MAYERS MEMORIAL
HEALTHCARE DISTRICT

Board of Directors
Special Meeting Agenda

April 7, 2025 @ 10:00 am

Mayers Memorial Healthcare District
Fall River Boardroom
43563 HWY 299 E
Fall River Mills, CA 96028

Mission Statement
Leading Rural healthcare for a lifetime of wellbeing.

In observance of the Americans with Disabilities Act, please notify us at 530-336-5511, ext 1264 at least 48 hours in advance of the meeting so that we may provide the agenda in alternative formats or make disability-related modifications and accommodations. The District will make every attempt to accommodate your request.

				Approx. Time Allotted
1	**CALL MEETING TO ORDER**			
2	2.1 **CALL FOR REQUEST FROM THE AUDIENCE - PUBLIC COMMENTS OR TO SPEAK TO AGENDA ITEMS** Persons wishing to address the Board are requested to fill out a "Request Form" prior to the beginning of the meeting (forms are available from the Clerk of the Board, 43563 Highway 299 East, Fall River Mills, or in the Boardroom). If you have documents to present for the members of the Board of Directors to review, please provide a minimum of nine copies. When the President announces the public comment period, requestors will be called upon one-at-a time, please stand and give your name and comments. Each speaker is allocated five minutes to speak. Comments should be limited to matters within the jurisdiction of the Board. Pursuant to the Brown Act (Govt. Code section 54950 et seq.) action or Board discussion cannot be taken on open time matters other than to receive the comments and, if deemed necessary, to refer the subject matter to the appropriate department for follow-up and/or to schedule the matter on a subsequent Board Agenda.			
3	Mayers Memorial Healthcare District Master Plan Construction Project Management Firm: Recommendation to Award Contract Resolution 2025-06		**Action Item**	10 min.
4	Policies and Procedures 1. Medical Staff Rules 2. Medical Staff Bylaws 3. Quality Assurance Performance Improvement – SNF	Attachment A	**Action Item**	5 min.
5	MMHD April Meeting Date Change to April 23rd Quality, Finance & Regular Board		**Action Item**	2 min.
6	**ADJOURNMENT**			

Posted 04/04/25

MAYERS MEMORIAL HEALTHCARE DISTRICT

Medical Staff Bylaws

2025

(To be used in conjunction with Mayers Memorial Hospital Medical Staff Rules)

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Preamble

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Governing Body of Mayers Memorial Hospital District in protecting the quality of medical care provided in the hospital and assuring the competency of the hospital's Medical Staff. The Bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

Accordingly, the Bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff, its committees, and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff Officers; and they address the respective rights and responsibilities of the Medical Staff and the Governing Body.

Finally, notwithstanding the provisions of these Bylaws, the Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith; and in approving these Bylaws, the Governing Body commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the Governing Body will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Definitions

Allied Health Professional or **AHP** means an individual, other than a licensed physician, dentist or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and Governing Body, these Bylaws and the Rules.

APPELLATE REVIEW BODY means the group designated pursuant to Section 13 to hear a request for appellate review properly filed and pursued by a Practitioner or the Medical Executive Committee.

Chief Executive Officer means the person appointed by the Governing Body to serve in an administrative capacity or his or her designee.

Chief of Staff means the chief officer of the Medical Staff elected by the Medical Staff.

Clinical Privileges Or Privileges means the permission granted by the Governing Body to individual Medical Staff members and Advanced Practitioner Practitioners to render specific patient services.

Clinical Emergency means a condition that requires immediate medical attention.

Clinical Urgency refers to conditions that require prompt medical attention, but are not life-threatening.

Completed Application means an application that includes all the information requested by the Medical Staff at any time during the application process by any person or committee charged with evaluating the application.

Conflict Of Interest means a personal or financial interest or conflicting fiduciary obligation on the part of an individual or an immediate family member of that individual (including a spouse, domestic partner, child or parent) that may negatively impact, as a practical matter, the individual's ability to act in the best interests of the Medical Staff without regard to the individual's private or personal interest, or creates the impression of such a conflict.

Date of Receipt means the date any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail. (See also, the definitions of **Notice** and **Special Notice**.)

Days means calendar days unless otherwise specified.

Distant Site Hospital means a Medicare-certified hospital where a Telehealth Provider is located.

Ex Officio means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.

Governing Body means the board of directors. As appropriate to the context and consistent with the hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

Hospital means Mayers Memorial Healthcare District and includes all inpatient and outpatient locations and services operated under the auspices of the hospital's license.

In Good Standing means a member currently meets all membership requirements (including, but not limited to, meeting attendance requirements and payment of dues or assessments) and is not currently under any limitation of any Medical Staff rights or privileges. "Limitation" may include, but is not limited to, suspension, concurrent proctoring unrelated to initial privileges, or consultation requirement.

Investigation means the formal process initiated by the Medical Executive Committee, as set forth in the Investigations Article of these Bylaws. To constitute an investigation, this formally commenced process generally must be the precursor to a decision regarding whether or not to take corrective action, and is ongoing until either formal action is taken, or the investigation is closed. Except as otherwise provided in these Bylaws, only the Medical Executive Committee or Governing Body may take or recommend corrective action as the result of an investigation. An investigation does not include activity of the Medical Staff Wellbeing Committee, which lacks the authority to take or recommend corrective action.

Notwithstanding the above, for the purposes of complying with applicable reporting requirements under Business and Professions Code Sections 805 and 805.01 or the National Practitioner Data Bank (collectively, "the Reporting Requirements"), the Medical Executive Committee will, as needed and on a case-by-case basis, evaluate whether a focused professional practice evaluation falls within the definition or description of "investigation" under the statutes, regulations, or guidance that govern the Reporting Requirements.

Medical Executive Committee or **Executive Committee** means the executive committee of the Medical Staff.

Medical Staff means the organizational component of the hospital that includes all physicians (M.D. or D.O.), dentists, and podiatrists who have been granted recognition as members pursuant to these Bylaws.

Medical Staff Year means the period from January 1 through December 31.

Member means any practitioner who has been appointed to the Medical Staff.

Notice means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the hospital. (See also, the definitions of **Date of Receipt** and **Special Notice**.)

Patient Contact means any provision of medical care by a Practitioner to a patient at the Hospital, including but not limited to, admission, consultation, surgical or other procedure, and care management, performed in any facility included on the Hospital's license or provided through a telemedicine link. The provision of medical care to a patient during a discrete admission at the Hospital is one patient contact, regardless of the extent of medical care provided during that admission.

Policies And Procedures means those documents adopted as Medical Staff policies in accordance with these Bylaws, unless specified otherwise.

"Department Policies" or "Section Policies" means the department or section policies adopted in accordance with applicable Bylaws, Rules, or policy.

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

Practitioner means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, or podiatrist, nurse practitioner or physician's assistant.

Privileges or **Clinical Privileges** means the permission granted to a Medical Staff member or AHP to render specific patient services.
Rules refers to the Medical Staff Rules adopted in accordance with these Bylaws unless specified otherwise.
Special Notice means a notice sent by certified or registered mail, return receipt requested. (See also, the definitions of **Date of Receipt** and **Notice** above.)
"Telehealth" is defined by California Business & Professions Code §2290.5 to mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth includes synchronous (a real-time interaction between a patient and a health care provider located at a distant site interactions and asynchronous (the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient) store and forward transfers**.** For purposes of these Bylaws, **"Telemedicine"** is that subset of Telehealth services delivered to hospital patients by practitioners who have been granted privileges by this hospital to provide services via Telehealth modalities (**"Telemedicine Providers").**

Article 1 Name and Purposes

1.1 Name

1.1-1 The name of this organization shall be the Medical Staff of Mayers Memorial Hospital District ("Medical Staff" or "Staff").

1.2 Description

1.2-1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff category depending upon nature and tenure of practice at the Hospital. New members are assigned to the Provisional Staff (see 3.01 for exceptions). Upon satisfactory completion of the provisional period, the members are assigned to one of the Staff categories described in Article 3, Categories of the Medical Staff.

1.2-2 There are also medical staff committees, which perform staff-wide responsibilities, and which oversee related activities being performed by the departments.

a. Overseeing all of this is the Medical Executive Committee, comprised of the elected officials of the Medical Staff.

1.3 Purpose and Responsibilities

1.3-1 The Purposes of the Medical Staff are:

a. To assure that all patients admitted or treated in any of the Hospital services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the Hospital's means and circumstances.
b. To provide for a level of professional performance that is consistent with generally accepted standards attainable within the Hospital's means and circumstances.
c. To organize and support professional education and community health education and support services.
d. To initiate and maintain rules for the Medical Staff to carry out its responsibilities for the professional work performed by the Hospital.
e. To provide a means for the Medical Staff, Governing Body and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.
f. To provide for accountability of the Medical Staff to the Governing Body.
g. To exercise its rights and responsibilities in a manner that does not jeopardize the Hospital's license, Medicare and Medi-Cal provider status, accreditation or Critical Access Hospital (CAH) status.

1.3-2 The Medical Staff's Responsibilities are:

a. To provide quality patient care.

b. To account to the Governing Body for the quality of patient care provided by all members authorized to practice in the Hospital through the following measures:
c. Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures.
d. An organizational structure and mechanisms that allow on-going monitoring of patient care practices.
e. A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;
f. A continuing education program based at least in part on needs demonstrated through the medical care evaluation program.
g. A utilization review program to provide for the appropriate use of all medical services.
h. To recommend to the Governing Body action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action.
i. To establish and enforce, subject to the Governing Body approval, professional standards related to the delivery of health care within the Hospital.
j. To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities.
k. To initiate and pursue corrective action with respect to members where warranted.
l. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts.
m. To establish and amend from time to time as needed Medical Staff Bylaws, Rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws.
n. To assess Medical Staff dues and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

1.4 Self Governance and Independent Rights

1.4-1 The Medical Staff's right to self-governance includes

a. Establishing, in Medical Staff Bylaws, Rules, or Regulations, criteria and standards for Medical Staff membership and privileges, and enforcing those criteria and standards.
b. Establishing, in Medical Staff Bylaws, Rules, or Regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not

limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

c. Selecting and removing Medical Staff officers.
d. Assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff.
e. The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff.
f. Initiating, developing, and adopting Medical Staff Bylaws, Rules and Regulations and Amendments hereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.

1.4-2 The Medical Staff has certain independent rights with which the Governing Body may not interfere. Those rights are:

a. Right to counsel. Upon the authorization of the Medical Executive Committee, the Medical Staff may retain and be represented by independent legal counsel, who shall be compensated through Medical Staff funds.
b. Right to dues. The Medical Staff has the ability to assess dues and use them for its own purposes.
c. Right to select officers. The Medical Staff may select and remove Medical Staff officers without interference

1.4-3 Meet and Confer

The Medical Staff and the Governing Body shall meet and confer in good faith to resolve any disputes regarding the Medical Staff's rights and responsibilities and any disputes regarding the operation or outcome of the process detailed in the Governing Documents; if necessary, the Medical Staff and Governing Body shall follow the conflict resolution process referenced in the Rules,

1.5 Relationship to Hospital's Goals

With respect to the Medical Staff, the goals of the Hospital are to maintain a highly qualified professional staff, to carefully screen and monitor applicants and members of the Medical Staff and other professionals exercising Clinical Privileges; to continually strive to achieve higher standards of patient care; to respond to community needs; and to achieve high confidence and communication among the Medical Staff, the Hospital administration, and the Governing Body. These Bylaws, together with Medical Staff Rules and policies and procedures, constitute the Medical Staff's articulated objectives toward achievement of these goals.

Article 2 Medical Staff Membership

2.1 Nature of Medical Staff Membership

Medical staff membership and/or privileges may be extended to and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards and requirements set forth in these bylaws and the rules. A practitioner, including one who has a contract with the hospital to provide medical-administrative services, may admit or provide services to patients in the hospital only if the practitioner is a member of the medical staff or has been granted temporary privileges in accordance with these bylaws and the rules. Appointment to the medical staff shall confer only such privileges and prerogatives as have been established by the medical staff and granted by the governing body in accordance with these bylaws.

2.2 Qualifications for Membership

2.2-1 General Qualifications

Membership on the Medical Staff and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules. Medical Staff Membership (except honorary Medical Staff) shall be limited to practitioners who are currently licensed or qualified to practice medicine, podiatry or dentistry in California.

2.2-2 Basic Qualifications

A practitioner must demonstrate compliance with all basic standards set forth in this Section to have an application for Medical Staff membership accepted for review. The practitioner must:

a. Qualify under California law to practice with an out-of-state license or be licensed as follows:
    1) Physicians must be licensed to practice medicine by the Medical Board of California or the Board of Osteopathic Examiners of the State of California;
    2) Telemedicine providers who are not licensed in California must be registered as a telemedicine provider with the Medical Board of California.
    3) Dentists must be licensed to practice dentistry by the California Board of Dental Examiners;
    4) Podiatrists must be licensed to practice podiatry by the California Board of podiatric Medicine;
b. If practicing clinical medicine, dentistry, or podiatry, have a federal Drug Enforcement Administration number.
c. Except for dentists, be board certified in his/her field, or have practiced in his/her field in a general acute care hospital for 10 consecutive years. Practitioners who do not meet the foregoing criteria in this Section 2.2-2 (c), but who can produce documentation of having completed all prerequisites for board certification except passage of the board

certification examination, may be granted privileges by the Medical Staff Executive Committee on a case by case basis.

d. Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs
e. Have liability insurance or equivalent coverage meeting the standards specified in by the Governing Body.
f. Be located close enough (office and residence) to the hospital to provide continuous care for his or her patients. The distance to the hospital may vary depending upon the Medical Staff category and privileges that are involved and the feasibility of arranging alternative coverage, and may be defined in the Rules.
g. Pledge to provide continuous care to his or her patients.
h. If requesting privileges in only Radiology or Pathology, have an employment or independent contractor relationship with the individual or group with whom the Hospital has entered into an exclusive contract for such services.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards. Applicants for the Telemedicine Staff need not comply with paragraph (g) of this Section 2.2-2. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these Bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the Governing Body, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Bylaws Section 2.2-4, below.

2.2-3 Additional Qualifications for Membership

a. In addition to meeting the basic standards, the practitioner must:
b. Document his or her:
    1) Adequate experience, education and training in the requested privileges;
    2) Current professional competence;
    3) Good judgment; and
    4) Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is sufficiently healthy and professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality and safety of care for this community.

Without limiting the foregoing, with respect to communicable diseases, practitioners are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others present in the hospital, and to comply with all reasonable precautions established by hospital and/or Medical Staff policy respecting safe provision of care and services in the hospital.

c. Be determined to:
    1) Adhere to the lawful ethics of his or her profession;
    2) Be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations; and
    3) Be willing to participate in and properly discharge Medical Staff responsibilities.

2.2-4 Waiver of Qualifications

Insofar as is consistent with applicable laws, the Governing Body has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Committee, if it determines that the practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the hospital. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to an hearing and appeal rights under these Bylaws.

a. Once the Board determines that a waiver is in the best interests of the Hospital and its patients, the Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question.
b. A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

2.3 Effect of Other Affiliations

No practitioner shall be entitled to Medical Staff membership merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, staff membership0 or privileges at another health care facility.

2.4 Nondiscrimination

Medical Staff membership or particular privileges shall not be denied on the basis of age, religion, race, creed, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the Bylaws or Rules of the Medical Staff or the hospital.

2.5 Administrative and Contract Practitioners

2.5-1 Contractors with No Clinical Duties

A practitioner employed by or contracting with the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the hospital and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff. Nonetheless, with respect to any contracts practitioners whose duties involve formal liaison with or advising the Medical Staff, hospital administration, or the Governing Body about Medical Staff activities or performance, the hospital shall first consult with the Medical Executive Committee and provide reasonable opportunity to review and comment on the scope of responsibilities and the qualifications of the proposed candidate; and at least bi-annually thereafter shall provide reasonable opportunity to participate in reviewing performance of the contracted practitioners.

2.5-2 Contractors Who Have Clinical Duties

A practitioner employed by or contracting with the hospital to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these Bylaws. Unless a written contract or agreement, executed after this provision is adopted, specifically provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing and appeal procedures of the Bylaws, Article 13. Hearing and Appellate Reviews, upon termination or expiration of such practitioner's contract or agreement with the hospital. Contracts between practitioners and the hospital shall prevail over these Bylaws and the Rules, except that the contract may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the federal National Practitioner Data Bank.

2.5-3 Subcontractors

Practitioners who subcontract with Practitioners or entities who contract with the Hospital will automatically forfeit (without the right of access to the fair hearing procedures of Article XI of these Bylaws) any Privileges that are subject to an exclusive or semi-exclusive arrangement if their relationship with the contracting Practitioner or entity is terminated, for other than medical disciplinary cause or reason, and the contract between the Hospital and the contracting Practitioner or entity is terminated. The Hospital may enforce such automatic termination even if the subcontractor's agreement fails to specifically recognize this right. Practitioners who subcontract with practitioners or entities who contract with the hospital may lose privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their Medical Staff membership) if their relationship with the contracting practitioner or entity is terminated, or the hospital and the contracting practitioner's or entity’s agreement or exclusive relationship is terminated. The hospital may enforce such an

automatic termination even if the subcontractor's agreement fails to recognize this right.

2.6 Basic Responsibilities of Medical Staff Membership

Each Medical staff member and each practitioner exercising privileges shall continuously meet all of the following responsibilities:

2.6-1 Provides his or her patients with care that is generally recognized professional level of quality and efficiency.

2.6-2 Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies and Rules of the Medical Staff and the hospital.

2.6-3 Abide by all applicable laws and regulations of governmental agencies and comply with the applicable standards of the Joint Commission on Accreditation of Healthcare Organizations including, but not limited to cooperating and complying with the Hospital's policies and procedures regarding patient complaints and grievances, sentinel events, unanticipated outcomes and error reporting;

2.6-4 Discharge, in a responsible and cooperative manner, such Medical Staff, committee and services functions for which he or she is responsible by appointment, election or otherwise.

2.6-5 Abide by all applicable requirements for timely completion and recording of a physical examination and medical history, as further described at Section 5.4-3 (D).

2.6-6 Abide by all applicable requirements for appropriately informing patients and obtaining consent, as further described in the Hospital's Informed Consent Policy

2.6-7 Prepare and complete, in a timely and accurate manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital, including compliance with such electronic health record (EHR) policies and protocols as have been implemented by the hospital.

2.6-8 Abide by the ethical principles of his or her profession.

2.6-9 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

2.6-10 Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment.

2.6-11 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or Allied Health Professional who is not qualified to undertake this responsibility or who is not adequately supervised.

2.6-12 Coordinate individual patients' care treatment and services with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or

when required by the Rules for policies and procedures of the Medical Staff.

2.6-13 Actively and equitably participate in and regularly cooperate with the Medical Staff in assisting the hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment and improvement, peer review, utilization management, quality evaluation, risk management and utilization management, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.

2.6-14 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients.

2.6-15 Provide information to appropriate Medical Staff officers when he/she obtains reasonable information bearing upon a fellow Staff member who may have engaged in unprofessional or unethical conduct or may have a health condition that poses a significant risk to the well-being or care of patients; and cooperate, as reasonably necessary, toward the appropriate resolution of any such matter;

2.6-16 Accept responsibility for participating in Medical Staff proctoring in accordance with the Rules and policies and procedures of the Medical Staff.

2.6-17 Complete continuing medical education that meets all licensing requirements and is appropriate to the practitioner's specialty.

2.6-18 Adhere to the medical Staff Standards of Conduct (as further described in Section 2.7, below), so as not to adversely affect patient care or hospital operations.

2.6-19 Participate in emergency service coverage and consultation panels as allowed and as require by the Rules.

2.6-20 Cooperate with the Medical Staff in assisting the hospital to meet its uncompensated or partially compensated patient care obligations.

