summary Suspension (see Fair Hearing Plan or Article IX of Allied Health Policies and Procedures as applicable), as well as make its report to the Medical Executive Committee.

9.2.3. **Expedited Procedure for Reports of Suspected Acute Impairment.** The suspected acutely impaired practitioner presents a special case requiring immediate action to insure patient safety. Later, formal investigation and evaluation by the PWBC may occur as outlined above.

9.2.3.1. **Report and Investigation**

9.2.3.1.1. Any report of possible acute impairment or alcohol on breath will be made to the Administrative Supervisor who will start the investigation. A verbal report must be immediately followed by a written report.

9.2.3.1.2. The practitioner will be evaluated as outlined in the Procedure for Evaluating Suspected Acutely Impaired Physician (Appendix A). The practitioner's refusal to fully cooperate with the Administrative Nursing Supervisor or the ED physicians will be reported immediately to the appropriate Medical Staff Officer and/or practitioner's Department Chair and/or the Administrator on Call.

9.2.3.2. **Action.** The ED physician will then contact any appropriate and available Medical Staff Officer (President or Vice President), Medical Director and/or the practitioner's Department Chair and/or Administrator on Call to discuss the findings and decide whether Summary Action is warranted as provided for in the Medical Staff Bylaws and the Fair Hearing Plan or Article IX of AHP Policies and Procedures as applicable.

9.2.3.2.1. Where no Summary Action is taken, a PWBC member will be notified within 24 hours and will make a report to the PWBC including the Assessment Form for possible initiation of formal investigation and evaluation.

9.2.3.2.2. Where Summary Action is taken, the matter will be referred to the Medical Executive Committee per Medical Staff Bylaws and the Fair Hearing Plan or Article IX of AHP Policies and Procedures as applicable.

9.2.4. **Treatment and Rehabilitation.** Where the Medical Executive Committee has recommended to take action restricting a practitioner's Privileges (or where continued unrestricted practice is contingent on treatment), it may request that the PWBC assist the practitioner in finding a suitable treatment program. The PWBC will maintain a list of such programs that have demonstrated competence in managing the complex problem of the impaired physician. Consultation from the Washington Physicians Health Program (WPHP) may be requested. The practitioner's choice of program must be approved by the Medical Executive Committee and the PWBC.

The practitioner must agree in writing to waive confidentiality and permit the PWBC and Medical Executive Committee to have access to reports from his/her treatment program and/or from his/her treating practitioners. The PWBC retains the right to seek independent evaluation and opinion from other consultants.

After the practitioner has entered into treatment, the PWBC may monitor the practitioner's compliance and progress at the request of the Medical Executive Committee. In the case of substance abuse, successful

completion of the program will involve compliance with all follow-up and rehabilitation recommendations for the standard period which currently is five years. The Medical Executive Committee may request the PWBC to assist in the drafting of a written agreement with the practitioner specifying what will be required in the way of performance monitoring and surveillance including possible random drug screening.

Failure of the practitioner to comply with the written agreement without prior approval of the PWBC Chair or Medical Executive Committee, will be reported immediately to the appropriate officer of the Medical Staff, and/or the practitioner's Department Chair, and/or the Hospital Administrator and will be grounds for Summary Suspension.

The Board of Commissioners shall be notified of any recommended actions taken by the Medical Executive Committee.

9.2.5. **Practitioner Appeal.** If at any point in time a practitioner's privileges are restricted, suspended or terminated as a result of a recommendation made by the PWBC, the practitioner will have the right to a fair hearing under the Fair Hearing Plan or Article IX of AHP Policies and Procedures as applicable.

9.3. **APPENDIX A - Procedure for Evaluating Suspected Acutely Impaired Practitioners**

9.3.1. Administrative supervisor is notified of suspected impairment. All verbal reports must be immediately followed by written documentation. The QMM form is recommended but not required.

9.3.2. Administrative supervisor starts the investigation. The administrative supervisor may ask the practitioner's Department chair or medical director or the ED physician on duty to act as an observer when approaching the suspected impaired practitioner. If none of these practitioners is available, then any practitioner or administrator in house may be asked to be an observer. The observer will be asked to submit a written report.

9.3.3. Administrative supervisor makes phone contact with appropriate ED practitioner.

9.3.4. Administrative supervisor calls laboratory technicians to inform them to meet at the designated ED office.

9.3.5. Laboratory technician provides lab form and urine tox screen. Chain of custody forms and procedures must be used. A split urine sample will be collected. One sample will be processed through the chain of custody process. The other will be run stat in the clinical laboratory for urine drugs of abuse.

9.3.6. ED practitioner provides BP cuff, and-breathalyzer. A blood alcohol level will be done if the breathalyzer is positive and/or unavailable or not functioning properly.

9.3.7. Administrative supervisor provides ED practitioner with the physical assessment form and these instructions. The form and instructions should also be available in the ED.

9.3.8. Female Administrative supervisor or female ED practitioner observes female urine tox screen collection; male Administrative supervisor or male ED practitioner observes male urine toxic screen collection. Record temperature, signature of suspected impaired practitioner and signature of

- observing person. Make sure chain of custody form is completely filled out. Tamper proof seals are used with initials.
- 9.3.9. Laboratory technician phones stat results of urine tox screen to ED practitioner.
 - 9.3.10. Laboratory technician provides copy of lab form to attach to ED assessment form.
 - 9.3.11. ED practitioner discusses findings with the Medical Staff President or Vice President, and/or the suspected practitioner's Department Chair and/or the Administrator on Call. They will determine if suspected practitioner is:
 - 9.3.11.1. Fit or not fit for duty
 - 9.3.11.2. Impaired or not impaired
 - 9.3.12. ED practitioner will discuss plan with the suspected practitioner
 - 9.3.13. Administrative Supervisor sends the ED assessment form with the lab form to the Medical Staff Office for the PWBC member to review in the a.m. and place in the PWBC file.
 - 9.3.14. If the suspected acutely impaired practitioner refuses to cooperate with the Administrative Supervisor, observing practitioner/administrator or the ED practitioner, then the Medical Staff President or President-Elect, and practitioner's Department Chair, and the Administrator on Call will be contacted at once to administer a Precautionary Summary Suspension.
 - 9.3.15. The ED practitioner will insure that any practitioner who is found to be not fit for duty has a plan for a safe disposition. (SEE FORM A)