2.6-21 Participate in patient and family education activities, as determined by the Medical Staff Rules, or the Medical Executive Committee.

2.6-22 Notify the Medical Staff office in writing immediately (within 24 hours) following any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Hospital; and

2.6-23 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these Bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug and/or alcohol testing, the

results of which shall be reportable to the Medical Executive Committee, the Well-Being Committee.

2.6-24 Discharge such other staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

2.7 Standards of Conduct

2.7-1 General

a. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees and visitors.

b. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and the hospital may be found to be disruptive behavior. It is specifically recognized that patient care and hospital operations can be adversely affected whenever any of the foregoing occurs with respect to interactions at any level of the hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

c. In assessing whether particular circumstances in fact are affecting quality patient care or hospital operations, the assessment need not be limited to care of specific patients, or the direct impact on patient health. Rather, it is understood that quality patient care embraces - in addition to medical outcome - matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payers) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

2.7-2 Conduct Guidelines

a. Upon receiving Medical Staff membership and/or privileges at the hospital, the member enters a common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

b. Members of the Medical Staff are expected to behave in a professional manner at all times with all people - patients, professional peers, hospital staff, visitors, and others in and affiliated with the hospital

c. Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the hospital.

d. Complaints and disagreements shall be aired constructively, in a nondemeaning manner, and through official channels.

e. Cooperation and adherence to the reasonable Rules of the hospital and the Medical Staff is required.
f. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral

2.7-3 Adoption of Rules

The Medical Executive Committee may promulgate Rules further illustrating and implementing the purposes of this Section including, but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and, where appropriate, progressive or other remedial measures. These measures may include establishing a Professional Conduct Committee to oversee practitioner conduct issues, alternative avenues for medical or administrative disciplinary action, which in turn may include but are not limited to conditional appointments and reappointments, requirements for behavioral contracts, mandatory counseling, practice restrictions, and/or suspension or revocation of Medical Staff membership and/or privileges

Article 3 Categories of the Medical Staff

3.1 Categories

Each Medical Staff member shall be assigned to a Medical Staff category based upon the qualifications defined in the Rules (see Rule 1, Categories of Membership). The members of each Medical Staff category shall have the prerogatives and carry out the duties defined by the Bylaws and Rules. Action may be initiated to change the Medical Staff category or terminating the membership of any member who fails to meet the qualifications or fulfill the duties described in the Bylaws or Rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges

3.2 General Exceptions to Prerogatives

Regardless of the category of membership in the Medical Staff, podiatrists, dentists, and limited license members:

- 3.2-1 May not hold any general Medical Staff office.
- 3.2-2 Shall have the right to vote only on matters within the scope of their licensure. Any disputes over voting rights shall be determined by the chair of the meeting, subject to final decisions by the Medical Executive Committee
- 3.2-3 Shall exercise privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and Rules

Article 4 Procedures for Appointment and Reappointment

4.1 General

The Medical Staff shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the Bylaws and Rules. The Medical Staff shall perform this function also for practitioners who seek temporary privileges and for Allied Health Professionals. The Medical Staff shall investigate each applicant for appointment or reappointment and make an objective, evidence-based decision based upon assessment of the applicant vis-à-vis the hospitals "general competencies," (as further described at Bylaws, Section 5.2, before recommending action to the Governing Body. The Governing Body shall ultimately be responsible for granting membership and privileges (provided, however, that these functions may be delegated to the Chief of Staff and Chief Executive Officer with respect to requests for temporary privileges). By applying to the Medical Staff for appointment or reappointment (or by accepting honorary Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff Bylaws and Rules as they exist and as they may be modified from time to time.

4.1-1 Any history of revocation, suspension, restriction or other disciplinary or corrective action by any state licensing authority, health care entity, (including an IPA, HMO, PPO, health plan, or private payor) regarding a Practitioner’s license, certificate, membership or clinical privileges, whether contested or voluntarily accepted may constitute grounds for denial of the applicant’s application for appointment or reappointment for membership and clinical privileges or practice prerogatives. The Medical Staff shall consider the nature and gravity of the charges or allegations and any resulting disciplinary or corrective action; however, the fact of the revocation, suspension, restriction or other disciplinary or corrective action shall independently be sufficient grounds for finding the denial to be reasonable and warranted. The provisions in this paragraph apply only to action taken for reasons related to that aspect of a Practitioner’s competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

4.2 Overview of the Process

The following chart depicts the basic steps of the appointment, reappointment, and temporary privileges process. Details of each step are described in Rules 2.2 through 2.9

APPOINTMENT, REAPPOINTMENT AND PRIVILEGES		
Person or Body	**Function**	**Report to**
Medical Staff Coordinator	Verify application information	Credentials Committee (See Rule 2.5)
Credentials Committee	Review applicant's qualifications vis-à-vis Medical Staff Bylaws general standards; recommend appointment and privileges	Medical Executive Committee (See Rule 2.7-1)
Medical Executive Committee	Review recommendations Credentials Committee; recommend appointment and privileges	Governing Body (See Rule 2.7-2)
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 2.7-3)
TEMPORARY PRIVILEGES		
Person or Body	Function	Report to
Medical Staff Coordinator	Verify key information	Chief of Staff
Chief of Staff	Recommend temporary privileges	Chief Executive Officer (See Bylaws Section 5.5-2d)
Chief Executive Officer	Make decision	Final action (See Bylaws Section 5.5-2d)

4.3 Applicant's Burden

4.3-1 An applicant for appointment, reappointment, advancement, transfer, and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an

application or request. This burden may include submission to a physical or mental health examination at the practitioner's expense, if deemed appropriate by the Medical Executive Committee. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee.

4.3-2 Applicants, at all times during the processing of their applications, have the burden of updating and correcting any information they have provided as part of the application process. An applicant must inform the Medical Staff in writing within 14 days of any change in the information previously provided, regardless of its source. Failure to inform the Medical Staff in writing of changes to the information previously provided may result in the denial of the application or request.

4.3-3 Any committee or individual charged under these Bylaws with responsibility of reviewing the appointment or reappointment application and/or request for clinical privileges may request further documentation or clarification. If the practitioner or member fails to respond within one month, the application or request shall be deemed withdrawn, and processing of the application or request will be discontinued. Unless the circumstances are such that a report to the Medical Board of California is required, such a withdrawal shall not give rise to hearing and appeal rights pursuant to Bylaws, Article 13, Hearings and Appellate Reviews.

4.4 Application for Initial Appointment and Reappointment

4.4-1 Application form

A practitioner applying for appointment and reappointment shall complete a written application form that seeks information regarding the applicant and documents the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the Bylaws and Rules. Following its investigation, the Medical Executive Committee shall recommend to the Governing Body whether to appoint, reappoint and/or grant specific privileges.

An applicant may be given an opportunity to render an incomplete application complete as described above. However, it is the applicant’s absolute responsibility to review the application carefully and verify that the information provided in it, or as part of it, is accurate and complete before it is submitted. Any substantial misrepresentation or misstatement in, or omission from, an application shall, itself alone, constitute cause for denial of the application. Similarly, in the event that any substantial misrepresentation or misstatement in, or omission from, an application is

discovered after the application has been approved, it shall constitute cause for summary suspension and/or immediate revocation of Medical Staff membership and/or all clinical privileges. This provision may be invoked by the Medical Executive Committee, at its discretion, after giving the applicant an opportunity to address the issues in writing or at a meeting

4.4-2 Basis for Appointment

a. Except as next provided with respect to telemedicine practitioners, recommendations for appointment to the Medical Staff and for granting privileges shall be based upon appraisal of all information provided in the application (including, but not limited to, health status and written peer recommendations regarding the practitioner's current proficiency with respect to the hospital's general competencies as further described at Bylaws, Section 5.2) the practitioner's training, experience, and professional performance at this hospital, if applicable, and in other settings whether the practitioner meets the qualifications and can carry out all of the responsibilities specified in these Bylaws and the Rules, and upon the hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner). Recommendations from peers in the same professional discipline as the practitioner, and who have personal knowledge of the applicant, are to be included in the evaluation of the practitioner's qualifications.
b. The initial appointment of practitioners to the Telemedicine Staff may be based upon:
    1) The practitioner's full compliance with this hospital's credentialing and privileging standards; And
    2) By using this hospital's standards but relying in whole or in part on information provided by the Joint Commission hospital(s) at which the practitioner routinely practices; Or
    3) If the hospital where the practitioner routinely practices is The Joint Commission-accredited and agrees to provide a report of the practitioner's qualifications, by relying entirely on the credentialing and privileging of that other hospital. This report includes at least the following:

Confirmation that the practitioner is privileged at that hospital for those services to be provided at this hospital.

Evidence of that hospital's internal review of the practitioner's performance of the requested privileges, including information useful to assist in this hospital's assessment of the practitioner's quality of care, treatment, and services. This must include, at a minimum: all adverse outcomes related to sentinel events that result from the telemedicine services provided; and any complaints received at that hospital relating to telemedicine services provided at this hospital.

4.4-3 Basis for Reappointment

a. Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's health status, current proficiency in the hospital's general competencies

(as further described at Bylaws, Section 5.2) in light of his/her performance at this hospital and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements as stated in these Bylaws, the Medical Staff Rules, the Medical Staff, and hospital policies [and the applicable department rules. Such reappraisal should also include relevant member-specific information from ongoing performance evaluations, Focused Professional Performance Evaluations (if any), performance improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills, and reappraisal of the hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner. Where applicable, the results of specific peer review activities shall also be considered. If sufficient review data are unavailable, peer recommendations may be used instead; or in the case of reappointment of a member of the Telemedicine Staff, reappointment may be based upon information provided by the hospital(s) where the practitioner routinely practices.

b. Reappointment of a Telemedicine Staff member's privileges may be based upon performance at this hospital, and/or (and subject to compliance with 42 CFR §482.12) upon information from the distant-site hospital(s) where the practitioner routinely practices.

4.4-4 Limitations on Extension of Appointment

If the reappointment application has not been fully processed before the member's appointment expires, the Medical Staff member's membership status and privileges shall may be automatically suspended until the review is completed, unless:

a. Good cause exists for the care of a specific patient or patients and no other health professional currently privileged possesses the necessary skills and is available to provide care to the specific patient(s), in which case the member's privileges may be temporarily extended while his or her full credentials information is verified and approved; or

b. The delay is due to the member's failure to timely return the reappointment application form or provide other documentation or cooperation, in which case the appointment shall terminate as provided in the next Section. An extension of an appointment does not create a vested right for the member to be reappointed. Time period for submission and resulting effect are in the Rules.

4.4-5 Failure to File Reappointment Application

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting and other privileges and prerogatives at the end of the current Medical Staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Governing Body, pursuant to Bylaws, Section 4.4-4, above. If the member fails to submit a

completed application for reappointment within the time specified in the rules, the practitioner shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the practitioner shall not be entitled to any hearing or review.

4.5 Approval Process for Appointment and Reappointment

4.5-1 Recommendations and Approvals

The Credentials Committee and Medical Executive Committee shall review applications, engage in further consideration if appropriate, as further described in the Rules, and make a recommendation to the Governing Body regarding staff appointments that is either favorable, adverse or defers the recommendation. If the Medical Executive Committee's recommendation to the practitioner is adverse, the Medical Executive Committee shall also assess and determine whether the adverse recommendation is for a "medical disciplinary" cause or reason. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 13, Hearings and Appellate reviews hearing purposes.

4.5-2 The Governing Body's Action

The Governing Body shall review any favorable recommendation from the Medical Executive Committee and take action by adopting, rejecting, modifying or sending the recommendation back for further consideration

a. After notice, the Governing Body may also take action on its own initiative if the Medical Executive Committee does not give the Governing Body a recommendation in the required time. The Governing Body may also receive and take action on a recommendation following any applicable procedural rights described in Bylaws, Article 13, hearings and Appellate Reviews.
b. The Governing Body shall make its final determination giving great weight to the actions and recommendations of the Credentials and Medical Executive Committees. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.

4.5-3 Expedited Review

The Governing Body may use an expedited process for appointment, reappointment or when granting privileges when criteria for that process are met, as further described in the Rules

4.5-4 Notice of Final Decision

The Chief Executive Officer shall give notice of the Governing Body's final decision to the Medical Executive Committee and to the applicant.

4.6 Leave of Absence

4.6-1 Routine Leave of Absence

Except as next provided with respect to military leave of absence, members may request a leave of absence, which must be approved by the Medical Executive Committee and cannot exceed two years. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the Rules for reappointment review. The member must provide information regarding his or her professional activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee.

4.6-2 Military Leave of Absence

Staff members in good standing may request a leave of absence for a stated purpose and a stated period, not to exceed two years. The Medical Executive Committee shall act on such requests, using its sole discretion as to whether the requested leave of absence is in the best interest of the Hospital and the Medical Staff. Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Bylaws, Section 4.6-1, above, but may be granted subject to focused professional practice evaluation, as determined by the Medical Executive Committee.

4.7 Waiting Period After Adverse Action

4.7-1 Who is Affected

a. A waiting period shall apply to the following practitioners:

1) An applicant who:

Has received a final adverse decision regarding appointment; or
Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body.

2) A former member who has:

Received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or
Resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Medical Executive Committee or Governing Body issuing an adverse recommendation

3) A member who has received a final adverse decision resulting in:

Termination or restriction of his or her privileges; or
Denial of his or her request for additional privileges.

b. An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

4.7-2 Duration and Commencement Date of the Waiting period

a. Ordinarily the duration of the waiting period shall be the longer of (i) 24 months or (ii) completion of all judicial proceedings pertinent to the action served within two years after completion of the hospital proceedings described in Bylaws, Section 4.7-2. However, for practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier are application upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Governing Body, to waive the 24-month period in other circumstances where it reasonably appears, by objective measures, that changed circumstances warrant earlier consideration of an application

b. The waiting period commences on the latest date on which the application or request was withdrawn, a member's resignation became effective, or upon final Governing Body action following completion or waiver of all Medical Staff and hospital hearings and appellate reviews and all judicial proceedings pertinent to the action served within two years after the completion of the hospital proceedings.

4.7-3 Effect of the Waiting Period

Except as otherwise allowed (per Bylaws, Section 4.7-1(b), above), practitioners subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the practitioner may reapply. The application will be processed like an initial application or request, plus the practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

4.8 Confidentiality; Impartiality

To maintain confidentiality and to assure the unbiased performance of appointment and reappointment functions, participants to the credentialing process shall limit their discussion of the matters involved to the formal avenues provided by the Bylaws and Rules for processing applications for appointment and reappointment.

Article 5 Privileges

5.1 Exercise of Privileges

Except as otherwise provided in these Bylaws or the Rules, every practitioner or Allied Health Professional providing direct clinical services at this hospital shall be entitled to exercise only those ***setting-specific*** privileges granted to him or her.

5.2 Criteria for Privileges/General Competencies

5.2-1 Criteria for Privileges

Subject to the approval of the Medical Executive Committee and Governing Body, Medical Staff committee will be responsible for developing criteria for granting setting-specific privileges (including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine). These criteria shall address the hospital's general competencies (as described below) and assure uniform quality of patient care, treatment, and services. Insofar as feasible, affected categories of Allied Health Professionals shall participate in developing the criteria for privileges to be exercised by Allied Health professionals. Such criteria shall not be inconsistent with the Medical Staff Bylaws, Rules or policies.

5.2-2 General Competencies

The Medical Staff shall assess all practitioners' current proficiency in the hospital's general competencies, which shall be established by the Medical Staff and shall include assessment of patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice. The Medical Staff shall define how to measure these general competencies as applicable to the privileges requested and shall use them to regularly monitor and assess each practitioner's current proficiency.

5.3 Delineation of Privileges in General

5.3-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The basic steps for processing requests for privileges are described at Bylaws, Section 4.2.

5.3-2 Basis for privilege Determinations

Requests for privileges shall be evaluated on the basis of the hospital's needs and ability to support the requested privileges and assessment of the applicant's general competencies with respect to the requested privileges, as evidenced by the applicant's license, education, training, experience, demonstrated professional competence, judgment and clinical performance, (as confirmed by peers knowledgeable of the applicant's

professional performance), health status, the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge, and compliance with any specific criteria applicable to the privileges requested. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges. This information shall be added to and maintained in the Medical Staff file established for each Staff member. In the event Privileges have been used so infrequently as to make it difficult or unreliable to assess current competency, reappointments may also be conditioned upon additional proctoring as deemed necessary by the Medical Executive Committee.

5.3-3 Telemedicine Privileges

5.4 Admissions; Responsible for Care; History and Physical Requirements; and Other General restrictions on Exercise of Privileges by Limited License Practitioners.

5.4-1 Admitting Privileges

a. The following categories of licensees are eligible to independently admit patients to the hospital:
   1) MD's or DO's
b. The following categories of licensees are eligible to co-admit patients to the hospital:
   1) Dentists;
   2) Podiatrists;
   3) FNPs
   4) NPs
   5) PAs

5.4-2 Responsibility for Care of patients

a. All patients admitted to the hospital must be under the care of a member of the Medical Staff
b. The admitting member of the Medical Staff shall establish, at the time of admission, the patient's condition and provisional diagnosis.
c. For patients admitted by or upon order of a dentist, oral surgeon, or podiatrist members, a physician member must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice or clinical privileges.

5.4-3 History and Physicals and Medical Appraisals

a. Members of the Medical Staff, with appropriate privileges, may perform history and physical examinations.
b. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the history or physical on his

or her own patient. Otherwise, a physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

c. All patients admitted for care in a hospital by a dentist, oral surgeon or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the Chief of Staff.

d. The admitting or referring member of the Medical Staff shall assure the completion of a physical examination and medical history on all patients within 24 hours after admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), or immediately before. This requirement may be satisfied by a complete history and physical that has been performed within the 30 days prior to admission or registration (the results of which are recorded in the hospital's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the hospital's medical record within 24 hours after admission or registration

e. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation. The practitioner responsible for administering anesthesia may, if granted clinical privileges, perform this updating history and physical.

5.5 Temporary Privileges

5.5-1 Circumstances

a. Temporary privileges may be granted after appropriate application
   1) for 60 day periods, subject to renewal during the pendency of an application, not to exceed a total of 120 days;
   2) For the care of up to 4 specific patients each consecutive 12 months;
   3) For practitioners who will served as locum tenens for a Medical Staff member for up to 60 days at a time, subject to renewal to a total of 120 days in any consecutive 12 months (if a locum tenens serves more than 4 times in a calendar year, or for greater than 120 days in a calendar year, he or she shall be required to apply for regular Medical Staff membership if he or she desires to exercise privileges at the hospital); or
   4) As otherwise necessary to fulfill an important patient care need.

b. Temporary members of the Medical Staff who are granted temporary membership for the purposes of serving on a standing or Ad Hoc Committee for investigation proceedings are not, by virtue of such membership; granted temporary clinical privileges.

5.5-2 Application and Review

a. Temporary privileges may be granted after the applicant completes the application procedure and the Medical Staff office completes the application review process. The following conditions apply:
   1) There must first be verification of
      Current licensure;
      Relevant training or experience;
      Current competence;
      Ability to perform the privileges requested.
   2) The results of the National Practitioner Data Bank and Medical Board of California queries have been obtained and evaluated.
   3) The applicant has:
      Filed a complete application with the Medical Staff office;
      No current or previously successful challenge to licensure or registration
      Not been subject to involuntary termination of Medical Staff membership at another organization; and
      Not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

b. There is no right to temporary privileges. Accordingly, temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's or Allied Health Professional's qualifications, ability and judgment to exercise the privileges requested.

c. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.

d. Temporary privileges may be granted by the Chief Executive Officer (or his or her designee) on the recommendation of the Chief of Staff.

e. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

5.5-3 General Conditions and Termination

a. Members granted temporary privileges shall be subject to the proctoring and supervision in accordance with the Focused Professional Practice Evaluation requirements specified in the Rules.

b. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Bylaws, Section 5.5-1(a), or earlier terminated as provided at Bylaws, Section 5.5-3(c), below.

c. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, or the Chief Executive Officer after conferring with the Chief of Staff. A person shall be entitled to the procedural rights afforded by the Bylaws, Article 13, Hearings and Appellate Reviews, only if a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for, a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.
d. Whenever temporary privileges are terminated, the Chief of Staff shall assign a member to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.
e. All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules.