ARTICLE X: CONFIDENTIALITY OF MEDICAL STAFF CREDENTIALING AND QUALITY INFORMATION

- 10.1 **Policy Statement.** It shall be the policy of Valley General Hospital Medical Staff Office and/or Quality Assurance Department to maintain the confidentiality of all records, discussions, and deliberations relating to credentialing, clinical and performance improvement activities. Disclosure of the aforementioned shall be permitted only as described in this policy.
- 10.2 **Location and Security**
 - 10.2.1 A separate record shall be maintained for each individual who has been granted staff membership and clinical privileges.
 - 10.2.2 All records shall be maintained under the care and custody of this hospital's authorized representative(s). The office and file cabinets where credentialing and quality records are stored shall be kept locked, except when an authorized representative supervises access. Records stored electronically shall be protected by passwords and read/write controls.
- 10.3 **ACCESS TO RECORDS**
 - 10.3.1 **Requests for access.** All requests for access to credentialing and quality records shall be presented to an authorized representative, who shall keep a record of requests made and granted.
 - 10.3.2 Unless otherwise stated, an individual permitted access under this section shall be afforded a reasonable opportunity to inspect the records and to make notes regarding the requested records in the presence of an authorized representative. In no case shall an individual remove or make copies of any records without express permission.

10.3.3 Access by individuals performing official functions

- 10.3.3.1 The following individuals may access credentialing/quality records to the extent described:
- 10.3.3.1.1 Authorized representatives and staff members may have access to all records as needed to fulfill their responsibilities.
 - 10.3.3.1.2 Consultants or attorneys engaged by this hospital may be granted access to records that are necessary to enable them to perform their functions.
 - 10.3.3.1.3 Representatives of regulatory or accreditation agencies may have access to records.
 - 10.3.3.1.4 An individual physician may review his or her credentials file under the following circumstances:
 - 10.3.3.1.4.1 The request is approved by the President, Medical Director, and Chief Executive Officer or its designee.
 - 10.3.3.1.4.2 Review of the file is accomplished in the presence of the medical staff coordinator, officer of the staff, or member of the medical executive committee.
 - 10.3.3.1.4.3 The physician understands that s/he may not remove any items from the credentials file.
 - 10.3.3.1.4.4 The physician understands that s/he may add an explanatory note or other document to the file.
 - 10.3.3.1.4.5 The physician understands that s/he may not review confidential letters of reference received during the initial appointment or any subsequent reappointment.
 - 10.3.3.1.4.6 No items may be photocopied without the express written permission of the President, Medical Director, or Chief Executive Officer or its designee.
- 10.3.3.2 Each individual described in Section 10.3.3.1.1. and 10.3.3.1.2. above shall be permitted access to records, provided that s/he has signed and dated the appropriate *Confidentiality Agreement (Form B)*. The original agreement shall be retained by this hospital.
- 10.3.3.3 The hospital will not release reports received from the National Practitioner Data Bank to any agent.
- 10.3.3.4 All subpoenas pertaining to records shall be referred to the authorized representative, who shall first consult with legal counsel regarding appropriate response.

10.3.3.5 Records requested by persons or organizations outside of this hospital shall be provided upon approval by the authorized representative.

10.4 **Sanctions.** Violation of this policy is grounds for progressive discipline.

10.5 **No Waiver.** Nothing in this section is intended to waive any privileges or confidentiality provision that may apply under state or federal law to credentialing peer review or quality improvement records maintained by the Hospital, the Medical Staff Office, or the Quality Assurance Department.

ARTICLE XI: EMERGENCY CREDENTIALING POLICY

11.1 **Policy:** All practitioners who do not possess medical staff or allied health privileges, may be granted temporary emergency privileges at this hospital by the Chief Executive Officer or his/her designee and one representative of the Medical Executive Committee during a state-wide or nation-wide “emergency” or “disaster”.

11.2 The practitioners must provide the following before emergency privileges are granted:

11.2.1 Valid Photo ID or Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT)

11.2.2 Valid professional license in the State of WA

11.2.3 Name of current malpractice insurance carrier

11.2.4 List of current hospital affiliations where practitioner holds Active OR Allied Health staff privileges

11.3 Primary source verification will be completed as soon as possible by the Medical Staff Office. A record of this information will be retained in the Medical Staff Office.

11.4 Practitioners will be supervised during the duration of the emergency or disaster event by a credentialed practitioner currently on staff who has a similar specialty.

11.5 In the event primary source verification cannot be completed, emergency privileges may still be issued pending verification of good standing.

11.6 A practitioner’s privileges shall immediately terminate in the event of the following:

11.6.1 Any adverse information received or discovered during the verification process in the Medical Staff Office;

11.6.2 Any immediate concern brought to the attention of the Medical Staff Office regarding a practitioner’s ability to practice; or

11.6.3 Statewide or nationwide emergency or disaster has been cleared

11.7 The termination of emergency privileges shall not entitle the practitioner the procedural rights afforded by the Fair Hearing Plan and is not considered to be an adverse action that is reportable to the National Practitioner Data Bank.

ARTICLE XII: NEW TECHNOLOGY/PROCEDURE POLICY AND PROCEDURE FOR REQUEST

- 12.1 **POLICY:** Any new technology/procedure to be initiated by any medical staff member at Valley General Hospital shall be reviewed by the Medical Executive Committee. Any requests shall only be processed when all necessary information has been provided to the Medical Executive Committee as outlined in this policy. The Board of Commissioners shall make the final determination regarding any request.
- 12.2 **PROCEDURE:** The burden is on the interested practitioner to provide all necessary information to the Medical Executive Committee about the device, technology, technique, or procedure (see Form C).
- 12.2.1 New technology/procedure name
 - 12.2.2 Names of other hospitals in which it is used;
 - 12.2.3 Any peer reviewed research demonstrating the risks and benefits of this technology/procedure;
 - 12.2.4 Any product literature or educational syllabus addressing the technology/procedure;
 - 12.2.5 Financial analysis of the new technology/procedure which should include operating revenue, expenses, capital equipment, and contribution margin;
 - 12.2.6 FDA approval letter;
 - 12.2.7 Anesthesia or other specialty concerns;
 - 12.2.8 Technology/procedure clinical indicators for peer review;
 - 12.2.9 Technology/procedure privilege form (See Form D)
- 12.3 **REVIEW:** The Medical Executive Committee shall review the information and then determine if it will recommend the new technology/procedure in the institution. The MEC shall invite the interested applicant to its regular scheduled meeting for review of information provided whenever necessary. When making this determination, the MEC shall discuss the institutions' current plan of care; whether or not the new technology/procedure is of proven clinical efficacy and effectiveness; and whether or not the new technology/procedure carries a greater risk than existing conventional therapy, and its financial impact to Valley General Hospital.
- 12.4 **APPROVAL:** The Medical Executive shall forward its recommended action to the Board of Commissioners for final approval.

ARTICLE XIII: PEER REVIEW POLICY

- 13.1 **PURPOSE:** The purpose of this policy is to promote continuous quality improvement of patient care in collaboration with the medical staff of Valley General Hospital through its peer review activities. Each practitioner's clinical activity shall be measured, assessed, and reviewed by their peers whenever indicators are identified.
- 13.2 **DEFINITION:** A peer is defined as a licensed independent practitioner with clinical privileges in the same professional discipline and with essentially equal qualifications as that of the practitioner under review.

"Peer review" is the process of evaluating one's professional performance and includes the identification of opportunities to improve care. The evaluation shall be conducted without biased opinions using recognized standards of care. Through the peer review process, the practitioner under review shall receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing such care.

13.3 **PEER REVIEW PARTICIPANTS:** Providers who do peer review at Valley General Hospital shall be selected from members with appropriate clinical expertise on an as-needed basis.

13.4 **POLICY:** Peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

The practitioner under review shall receive specific feedback of cases reviewed.

Provider-specific peer review results will be available for review by his/her department chairman for appropriate recommendation during its biennium credentialing and privileging process and as indicated by its performance improvement activities.

Provider-specific peer review information consists of information related to quality and utilization review data; sentinel events; and specific indicators related to one's professional discipline, compliments and/or complaints, physician commendations, comments regarding practice performance, and/or corrective actions.

13.5 **ACCESS TO RECORDS:** Peer review information shall be kept secure and in a locked file at all times.

Peer review information is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as medical staff leaders or hospital employees. These individuals (medical executive committee, department chairs, quality committee, risk manager, director of quality and education, medical staff professionals for credentialing purposes, state and federal representatives, and individuals determined by legal counsel and/or board of commissioners) shall only have access to this information for the purpose of quality improvement and to the extent necessary to carry out assigned responsibilities.

No copies of peer review documents shall be created and distributed unless appropriate authorization has been obtained from medical executive committee and/or risk manager.

13.6 **CIRCUMSTANCES REQUIRING PEER REVIEW:** Peer review shall be conducted on an ongoing basis and reported to the appropriate committee for review and action. Additional evaluation shall be conducted when a sentinel event or "near miss" is identified during concurrent or retrospective review; or an unusual clinical pattern of care is identified. Medical executive committee will be informed of external peer review as applicable.

13.6.1 **Circumstances requiring external peer review:** External peer review will take place under the following circumstances indicated, **if and only if** deemed appropriate by the risk manager, medical executive committee, or board of commissioners.

No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the risk manager, medical executive committee, or board of commissioners.

13.6.1.1 Litigation: when dealing with the potential for a lawsuit;

- 13.6.1.2 Internal peer review ambiguity (vague or conflicting recommendations);
- 13.6.1.3 Lack of internal expertise (when no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are partners, associates, or direct competitors of the practitioner under review. Medical executive committee will be informed of the need for external review and its outcome.
- 13.6.1.4 New technology: when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved;
- 13.6.1.5 Miscellaneous issues: when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring;
- 13.6.1.6 Deemed appropriate: when the risk manager, medical executive committee, or board of commissioners require external peer review in any circumstances

13.7 **PARTICIPANTS IN THE REVIEW PROCESS:** Participants in the review process shall be selected by their respective departments or medical executive committee. All practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities.

In the event of a conflict of interest or circumstances that would suggest a biased review, the medical executive committee will replace, appoint, or determine who will participate in the process so that bias does not interfere in the decision-making process. The MEC will consider and record minority opinions and views of the person whose care is under review.

13.8 **PEER REVIEW FOR SPECIFIC CIRCUMSTANCES:** In the event a decision is made by the governing body to investigate a practitioner's performance or if circumstances warrant the evaluation of one or more providers with privileges, the MEC or its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities.