5.6 Disaster Privileges

5.6-1 Disaster privileges may be granted when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

a. Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon recommendation of the Chief of Staff, or by his/her designee, upon presentation of a valid government-issued photo identification issued by a state or federal agency and any of the following:
    1) A current picture hospital identification card;
    2) A current license to practice and primary source verification of the license (as further described in the Rules);
    3) Identification indicating that the practitioner is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;
    4) Identification indicating that the practitioner has been granted authority to render patient care in emergency circumstances, such authority having been granted b a federal, state, or municipal entity;
    5) Presentation by current hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's identity.
b. Persons granted disaster privileges shall wear identification badges denoting their status as a Disaster Medical Assistance Team member.
c. The Medical Staff office shall begin the process of verification of credentials and privileges as soon as the immediate situation is under

control, using a process identical to that described in Bylaws, Section 5.5-2, above (except that the individual is permitted to begin rendering services immediately, as needed).

d. The Chief of Staff shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster privileges.

e. Based on the Medical Staff's oversight of each practitioner granted disaster privileges, the Chief Executive Officer, upon recommendation of the Chief of Staff, or his/her designee, shall determine within 72 hours of the practitioner's arrival if granted disaster privileges shall continue.

5.6-2 Emergency Privileges

In the event of an emergency, any member of the Medical Staff or credentialed Allied Health professional shall be permitted to do everything reasonably possible, within the scope of their licensure, to save the life of a patient or to save a patient from serious harm. The member or Allied Health Professional shall promptly yield such care to a qualified member when one becomes available.

5.6-3 Transport and Organ Harvest Teams

Properly licensed practitioners who individually, or as members of a group or entity, have contracted with the hospital to participate in transplant and/or organ harvesting activities contracted with the hospital to participate in transplant and/or organ harvesting activities may exercise clinical privileges within the scope of the agreement with the hospital

5.6-4 Dissemination of Privileges List

Documentation of current privileges (granted, modified, or rescinded) shall be disseminated to the hospital admissions/registration office and such other scheduling and health information services personnel as necessary to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring to assure that practitioners are appropriately privileged to perform all services rendered.

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Article 6 Allied Health Professionals

6.1 Qualifications of Allied Health Professionals

Allied Health Professionals (AHPs) are eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of AHPs that the Governing Body (after securing Medical Executive Committee comments) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules.

6.2 Categories

The Governing Body shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise privileges in the hospital. Such AHPs shall be subject to the supervision requirements developed by the Interdisciplinary Practice Committee, the Medical Executive Committee and the Governing Body.

6.3 Privileges

6.3-1 AHPs may exercise only those setting-specific privileges granted to them by the Governing Body. The range of privileges for which each AHP may apply and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Medical Executive Committee and the Governing Body.

6.3-2 An AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges and biennial renewal there of shall be submitted and processed in a similar manner to that provided for practitioners, unless otherwise specified in the Rules.

6.3-3 Each AHP shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.4 Prerogatives

The prerogatives which may be extended to an AHP shall be defined in the Rules and/or hospital policies. Such prerogatives may include:

6.4-1 Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification, as specified in the Rules

6.4-2 Service on the Medical Staff, and hospital committees

6.4-3 Attendance at hospital education programs in the AHP's field of practice.

6.5 Responsibilities:

Each AHP shall:

6.5-1 Meet those responsibilities required by the Rules and as specified for practitioners in Bylaws, Section 2.6, as they may be logically applied to reflect the more limited practice of the AHP.

6.5-2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the hospital for whom the AHP is providing services.

6.5-3 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

6.6 Procedural Rights of Allied Health Professionals

6.6-1 Fair Hearing and Appeal

AHPs shall be entitled to certain fair hearing and appeal rights, as described below:

a. Clinical psychologists, marriage and family therapists, and clinical social workers shall be entitled to the procedural rights set forth at Bylaws. Article 13, Hearings and Appellate Reviews.

b. Other AHP applicants shall have the right to challenge a recommendation of the Interdisciplinary Practice Committee to deny or restrict requested privileges by filing a written grievance with the Medical Executive Committee within 15 days of such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct a review that shall afford the AHP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a hearing as established by Bylaws, Article 13, Hearings and Appellate Reviews, and shall not be conducted according to the procedural Rules applicable to such hearings. Before the interview, the AHP shall be informed of the general nature and circumstances giving rise to the action, and the AHP may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it.

c. An AHP other than a clinical psychologist, marriage and family therapist, or clinical social worker holding clinical privileges who is subject to recommendation of the Interdisciplinary Practice Committee to revoke, restrict or not renew any or all of such AHP's privileges shall be entitled to the rights set forth below.

1) The affected AHP shall be given written notice of the recommended action.

2) The affected AHP shall have 10 days within which to request a Medical Executive Committee review hearing of the action

d. If a review is requested, the affected AHP shall be given written notice of the general reasons for the action, and the date, time and place that the Medical Executive Committee review hearing is scheduled. Such date shall afford the AHP at least 14 calendar days' notice.
e. The affected AHP and the Interdisciplinary Practice Committee, through its designated representative, shall each have 10 days to submit written information and argument in support of their positions.
f. The affected AHP shall have a right to appear at the Medical Executive Committee hearing, to hear such evidence as the Interdisciplinary Practice Committee representative may present in support of the committee's recommended action, and to present evidence in support of the AHP's challenge to that recommendation. Neither party shall be represented by legal counsel in the hearing.
g. The Medical Executive Committee may then, at a time convenient to itself, deliberate outside the presence of the parties.
h. The Medical Executive Committee decision following such a hearing shall be effective immediately, but shall be subject to appeal to the Governing Body (or, in the discretion of the Governing Body, to an Appeal Board appointed by the Governing Body).
i. The affected AHP shall be promptly informed, in writing, of the Medical Executive Committee's decision, and of his or her right to appeal the decision.
j. Either party shall have 10 days to request an appeal hearing. The request for appeal shall state, with specificity, the basis for the appeal.
k. The appeal hearing shall be conducted within 30 days. The parties to the appeal shall be the Medical Executive Committee (which shall be represented by a member of the Medical Staff, who may, but need not be a member of the Medical Executive Committee or the Interdisciplinary Practice Committee) and the affected AHP.
l. Each party shall have the right to present a written statement in support of his, her or its position on appeal. The Governing Body (or Appeal Board, if applicable) Chair may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Governing Body or Appeal Board, if applicable) may then, at a time convenient to itself, deliberate outside the presence of the parties.
m. The Governing Body (or Appeal Board, if applicable) shall issue a final decision in writing.

6.6-2 Automatic Termination

a. Notwithstanding the provisions of Bylaws, Section 6.6-1, an AHP's privileges shall automatically terminate, without review pursuant to Bylaws, Section 6.6-1 or any other Section of the Medical Staff Bylaws, in the event:

1) The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;
2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the AHP and the supervising practitioner is otherwise terminated, regardless of the reason therefore; or
3) The AHP's certification or license expires, is revoked, or is suspended.

b. Where the AHP's privileges are automatically terminated for reasons specified in Section 6.6-2(a) 1) or 2), above, the AHP may apply for reinstatement as soon as the AHP has found another supervising practitioner who agrees to supervise the AHP and receives privileges to do so. In this case, the Medical Executive Committee may in its discretion, expedite the reapplication process.

c. Additionally, AHPs are subject to the automatic action provisions of Section 12.3 of these Bylaws.

6.6-3 Review of the Category Decisions

The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Governing Body, which has the discretion to decline to review the request or to review it using any procedure the Governing Body deems appropriate.

Article 7 Performance Evaluation and Monitoring

7.1 General Overview of Performance Evaluation and Monitoring Activities

The credentialing and privileging processes described in Bylaws, Article 4, Procedures for Appointment and Reappointment, and Article 5, privileges, require that the Medical Staff develop ongoing performance evaluation and monitoring activities to granting or renewing of privileges are, among other things, detailed, current, accurate, objective and evidence-based. Additionally, performance evaluation and monitoring activities help assure timely identification of problems that may arise in the ongoing provision of services in the hospital. Problems identified through performance evaluation and monitoring activities are addressed via the appropriate performance improvement and/or remedial actions as described in Bylaws, Article 12, performance Improvement and Corrective Action.

7.2 Performance Monitoring Generally

7.2-1 Except as otherwise determined by the Medical Executive Committee and Governing Body, the Medical Staff shall regularly monitor all members' privileges in accordance with the provisions set forth in these Bylaws and such performance monitoring policies as may be developed by the Medical Staff and approved by the Medical Executive Committee and the Governing Body.

7.2-2 Performance monitoring is not viewed as a disciplinary measure, but rather is an information-gathering activity. Performance monitoring does not give rise to the procedural rights described in Bylaws, Article 13, Hearings and Appellate Reviews (unless the form of monitoring is Level III proctoring and its imposition becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor).

7.2-3 The medical Staff shall clearly define how information gathered during performance monitoring shall be shared in order to effectuate change and additional action, if determined necessary.

7.2-4 Performance monitoring activities and reports shall be integrated into other quality improvement activities.

7.2-5 The results of any practitioner-specific performance monitoring shall be considered when granting, renewing, revising, or revoking clinical privileges of that practitioner.

7.3 Ongoing Professional Performance Evaluations [OPPE]

7.3-1 The Medical Staff shall recommend, for Medical Executive Committee and Governing Body approval, the criteria to be used in the conduct of Ongoing Professional Performance Evaluations for its practitioners.

7.3-2 Methods that may be used to gather information for Ongoing Professional Performance Evaluations include, but are not limited to:

a. Periodic chart review;
b. Direct observation;

c. Monitoring of diagnostic and treatment techniques;
d. Discussion with other individuals involved in the care of each patient including consulting physicians, assistants at surgery, nursing and administrative personnel.

7.3-3 Ongoing performance review data will be used as a measure of competency and shall be factored into the decision to maintain, revise, or revoke a practitioner's existing privilege(s) at the time of reappointment.

7.3-4 Ongoing performance review is completed three times in the two-year appointment period for all members of the medical staff granted clinical privileges, including Allied Health Practitioners.

7.3-5 At least two performance measures are administrative indicators in order to evaluate compliance with medical staff bylaws, rules and regulations, and hospital policies. Examples of administrative indicators include:

a. Admissions
b. Consultations
c. Weeks on Surgery Suspension List
d. Medical record delinquency rate, Admission Suspension list

7.3-6 At least two performance measures are clinical indicators in order to evaluate current competence of privileges granted. Examples of clinical indicators include:

a. Core measures (sepsis, stroke, etc.).
b. Returns to surgery
c. Surgical complication rate
d. Procedural complication data
e. Cesarean section births, not medically necessary

7.3-7 The sponsoring physician or department chair will complete an evaluation of competency for privileges granted for all mid-level practitioners (NP, PA, CRNA) that are relevant to their practice.

7.3-8 Practitioners without sufficient volume of patient encounters to perform OPPE may submit patient logs and quality data from other hospitals to be evaluated, as well as focused professional practice evaluation, as described in 7.4(b) below.

7.3-9 The medical staff establish triggers for OPPE measures that trigger the need for focused professional practice evaluation / monitoring. Triggers may be a single incident or evidence of a clinical practice trend. Examples include:

a. A number of adverse events.
b. A number of peer review events with adverse determination.
c. Infection rates are higher than most practitioners.
d. Sentinel or serious safety events.
e. Low volume admissions / procedures over an extended period.
f. Increased length of stay.
g. Frequent / repeat readmission for same issue.
h. Increased number of or trend of complications for same issue.
i. Patterns of unnecessary diagnostic testing / treatments.

j. Failure to follow approved clinical practice guidelines.
k. Patient, family, or staff complaints, substantiated.

7.3-10 To provide security and confidentiality of OPPE data the following may access and review data:
a. Respective department chair
b. Credentials Committee
c. Medical Executive Committee
d. Chief of Staff
e. Personnel working in the Quality Department
f. The individual practitioner for his / her own data and information

7.3-11 OPPE outcome is reviewed by Medical Staff Leadership, the credentials committee, or the Medical Executive Committee with recommendations to the governing body regarding:
a. Implementation of FPPE.
b. Positive OPPE outcome with continuation of current clinical privileges.

7.3-12 Practitioners may review OPPE findings and submit opinions to be considered by the MEC and Governing Board, when results of OPPE trigger FPPE or other actions.

7.4 Focused Professional Practice Evaluation [FPPE]

7.4-1 The focused professional practice evaluation (FPPE) process is designed to be a fair, balanced, and educational approach to ensure the competency of the staff. FPPE is consistently implemented in accordance with the criteria and requirements defined by the organized medical staff. Indications for a Focused Professional Practice Evaluation (FPPE):
a. When granting initial privileges.
b. When granting new privileges to a practitioner with current privileges.
c. For underperformance / quality of care issues.

7.4-2 The Medical Staff may supplement these Bylaws with policies, for approval by the Medical Executive Committee and the Governing Body, that will clearly define the circumstances what criteria and methods should be used for conducting the focused evaluation, the duration of the evaluation period, requirements for extending the evaluation period and how the information gathered during the evaluation process will be analyzed and communicated.

7.4-3 The department chair is responsible to assign the focused evaluation. The focused evaluation may be defined as either a period of time (e.g., six months) or a specific number of cases. The focused evaluation may be extended, as defined in the bylaws. Data sources for the focused evaluation are defined and may include:
1) Retrospective or concurrent medical record review
2) Direct observation
3) Proctoring, as more fully described at Bylaws, Section 7.4-5.
4) Simulation

5) Discussion with others involved in the care of each patient.
6) External peer review
7) Monitoring clinical practice patterns.

7.4-3 A Focused Professional Practice Evaluation shall be used in at least the following situations:

a. All initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of focused professional practice evaluation in accordance with these Bylaws. Such focused evaluation will generally include a period of Level 1 proctoring in accordance with Bylaws, Section 7.4-5(a), below, unless additional circumstances appear to warrant a higher level of proctoring, as described below.

b. In special instances, focused evaluation will be imposed as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competency in that area). Such evaluation will generally consist of Level 1 proctoring in accordance with Bylaws, Section 7.4-5(a)(1) below, unless additional circumstances appear to warrant a higher proctoring level, as described below.

c. When questions arise regarding a practitioner's competency in performing specific privilege(s) at the hospital as a result of specific concerns or circumstances, a focused evaluation may be imposed. Such evaluations may include either Level 2 or 3 proctoring, in accordance with these Bylaws, Section 7.4-5(a)(2) or (3).

d. As otherwise defined in these Bylaws or applicable Focused Professional Practice Evaluation policies.

e. Nothing in the foregoing precludes the use of other Focused Professional Practice Evaluation tools, in addition to or in lieu of proctoring, as deemed warranted by these circumstances.

7.4-4 Proctoring

a. Overview of Proctoring Levels

1) Level 1 proctoring shall be considered routine and is generally implemented as a means to review initially requested privileges in accordance with the Bylaws, Section 7.4-3(a), above and for review of infrequently used privileges in accordance with Bylaws, Section 7.4-3(b), above.
2) Level 2 proctoring is appropriate in situations where a practitioner's competency or performance is called into question, in accordance with Bylaws, Section 7.4-3(c), above, but where the circumstances do not involve a "medical disciplinary" cause or reason or where the proctoring does not constitute a restriction on the practitioner's privilege(s) (i.e., the practitioner is required to participate in proctoring, and to notify either the proctor or other designated individual(s) prior to

providing services, but is permitted to proceed without the proctor if one is not available).

3) Level 3 proctoring is appropriate in situations where a practitioner's competency or performance is called into question due to a "medical disciplinary" cause or reason in accordance with Bylaws, Section 7.4-3(c), above and where the form of proctoring is a restriction on the practitioner's privilege(s) (because the practitioner may not perform a procedure or provide care in the absence of the proctor). Upon imposition of Level 3 proctoring, that practitioner is afforded such procedural rights as provided at Bylaws, Article13, hearings and Appellate Reviews.

b. Overview of Proctoring Procedures

1) Whenever proctoring is imposed, the number (or duration) and types of procedures to be proctored shall be delineated.
2) During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.
3) In the event that the new applicant has privileges at a neighboring hospital where members of this hospital's Medical Staff are familiar with the member to be proctored, and familiar with that neighboring hospital's peer review standards, privileging and proctoring information from the neighboring hospital may, at the discretion of the Medical Executive Committee, be acceptable to satisfy a portion of the focused professional practice evaluation required for this hospital.

c. Proctor: Scope of Responsibility

1) All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the Medical Executive Committee and the Governing Body. When possible, no business relationship shall exist between proctor and proctored.
2) The intervention of a proctor shall be governed by the following guidelines:

A member who is serving as a proctor may act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the Credentials Committee

A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.

In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so.

d. Completion of Proctoring

1) The member shall remain subject to such proctoring until the medical Executive Committee has been furnished with:
    a. A report signed by the Director of the department to which the member is assigned describing the types and numbers of cases observed and the evaluation of the member's performance, a statement that the member appears to meet all of the qualifications for unsupervised practice in the hospital, has discharged all of the responsibilities of the Medical Staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and
    b. A report signed by the Director of such other department(s) in which the member may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the member's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

e. Effect of Failure to Complete Proctoring
1) Failure to Complete Necessary Volume. Any practitioner or member undergoing Level 1 or level 2 proctoring who fails to complete the required number of proctored cases within the time frame established in the Bylaws and Rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Bylaws, Article 13, Hearings and Appellate Reviews. However, the Chief of Staff has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Bylaws, Article 13, Hearings and Appellate Reviews.
2) Failure to Satisfactorily Complete Proctoring. If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Bylaws, Article 13, Hearings and Appellate Reviews.
3) Effect on Advancement. The failure to complete proctoring for any specific privileges shall not, by itself, preclude advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to

Bylaws, Section 7.4-4(e)(1) or (2) if proctoring is not completed thereafter within a reasonable time.

7.4-5 The Medical Staff defines the methods to resolve performance issues. The methods may include:

a. Necessary education.
b. Additional proctoring / assisting for defined privileges.
c. Counseling.
d. Physician / practitioner assistance programs.
e. Suspension of specific privileges.
f. Revocation of specific privileges.
g. The improvement plan will be documented and include who is accountable, and how the improvement will be measured and documented.

7.4-6 FPPE outcome: the Medical Staff leadership submit recommendation to the governing body regarding:

a. The need to continue FPPE.
b. Continuation or limiting of the privilege.
c. Successful completion of FPPE and progression to routine OPPE monitoring.

7.4-7 Practitioners may review FPPE findings and determinations and submit opinions to be considered by the MEC and Governing Board.

Article 8 Medical Staff Officers (and Medical Directors)

8.1 Medical Staff Officers - General Provisions

8.1-1 Identification

a. There shall be the following general officers of the Medical Staff:
   1) Chief of Staff
   2) Vice Chief of Staff
   3) Secretary-Treasurer
b. In addition, the Medical Staff's Committee Chairs shall be deemed Medical Staff officers within the meaning of California law.

8.1-2 Qualifications

a. All Medical Staff officers shall:
b. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;
c. Understand and be willing to work toward attaining the hospital's lawful and reasonable policies and requirements;
d. have administrative ability as applicable to the respective office;
e. Be able to work with and motivate others to achieve the objectives of the Medical Staff and hospital;
f. Demonstrate clinical competence in his or her field of practice;
g. Be an active or consulting Medical Staff member, or an Allied Health Professional (and remain in good standing as a Medical Staff member while in office); and
h. Not have any significant conflict of interest.