13.9 **ONGOING PEER REVIEW PROCESS AND TIMELINE**

Process	Time Period
Chart screened for indicators as identified	Chart complete or 30 days post-admission, whichever occurs first
Chart assigned to reviewer by clinical directors and/or chair of medical staff quality committee [chair of clinical department]. Reviewer shall be a member of the medical staff quality committee [member of the same department as the physician under review] or subject matter expert, as appropriate.	Initially assigned at discharge or when indicators identified, whichever occurs first

Reviewer examines the case and information submitted to appropriate medical staff committee	Within 15 days of assignment of the chart
Case is reviewed by medical staff quality committee (clinical department)	At next regularly scheduled medical staff quality committee (clinical department)
Practitioner involved and peer reviewer are both notified of upcoming QA chart review	MSO will notify both reviewer and practitioner involved with care regarding upcoming records to be reviewed at QA meetings
After QA meetings, practitioner will receive educational feedback form indicating the results of the review both by the reviewer and the QA committee	MSO will send out educational QA feedback form within 5 business days of chart review if not immediately

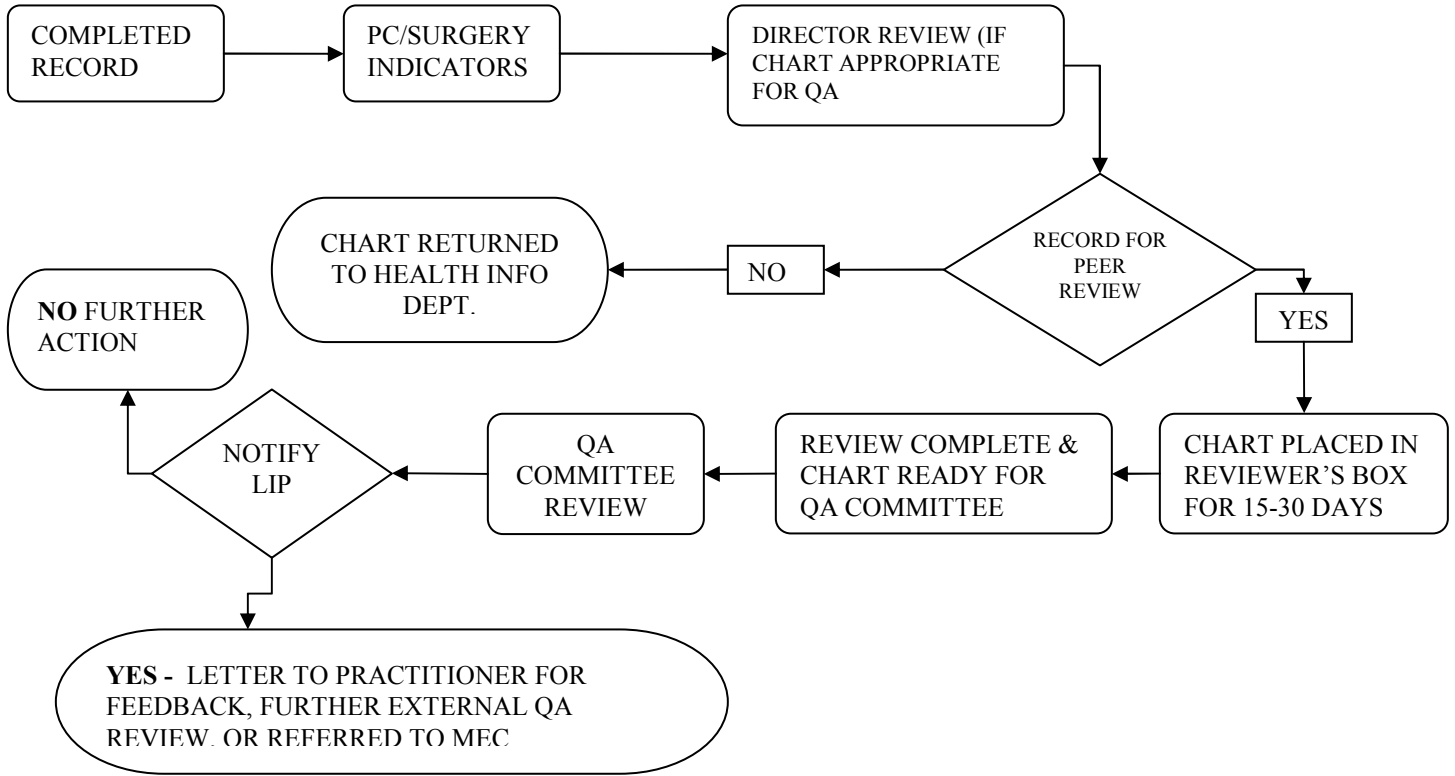
13.10 **HIGH-RISK CASE TIMELINES:** Timely processing of practitioner-specific information is necessary for high-risk cases to ensure proper adjustment to privileges if needed.

Case	Responsible	Time Frame
Sentinel event	Department chair Medical executive committee Board Quality Review and action taken will be determined upon completion of a root-cause analysis	Immediate review within 72 hours of identification with action/decision within 45 days of event
Identification of case needing immediate review, but not considered a sentinel event, such as a "near miss"	Refer to the appropriate department chair for review and action Information reported to the appropriate committee on an ongoing basis.	Review within 72 hours upon identification

Additional information (such as a literature search, second opinion, or external peer review) may be necessary before making a decision on action. Under these circumstances, the timelines may be extended whenever deemed necessary by medical staff quality committee.

These policies and procedures shall have the same force as the bylaws and shall be amended according to Article X of the medical staff bylaws.

PEER REVIEW FLOW CHART



ARTICLE XIV: SECTION CHIEF JOB DESCRIPTION

14.1. PURPOSE:

- 14.1.1. Each section chief acts as the primary medical administrative officer for his or her section.
- 14.1.2. Each section chief is responsible for all administrative and medical activities occurring within his or her section and must report to his or her respective department chair.