8.1-3 Disclosure of Conflict of Interest

a. All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to Bylaws, Section 8.2-3) shall, at least 30 days prior to the date of the election or appointment, disclose in writing to the Medical Executive Committee those personal, professional or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest

exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

b. A person nominated from the floor shall be asked to verbally disclose conflicts to those in attendance at the meeting, and the Medical Executive Committee or its representative shall have an opportunity to comment thereon, prior to the vote

8.2 Method of Selection - General Officers

8.2-1 Nominating Committee

An ad hoc nominating committee composed of the Chief of Staff, two staff members appointed by the Chief of Staff shall develop a slate of candidates meeting the qualifications of office as described in Bylaws, Section 8.1-2, above. This slate shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated for each of the following positions:

a. Chief of Staff and
b. Vice Chief of Staff and
c. Secretary-Treasurer

8.2-2 Nomination by Petition

The Medical Staff may nominate candidates for office by a petition signed by at least five members who are eligible to vote and a statement from the candidate signifying willingness to run. Such nominations must be received by the Chief of Staff at least 30 days prior to the scheduled elections.

8.2-3 Election

The election shall be by mail ballot, and the outcome shall be determined by a majority of the votes cast by mail ballots that are returned to the Medical Staff office within 15 days after the ballots were mailed to the voting Medical Staff members.

8.2-4 Term of Office

a. Officers shall be elected in the fall of even-numbered years and shall take office the following January.
b. The term of office shall be two years.

8.3 Recall of Officers

A general Medical Staff Officer may be recalled from office for any valid cause including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of a general Medical Staff Officer may be initiated by the members eligible to vote for officers; but recall itself shall require a 2/3 vote of the Medical Executive Committee or 2/3 vote of the Medical Staff members eligible to vote for general Medical Staff officers.

8.4 Filling Vacancies

8.4-1 Vacancies created by resignation, removal, death, or disability shall be filled as follows:

8.4-2 A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff

8.4-3 A vacancy in the office of Vice Chief of Staff shall be filled the Secretary-Treasurer

8.4-4 A vacancy in the office of Secretary-Treasurer shall be filled by appointment by the Medical Executive Committee.

8.5 Duties of Officers

8.5-1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

a. Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;
b. Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
c. Serving as Chair of the Medical Executive Committee, and in that capacity shall be deemed the individual responsible for the organization and conduct of the Medical Staff;
d. Serving as an ex officio member of all other Staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;
e. Appointing, in consultation with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees except where otherwise provided by these Bylaws and, except where otherwise indicated, designating the Chairs of these committees;
f. Being a spokesperson for the Medical Staff in external professional and public relations;
g. Serving on liaison committees with the Governing Body and administration, as well as outside licensing or accreditation agencies;
h. Appointing members of the Medical Staff to participate, as a Medical Staff liaison, in the development of hospital policies;
i. Regularly reporting to the Governing Body on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the Governing Body;
j. In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;

k. Interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the hospital;
l. Representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer and serving as an ex-officio member of the Governing Body;
m. Serving on the Joint Conference Committee;
n. Being accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the hospital and for the effectiveness of the quality assurance and utilization review programs; and
o. Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff or the Medical Executive Committee.

8.5-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee and of the Joint Conference Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these Bylaws or the Medical Executive Committee.

8.5-3 Secretary-Treasurer

The Secretary-Treasurer shall be a member of the Medical Executive Committee. The duties shall include, but not be limited to:

a. Maintaining a roster of members;
b. Keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings;
c. Calling meetings on the order of the Chief of Staff or Medical Executive Committee;
d. Attending to correspondence and notices on behalf of the Medical Staff;
e. Receiving and safeguarding all funds of the Medical Staff;
f. Excusing absences from meetings on behalf of the Medical Executive Committee; and
g. Performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

Article 9 Committees

9.1 General

9.1-1 Designation

The Medical Executive Committee and the other committees described in these Bylaws and the Rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Any committee — whether Medical Staff-wide or other clinical unit or standing or ad hoc — that is carrying out all or any portion of a function or activity required by these Bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

9.1-2 Appointment of Members

a. Unless otherwise specified, the Chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.
b. A Medical Staff committee created in these Bylaws is composed as stated in the description of the committee in these Bylaws or the Rules. Except as otherwise provided in the Bylaws, committees established to perform Medical Staff functions required by these Bylaws may include any category of Medical Staff members; Allied Health Professionals; representatives from hospital departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with votes unless the statement of committee composition designates the position as nonvoting.
c. The Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.
d. The Committee Chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.
e. Each Committee Chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

9.1-3 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing Medical

Staff representation on hospital committees established to perform such functions.

9.1-4 Ex Officio Members

The Chief of Staff and the Chief Executive Officer, or their respective designees are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

9.1-5 Action Through Subcommittee

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The Committee Chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff members, and the Chief Executive Officer regarding hospital staff.

9.1-6 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

9.1-7 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee

9.1-8 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meetings in Bylaws, Article 9, Meetings.

9.1-9 Attendance of Nonmembers

Any Medical Staff member who is in good standing may ask the Chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The Committee Chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. if the request is granted, the invited member shall abide by all Bylaws and Rules applicable to that committee.

9.1-10 Conflict of Interest

a. In any instance where a Medical Staff member has or reasonably could be perceived to have a conflict of interest, as defined below, such

individual shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual with a conflict may be asked, and may answer, any questions concerning the matter before leaving. Any dispute over the existence of a conflict of interest shall be resolved by the chairperson of the committee, or, if it cannot be resolved at that level, by the Chief of Staff.

b. A conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. the fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The fact that a committee member or Medical Staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

9.1-11 Accountability

All committees shall be accountable to the Medical Executive Committee.

9.2 Medical Executive Committee

9.2-1 Composition

The Medical Executive Committee shall be composed of the Medical Staff officers listed in Bylaws, Article 8, Medical Staff officers (and Medical Director), at least one at-large representative. The Chief Executive Officer or designee shall serve as an ex officio member. The Chief of Staff shall chair the Medical Executive Committee. A majority of the committee shall be physicians.

9.2-2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below.

a. Supervise the performance of all Medical Staff functions, which shall include:
   1) Requiring regular reports and recommendations from the committees and officers of the Medical Staff concerning discharge of assigned functions;
   2) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

3) Following up to assure implementation of all directives.

b. Coordinate the activities of the committees.
c. Assure that the Medical Staff adopts Bylaws and Rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which members on the Medical Staff may be terminated, and the mechanism for hearing procedures.
d. Assure that the Medical Staff adopts Bylaws, Rules or regulations establishing criteria and standards, consistent with California law, for Medical Staff membership and privileges (including, but not limited to, any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.
e. Assure that the Medical Staff adopt Bylaws, Rules or regulations establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and review and analysis of patient medical records.
f. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's, member's, or Allied Health professional's ability to perform requested privileges
g. Based upon input from Credentials Committee, make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.
h. When indicated, initiate disciplinary or corrective actions affecting Medical Staff members
i. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:
    1) The Medical Staff Bylaws, Rules, and policies;
    2) The hospital's Bylaws, Rules, and policies;
    3) State and federal laws and regulations; and
j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.
k. Implement, as it relates to the Medical staff, the approved policies of the hospital.
l. Set objectives for establishing, maintaining and enforcing professional standards within the hospital and for the continuing improvement of te quality of care rendered in the hospital; assist in developing programs to achieve these objectives.
m. Regularly report to the Governing Body through the Chief of Staff and the Chief Executive Officer on at least the following:

1) The outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and
2) The general status of any Medical Staff disciplinary or corrective actions in progress.

n. Review and make recommendations to the Chief Executive Officer regarding quality-of-care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall assist the hospital in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to notice-and-administration in making exclusive contracting decisions.
o. Prioritize and assure that hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.
p. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.
q. Establish the date, place, time and program of the regular meetings of the Medical Staff.
r. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.
s. Take such other actions as may reasonably be deemed necessary in the best interest of the Medical Staff and the hospital.

The authority delegated pursuant to this Section 9.2-2 may be removed by amendment of these Bylaws

9.2-3 Meetings

The Medical Executive should be scheduled to meet on a bi-monthly basis and shall meet at least 4 times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

9.2-4 Scope

The Medical Executive Committee is empowered to act on behalf of the medical staff when the medical staff cannot assemble or between their regular meetings.

Article 10 Meetings

10.1 Medical Staff Meetings

10.1-1 Medical Staff Meetings

There shall be at least one meeting of the Medical Staff during each Medical Staff year. The date, place, and time of the meeting(s) shall be determined by the Chief of Staff. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

10.1-2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Body, or upon the written request of 10 percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.1-3 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint Medical Staff meetings with staff members from other hospitals, health care entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff through its authorized representative(s) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

10.2 Notice of Meetings

Written notice stating the place, day, and hour of any regular or special Medical Staff meeting or of any regular or special committee meeting not held pursuant to resolution shall be delivered either personally, by mail, or by e-mail to each person entitled to be present not fewer than two working days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.3 Quorum

10.3-1 Medical Staff Meetings

The presence of 2 members of the voting Medical Staff members at any regular or special Medical Executive Committee meeting shall constitute a quorum,

10.3-2 Committee Meetings

For other committees, a quorum shall consist of no less than one voting committee member.

10.4 Manner of Action

10.4-1 Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Committee action may be conducted by telephone or internet conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone or internet conference. Valid action may be taken without a meeting if at least 10 days notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved in writing setting forth the action so taken, which is signed by at least 2/3 of the members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie.

10.4-2 Committee and Department meetings may be held in person, telephonically, via internet conference, or other electronic systems, so long as the quorum requirements are met and the meeting is held in a manner that allows all committee members the opportunity to hear, participate, and (if a voting member) vote. The validity of actions does not depend on whether the meeting was held in person, telephonically, via internet conference, or other electronic systems.

10.4-3 Valid action may be taken without a meeting if at least [10] days' notice of the proposed action has been given to all members entitled to vote, and the proposed action is thereafter approved in writing or via email by at least two thirds of the members entitled to vote, with such writing or email specifying the proposed action the member is approving.

10.5 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer or his or her designee and forwarded to the Medical Executive Committee or other designated committee and Governing Body. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

10.6 Attendance Requirements

10.6-1 Regular Attendance Requirements

Each Active member of the Medical Staff is required to attend meetings under Rule 1.3, Prerogatives and Responsibilities, shall be required to attend six general staff meetings during the two-year reappointment period. Each Medical Staff member of a committee shall be required to attend at least one-half of the committee meetings held in any given calendar year.

10.6-2 Failure to Meet Attendance Requirements

Medical Staff members will be notified semi-annually if they have not yet met the full attendance requirements. Practitioners who have not met meeting attendance requirements before the end of the appointment/reappointment period will be reappointed for a maximum of

two years on probationary status. Practitioners who do not meet the meeting attendance requirements during the reappointment period will not be reappointed. Exceptions can be made at the discretion of the Chief of Staff and the Medical Executive Committee. Such discretion may be exercised for good cause only, including, but not limited to, serious illness or injury to the physician or a member of the physician's immediate family, death of a family member, medical emergency involving a patient of the physician, or other serious and unpredictable event or condition.

10.6-3 Special Appearance

A committee, at its discretion, may require the appearance of a practitioner during a review of the clinical course of treatment regarding a patient. If possible, the Chair of the meeting should give the practitioner at least 10 days advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given special notice shall (unless excused by the Medical Executive Committee upon a showing of good cause) result in an automatic suspension of the practitioner's privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. The practitioner shall be entitled to the procedural rights as describe in Bylaws, Article 13, Hearings and Appellate Reviews.

10.7 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such meeting.

10.8 Electronic Voting

Unless otherwise provided in these Bylaws, any vote for an election, adoption, or amendment process may be accomplished through an electronic voting process approved by the Medical Executive Committee, so long as the Medical Executive Committee has determined that the electronic voting process has sufficient safeguards to protect the integrity of the vote and the process has been approved by the Governing Body. “Electronic voting process” includes, but is not limited to, email and web-based voting processes.

Article 11 Confidentiality, Immunity, Releases and Indemnification

11.1 General

Medical Staff, or committee minutes, files and records - including information regarding any member or applicant to this Medical Staff - shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff committee files and shall not become part of any particular patient's file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

11.2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff committees, except in conjunction with another health facility, professional society or licensing authority for peer review activities, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

11.3 Access to and Release of Confidential Information

11.3-1 Access for Official Purposes

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

a. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.
b. Medical Staff officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.
c. The Chief Executive Officer, the Governing Body, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.
d. Information which is disclosed to the Governing Body or its appointed representatives shall be maintained as confidential.

11.3-2 Member's Access

a. Medical Staff member shall be granted access to his or her own credentials file, subject to the following provisions:
    1) Notice of a request to review the file shall be given by the member to the Chief of Staff (or his or her designee) at least three days before the requested date for review.

2) The member may review and receive a copy of only those documented, provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letter of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized.
3) The review by the member shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Chief of Staff present.
4) In the event a Notice of Charges is filed against a member, access to that member's credentials file shall be governed by Bylaws, Section 13.6-9.

b. A member may be permitted to request correction of information as follows:
1) After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.
2) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee whether to make the correction as requested, and the Medical Executive Committee shall make the final determination.
3) The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.
4) In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Committee, and shall be placed in the credentials file immediately following review by the Medical Executive Committee.

11.4 Immunity and Releases

11.4-1 Immunity from Liability for Providing Information or Taking Action. Each representative of the Medical Staff and hospital and all third parties shall be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, hospital, or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this hospital or by reason of otherwise participating in a Medical Staff or hospital credentialing, quality improvement, or peer review activities.

11.4-2 Activities and Information Covered

a. Activities

The immunity provided by this Bylaws, Article 11, shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health-related institution's or organization's activities concerning, but not limited to:

1) Applications for appointment, privileges, or specified services;
2) Periodic reappraisals for reappointment, privileges, or specified services;
3) Corrective action;
4) Hearings and appellate reviews;
5) Quality improvement review, including patient care audit;
6) Peer review;
7) Utilization reviews;
8) Morbidity and mortality conferences; and
9) Other hospital or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

b. Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Bylaws Article 11 may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

11.5 Releases

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of these Bylaws, Article 12; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of these Bylaws, Article 12.

11.6 Cumulative Effect

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information, and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

11.7 Indemnification

The hospital shall indemnify, defend, and hold harmless the Medical Staff and its individual members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

a. As a member of or witness for a Medical Staff, committee, or hearing committee;
b. As a member of or witness for the hospital Governing Body or any hospital task force, group or committee; and
c. As a person providing information to any Medical Staff or hospital group, officer, Governing Body member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

The hospital shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these Bylaws. In no event will the hospital indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee's private economic interests.

Article 12 Performance Improvement and Corrective Action

12.1 Peer Review Philosophy

12.1-1 Role of Medical Staff in Organization wide Quality Improvement Activities

The Medical Staff is responsible to oversee the quality of medical care, treatment and services delivered in the hospital. An important component of that responsibility is the oversight of care rendered by members and Allied Health Professionals practicing in the hospital. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measures and/or corrective action as necessary to achieve and assure quality of care, treatment and services. Toward these ends:

a. Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess and improve performance of their peers in the hospital.
b. The initial goals of the peer review processes are to prevent, detect and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, corrective measures, including formal investigation and discipline, must be implemented and monitored for effectiveness.
c. Peers in the committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful and ongoing. The term "peers" generally requires that a majority of the peer reviewers be members holding the same license as the practitioner being reviewed, including, where possible, at least one member practicing the same specialty as the member being reviewed. Notwithstanding the foregoing, DOs and MDs shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

12.1-2 Informal Corrective Activities

The Medical Staff officers, and committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent proctoring or monitoring in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the officer, or committee. Any informal actions, monitoring or counseling shall be documented in the member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of privileges or grounds for any formal hearing

or appeal rights under Bylaws, Article 13, Hearings and Appellate Reviews.

12.1-3 Criteria for Initiation of Formal Corrective Action

Formal corrective action may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the hospital, that is reasonably likely to be:

a. Detrimental to patient safety or to the delivery of quality patient care within the hospital;
b. Unethical;
c. Contrary to the Medical Staff Bylaws or Rules;
d. Below applicable professional standards;
e. Disruptive of Medical Staff or hospital operations; or
f. An improper use of hospital resources.

Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of applicant-specific information.

12.1-4 Initiation

a. Any person who believes that formal corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any Medical Staff committee, the chair of any Medical Staff Committee, the Governing Body or the Chief Executive Officer.
b. If the Chief of Staff, any other Medical Staff officer, any Medical Staff Committee, the chair of any Medical Staff committee, the Governing Body or the Chief Executive Officer determines that formal corrective action may be warranted under Bylaws, Section 12.1-3, above, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee orally or in writing.
c. The Chief of Staff shall notify the Chief Executive Officer, or his or her designee in his or her absence, and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the Medical Executive Committee may dispense with further investigation of

matters deemed to have been adequately investigated by a committee pursuant to Bylaws, Section 12.1-6, below, or otherwise.

12.1-5 Expedited Initial Review

a. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal corrective action investigation.

b. In cases of complaints of harassment or discrimination involving a patient, etc., an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Chief of Staff, the Chief of Staff's designee, together with representatives of administration, or by an attorney for the hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient, an expedited initial review shall be conducted by the hospital's human resources director or their designee, or by an attorney for the hospital, who shall use best efforts to complete the expedited initial review within the time frame set out at Bylaws, Section 12.1-8, below. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff member.

12.1-6 Formal Investigation

a. If the Medical Executive Committee concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.

b. If the Medical Executive Committee concludes a further investigation is warranted, it shall direct a formal investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise). If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner, using best efforts to complete the expedited initial review within the time frame set out at Bylaws, Section 12.1-8, below, and shall forward a written report of the

investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action.

c. Prior to any adverse action being approved, the Medical Executive Committee shall assure that the member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in Bylaws, Article 13, Hearings and Appellate Reviews, nor shall the hearings or appeals Rules apply.

d. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

e. The provisions of this Bylaws Section 12.1-6 (including a determination to dispense with formal investigation and proceed immediately to further action pursuant to Section 12.1-6(a)) shall demark the point at which an "impending investigation" is deemed to have commenced within the meaning of Business & Professions Code Section 805(c).

12.1-7 Medical Executive Committee Action

a. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action including, without limitation:

1) Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file;
2) Deferring action for a reasonable time;
3) Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude Committee Chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's file;
4) Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring
5) Recommending reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;

6) Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
7) Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated;
8) Referring the member to the Well-Being Committee for evaluation and follow-up as appropriate; and
9) Taking other actions deemed appropriate under the circumstances.

b. If the Medical Executive Committee takes any action that would give rise to a hearing pursuant to Bylaws, Section 13.2, it shall also make a determination whether the action is a "medical disciplinary" action or an "administrative disciplinary" action. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions. In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 13, Hearings and Appellate Reviews, hearing purposes.
c. And, if the Medical Executive Committee makes a determination that the action is medical disciplinary, it shall also determine whether the action is taken for any of the reasons required to be reported to the Medical Board of California pursuant to California Business & Professions Code Section 805.1.

12.1-8 Time Frames

a. Insofar as feasible under the circumstances, formal and informal investigations should be conducted expeditiously, as follows:
b. Informal investigations should be completed and the results should be reported within 60 days.
c. Expedited initial reviews should be completed and the results should be reported within 30 days.
d. Other formal investigations should be completed and the results should be reported within 90 days.