14.2. REPORTING: Each section chief shall:

- 14.2.1. Be immediately responsible to his or her department chair
- 14.2.2. Keep the department chair and/or chief of staff informed of any and all violations of medical staff bylaws and its related documents and/or Hospital policies including a written action plan to resolve any violation and/or issues for improvement of quality of care without jeopardizing patient's safety and care
- 14.2.3. Keep the department chair and/or chief of staff apprised of the progress towards resolution of any violation and/or issues agreed upon by his or her department chair
- 14.2.4. Regularly report to the department chair and/or chief of staff regarding:
 - 14.2.4.1. clinical functions and/or improvements related to the quality of medical care rendered within his or her section
 - 14.2.4.2. any and all variation from standard of care as reported during peer reviews and/or performance improvement programs
 - 14.2.4.3. any and all disciplinary actions in progress
 - 14.2.4.4. unacceptable conduct of becoming a medical staff member

14.3. ACCOUNTABILITY AND FUNCTIONS: Each section chief shall:

- 14.3.1. Be a medical staff member appropriately credentialed and approved by the Board of Commissioners
- 14.3.2. Be responsible for all clinical and administrative related activities within his or her section
- 14.3.3. Monitor and evaluate the quality and appropriateness of patient care provided within his or her section
- 14.3.4. Monitor the professional performance of all its members who have been granted membership and clinical privileges in his or her section
- 14.3.5. Recommend criteria for clinical privileges within his or her section
- 14.3.6. Be responsible for the integration of his or her service into the primary functions of the organization
- 14.3.7. Be responsible for the coordination and integration of interdepartmental and intradepartmental services as applicable
- 14.3.8. Be responsible for the development and implementation of policies and procedures that guide and support the provisions of medical services within the scope of responsibility and standard of care as recognized by its society and its academic board
- 14.3.9. Be responsible to carry out performance improvement activities as related to his or her section
- 14.3.10. Provide a report to department meetings as necessary relating to appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in his or her section

- 14.3.11 Assist the Hospital in accordance with the provisions of the bylaws and its related documents, hospital policies, with respect to requesting of locum tenens privileges within his or her section
- 14.3.12 Be responsible within his or her section for the enforcement of medical staff bylaws and its related documents and Hospital policies and procedures
- 14.3.13 Be responsible for implementation within his or her section relating to actions taken by the Board in recommendation of the Medical Executive Committee
- 14.3.14 Be responsible for the establishment, implementation, and effectiveness of the staff orientation and education programs as related to his or her section
- 14.3.15 Report and recommend to department chair, medical staff leaders, and/or Hospital leaders when necessary with respect to matters affecting patient care including personnel, space and other resources, supplies, special regulations, standing orders, and techniques
- 14.3.16 Assist Hospital and medical staff leaders in the preparation of annual reports and such budget planning pertaining to his or her section as may be required by the department chair
- 14.3.17 Be responsible for assessing and recommending to the department chair off-site sources for needed patient care services not provided by the department or the Hospital
- 14.3.18 Be a liaison for infection control as it relates to his or her specialty

14.4 POSITION REQUIREMENTS: This individual must:

- 14.4.1 Be an Active staff member of the medical staff during his or her term of office
- 14.4.2 Have no pending adverse professional review recommendations concerning staff appointment and/or clinical privileges
- 14.4.3 Not be presently serving as a Medical Staff and/or Board officer, or department, or committee chairperson at another hospital, and shall not so serve during the term of office
- 14.4.4 Use this Hospital as his/her primary hospital facility
- 14.4.5 Have constructively participated in medical staff affairs, including professional peer review activities
- 14.4.6 Have actively served on at least one (1) medical staff committee
- 14.4.7 Be willing to discharge faithfully the duties and responsibilities of the position
- 14.4.8 Be knowledgeable concerning the duties of the office
- 14.4.9 Possess and have demonstrated the ability for harmonious, professional interpersonal relationships
- 14.4.10 Possess an understanding of the purposes and the functions of the organization and a demonstrated willingness to assure that patient safety takes precedence over other concerns
- 14.4.11 Possess an understanding of and willingness to work in accordance with the medical staff bylaws and its related documents, Hospital's policies and procedures, and requirements by federal, state, and local association and societies as applicable
- 14.4.12 Be board certified by the appropriate specialty board or deemed equivalent by the appropriate clinical department
- 14.4.13 Be a member in good standing by his or her assigned clinical department
- 14.4.14 Be elected by a majority vote of those members eligible to vote and appointed by the Board.