12.1-9 Procedural Rights

a. If, after receipt of a request for formal corrective action pursuant to By-laws, Section 12.1-4, above, the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the Governing Body. The Governing Body may affirm, reject or modify the action. The Governing Body shall give great weight to the Medical Executive Committee's decision

and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted. The decision shall become final if the Governing Body affirms it or takes no action on it within 70 days after receiving the notice of decision.

b. If the Medical Executive Committee recommends an action that is a ground for a hearing under Bylaws, Section 13.2, the Chief of Staff shall give the practitioner special notice of the adverse recommendation and of the right to request a hearing. The Governing Body may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.
c. Any action by the Medical Executive Committee, or any other action that must be reported to the Medical Board of California pursuant to Business and Professional Code section 805, shall entitle the Practitioner to the procedural rights as provided in Article 13.
d. There shall be hearing rights as provided in Article 13 for actions. If the remedial action is one that must be reported to the Medical Board of California pursuant to Business and professional Code section 805; otherwise no hearing rights shall apply
e. There shall be no hearing rights associated with any action; nor shall there be hearing rights for consultations imposed by the Rules, or imposed by the Chief of Staff on a case-by-case basis.
f. There shall be no hearing rights arising out of the Medical Staff's failure to accept and process an application in cases where the applicant is seeking Privileges in an area that is operated by an exclusive contract and potential applicant is not a member of or contractor with the contracting group.
g. Provisions elsewhere in these Bylaws shall govern procedural rights in other specific.

12.1-10 Initiation by Governing Body

a. The Medical Staff acknowledges that the Governing Body must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities.
b. Accordingly, if the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Governing Body may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to act in response to that Governing Body direction, the Governing Body may, in furtherance of the Governing Body's ultimate responsibilities and fiduciary duties, initiate corrective action,

but must comply with applicable provisions of Bylaws, Article 13, Performance Improvement and Corrective Action, and Article 14, Hearings and Appellate Reviews. The Governing Body shall inform the Medical Executive Committee in writing of what it has done.

12.2 Summary Restriction or Suspension

12.2-1 Criteria for Initiation

a. Whenever a practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff, the Medical Executive Committee, or the Chief Executive Officer may summarily restrict or suspend the Medical Staff membership or privileges of such member.
b. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give special notice to the member and written notice to the Governing Body, the Medical Executive Committee, and the Chief Executive Officer. The special notice shall fully comply with the requirements of Bylaws, Section 12.2-1(d), below.
c. The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, the member's patients shall be promptly assigned to another member by the Chief of Staff considering, where feasible, the wishes of the patient and the affected practitioner in the choice of a substitute member.
d. Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with verbal notice of such suspension; followed, within three working days of imposition, by written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was reasonable and warranted because failure to suspend or restrict the member's privileges summarily could reasonably result in an imminent danger to the health of any individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Bylaws, Section 13.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Bylaws, Section 13.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.
e. The notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Bylaws, Section 12.1-4 shall be followed.

12.2-2 Medical Executive Committee Action

Within one week after such summary action has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Bylaws, Article 13, Hearings and Appellate Reviews, nor shall any procedural Rules apply. The Medical Executive Committee may thereafter continue, modify or terminate the terms of the summary action. It shall give the practitioner special notice of its decision, within two working days of the meeting, which shall include the information specified in Bylaws, Section 12.3-1 if the action is adverse.

12.2-3 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary action, and if the summary action constitutes a suspension or restriction of clinical privileges required to be reported to the Medical Board of California pursuant to Business & Professions Code Section 805), the member shall be entitled to the procedural rights afforded by Bylaws, Article 13, Hearings and Appellate Reviews.

12.2-4 Initiation by Governing Body

a. If no one authorized under Bylaws, Section 12.2-1(a) to take a summary action is available to summarily restrict or suspend a member's membership or privileges, the Governing Body (or its designee) may immediately suspend or restrict a member's privileges if a failure to act immediately may result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) made reasonable attempts to contact the Chief of Staff before acting.
b. Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

12.3 Automatic Suspension or Limitation

In the following instances, the member's privileges or membership may be suspended or limited as described:

12.3-1 Licensure

a. **Revocation, Suspension or Expiration.** Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended or expired without an application pending for renewal, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.

b. **Restriction.** Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

c. **Probation.** Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

12.3-2 Drug Enforcement Administration Certificate

a. **Revocation, Suspension, and Expiration.** Whenever a member's Drug Enforcement Administration certificate is revoked, limited, suspended or expired, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

b. **Probation.** Whenever a member's Drug Enforcement Administration certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

12.3-3 Failure to Satisfy Special Appearance Requirement

A member who fails without good cause to appear and satisfy the requirements of Bylaws, Section 10.6-3 shall automatically be suspended from exercising all or such portion of privileges as the Medical Executive Committee specifies.

12.3-4 Medical Records

Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Committee (14 days), excluding slated vacations. Fourteen (14) days after warning of delinquency, an automatic suspension from Staff membership shall be imposed for failure to complete medical records as specified in the Medical Staff Rules. Such suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating; provided, however, members whose privileges have been suspended for delinquent records may admit and treat new patients in life-threatening situations. The suspension shall continue until the medical records are completed. If after 30 consecutive days of suspension the member remains suspended, the member shall be considered to have voluntarily resigned from the Medical Staff. Nothing in the foregoing shall preclude the implementation,

by the Medical Executive Committee, of a monetary fine for delinquent medical records.

12.3-5 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate coverage within six months after the date of automatic suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

12.3-6 Failure to Pay Dues or Fines

If the member fails to pay required dues or fines within 30 days after written warning of delinquency, a practitioner's Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. If after 60 consecutive days of suspension the member remains suspended, the member will be considered to have voluntarily resigned from the Medical Staff.

12.3-7 Failure to Comply with Government and Other Third Party Payor Requirements

The Medical Executive Committee shall be empowered to determine that compliance with certain specific third party payor, government agency, and professional review organization Rules or policies is essential to hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The Rules may authorize the automatic suspension of a practitioner who fails to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.

12.3-8 Automatic Termination

If a practitioner is suspended for more than six months, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

12.3-9 Executive Committee Deliberation and Procedural Rights

a. As soon as practicable after action is taken or warranted as described in Bylaws, Section 12.3-1, Section 12.3-2, or Section 12.3-3, the Medical Executive Committee shall convene to review and consider the facts and may recommend such further corrective action as it may deem appropriate following the procedure generally set forth commencing at Bylaws, Section 12.1-6, Formal Investigation. The Medical Executive Committee review and any subsequent hearings and reviews shall not

address the propriety of the licensure or Drug Enforcement Administration action, but instead shall address what, if any, additional action should be taken by the hospital. There is no need for the Medical Executive Committee to act on automatic suspensions for failures to complete medical records (Bylaws, Section 12.3-4), maintain professional liability insurance (Bylaws, Section 12.3-5), to pay dues (Bylaws, Section 12.3-6) or comply with government and other third party payer Rules and policies (Bylaws, Section 12.3-7).

b. Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the federal National Practitioner Data Bank.

12.3-10 Notice of Automatic Suspension or Action

Special notice of an automatic suspension or action shall be given to the affected individual, and regular notice of the suspension shall be given to the Medical Executive Committee, Chief Executive Officer and Governing Body, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the Chief of Staff. The wishes of the patient and affected practitioner shall be considered, where feasible, in choosing a substitute member.

12.3-11 Automatic Action Based upon Actions Taken by Another Peer Review Body after a Hearing

a. The Medical Executive Committee shall be empowered to automatically impose any adverse action that has been taken by another peer review body (as that term is used in the Medical Staff Hearing Law, Business & Professions Code Section 809 et seq.) after a hearing at that other peer review body that meets the requirement of the Medical Staff Hearing Law. Such an adverse action may be any action taken by the other peer review body, including, but not limited to, denying membership and/or privileges, restricting privileges or terminating membership and/or privileges. The action may be taken automatically only if the other peer review body took action based upon standards that were essentially the same as those in effect at this hospital at the time the automatic action will be taken. Also, the action that will be the basis of the automatic action must have become final within the past 36 months. The automatic action may be taken only after the practitioner has completed the hearing and any appeal at that other peer review body; however, it is not necessary to await a final disposition in any judicial proceeding that may be brought challenging that other peer review body's action.

b. The practitioner shall not be entitled to any hearing or appeal at this hospital unless the Medical Executive Committee takes an action that is more restrictive than the final action taken by the other peer review

body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the other peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the other peer review body's action. The practitioner shall not be entitled to challenge the automatic peer review action unless he or she successfully overturns the other peer review action in court.

c. Nothing in this Section shall preclude the Medical Staff or Governing Body from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

12.4 Interview

Interviews shall neither constitute nor be deemed a hearing as described in Bylaws, Article 13, Hearings and Appellate Reviews, shall be preliminary in nature, and shall not be conducted according to the procedural Rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant an interview only when so specified in these Bylaws, Article 13. In the event an interview is granted, the practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. A record of the matters discussed and the findings resulting from an interview shall be made.

12.5 Confidentiality

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these Bylaws for peer review and discipline.

Article 13 Hearings and Appellate reviews

13.1 General Provisions

13.1-1 Review Philosophy

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and Governing Body from carrying out peer review.

Accordingly, discretion is granted to the Medical Staff and Governing Body to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review

The Medical Staff, the Governing Body, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

13.1-2 Exhaustion of Remedies

If an adverse action as described in Bylaws, Section 14.2 is taken or recommended, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

13.1-3 Intra-Organizational Remedies

The hearing and appeal rights established in the Bylaws are strictly adjudicative rather than legislative in structure and function. The hearing committees have no authority to adopt or modify Rules and standards or to decide questions about the merits or substantive validity of Bylaws, Rules or policies. However, the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Bylaws, Rules or policies and decide those questions. If the only issue in a case is whether a Bylaw, Rule or policy is lawful or meritorious, the practitioner is not entitled to a hearing or appellate review. In such cases, the practitioner must submit his challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

13.1-4 Joint Hearings and Appeals

The Medical Staff and Governing Body are authorized to participate in joint hearings and appeals in accordance with Bylaws, Section 13.1.14.

13.1-5 Definitions

Except as otherwise provided in these Bylaws, the following definitions shall apply under this Article:

a. Body whose decision prompted the hearing refers to the Medical Executive Committee in all cases where the Medical Executive

Committee or authorized Medical Staff officers, members or committees took the action or rendered the decision which resulted in a hearing being requested. It refers to the Governing Body in all cases where the Governing Body or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. Practitioner, as used in this Article, refers to the practitioner who has requested a hearing pursuant to Bylaws, Section 14.3-2.

13.1-6 Substantial Compliance

Technical, insignificant or nonprejudicial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

13.2 Grounds for Hearing

Except as otherwise specified in these Bylaws (including those Exceptions to Hearing Rights specified in Bylaws, Section 14.13, of this Article), any one or more of the following actions or recommended actions shall be deemed an actual or potential adverse action and constitute grounds for a hearing:

13.2-1 Denial of Medical Staff initial applications for membership and/or privileges.

13.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

13.2-3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or privileges.

13.2-4 Involuntary imposition of significant consultation or Level III proctoring requirements, as described at Bylaws, Section 7.4-4(a)(3), that cannot be completed prior to the time frame required for reporting the restriction to the Medical Board of California (i.e., Level I and Level II proctoring requirements, as well as transitory restrictions that do not require reporting to the Medical Board of the Data Bank do not entitle the practitioner to a hearing).

13.2-5 Summary suspension of Medical Staff membership and/or privileges during the pendency of corrective action and hearings and appeals procedures.

13.2-6 Any other “medical disciplinary” action or recommendation that must be reported to the Medical Board of California under the provisions of California Business & Professions Code, Section 805 or to the National Practitioner Data Bank.

13.3 Notices of Actions and Requests for Hearing or Mediation

13.3-1 Notice of Action or Proposed Action, Right to Hearing, Option for Mediation

a. In all cases in which action has been taken or a recommendation made as set forth in Bylaws, Section 13.2, the practitioner shall be given special notice of the recommendation or action and of the right to request a hearing pursuant to Bylaws, Section 13.3-2, below. The notice must state:

1) What action has been proposed against the practitioner;
2) Whether the action, if adopted, must be reported under Business & Professions Code Section 805;
3) A brief indication of the reasons for the action or proposed action;
4) That the practitioner may request a hearing;
5) That a hearing must be requested within 30 days; and
6) That the practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in Bylaws, Section 13.6, Hearing Procedure.

b. The notice shall also advise the practitioner that he or she may request mediation of the dispute pursuant to Bylaws, Section 13.4, and that mediation must be requested, in writing, within 10 days.

13.3-2 Request for Hearing or Mediation

a. The practitioner shall have 30 days following receipt of special notice of such action to request a hearing (and, if applicable, a preliminary hearing, as further described in Bylaws, Section 13.5). The request shall be in writing addressed to the Chief of Staff with a copy to the Chief Executive Officer. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the Governing Body within 70 days and shall be given great weight by the Governing Body, although it is not binding on the Governing Body.
b. The practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Additionally, the practitioner shall provide the names of any attorneys the practitioner wishes to proffer as a possible hearing officer, as further described at Bylaws, Section 13.6-5.
c. Any request for mediation must be received within 10 days of the date of receipt of the notice sent pursuant to Bylaws, Section 13.3-1(b).

13.4 Mediation of Peer Review Disputes

13.4-1 Mediation is a confidential process in which a neutral person facilitates communication between the Medical Executive Committee and a practitioner to assist them in reaching a mutually acceptable resolution of a peer review controversy in a manner that is consistent with the best interests of patient care.

13.4-2 The parties are encouraged to consider mediation whenever it could be productive in resolving the dispute.

13.4-3 In order to obtain consideration of mediation, the practitioner must request mediation in writing, as defined herein, within 10 days of his/her receipt of a notice of action or proposed action that would give rise to a hearing pursuant to Bylaws, Section 13.2.

13.4-4 If the practitioner and the Medical Executive Committee agree to mediation, all deadlines and time frames relating to the fair hearing process shall be tolled while the mediation is in process, and the practitioner agrees that no damages may accrue as the result of any delays attributable to the mediation.

13.4-5 Mediation cannot be used by either the Medical Staff or the practitioner as a way of unduly delaying the corrective action/fair hearing process. Accordingly, unless both the Medical Staff and the practitioner agree otherwise, mediation must commence within 30 days of the practitioner's request and must conclude within 30 days of its commencement. If the mediation does not resolve the dispute, the fair hearing process will promptly resume upon completion of the mediation.

13.4-6 The parties shall cooperate in the selection of a mediator (or mediators). Mediators should be both familiar with the mediation process and knowledgeable regarding the issues in dispute. The mediator may also serve as the Hearing Officer at any subsequent hearing, subject to the agreement of the parties which may be given prior to the mediation or after, with the parties to decide when they will agree on this issue. The costs of mediation shall be shared two-thirds by the Medical Staff and one third by the practitioner. The inability of the Medical Staff and the practitioner to agree upon a mediator within the required time limits shall result in the termination of the mediation process and the resumption of the fair hearing process.

13.4-7 Once selected, the mediator and the parties, working together, shall determine the procedures to be followed during the mediation. Either party has the right to be represented by legal counsel in the mediation process.

13.4-8 All mediation proceedings shall be confidential and the provisions of California Evidence Code Section 1119 shall apply except that communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented. Except as otherwise permitted in this Section, no other evidence of anything said at, or any writing prepared for or as the result of, the mediation shall be used in any subsequent fair hearing process that takes place if the mediation is not successful.

13.5 Preliminary Hearing

13.5-1 Any affected practitioner shall have the right to challenge imposition of a summary action, particularly on the issue of whether or not, based on the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect (as described at Bylaws, Section 12.2-2), the Medical Executive Committee

reasonably determined that failure to summarily restrict or suspend could reasonably result in an imminent danger to the health of an individual. Initially, the practitioner may present this challenge to the Medical Executive Committee at the meeting held within seven calendar days of imposition of the suspension action. If the Medical Executive Committee's decision is to continue the summary action, then any practitioner who has properly requested a hearing under the Medical Staff Bylaws may, within the timeframe and as described at Bylaws, Section 13.3-2, also request a preliminary hearing devoted exclusively to whether there is sufficient evidence based on the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect, that failure to summarily restrict or suspend could reasonably result in an imminent danger to the health of an individual.

13.5-2 This preliminary hearing shall be conducted by the Hearing Officer appointed pursuant to Bylaws, Section 13.6-5, and, unless waived by the practitioner, the Hearing Committee appointed for the full hearing, comprised pursuant to Bylaws, Section 13.6-4. Except as otherwise agreed by the parties, the preliminary hearing shall be convened within 15 days of the date all members of the Hearing Committee have been appointed. The Hearing Officer and Hearing Committee members shall be subject to reasonable questions and challenges to qualifications and potential conflicts, as provided at Bylaws, Section 13.6-14, and the evidentiary portion of the preliminary hearing shall be commenced, diligently pursued, and completed as promptly as reasonably possible. Except as modified by this Bylaws, Section 13.5, the provisions of Bylaws, Section 13.6-14, shall apply; however, the Hearing Officer shall be empowered to adjust time frames and modify procedures otherwise described in Bylaws, Section 13.6, as necessary to achieve a timely preliminary hearing. If the Hearing Officer determines that the member is not proceeding diligently in furtherance of a timely preliminary hearing, the Hearing Officer, in consultation with the Hearing Committee, if one has been appointed, may terminate the preliminary hearing, and order that the matter be heard as part of the full hearing, as described at Bylaws, Section 13.6.

13.5-3 At the conclusion of the preliminary hearing, the Hearing Officer, or Hearing Committee, as applicable, shall issue a written decision as to whether, based on the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect (as described at Bylaws, Section 12.2-2) reasonably determined that failure to summarily restrict or suspend could reasonably result in "imminent danger" to the health of an individual. The decision may affirm or reject, but may not modify, the action imposed by the Medical Executive Committee (although it may recommend that the Medical Executive Committee consider

modification). The written decision shall include documented findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached, and shall be transmitted to both the affected practitioner and the Medical Executive Committee within 15 calendar days from the conclusion of the preliminary hearing.

13.5-4 If the Hearing Officer's or Hearing Committee's (as applicable) determination is that the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect does not reasonably support a determination that failure to summarily restrict or suspend the practitioner's privileges could reasonably result in imminent danger to the health of an individual, the determination shall be immediately transmitted to the Medical Executive Committee for reconsideration of its imposition of summary action. If the Medical Executive Committee does not rescind the summary action within 10 days of receipt of the Hearing Officer's or Hearing Committee's determination, the matter shall be immediately transmitted to the Governing Body, which shall process the matter as an appeal from a favorable hearing recommendation, as further described at Bylaws, Section 13.7; provided, however, the appeal shall be heard within 45 calendar days of the date of the Hearing Officer's or Hearing Committee's initial determination in the matter; and further provided that the full hearing on the merits is not stayed and may proceed as usual during the pendency of the appeal.

13.5-5 Nothing in the foregoing precludes the Medical Executive Committee from imposing other remedial action in lieu of the initial summary action; and if such other action is itself a summarily imposed restriction of privileges that is reportable to the Medical Board of California, then the affected member shall be entitled to challenge such alternative summary actions in the same manner as described above for the initial summary action.

13.5-6 If the Hearing Officer, or Hearing Committee, determines that the information presented to the Medical Executive Committee at the time the summary action was imposed and/or continued in effect reasonably supports a determination that failure to summarily restrict or suspend could reasonably result in imminent danger to the health of an individual, the summary action shall remain in effect pending conclusion of the full hearing and any appellate review.

13.5-7 A full hearing on the merits of the summary action and any additional restrictions or discipline shall be conducted as soon as reasonably possible, in accordance with the provisions of Business & Professions Code Section 8.09 et seq. Subject to the following limitations, the findings of fact from the preliminary hearing shall be deemed established in the full hearing; provided, however, the Hearing Committee shall be permitted to hear additional evidence and to

reconsider the conclusions previously reached in light of the evidence produced at the full hearing. Notwithstanding the foregoing, a preliminary hearing determination that a summary action was not warranted shall, if upheld by the Governing Body pursuant to the appeal provisions set forth above, be binding on the hearing committee with respect to that particular decision.

13.6 Hearing Procedure

13.6-1 Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the chair of the Governing Body shall fulfill the functions assigned in this Section to the Chief of Staff, and the Governing Body shall assume the role of the Medical Executive Committee. The Governing Body may, but need not, grant appellate review of decisions resulting from such hearings.

13.6-2 Time and Place for Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give special notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing; provided, however, that when the request is received from a member who is under summary action and has timely requested a preliminary hearing as described in Bylaws, Section 13.5-1, the timely commencement of a preliminary hearing shall be deemed to satisfy the provisions of these Bylaws for timely commencement of the hearing.

13.6-3 Notice of Charges

Together with the special notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable. A supplemental notice may be issued at any time, provided the practitioner is given sufficient time to prepare to respond.

13.6-4 Hearing Committee

a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three members who shall gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint members from other

Medical Staff categories or practitioners who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one member who has the same healing arts licensure as the practitioner and who practices the same specialty as the practitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

b. Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all of the duties assigned to the Hearing Officer and to the Hearing Committee.
c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

13.6-5 The Hearing Officer

a. The use of a Hearing Officer to preside at a hearing is mandatory. Unless otherwise agreed upon by the practitioner and the Medical Staff, the following procedure shall be used to select the Hearing Officer:
    1) As part of his/her request for a hearing pursuant to Bylaws, Section 13.3-2, the practitioner must list five attorneys who the practitioner would accept as a Hearing Officer, three of whose names must be obtained from the list maintained by the hearing officer listing service operated by the California Society for Healthcare Attorneys, or such other hearing officer listing service as may be endorsed for that purpose by both the California Medical Association (CMA) and the California Hospital Association (CHA). The Medical Staff may then select the Hearing Officer from the practitioner's list. Failure of the practitioner to submit the requisite list shall constitute a waiver of any right to participate in the Hearing Officer selection process and the Medical Staff may then select a duly qualified Hearing Officer.
    2) If the Medical Staff is not willing to accept any of the five proposed Hearing Officers identified by the practitioner, the Medical Staff, within five working days of receipt of the practitioner's list, must provide the practitioner an alternative written list of five potential Hearing Officers (three of whom must be obtained from the hearing officer listing service). Failure to provide an alternative list within the five working days shall constitute a waiver of the right to reject the practitioner's list and the Medical Staff would then be required to select one of the persons previously identified by the practitioner from the hearing officer listing service list as the Hearing Officer.
    3) If the Medical Staff provides an alternative list, the practitioner has five working days to select the Hearing Officer from that list. The

failure of the practitioner to respond to the proposed candidates within the five working days shall constitute a waiver of the right to reject the Medical Staff's alternative list and the Medical Staff may then select anyone from that list as the Hearing Officer.

4) If the practitioner timely rejects all of the Hearing Officer candidates from the Medical Staff's alternative list, the Medical Staff, within five working days, shall contact the hearing officer listing service for a final list of five additional Hearing Officer candidates. In submitting its request, the Medical Staff may ask the hearing officer listing service to screen potential candidates for obvious conflicts and availability. Once the list has been supplied, if the Medical Staff and the practitioner cannot agree upon a candidate, the Medical Staff and the practitioner shall, in turn, each strike two candidates and the remaining candidate shall be the Hearing Officer. The side that strikes first shall be determined by lot. Unless a Hearing Officer is selected pursuant to stipulation of the parties, as opposed to striking candidate names, he/she shall be subject to reasonable voir dire.
5) Unless waived by the parties, the Hearing Officer so selected must meet the qualifications set forth in Bylaws, Section 13.6-5(b).

b. The Hearing Officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as Hearing Officer. The Hearing Officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate.
c. The Hearing Officer shall preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed hearing committee members or the Hearing Officer. The Hearing Officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence.
d. The Hearing Officer's authority shall include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.

e. If the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case. Under extraordinary circumstances, the Hearing Officer may recommend termination of the hearing; however, the Hearing Officer may not unilaterally terminate the hearing and may only issue an order that would have the effect of terminating the hearing (a "termination order") at the direction of the Hearing Committee. The terminating order shall be in writing and shall include documentation of the reasons therefore. If a terminating order is against the Medical Executive Committee, the charges against the practitioner will be deemed to have been dropped. If, instead, the terminating order is against the practitioner, the practitioner will be deemed to have waived his/her right to a hearing. The party against whom termination sanctions have been ordered may appeal the terminating order to the hospital Governing Body. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal shall be conducted in general accordance with the provisions of Bylaws, Section 13.7. If the order is found to be unwarranted, the Hearing Committee shall reconvene and resume the hearing. If the Governing Body determines that the terminating order should not have been issued, the matter will be remanded to the Hearing Committee for completion of the hearing.
f. Upon adjournment of the evidentiary portion of the hearing, the Hearing Officer shall meet with the members of the hearing committee to assist them with the process for their review of the evidence and preparation of the report of their decision. Upon request from the hearing committee members, the Hearing Officer may remain during the hearing committee's full deliberations. During the deliberative process, the Hearing Officer shall act as legal advisor to the hearing committee, but shall not be entitled to vote.
g. In all matters, the Hearing Officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the Hearing Officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the Hearing Officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

13.6-6 Representation

a. The practitioner shall have the right, at his or her expense, to attorney representation at the hearing. If the practitioner elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may be represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney.
b. Notwithstanding the foregoing and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.
c. Any time attorneys will be allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

13.6-7 Failure to Appear or Proceed

Failure without good cause of the practitioner to personally attend and proceed at a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

13.6-8 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted upon a showing of good cause, as follows:

a. Until such time as a Hearing Officer has been appointed, by the Hearing Committee or its Chair acting upon its behalf; or
b. Once appointed by the Hearing Officer.

13.6-9 Discovery

a. Rights of Inspection and Copying. The practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The body whose decision prompted the hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.
b. **Limits on Discovery.** The Hearing Officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring to individually identifiable

practitioners other than the practitioner under review nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

c. **Ruling on Discovery Disputes.** In ruling on discovery disputes, the factors that may be considered include:
   1) Whether the information sought may be introduced to support or defend the charges;
   2) Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;
   3) The burden on the party of producing the requested information; and
   4) What other discovery requests the party has previously made.

d. **Objections to Introduction of Evidence Previously Not Produced for the Medical Staff**. The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the Hearing Officer unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

13.6-10 Pre-Hearing Document Exchange

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least 10 days prior to the hearing. A failure to comply with this rule is good cause for the Hearing Officer to grant a continuance. Repeated failures to comply shall be good cause for the Hearing Officer to limit the introduction of any documents not provided to the other side in a timely manner.

13.6-11 Witness Lists

Not less than 15 days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least 10 days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

13.6-12 Procedural Disputes

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural

disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

b. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer shall determine whether to allow oral argument on any such motions. The Hearing Officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses and rulings thereon shall be entered into the hearing record by the Hearing Officer.

13.6-13 Record of the Hearing

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the Hearing Officer. The cost of attendance of the court reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

13.6-14 Rights of the Parties

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and Hearing Officer questions which are directly related to evaluating their qualifications to serve and for challenging such members or the Hearing Officer, call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Hearing Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

13.6-15 Rules of Evidence

Judicial Rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under these Bylaws, Article 13. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

13.6-16 Burdens of Presenting Evidence and Proof

a. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner shall be obligated to present evidence in response.
b. An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied privileges. The practitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges.
c. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

13.6-17 Adjournment and Conclusion

The Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted with due consideration for reaching an expeditious conclusion to the hearing.

13.6-18 Basis for Decision

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

13.6-19 Presence of Hearing Committee Members and Vote

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

13.6-20 Decision of the Hearing Committee

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of

the decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the Governing Body, and by special notice to the practitioner. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

13.7 Appeal

These procedures apply to appeals from the results of a preliminary hearing (as described at Bylaws, Section 13.5), as well as appeals from the full hearing; however, in the context of an appeal from a preliminary hearing, the appeal Hearing Officer shall be empowered to adjust time frames and modify procedures as necessary to achieve a timely appeal from a preliminary hearing.

13.7-1 Time for Appeal

Within 40 days after receiving the decision of the Hearing Committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer and the other side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The Governing Body shall consider the decision within 70 days, and shall give it great weight.

13.7-2 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a request for appeal, schedule a review date and cause each side to be given notice (with special notice to the practitioner) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date of such notice provided; however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Appeal Board for good cause.

13.7-3 Appeal Board

The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an appellate Hearing Officer and shall have

all of the authority of and carry out all of the duties assigned to a Hearing Officer as described in this Article 13. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

13.7-4 Appeal Procedure

The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record of the hearing before the Hearing Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel or any other representative designated by that party in connection with the appeal. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her or its position on appeal. The appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then at a time convenient to itself, deliberate outside the presence of the parties.

13.7-5 Decision

a. Within 30 days after the adjournment of the appellate review, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.
b. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.
c. The Appeal Board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. Unless the Appeal Board elects to conduct a de novo review, the Appeal Board shall sustain the factual findings of the Hearing Committee if they are supported by substantial evidence. The Appeal Board may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted in light of the supported findings, and whether any bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any),

and the decision reached, if such reasons, findings and conclusions differ from those of the Hearing Committee.

d. The Appeal Board shall forward copies of the decision to each side involved in the hearing.

e. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full Governing Body for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 unless the parties agree otherwise or for good cause as determined by the Appeal Board.

13.7-6 Administrative Action Hearings

The following modifications to the hearing process apply when the Medical Executive Committee (or Governing Body) has taken or recommended an action described in Bylaws, Section 13.2 for a non-medical disciplinary cause or reason. Such actions shall be deemed administrative disciplinary actions.

13.8 Administrative Action Hearing

The following modifications to the hearing process apply when the Medical Executive Committee (or Governing Body) has taken or recommended an action described in Bylaws, Section 13.2 for a non-medical disciplinary cause or reason. Such actions shall be deemed administrative disciplinary actions.

13.8-1 Administrative Action Hearing

a. The affected practitioner shall be entitled to an administrative action hearing, conducted in accordance with Bylaws, Section 13.6, except as follows:

b. At the election of the body whose decision prompted the hearing, the hearing shall be conducted by an arbitrator, meeting the qualifications of Bylaws, Section 13.6-4(b), and selected by mutual agreement of the parties, if agreement can be reached within 10 days, failing which the arbitrator shall be selected by the body whose decision prompted the hearing.

c. The arbitrator shall have all of the rights and responsibilities of a Hearing Officer and a Hearing Committee, as described in Bylaws, Section 13.6.

d. At the election of the body whose decision prompted the hearing, both parties shall have the right to be represented by an attorney, whether or not the other party elects to be represented by an attorney. The parties shall be notified of this election at the time the practitioner is notified of his/her right to a hearing. If attorney representation is permitted, the parties shall promptly notify each other of their elections regarding attorney representation, together with the name and contact information of their attorneys.

13.8-2 Nonreportability of Administrative Actions

Administrative disciplinary actions are not reportable to the Medical Board of California or the National Practitioner Data Bank.

13.8-3 Nonwaiver of Protections

Notwithstanding the foregoing, it is understood that circumstances precipitating administrative disciplinary actions may nonetheless involve or affect quality of care in the hospital (e.g., conduct that does or may impair the ability of others to render quality care, or that affects patients' perceptions of the quality of care rendered in the hospital). Processing a matter as and administrative disciplinary action does not waive any protections that may be available under California or federal law for peer review actions taken in furtherance of quality of care or services provided in the hospital.

13.9 Right to One Hearing

No practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

13.10 Confidentiality

To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff Bylaws.

All proceedings conducted pursuant to these Bylaws, Article 13, shall be held in private unless otherwise ordered by the Governing Body pursuant to a request of the practitioner. The practitioner may request a public hearing. Prior to exercising its discretion on any request for a public hearing, the Governing Body shall seek and consider the comments of the Medical Executive Committee as to the implications and feasibility of conducting such a hearing in public.

13.11 Release

By requesting a hearing or appellate review under these Bylaws, a practitioner agrees to be bound by the provisions in the Medical Staff Bylaws relating to immunity from liability for the participants in the hearing process.

13.12 Governing Body Committees

In the event the Governing Body should delegate some or all of its responsibilities described in these Bylaws, Article 13 to its committees (including a committee serving as an Appeal Board), the Governing Body shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee.

13.13 Exceptions to Hearing Rights

13.13-1 Exclusive Use Hospital Contract Practitioners

a. Exclusive Use

The procedural rights of Bylaws, Article 13 do not apply to a practitioner whose application for Medical Staff membership and privileges was denied or whose privileges were terminated on the basis that the privileges he or she seeks are granted only pursuant to an exclusive use policy. Such practitioners shall have the right, however, to request that the Governing Body review the denial, and the Governing Body shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position to the Governing Body.

b. Hospital Contract Practitioners

The hearing rights of Bylaws, Article 13 do not apply to practitioners who have contracted with the hospital to provide clinical services. Removal of these practitioners from office and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the hospital. The hearing rights of Bylaws, Article 13 shall apply if an action is taken which must be reported under Business & Professions Code Section 805 and/or the practitioner's Medical Staff membership status or privileges which are independent of the practitioner's contract are removed or suspended.

The hearing rights of Bylaws, Article 13 do not apply to practitioners who have contracted with the hospital to provide clinical services. Removal of these practitioners from office and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the hospital. The hearing rights of Bylaws, Article 13 shall apply if an action is taken which must be reported under Business & Professions Code Section 805 and/or the practitioner's Medical Staff membership status or privileges which are independent of the practitioner's contract are removed or suspended.

13.13-2 Denial of Applications for Failure to Meet the Minimum Qualifications

practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California License to practice medicine, dentistry or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these Bylaws or the Rules); to maintain professional liability insurance as required by the Rules; or to meet any of the other basic standards specified in Bylaws, Section 2.2-2 or to file a complete application.

13.13-3 Automatic Suspension or Limitation of Privileges/Automatic Termination

a. No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Bylaws, Section

12.3-1, or automatically terminated as set forth in Bylaws, Section 12.3-8. In other cases, described in Bylaws, Section 12.3-1 and Section 12.3-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or the Drug Enforcement Administration was unwarranted, but only whether the member may continue to practice in the hospital with those limitations imposed.

b. Practitioners whose privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Bylaws, Section 12.3-3), failing to complete medical records (Bylaws, Section 12.3-4), failing to maintain malpractice insurance (Bylaws, Section 12.3-5), failing to pay dues (Bylaws, Section 12.3-6), or failing to comply with particular government or other third party payor Rules or policies (Bylaws, Section 12.3-7) are not entitled under Bylaws, Section 12.3-9 to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and it must be reported to the Medical Board of California.

13.13-4 Failure to Meet Minimum Activity Requirements

Practitioners shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their Medical Staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff Bylaws or Rules. In such cases, the only review shall be provided by the Medical Executive Committee through a subcommittee consisting of at least three Medical Executive Committee members. The subcommittee shall give the practitioner notice of the reasons for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than 30 days and no more than 100 days after the date the notice was given. At this interview, the practitioner may present evidence concerning the reasons for the action, and thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the practitioner, Medical Executive Committee and Governing Body. The subcommittee decision shall be final unless it is reversed or modified by the Medical Executive Committee within 45 days after the decision was rendered, or the Governing Body within 90 days after the decision was rendered.

Article 14 General Provisions

14.1 Rules and Policies

14.1-1 Overview and Relation to Bylaws

These Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these Bylaws. Additional provisions, including, but not limited to, procedures for implementing the Medical Staff standards may be set out in Medical Staff Rules, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such Rules and policies shall be deemed an integral part of the Medical Staff Bylaws.

14.1-2 General Medical Staff Rules

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 50% of the voting members of the Medical Staff. Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility. Proposed Rules shall be submitted to the Medical Executive Committee for review and action, as follows:

a. Except as provided at Section 14.1-2(d), below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website at least thirty days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of at least 15 days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.
b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least 50% of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 14.1-4:
    1) If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed

Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1-2(b)(3), the proposed Rule shall be* forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed Rule.

2) If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Governing Body.
3) With respect to proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least 50% of votes have been cast.

c. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body.
d. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Governing Body for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 14.1-2(a)) the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least 50% of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided, however, the approved Rule shall remain effective until such time as a superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 14.1-2.

14.1-3 Medical Staff Policies

a. Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules. New or revised policies (proposed policies) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 50 of the voting members of the Medical Staff. Proposed policies shall not be inconsistent with the Medical Staff

or hospital Bylaws, Rules or other policies, and upon adoption shall have the force and effect of Medical Staff Bylaws.

b. Medical Executive Committee approval is required, unless the proposed policy is one generated by petition of at least 50% of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed policy, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 14.1-4.
    1) If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 14.1-3(b)(3), the proposed policy shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed policy.
    2) If conflict management is invoked, the proposed policy shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the Governing Body.
    3) Approval of the Medical Staff shall require the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed policy, has been given and at least 3 votes have been cast.

c. Following approval by the Medical Executive Committee or the voting Medical Staff as described above, a proposed policy shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body.

d. The Medical Staff shall be notified of the approved policy, and may, by petition signed by at least 50% of the voting members of the Medical Staff require the policy to be submitted for possible recall; provided, however, the approved policy shall remain effective until such time as it is repealed or amended pursuant to any applicable provision of this Section 14.1-3.

14.1-4 Conflict Management

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least 50% of the voting members of the Medical Staff) regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the President of the Medical Staff shall convene a meeting with the

petitioners' representative(s). The foregoing petition shall include a designation of 1 member of the voting Medical Staff who shall serve as the petitioners' representative. The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioner's representatives. Unresolved differences shall be submitted to the Governing Body for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

14.2 Forms

Application forms and any other prescribed forms required by these Bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Executive Committee and the Governing Body. Upon adoption, they shall be deemed part of the Medical Staff Rules. They may be amended by approval of the Medical Executive Committee and the Governing Body.

14.3 Dues

The Medical Executive Committee shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff

14.4 Medical Screening Exams

14.4-1 All patients who present to the hospital, including the Emergency Department, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition or, where applicable, active labor.

14.4-2 Medical screening examinations and emergency services shall be provided in compliance with all applicable provisions of state and federal law, and hospital policies and procedures respecting Emergency Medical Services.

14.4-3 Licensed nurses may do medical screenings through the Emergency Department as designated by the on-duty physician.

14.5 Legal Counsel

The Medical Staff may, at its expense, retain and be represented by independent legal counsel.

14.6 Authority to Act

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

14.7 Disputes with the Governing Body

In the event of a dispute between the Medical Staff and the Governing Body relating to the independent rights of the Medical Staff, as further described in California Business & Professions Code Section 2282.5, the following procedures shall apply.

a. Invoking the Dispute Resolution Process
    1) The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25 percent of the members of the active staff.
    2) In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the active staff.

b. Dispute Resolution Forum
    1) Ordinarily, the initial forum for dispute resolution shall be conducted in a joint conference of equal numbers of Medical Staff and Governing Body members selected by the Chief of Staff and Chairperson of the Governing Body, plus the Chief Executive Officer.
    2) However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of:
    At least a majority of the Medical Executive Committee plus two members of the Governing Body; or
    At least a majority of the Governing Body plus two members of the Medical Executive Committee.

c. The parties' representatives shall convene as early as possible, shall gather and share relevant information, and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute the Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.

14.8 No Retaliation

Neither the Medical Staff, its members, committees or department heads, the Governing Body, its chief administrative officer, or any other employee or agent of the hospital or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, hospital employee, member of the Medical Staff, or any other health care worker of the health facility because that person has done either of the following:

a. Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the Medical Staff of the facility, or to any other governmental entity.
b. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to, the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Medical Staff, or governmental entity.