ARTICLE XV: CONFLICT OF INTEREST

- 15.1 **Definitions:** The hospital defines the key terms used in this policy as follows:
- 15.1.1 **Affiliate:** Any organization that controls, is controlled by, or is related by common control (majority or minority) to this corporation.
 - 15.1.2 **Board committee:** Any committee that has a specific, delegated authority to take final action relative to the charitable, business, or clinical aspects of this corporation delegated to it by the board or the bylaws of this corporation (as opposed to a committee that is simply advisory).
 - 15.1.3 **Board member:** Any director or trustee of this corporation—whether appointed, elected, or ex officio and including, but not limited to, physicians.
 - 15.1.4 **Compensation:** Any direct or indirect remuneration, including any substantial gifts or favors.
 - 15.1.5 **Conflicting interest:** Service as a member, shareholder, trustee, owner, partner, director, officer, or employee of any organization or governmental entity that
 - 15.1.5.1 competes with this corporation or any affiliate
 - 15.1.5.2 provides goods or services to the organization or receives goods or services from the organization;
 - 15.1.5.3 provides regulatory inspection, supervision, accreditation, or other oversight in the organization;
 - 15.1.5.4 is involved—or is likely to become involved—in any litigation or adversarial proceeding with this corporation or any affiliate.
 - 15.1.6 **Financial interest:** Any direct or indirect arrangement or transaction in which an interested person has through business, investment, or family a present or potential ownership, investment interest, or compensation arrangement with this corporation. Financial interest is also an issue with any entity or individual with which this corporation or any affiliate has, or may have, a transaction or arrangement.
 - 15.1.7 **Interested person:** Any person who has a direct or indirect financial interest or conflicting interest.
 - 15.1.8 **Key management personnel:** The chief executive officer of this corporation, any managers who report directly to the chief executive officer or the board, and any other personnel so designated by the chief executive officer.
 - 15.1.9 **Person covered by this policy:** Any board member, member of any board committee, officer of this corporation, and key management personnel of this corporation.
- 15.2 **Disclosure of potential conflicts of interests:** Every person covered by this policy shall submit in writing to the chief executive officer a Conflict of Interest Disclosure Statement listing all financial and/or potential conflicting interests. Individuals should resubmit each statement with any necessary changes each year or as any additional conflicting or financial interests arise. All board members will receive an annual summary of the disclosures. In addition, the chair and the vice chair of the board shall have disclosure statements available at the time of all board meetings in case a potential conflict arises.
- 15.3 **Procedure to be followed at meetings:** Whenever the board or a board committee is to consider a transaction or arrangement with an organization, entity, or individual in which a person covered by this policy has a financial or conflicting interest, the following must occur:
- 15.3.1 The interested person must disclose the financial or potential conflicting interest to the board or board committee.

- 15.3.2 The board chair, the board committee, or the board may ask the interested person to leave the meeting during discussion of the matter regarding the potential conflict. If asked, the interested person must leave the meeting, but may make a statement or answer any questions on the matter before his or her departure.
- 15.3.3 The interested person shall not vote on the matter regarding the potential conflict.
- 15.3.4 The board or board committee must approve the transaction or arrangement by a majority vote of a quorum of the board members present—not including the presence of the interested person.

If an interested person has a financial interest in a transaction or arrangement that might involve personal financial gain or loss, consider the following provisions in additions to the ones described above.

- 15.3.5 If appropriate, the board or board committee may appoint a disinterested person or committee to investigate alternatives to the proposed transaction or arrangement.
- 15.3.6 A majority vote of the board members, not including the interested person, must approve the transaction or arrangement.
- 15.3.7 To approve the transaction, the board or board committee must first find, by a majority vote of the board members in office—not including the vote of the interested person—that the proposed transaction or arrangement is in the corporation’s best interest. It also must find that for its own benefit, the proposed transaction is fair and reasonable to the corporation, and that after reasonable investigation, the corporation cannot obtain a more advantageous transaction or arrangement with reasonable efforts.
- 15.3.8 The interested person shall not be present for the discussion or vote regarding the transaction or arrangement.

15.4 **Minutes of meetings:** Minutes of all board and board committee meetings shall include the following:

- 15.4.1 The name of the person who disclosed a potential conflicting or financial interest
- 15.4.2 The nature of the potential conflicting or financial interest
- 15.4.3 Whether the board determined there is a conflict of interest
- 15.4.4 The names of the persons who were present for discussions and votes relating to the transaction or arrangement and the content of these discussions including any alternatives to the proposed transaction or arrangement
- 15.4.5 A record of the vote regarding the transaction or arrangement

15.5 **Dissemination and acknowledgement of policy:**

- 15.5.1 This policy shall be distributed to all persons covered by this policy.
- 15.5.2 Each person covered by this policy shall sign an annual statement that he or she
 - 15.5.2.1 received a copy of the policy
 - 15.5.2.2 read and understands the policy
 - 15.5.2.3 agrees to comply with the policy
 - 15.5.2.4 understand that the policy applies to the board and all board committees; and
 - 15.5.2.5 understand that this corporation and its affiliates are organized to advance charitable purposes, and that in order to maintain tax-exempt status, they must continuously engage primarily in activities that accomplish one or more tax-exempt purposes.

15.6 Compensation Committees

15.6.1 A voting member of any committee whose jurisdiction includes compensation matters, and who receives compensation directly or indirectly from the corporation for service, may not vote on matters pertaining to his or her compensation.

15.6.2 Physicians who receive compensation directly or indirectly from the corporation—whether as employees or independent contractors—may not serve on any committee whose jurisdiction includes compensation matters.

15.7 Periodic Reviews

15.7.1 To ensure that the corporation operates in a manner consistent with its charitable purposes and does not engage in activities that could jeopardize its status as an organization exempt from federal income tax, the hospital will conduct periodic reviews.

15.7.2 The periodic reviews shall, at a minimum, include the following subjects:

15.7.2.1 Whether compensation arrangements and benefits are reasonable and are the results of arm's-length bargaining

15.7.2.2 Whether acquisitions or other arrangements with providers result in increment or impermissible private benefit

15.7.2.3 Whether partnerships and arrangements with other organizations conform to written policies, are properly recorded, reflect reasonable payments for goods and services, further the corporation's charitable purposes, and do not result in inurement or impermissible private benefit

15.7.2.4 Whether agreements to provide healthcare and agreements with other healthcare providers, employees, and third-party payers further the corporation's charitable purposes and do not result in inurement or impermissible private benefit

15.8 **Penalties for noncompliance:** Failure to comply with this policy constitutes grounds for removal from office and, in the case of key management personnel, termination of employment.

15.9 Policy on billing practices

15.9.1 The hospital has a proud history of participation in the Medicare and Medicaid programs. This hospital views participation in these programs to be an integral part of its mission of the promotion of health to the community it serves. To receive funds from the Centers for Medicare and Medicaid Services, the agency formerly known as the Health Care Financing Administration, and state agencies, and hospitals must all comply with special laws and regulations.