Article 15 Adoption and Amendment of Bylaws

15.1 Medical Staff Responsibility and Authority

15.1-1 The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff Bylaws and amendments which shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body. Additionally, hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on hospital operations and feasibility.

15.1-2 Proposed amendments shall be submitted to the Governing Body for comments at least 30 days before they are distributed to the Medical Staff for a vote. The Governing Body has the right to have its comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

15.1-3 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least 50% of the voting Medical Staff members. Amendments submitted upon petition of the voting Medical Staff members shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Governing Body for review and comment as described in Section 15.1-2. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Governing Body when the proposed amendments are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

15.2 Methodology

15.2-1 Medical Staff Bylaws may be adopted, amended or repealed by the following combined actions:

a. The affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given; and

b. The approval of the Governing Body, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the Governing Body in writing, and shall be forwarded to

the Chief of Staff, the Medical Executive Committee and the Bylaws Committee.

15.2-2 In recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued state licensure, approval by accrediting bodies, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the Governing Body in its actions.

15.3 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the Governing Body. Such corrections are effective upon adoption by the Medical Executive Committee; provided however, they may be rescinded by vote of the Medical Staff or the Governing Body within 120 days of the date of adoption by the Medical Executive Committee. (For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least 25 percent of the voting members of the Medical Staff cast ballots.)

MAYERS MEMORIAL HEALTHCARE DISTRICT

Medical Staff Rules

2025

(To be used in conjunction with Mayers Memorial Hospital Medical Staff Bylaws)

Table of Contents

Rule 1 Categories of Membership

1.1 Categories

The Medical Staff shall consist of the following categories. The Rules applicable to each staff category are set forth in the corresponding .

	See Appendix
Active Staff	1A
Consulting Staff	1B
Courtesy Medical Staff	1C
Provisional Staff	1D
Telemedicine Staff - Independent	1E
Telemedicine Staff	1F
Post Graduate and Student Training	1G
Refer and Follow	1H

1.2 Qualifications Generally

Each practitioner who seeks or enjoys staff appointment must continuously satisfy the basic qualifications for membership set forth in the Bylaws and Rules, except those that are specifically waived for a particular category, and the additional qualifications that attach to the staff category to which he or she is assigned. The Governing Body may, after considering the Medical Executive Committee's recommendations, waive any qualification in accordance with Bylaws, Section 2.2-4, Waiver of Qualifications.

1.3 Prerogatives and Responsibilities

1.3-3 The prerogatives available to a Medical Staff member depending upon staff category enjoyed are:

i. **Admit patients:** Admit patients consistent with approved privileges.
ii. **Eligible for Clinical Privileges:** Exercise those clinical privileges that have been approved.
iii. **Vote:** Vote on any Medical Staff matter including Bylaws amendments, officer selection and other matters presented at any general or special staff meetings and on matters presented at department meetings.
iv. **Hold Office:** Hold office in the Medical Staff and in the department to which he or she is assigned.
v. **Serve on Committees:** Serve on committees and vote on committee matters.

1.3-4 The responsibilities which Medical Staff members will be expected to carry out in addition to the basic responsibilities set forth in the Bylaws, Article 2, Section 2.6, Basic Responsibilities of Medical Staff Membership, are to:

i. **Medical Staff Functions:** Contribute to and participate equitably in staff functions, at the request of a staff officer, including: contributing to the organizational and administrative activities of the Medical Staff, such as quality improvement, risk management and utilization management; serving

in Medical Staff offices and on hospital and Medical Staff committees; participating in and assisting with the hospital's medical education programs; proctoring of other practitioners; and fulfilling such other staff functions as may reasonably be required.

ii. **Consulting:** Consulting with other staff members consistent with his or her delineated privileges.

iii. **Emergency Call:** Serving on the on-call roster and accepting responsibility for providing care to any patient requiring on-call coverage in his or her specialty, in accordance with rules established by the Medical Executive Committee and the Governing Body.

iv. **Attend Meetings:** Attend at least the minimum number of staff meetings specified in the Medical Staff Bylaws.

v. **Pay Fees/Dues:** Pay staff application fees, dues and assessments in the amounts specified in the rules.

1.3-5 Prerogatives and Obligations of Staff Categories

The prerogatives and obligations of each staff category are described in the table on the following page.

1.4 Qualifications for Staff Category

1.4-3 Assignment and Transfer in Staff Category

A. Medical Staff members shall be assigned to the category of staff membership based upon the qualifications identified below. Active staff members who fail to achieve the minimum activity for two consecutive years shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate and possibly terminate the privileges and membership of any staff member who has failed to have any activity. A Courtesy Member who has exceeded the maximum activity permitted for two consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve these assignments and transfers, which shall then be evaluated in accordance with the bylaws and these rules. The transfers shall be done at the time of reappointment.

B. In assigning practitioners to the proper staff category, the Medical Staff shall also consider whether the practitioner participated in other aspects of the hospital's activities by, for example, serving on committees. The Governing Body (on recommendation of the Medical Executive Committee) may rescind an automatic transfer, but only if the practitioner clearly demonstrates that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

Appendix 1A Active Staff

The Active Staff shall consist of the members who are:

A. Are regularly involved in caring for patients or demonstrate, by way of other substantial involvement in Medical Staff or hospital activities, a genuine concern and interest in the hospital. Regular involvement in patient care shall mean admitting inpatients or outpatients, referring or consulting on at least ten cases each Medical Staff.

B. Have been members in good standing of the provisional staff for at least twelve months.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	Yes
Eligible for clinical privileges	Yes
Vote	Yes
Hold office	Yes
Serve as Committee Chair	Yes
Serve on Committee	Yes
Responsibilities	
Medical staff functions	Yes
Consulting	Yes
Emergency room duties	No
Attend meetings	Yes
Pay application fee	Yes
Pay dues	Yes
Additional Particular Qualifications	
Must first complete provisional	Yes
Malpractice insurance	Yes
File application and apply for reappointment	Yes

Appendix 1B Consulting & Telemedicine Consulting Staff

The Consulting Staff shall consist of practitioners who possess ability and knowledge that enable them to provide valuable assistance in difficult cases.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	No
Eligible for clinical privileges	Yes
Vote	No
Hold office	Yes
Serve as Committee Chair	Yes
Serve on Committee	Yes
Responsibilities	
Medical staff functions	No
Consulting	Yes
Emergency room call	No
Attend meetings	No
Pay application fee	No
Pay dues	No
Additional Particular Qualifications	
Must first complete provisional or be subject to focused professional practice evaluation for new privileges	No
Malpractice insurance	Yes
File application and apply for reappointment	Yes

Appendix 1C Courtesy Medical Staff

The Courtesy Medical Staff shall consist of the members who:

A. Admit, refer or otherwise provide services for no more than ten patients during each Medical Staff year.
B. Prior to reappointment, provide evidence of current clinical performance at the hospital where they practice in such form as the Credentials Committee, or the Medical Executive Committee may require in order to evaluate their current ability to exercise the requested clinical privileges.
C. Have completed satisfactory performance on the provisional staff.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	Yes
Eligible for clinical privileges	Yes
Vote	Yes
Hold office	NO
Serve as Committee Chair	Yes
Serve on Committee	Yes
Responsibilities	
Medical staff functions	NO
Consulting	Yes
Emergency room duties	NO
Attend meetings	No
Pay application fee	Yes
Pay dues	Yes
Additional Particular Qualifications	
Must first complete provisional	Yes
Malpractice insurance	Yes
File application and apply for reappointment	Yes

Appendix 1D Provisional Staff

The Provisional Staff shall consist of the members who:

A. Are initial appointees to the Medical Staff and plan to qualify for, and seek transfer to, the Active Staff in 23 to 24 months.

B. In the ordinary course of events, are transferred to active status after serving at least 12 but not more than 24 months on the provisional staff. Action shall be initiated by the Medical Executive Committee to terminate the privileges and membership of a provisional member who does not qualify for advancement within 24 months. The member shall not be entitled to any hearing and appeal under Bylaws, Article 13, Hearings and Appellate Reviews, if advancement was denied because of a failure to have a sufficient number of cases proctored or because of a failure to maintain a satisfactory level of activity. The member shall be entitled to the hearing and appeal rights under Bylaws, Article 13, Hearings and Appellate Reviews, if advancement was denied because the member's clinical performance or professional conduct was unsatisfactory.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBILITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	Yes
Eligible for clinical privileges	Yes
Vote	No
Hold office	No
Serve as Committee Chair	No
Serve on Committee	Yes
Responsibilities	
Medical staff functions	Yes
Consulting	Yes
Emergency room call	NO
Attend meetings	NO
Pay application fee	Yes
Pay dues	Yes
Additional Particular Qualifications	
Must first complete provisional	N/A
Malpractice insurance	Yes
File application and apply for reappointment	Yes

Appendix 1E Telemedicine Staff, Independent

A. Telemedicine Definitions

i. Distant Site is the site where a Telemedicine Provider who provides health care services is located while providing these services via a telecommunications system.

ii. Originating Site is the where the patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

iii. Telemedicine Provider is the individual provider who uses the telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is generally a physician, but other health professionals may also be involved as Telemedicine Providers. The Telemedicine Provider would generally contract with (or in the case of nonphysicians, be employed by) the entity that serves as the Distant Site.

B. Prerogatives and Responsibilities of the Telemedicine Staff

The Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic, consulting, or treatment services, from the Distant Site to hospital patients at the Originating Site via telecommunication devices. Telecommunication devices include interactive (involving a real time or near real time two-way transfer of medical data and information) telecommunications between the Telemedicine Provider at the Distant Site and the patient at the Originating Site.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBLITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	No
Eligible for clinical privileges	Yes
Vote	No
Hold office	No
Serve as Committee Chair	No
Serve on Committee	No
Responsibilities	
Medical staff functions	No
Consulting	Yes
Emergency room duties	No
Attend meetings	No
Pay application fee	No
Pay dues	No
Additional Particular Qualifications	
Must first complete provisional or be subject to focused professional practice evaluation for new privileges	No
Malpractice insurance	Yes
File application and apply for reappointment	No

C. Additional Provisions Applicable to Independent Telemedicine Staff

i. Requirement for Contract with Distant Site: This hospital must have a written agreement with each Distant Site from which a Telemedicine Provider delivers telemedicine services that specifies the following:
   a. The Distant Site is a contractor of services to the hospital.
   b. The Distant Site furnishes services in a manner that permits this hospital to be in compliance with the Medicare Conditions of Participation.
   c. This hospital makes certain through the written agreement that all Distant Site Telemedicine Providers' credentialing and privileging processes meet, at a minimum, the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).

ii. Requirement to Communicate Regarding Clinical Services:
The medical staffs at both this hospital and the Distant Site shall recommend the clinical services to be provided through a telemedical link at their respective sites. The Medical Staff at this hospital evaluates this hospital's ability to safely provide services on an ongoing basis. The medical staff at the Distant Site evaluates and communicates with this hospital with respect to performance of those services as part of privileging and as part of the reappraisal conducted at the time of reappointment, renewal, or revision of clinical privileges.

iii. Responsibility to Communicate Concerns/Problems:
   a. There is a need for clear delineation of reporting responsibilities respecting the Telemedicine providers' performance. At the very least, the Medical Staff officials at this hospital must be informed of any practitioner-specific problems that arise in the delivery of services to this hospital's patients.
   b. Additionally, this hospital should communicate to the Medical Staff officials at the Distant Site, through peer review channels, any problems that may arise in the delivery of care by the Telemedicine Provider to patients at this hospital.
   c. Similarly, when a member of this hospital's Medical Staff is providing telemedicine services to patients at another facility, this hospital's Medical Staff should communicate to the Medical Staff officials at the Originating Site, through peer review channels, any problems that may arise in the delivery of telemedicine services by members of this hospital's Medical Staff.

iv. The Chief of Staff may enter into appropriate information sharing agreements and/or develop and implement appropriate protocols to effectuate these provisions.

D. Responsibility to Review Practitioner-Specific Performance:

i. Special proctoring arrangements may be made for qualified practitioners at the Distant Site to proctor cases performed by new members of the Telemedicine Staff.

ii. Primary responsibility to assess what, if any, practitioner-specific performance improvement and/or corrective action may be warranted rests with the Originating Site. If such action gives rise to procedural rights at this hospital, the provisions of Bylaws, Article 13, Hearings and Appellate Reviews, will apply.

Appendix 1F Telemedicine Staff

The telemedicine staff consist of members who solely provide telemedicine services to patients at the hospital.

A. Telemedicine staff members must meet each of the minimum qualifications and additional qualifications detailed in membership qualifications and responsibilities article, except they do not need to:
   - hold a DEA number, unless they do not request prescribing privileges.
   - be board certified.
   - meet the location requirements.
   - pledge to continuous care.

B. Prerogatives and Responsibilities of the Telemedicine Staff

The Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic, consulting, or treatment services, from the Distant Site to hospital patients at the Originating Site via telecommunication devices.

Telecommunication devices include interactive (involving a real time or near real time two-way transfer of medical data and information) telecommunications between the Telemedicine Provider at the Distant Site and the patient at the Originating Site.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBLITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	No
Eligible for clinical privileges	Yes
Vote	No
Hold office	No
Serve as Committee Chair	No
Serve on Committee	No
Responsibilities	
Medical staff functions	No
Consulting	Yes
Emergency room duties	No
Attend meetings	No
Pay application fee	Yes
Pay dues	Yes
Additional Particular Qualifications	
Must first complete provisional or be subject to focused professional practice evaluation for new privileges	No
Malpractice insurance	Yes
File application and apply for reappointment	Yes

Appendix 1G Post Graduate Student

Visiting fellows, residents, medical interns and medical students working at the Hospital through a family practice residency program rural training agreement or other residency program training agreement are not members of the Medical Staff. Such post-graduate and student trainees shall function at the Hospital only pursuant to a Medical Staff member's supervision. All visiting post-graduate and student trainees are required to comply with the provisions of the Medical Staff Bylaws, the Medical Staff Rules and Regulations, the policies and procedures of the Hospital and of any department to which the resident or other trainee has been assigned.

A. Visiting Fellows and Residents

Visiting fellows and residents must be currently enrolled in an approved training program and meet those eligibility qualifications listed in the "essentials of Accredited Residencies in Graduate Medical Education," as set forth in the AMA Graduate Medical Education Directory.

Visiting fellows are either: (1) California licensed physicians engaged in post-graduate medical education at the hospital on rotation form, and under the auspices of, a Medical Board of California-approved training program; or (2) commissioned officers on active duty in the medical corps of any branch of the U.S. Armed Forces with a valid, unrestricted license to practice medicine (or osteopathic medicine) in any state or territory of the United States.

Residents are California licensed physicians who are practicing at the Hospital only in connection with an approved post-graduate medical education training program.

The duties of visiting fellows and residents at the Hospital shall be defined by their training programs, subject to the Hospital's approval. Trainees shall be supervised by Medical Staff members. Visiting fellows and residents are not members of the Medical Staff and are not entitled to the procedural rights set forth in Article XI of the Hospital's Medical Staff Bylaws and these Rules and Regulations. Visiting fellows and residents practicing outside of their affiliated training programs must apply and qualify for Medical Staff membership and privileges on an independent basis.

B. Criteria to be Satisfied Prior to Rotation

Visiting fellows and residents must provide the following documentation to the Medical Staff office no less than 60 days prior to the commencement of training at the Hospital:

i. Completed and signed Hospital application and all supporting documentation requested;
ii. Evidence of current professional liability insurance coverage for the entire duration of his/her training at the Hospital;
iii. Letter of recommendation and of good standing from the Chair of the training program from which the visiting fellow and/or resident is on rotation;

iv. Written recommendation of the Director of the department, if any, to which the visiting fellow and/or resident will be assigned at the Hospital;
v. Completion of an appropriate health screening with medical clearance; and
vi. Written acknowledgement of his/her receipt of, or access to, the Rules and Regulations of the Medical Staff and pertinent potions of the Medical Staff Bylaws and his/her agreement to comply with and be bound by the terms thereof.

C. Prerogatives

Visiting fellows and residents do not have clinical privileges at the Hospital and are permitted to only provide coverage for patients admitted by Medical Staff members. Visiting fellows and residents cannot manage patients independently and must coordinate care with the attending Medical Staff member as referenced in these Medical Staff Rules and Regulations. Visiting fellows and residents may attend, in a non-voting capacity, meetings of the Medical Staff, Medical Staff committees, and any department to which they are assigned.

D. Medical Students (Interns)

Medical students are not considered members of the Medical Staff.

i. **Qualifications**

Medical students who are enrolled in training programs recognized and licensed under an appropriate licensing board, and/or accrediting agency located within, or outside of, the State of California, may be considered for acceptance to the Hospital for training. The following qualifications must be satisfied no less than 60 days in advance of the anticipated started date in order to be considered for acceptance to the Hospital for training:

a. The student must be a full-time student in good standing;
b. The student must be authorized by the academic institution in which he/she is enrolled to participate in a training program at the Hospital;
c. The student must complete an appropriate health screening with medical clearance prior to his/her commencement of his/her training at the Hospital; and
d. The student must provide evidence of professional liability (malpractice) insurance coverage for the entire duration of his/her training at the Hospital.

ii. **Medical Student Activities**

Medical students may apply for rotation at the Hospital in accordance with the procedures applicable to residents. The medical student is expected to carry out his/her activities: (i) subject to the responsible Hospital/Department policies and procedures; (ii) in compliance with the supervisory requirements and guidelines established by the assigned Medical Staff member; and (iii) consistent with the requirements of his/her approved training program.

Medical students do not receive admitting or clinical privileges at the Hospital. Students cannot manage patients or write orders independently and function only under the direct supervision of a Medical Staff member. With respect to patient procedures, excluding histories and physicals, the Medical Staff member must be physically present at the time of performance. With respect

to orders, the Medical Staff member must co-sign before orders are carried out. Ultimate responsibility for patient care, supervision, and evaluation of the medical student rests with the Medical Staff member to which the student is assigned.

E. Duties of Fellows, Residents and Medical Students

In carrying out his/her anticipated duties, the trainee must:

i. act in accordance with the program/agreement governing his/her training at the Hospital;
ii. follow the Medical Staff Bylaws, Rules and Regulations and policies and procedures of the Hospital and Department to which the trainee has been assigned;
iii. perform only activities commensurate with his/her level of advancement and competence;
iv. carry out all duties under the supervision of appropriately privileged members of the Medical Staff;
v. participate in Hospital orientation and education programs and other activities of the Medical Staff;
vi. participate in educational activities of the training program;
vii. attend committee meetings, as appropriate; and
viii. perform in accordance with established hospital practice and policy, program requirements, clinical services, and standards set by regulatory agencies and accreditation organizations.

F. Supervision Requirements

The attending physician, as a member of the Medical Staff, has ultimate responsibility for his/her patients welfare and clinical care and must supervise the fellow, resident, intern or other trainee, in carrying out patient care. See Table in Section III-7.7 for specific activity requirements.

Supervision shall consist of: validation and authentication of patient history and physical examination findings, discussion and oversight of patient management techniques and determinations, participation in joint patient rounds, and participation in Hospital and Medical Staff education and quality assurance programs. Orders regarding all significant diagnostic, management, and therapeutics interventions, and all interventions, medication regimes, and operative procedures must be reviewed and approved by the Medical Staff member who is the patient's attending physician or attending physician's designee prior to implementation.

Students under the supervision of Medical Staff members may participate in aspects of care of any patient as deemed appropriate by the supervising physician and commensurate with their levels of training, experience and competence and in accordance with their training program agreement with the Hospital. Trainees must first be properly introduced to the patient and the patient's verbal consent to their presence must be obtained. Should a patient or surrogate decision maker object to the participation of a trainee, other medical staff members shall provide all needed services.