15.9.2 The hospital expects employees to participate in education offered by this hospital and by various professional groups and associations. It also expects employees to be familiar with the laws and regulations governing the billing of inpatients and outpatients under the Medicare, Medicaid, and private insurance programs that affect their specific job responsibilities. In the event that an employee is unclear as to how to submit a claim in a particular situation, the employee is to exercise sound discretion, and in any doubtful case seek appropriate advice. The burden is on each employee to avoid submitting a claim with actual knowledge of its falsity, in deliberate ignorance of its falsity, or with reckless disregard of applicable state or federal law.

15.9.3 For the protection of this hospital, its employees, and the community it serves, it is essential that prompt and full disclosure be made of any situation that might

involve a violation of any billing regulation. It is each employee's duty to report any known or suspected violation of any billing regulation or any of these standards to this hospital's corporate compliance officer. This hospital shall protect the confidentiality of any employee who makes any such report. Employees will not experience retribution by this hospital as a result of reporting violations of any billing regulations or any of these standards.

- 15.10 **Policy review and amendment:** The hospital will periodically review, revise, and amend this policy as necessary. It is the responsibility of the chief executive officer to initiate such a review.

DATE: _____
TIME: _____

Impaired Physician Assessment Form

Name of Practitioner: _____ SS# _____

History (reason for assessment): _____

Exam (may include the following):

Vital signs _____

General appearance (mental status) _____

Odor- breath (alcohol, ketone) _____

Speech (slurred) _____

Gait (steady/unsteady) _____

Skin (diaphoresis, spiders, jaundice, bruises, needle marks) _____

Eyes (nystagmus pupillary size) _____

Lungs _____

Heart sounds _____

Abdomen (organomegaly, tenderness, ascites) .Extremities (tremors, flap) _____

Neurological (CR nerves, strengths, sensory, DTR's, Babinski, cerebellar) _____

Lab (CBC, SMA, Lytes, UA, Urine Tox Screen, Chem Strip) _____

Breathalyzer _____

Stat Urine Tox Screen _____

Impression:

- No Impairment
- Possible impairment
- Impairment
- Intoxication

Plan: No Return to work
OK return to work
Follow-up with PWBC member in AM _____
Name of PWBC member _____

Signature

Date

Valley General Hospital
Monroe, Washington

CONFIDENTIALITY AGREEMENT



As an employee or authorized staff representative of Valley General Hospital, I may be involved in the evaluation and improvement of the quality of care. I recognize that confidentiality is vital to the free and candid discussions necessary for effective peer review activities conducted by the Medical Staff. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities, and to make no voluntary disclosure of such information except to those individuals authorized to receive it in the conduct of the Medical Staff affairs of Valley General Hospital.

Furthermore, my participation in peer review and quality assurance activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every staff member or authorized staff representative of Valley General Hospital or other individuals involved. I understand that Valley General Hospital or its authorized representative is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

Signature

Date

Print Name

Valley General Hospital
Monroe, Washington

NEW TECHNOLOGY/PROCEDURE BRIEFING

Practitioner Name: _____

Date: _____

NAME OF NEW TECHNOLOGY/PROCEDURE:

NAME (3) HOSPITALS WHERE TECHNOLOGY/PROCEDURE IS UTILIZED:

**PEER REVIEWED RESEARCH DEMONSTRATING THE RISKS AND BENEFITS OF THE
NEW TECHNOLOGY/PROCEDURE:**

FINANCIAL ANALYSIS OF NEW TECHNOLOGY/PROCEDURE (must include operating revenues, expenses, capital equipments, and contribution margin):

ANESTHESIA OR OTHER SPECIALTY CONCERNS:

CLINICAL INDICATORS FOR PEER REVIEW

Please submit the following materials including form:

- Copies of research/Literature concerning the proposed technology/procedure
- Product literature or educational syllabus addressing the new technology/procedure
- FDA approval letter

CRITERIA FOR PRIVILEGE REVIEW

Privilege(s)/Procedure(s) in question: _____

GENERAL REQUIREMENTS

SPECIFIC REQUIREMENTS

1. Education	MD, DO, DDS, DPM, other special education course specify: _____ _____
--------------	-----------------------------------------------------------------------------

2. Training/fellowship/ board status/other	MD, DO, DDS, DPM, other special education course specify: _____ _____ years of approved post-graduate training in: _____
-----------------------------------------------	-----------------------------------------------------------------------------------------------------------------------------------

3. Experience	_____ during the past _____ months Specifications: _____ _____ _____
---------------	-------------------------------------------------------------------------------

4. References	References specific to this clinical privilege are required () yes () no Specifications: _____ _____ _____ _____
---------------	--------------------------------------------------------------------------------------------------------------------------------

PRIVILEGE REQUEST FORM

In order to be eligible to request clinical privileges for _____
_____ a practitioner must meet the following minimum threshold criteria:

EDUCATION: _____

MINIMUM FORMAL TRAINING: _____

REQUIRED PREVIOUS EXPERIENCE: _____

REAPPOINTMENT CRITERIA: _____

I understand that in making this request I am bound by the applicable bylaws or policies of the hospital and hereby stipulate that I meet the minimum threshold criteria for this request.

Practitioner Name: _____

Signature: _____

Date: _____

PROCEDURES FOR FORM D

In using Form D, determine:

- First:** What degree must the successful applicant have (MD, DO, DDS, DPM)?
- Second:** How many years of approved postgraduate residency or fellowship training are required and in what types of residency programs?
- Third:** Must the applicant be board certified/board admissible?
- Fourth:** How must recent direct or indirect experience in the procedure, illness or related filed (within the past 12-24 months) must the applicant demonstrate?
- Fifth:** How many references from what type of individuals will be required to permit evaluation of ability, judgment, and current competence?

NOTE: you should state the amount of education, training, and experience that is (in your opinion) necessary to engage in the specific clinical activity under your consideration.

Unless otherwise specified:

- 1) All required education must have taken place in an institution approved by a national or international organization.
- 2) All training must have taken place in a postgraduate training program approved by either the AMA, AOA, APMA, or AAOMS
- 3) All experience must have occurred within the past twelve months in an institution with formal performance monitoring improvement programs (organization accredited by the Joint Commission on Accreditation of Healthcare Organization and The American Osteopathic Association are deemed to meet requirement)
- 4) References must be responsive to the hospital's request and (if provided) returned on a form specified by the hospital
- 5) The column headed "privilege(s)/procedure(s) in question" may often refer to specific attached forms.

STEPS FOR DEVELOPING CRITERIA FOR PRIVILEGES DELINEATION

- 1) One form should be finalized for each area in which privileges are requested or granted (either by general category or specific privileges, i.e., Core medical privileges, gastroscopies, acute myocardial infarction).
- 2) When a privilege crosses specialty designation and controversy exists, this form should be "drafted" by each involved specialty and submitted to the medical executive committee for adjudication.
- 3) Each person or group completing a form should list all possible combinations of qualifications (i.e., if general surgery is drafting a form for "hysterectomy" they should indicate that four years of either general surgery or obstetrical training are required).
- 4) If a particular category is not required indicate with N/A.

**VALLEY GENERAL HOSPITAL – Monroe, Washington
EMERGENCY CREDENTIALING FORM**

NAME: _____

SPONSORING PRACTITIONER: _____

(sponsoring practitioner must be in same specialty)

Documents Needed	Query Date	Receive Date	Comments
Application: Complete			
Agreement to Abide			
Disclosure Questions			
Valid ID/Photo indicating the individual is a member of a disaster medical assistance team (DMAT)			
Professional Licensure			
DEA Certificate			
Liability Coverage facesheet			
Malpractice/Liability History			
NPDB Report			
Office of the Inspector General Report			
General Services Administration Report			
Criminal History Report (WSP)			
<i>Peer Reference</i>			
<i>Peer Reference</i>			
<i>Hospital Privileges</i>			

I attest that the above items are present and verified with relevant primary sources and have noted any irregularities in the credentialing file.

Jeannie R. Dominguez-Burton, RHIT, CPCS
Signature of Medical Staff Coordinator

Date: _____

**Valley General Hospital ~ Monroe, WA
Verification of Credentials Signature Form**

Upon recommendation of the Medical Staff President and/or any MEC designee where the privileges will be exercised, the Chief Executive Officer/designee may grant temporary membership and privileges on the basis of information available as required by the Medical Staff Bylaws, and Policies and Procedures.

Name: _____ **Specialty:** _____

Temporary membership and/or privileges are being given for the following circumstances (see Article XI of MS Policies & Procedures):

JUSTIFICATION: (INDICATE EMERGENCY NEED)

APPROVAL:

_____/_____/_____
Medical Staff President and/or MEC Designee Date

_____/_____/_____
Chief Executive Officer and/or Designee Date

MEDICAL STAFF LEADERSHIP CONFLICT OF INTEREST

ANNUAL QUESTIONNAIRE REGARDING POTENTIAL CONFLICTS OF INTEREST

All Medical Executive Committee, must answer the questions below to disclose any financial or other relationships or arrangements that the physician has with the hospital and its affiliates or with any organizations with which the hospital does business or competes.

Such disclosures are required to ensure compliance with anti-kickback, Stark, and other federal, and state laws, and regulations and to avoid potential conflicts of interest in governing the hospital's operations.

1. Are there any financial arrangements between the hospital or any of its affiliates and you or a member of your family, or the physician group or other entity in which you practice medicine?

Yes _____ No ___ If yes, please describe: _____

2. Do you, a family member or your physician group or employer have any current or past financial or other relationships with suppliers, pharmaceutical companies, durable medical equipment suppliers, and other vendors (including ownership or investment interests, loans, employment, or other compensation arrangements)?

Yes _____ No ___ If yes, please describe: _____

3. Are you the member of the board of directors or shareholders or do you have any ownership or other interest in or relationship with entities that provide healthcare services (e.g., ambulatory surgical centers or physician practices), including employment or other compensation arrangements but excluding less than 1% stock ownership of publicly traded companies?

Yes _____ No ___ If yes, please describe: _____

4. Are there any outstanding loans between you or a family member or your physician group or employer and the hospital or an affiliate or any organization that does business with or competes with the hospital or its affiliates?

Yes _____ No ___ If yes, please describe: _____

5. Have you, a family member, or your physician group or other employer received any gifts, entertainment, or other benefits from any organization doing business with or seeking to do business with the hospital (e.g., gifts and entertainment received from pharmaceutical companies?)

Yes _____ No ___ If yes, please describe: _____

6. Please identify any other interests in, relationships with, or benefits received from any entity that could influence decision-making on behalf of the hospital _____

The answers to the above questions are true and accurate to the best of my knowledge, and I will inform the medical staff office of any changes to these answers that may occur in the following year.

Name:

Signature: _____

Date:

ADOPTED by the Medical Staff of Valley General Hospital:

APPROVED IN FILE
President of the Medical Staff, Valley General Hospital

June 4, 2009
Date Signed

Medical Director, Valley General Hospital

Date Signed

APPROVED by the Board of Commissioners, Public Hospital District No. 1 of Snohomish County dba Valley General Hospital:

APPROVED IN FILE
Board of Commissioners, Valley General Hospital

June 30, 2009
Date Signed

APPROVED IN FILE
Board of Commissioners, Valley General Hospital

June 30, 2009
Date Signed

APPROVED IN FILE
Board of Commissioners, Valley General Hospital

June 30, 2009
Date Signed