G. Utilization of Trainees

Refer to the Table in this Section denoting the permitted activities and the supervisions required for each level of trainee.

The Table below denotes the permitted activities and the supervision (review and countersignature) required for each level of Trainee:

ACTIVITY	Medical Student/Unlicensed Resident	Licensed Resident and Visiting Fellow
ADMISSION H&P	Yes*	Yes*
PROGRESS NOTES	Yes**	Yes**
CONSULTATIONS	No	Yes*
ORDER MEDS	No	Yes
ORDER TREATMENT	No	Yes
ORDER DNR	No	No
CHEMO ORDERS	No	No
PRE-OP NOTE	Yes*	Yes*
OPERATIVE NOTE	Yes*	Yes*
DISCHARGE SUMMARY	Yes*	Yes*

Code: * must have countersignature within 48 hours

** must have countersignature on all notes and note of agreement weekly

H. Record Keeping and Documented Supervision

The competence of each trainee in areas such as patient assessment and management will be evaluated in accordance with the Table in Section III-7.7 by the supervising Medical Staff member. When required, a confidential, written explanation shall be prepared and forwarded to the post-graduate training program in which the trainee is enrolled. The evaluation shall include, as appropriate, information about the quality of care, treatment and services and any educational needs of the participant.

I. Corrective Action

Fellows, residents and other student trainees shall not be entitled to the hearing and appellate procedures specified in Article XI of the Medical Staff Bylaws and these Rules and Regulations. In the event any corrective action recommended or taken

against a fellow or licensed resident constitutes grounds for a hearing under Article XI of the Medical Staff Bylaws following procedures shall apply:

Within 15 days of the fellow/resident's receipt of notice of corrective action, he/she may challenge such action by filing a written grievance with the Chief of the Medical Staff. Upon receipt of such a grievance, the Chief of Staff shall initiate an investigation and afford the fellow/resident an opportunity for an interview before an *ad hoc* grievance committee consisting of the Hospital's Chief Executive Officer and the Chief of Staff or their respective designees. Before the interview, the fellow/resident shall be informed of the nature of the circumstances giving rise to the proposed action, and be given an opportunity to review any evidence supporting the action.

The interview shall not constitute a "hearing" as is defined in Article XI of the Medical Staff Bylaws and these Rules and Regulations, and shall not be conducted according to the procedural rules applicable with respect to such medical staff hearings. At the interview, the fellow/resident may present any information relevant thereto. Following the interview, a report of the findings and recommendations shall be made by the grievance committee for transmittal to the Medical Executive Committee with a copy to the fellow/resident. Within 7 days of the date of the grievance committee report the fellow/resident may request an appellate review by the Medical Executive Committee which shall consider the apply at its next regularly scheduled meeting. Thereafter, the action of the Medical Executive Committee shall be final, subject to approval by the governing body, with notice to the fellow/resident.

With respect to medical students, the ground for disciplinary action and procedural due process associated with the imposition of proposed disciplinary action shall be determined by the policies established by the trainee's training program. The Hospital and the training program will cooperate and assist one another in investigating facts which may serve as a basis for taking disciplinary action against such trainees.

Appendix 1H Refer and Follow - Membership Without Clinical Privileges

Membership without Clinical Privileges Medical Staff shall consist of those physicians who desire to be associated with the Hospital for the purposes of continuity of care and promoting educational opportunities, but who do not intend to treat patients at the Hospital.

A. Prerogatives

May refer patients for outpatient diagnostic testing and specialty services provided by the Hospital; may refer patients to other appointees of the Medical Staff for admission, evaluation, and/or care and treatment; may visit his/her patients in the Hospital, review patient medical records and receive information concerning the patient's medical condition and treatment, so long as the admitting/attending physician agrees and grants permission; shall not be eligible for clinical privileges and under no circumstances participate in any treatment or procedure, make any entries in the medical record, admit a patient to the Hospital, or otherwise be regularly involved in patient care in the Hospital as defined in Section 4.1; shall not be subject to the requirements for ongoing professional practice evaluation or focused professional practice evaluation; and Shall not vote on staff matters, hold office, or serve on committees.

B. **Responsibilities**

Individuals requesting Refer & Follow Staff appointment shall be required to submit an application for initial appointment or reappointment as prescribed by Article 4 of the Bylaws with the exception of the requirement to provide information regarding the demonstration of current competency and other exceptions approved by the MEC and Board.

SUMMARY OF APPLICABLE PREROGATIVES, RESPONSIBLITIES, ETC.	***APPLICABLE***
Prerogatives	
Admits, consults and refers patients (inpatients and outpatients)	No
Eligible for clinical privileges	No
Vote	No
Hold office	No
Serve as Committee Chair	No
Serve on Committee	No
Responsibilities	
Medical staff functions	No
Consulting	No
Emergency room duties	No
Attend meetings	No
Pay application fee	Yes
Pay dues	Yes
Additional Particular Qualifications	

Must first complete provisional or be subject to focused professional practice evaluation for new privileges	No
Malpractice insurance	Yes
File application and apply for reappointment	Yes

C. **Termination**

Appointment and reappointment to the Refer & Follow Staff is a courtesy which may be terminated by the Board of Trustees, upon recommendation of the Medical Executive Committee, without affording the right to fair hearing proceedings. Medical staff members granted Refer and Follow status as part of a contractual agreement between the Hospital and the Vendor: termination of the contractual agreement terminates all membership rights of practitioners employed by the vendor.

Rule 2 Appointment and Reappointment

2.1 Overview of Process

The following charts summarize the appointment, temporary privileges and reappointment processes. Details of each step are described in Rule 2.2 through Rule 2.7.

APPOINTMENT		
Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify application information	Credentials Committee (See Rule 2.7-1)
Credentials Committee	Review department's recommendation; review applicant's qualifications vis-à-vis Medical Staff bylaws general standards; recommend appointment and privileges	Medical Executive Committee (See Rule 2.7-2)
Medical Executive Committee	Review recommendations of department and Credentials Committee; recommend appointment and privileges	Governing Body (See Rule 2.7-3)
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 2.7-4)

TEMPORARY PRIVILEGES		
Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify key information	Chief of Staff (See Bylaws Section 5.5-2(d).)
Chief of Staff	Review recommendations of Department Chair; recommend temporary privileges	Chief Executive Officer (See Bylaws Section 5.5-2(d).)
Chief Executive Officer	Make decision	Final action (See Bylaws Section 5.5-2(d).)

APPOINTMENT		
Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify reappointment information	Credentials Committee (See Optional Rule 2.9-5)

Credentials Committee	Review applicant's performance vis-à-vis Medical Staff bylaws general standards; recommend appointment and privileges	Medical Executive Committee (See Optional Rule 2.9-6)
Medical Executive Committee	Review recommendations of Credentials Committee; recommend appointment and privileges	Governing Body (See Rule 2.9-7)
Governing Body	Review recommendations of the Medical Executive Committee; make decision	Final Action (See Rule 2.9-6)

2.2 Application

2.2-1 Each practitioner who expresses formal interest in a recognized and appropriate category of membership and privileges shall be provided an application form for Medical Staff membership. Upon completion by the practitioner, the form shall be returned to the Medical Staff office together with the nonrefundable application fee required by the rules.

2.2-2 The application form shall be approved by the Medical Executive Committee and the Governing Body and, once approved, shall be considered part of these rules. The application shall include an agreement to abide by the Medical Staff and hospital bylaws, rules and applicable policies. The application shall request information pertinent to the applicant's qualifications, such as (but not limited to) information regarding the applicant's education (including participation in continuing medical education), specialty training, experience, abilities and current competencies, professional affiliations, proffered references (including the names and addresses of professional peers when possible from the same professional discipline as the applicant who will be able to attest in writing to the applicant's relevant qualifications, experience, abilities and current competencies), relevant health status (as further described at Rule 2.3), as well as information regarding possible involvement in professional liability actions (including, but not limited to, all final judgments or settlements involving the applicant); previously completed or currently pending challenges involving professional licensure, certification or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification or registration; voluntary or involuntary termination, limitation, reduction or loss of Medical Staff or medical group membership and/or clinical privileges at any other hospital or health facility or entity; any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and information detailing any prior or pending government agency or third party payor investigation, proceeding or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including, but not limited to, Medicare or Medi-Cal fraud and abuse proceedings or convictions.

The application shall also release all persons and entities from any liability that might arise from their investigating and/or acting on the application. Additionally, the practitioner shall provide the names and addresses of professional peers who are able to attest to the practitioner's relevant qualifications.

2.3 Physical and Mental Capabilities

2.3-3 Obtaining Information

A. The application shall require the applicant to submit a statement attesting that no health problems exist that could affect his or her ability to perform the responsibilities of Medical Staff membership or exercise of requested clinical privileges. If the applicant does have a health condition and/or requires special accommodations with respect to a health condition, he/she shall provide information pertaining to his/her physical and mental health on a separate page of the form, which can be removed from the remaining application and processed separately. Upon receipt of the application, the page addressing physical and mental disabilities or conditions requiring accommodation shall be removed and referred to the Physician Well-Being Committee.

B. When the Medical Staff office verifies information and obtains references, it shall ask for any information concerning physical or mental status to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant. This information will also be referred to the Physician Well-Being Committee.

C. The Physician Well-Being Committee shall be responsible for investigating any practitioner who has or may have a physical or mental disability or condition that might affect the practitioner's ability to exercise his or her requested privileges in a manner that meets the hospital and Medical Staff's quality of care standards. This may include one or all of the following:

   i. **Medical Examination:** To ascertain whether the practitioner has a physical or mental disability that might interfere with his or her ability to provide care which meets the hospital and Medical Staff's quality of care standards.

   ii. **Interview:** To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.

D. Any practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Well-Being Committee. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

2.3-4 Review and Reasonable Accommodations

A. Any practitioner who discloses or manifests a qualified physical or mental disability or condition requiring accommodation will have his or her application processed in the usual manner without reference to the condition.

B. The Physician Well-Being Committee shall not disclose any information regarding any practitioner's qualified physical or mental disability or condition until the Medical Executive Committee (or, in the case of temporary privileges, the Medical Staff representatives who review temporary privilege requests) have

determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the Physician Well-Being Committee may disclose information it has regarding any physical or mental disabilities or conditions and the effect of those on the practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Committee to evaluate what, if any, accommodations may be necessary and feasible. The Physician Well-Being Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

C. As required by law, the Medical Staff and hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities or conditions, if the practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner which meets the hospital and Medical Staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in Bylaws, Article 13, Hearings and Appellate Reviews.

2.4 Effect of Application

By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

2.4-1 Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.

2.4-2 Authorizes Medical Staff and hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

2.4-3 Consents to the inspection and copying, by hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

2.4-4 Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Credentials Committee/Medical Executive Committee and the Chief Executive Officer.

2.4-5 Releases from any and all liability the Medical Staff and the hospital and its representatives for their acts performed in connection with evaluating the applicant.

2.4-6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to hospital representatives.

2.4-7 Authorizes and consents to hospital representatives providing other hospitals, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the hospital may have concerning him or her, and releases the hospital and hospital representatives from liability for so doing.

2.4-8 Consents to undergo and to release the results of a physical or mental health examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

2.4-9 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the Bylaws and these Rules.

2.4-10 For purposes of this Rule 2.4, the term "hospital representative" includes the Governing Body, its individual Directors/Trustee and committee members; the Chief Executive Officer, the Medical Staff, all Medical Staff officers and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

2.5 Verification of Information

2.5-3 **General:** The applicant shall fill out and deliver an application form to the Medical Staff office, which shall seek to verify the information submitted. Verification shall encompass a complete application, which includes, but is not limited to,

A. Licensure History**:** current license(s), licensure sanction(s), state(s) of current practice or intended practice, and all previous licenses held.
B. Medical Education and Postgraduate Training
C. Malpractice Insurance and History: 5-year history.
D. Specialty Board Status: (if applicable).
E. Sanctions or Disciplinary Actions: actions taken by healthcare facilities, specialty boards, federal or state agencies, malpractice carriers.
F. Criminal History: felony convictions/ criminal history (7-10 years).
G. Healthcare Employment History: healthcare related employment/ appointment history (work history).
H. Professional References: current competence and peer recommendations/references, ability to perform privileges requested (health status).
I. Primary Source Verification (PSV) from State Licensing Agency (Agencies), the Drug Enforcement Administration, and query from the National Practitioner Data Bank (NPDB).
J. Information regarding previously successful and/or currently pending challenges to any license, and/or voluntary or involuntary relinquishment of license.
K. Results from search of OIG Medicare / Medicaid Exclusion databank, Federation of State Medical Boards (FSMB) Disciplinary Action Databank or Fraud and Abuse Control Information Systems (FACIS).

L. If telemedicine is used, review the process for validation of licensure and validate it is being enforced.
M. Primary Source Verification (PSV) includes AMA Physicians Profile, AOA Official Osteopathic Physician Profile, and Educational Commission for Foreign Medical Graduates (ECFMG), as applicable.
N. Documentation regarding training and education sufficient to support requested privileges; evidence of continuing educational activities every two years may be requested.
O. Evidence of professional liability insurance including current certificates showing professional liability insurance for the privileges requested in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.
P. Malpractice litigation history from insurance carrier.
Q. National Practitioner Data Bank (NPDB) query on professional liability actions resulting in final settlements or judgments within the past 5 years.
R. Documentation regarding specialty board status.
S. If certified by a member of ABMS, verify with ABMS.
a. If certified by a specialty board of AOA, verify with AOA Official Osteopathic Physician Profile
T. Health Status
U. Current proficiency / competency with respect to the hospital's general competencies [as applicable to the privileges requested].
V. Verification of identification confirming the practitioner is the same individual identified in the credentialing documents [by viewing picture identification card, valid picture hospital ID card, or a valid state or federal agency picture ID card].

Note: Re-applicants do not need to provide letters of reference. For re-applicants, peer review via routine review (e.g., OPPE, clinical peer review, medical records review, credential's function, Medical Executive Committee) will suffice. However, clinical competence review must be a component of recredentialing.

- Applicants must provide documentation regarding clinical activity (from residency or from facilities where the applicant has been practicing medicine) and competency for consideration of privileges requested.
- Re-applicants must provide recommendations from the department volume is low, this may require review of procedure logs/ competency from other institutions to verify competency) including:
    - Scope of specific privileges based upon recent experience and
    - Recommendations from quality assurance committee and/or other staff committees based upon peer review findings.

2.5-4 **Primary Source Verification for Disaster Privileges:** With respect to volunteer practitioners who may be permitted to exercise privileges or perform functions when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs:

A. Primary source verification of licensure must occur as soon as the disaster is under control or within 72 hours from the time the volunteer practitioner presents him- or herself to the hospital, whichever comes first. If primary source verification of a volunteer practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, all the following must be documented:
   i. Reason(s) it could not be performed within 72 hours of the practitioner's arrival
   ii. Evidence of the practitioner's demonstrated ability to continue to provide adequate care, treatment, and services
   iii. Evidence of the hospital's attempt to perform primary source verification as soon as possible.

B. If, due to extraordinary circumstances, primary source verification of licensure of the volunteer practitioner cannot be completed within 72 hours of the practitioner's arrival, it must be performed as soon as possible.
   (Note: Primary source verification of licensure is not required if the volunteer practitioner has not provided care, treatment, or services under the disaster privileges.)

2.6 Incomplete Application

2.6-1 If the Medical Staff office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the Medical Staff office may delay further processing of the application, or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.

2.6-2 If the processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected practitioner shall be so informed. He or she shall then be given the opportunity to withdraw his or her application, or to request the continued processing of his or her application. If the applicant does not respond within 30 days, he or she shall be deemed to have voluntarily withdrawn his or her application. If the applicant requests further processing, but then fails to provide or arrange for the provision within 45 days or any other date mutually agreed to when the extension was granted (whichever is later) of the necessary information that the practitioner could obtain using reasonable diligence, the practitioner shall be deemed to have voluntarily withdrawn his or her application.

2.6-3 Any application deemed incomplete and withdrawn under this rule may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

2.7 Action on the Application

2.7-1 Credentials Committee Action

The Credentials Committee shall review the application, the supporting documentation, the department's report and recommendations, and other such

information available to it that may be relevant. The Credentials Committee or a subcommittee thereof may personally interview the applicant. The Credentials Committee shall then transmit to the Medical Executive Committee on the prescribed form a written report and recommendations as to staff appointment, and clinical privileges.

2.7-2 Medical Executive Committee Action

A. **Preliminary Recommendation:** At its next regular meeting after receipt of the Credentials Committee report and recommendations, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee shall then formulate a preliminary recommendation as to whether the applicant meets the relevant criteria specified in Bylaws, Article 4, Procedures for Appointment and Reappointment (with respect to membership), and Article 5, Privileges (with respect to privileges). If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff.

B. **Final Recommendation:** Thereafter, a final recommendation shall be formulated, and the Medical Executive Committee shall forward to the Governing Body a written report and recommendations, as follows:

   i. **Favorable Recommendation:** Favorable recommendations shall be promptly forwarded to the Governing Body together with the application form and its accompanying information and the reports and recommendations of the department and Credentials Committee as to staff appointment, affiliations, clinical privileges to be granted and any special conditions to be attached to the appointment.

   ii. **Adverse Recommendation:** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the practitioner by special notice, and he or she shall be entitled to such procedural rights as may be provided in Bylaws, Article 14, Hearings and Appellate Reviews. The Governing Body shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights. (For the purposes of this section, an adverse recommendation by the Medical Executive Committee is as defined in Bylaws, Section 13.2, Grounds for Hearing.)

   iii. **Deferral:** The Credentials Committee or Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and privileges, or for rejection of staff membership.

2.7-3 **Governing Body Action**

A. On Favorable Medical Executive Committee Recommendation: The Governing Body shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral

and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Body's action is a ground for a hearing under the Bylaws, Section 13.2, Grounds for Hearing, the Chief Executive Officer shall promptly inform the applicant by special notice, and he or she shall be entitled to the procedural rights as provided in the Bylaws, Article 13, Hearings and Appellate Reviews.

B. Without Benefit of Medical Executive Committee Recommendation: If the Governing Body does not receive a Medical Executive Committee recommendation within the time specified in Rule 2.7-6, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is a ground for a hearing under the Bylaws, Section 13.2, Grounds for Hearing, the Chief Executive Officer shall give the applicant special notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the Bylaws, Article 13, Hearings and Appellate Reviews, procedural rights before any final adverse action is taken.

C. After Procedural Rights: In the case of an adverse Medical Executive Committee recommendation pursuant to Rule 2.7-2 or an adverse Governing Body decision pursuant to Rule 2.7-4(a) or (b), the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws, Article 13, Hearings and Appellate Reviews, procedural rights. Action thus taken shall be the conclusive decision of the Governing Body, except that the Governing Body may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the Governing Body shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the Governing Body shall make a final decision.

D. Expedited Review: The Governing Body may use an expedited process for appointment, reappointment or when granting privileges when criteria for that process are met. The Governing Body may delegate this authority to any other committee of at least two voting members of the Governing Body; however, any final decision of the delegated committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting. Expedited processing is generally not available if:
    i. The practitioner or member submits an incomplete application;
    ii. The Medical Executive Committee's final recommendation is adverse in any respect or has any limitations;
    iii. There is a current challenge or a previously successful challenge to the practitioner's licensure or registration;
    iv. The practitioner has received an involuntary termination of Medical Staff membership or some or all privileges at another organization;
    v. The practitioner has received involuntary limitation, reduction, denial, or loss of medical privileges;

i. There has been a final judgment averse to the practitioner in a professional liability action.

2.7-4 Notice of Final Decision

A decision and notice to appoint shall include:

A. The staff category to which the applicant is appointed;

Reviewer	*Time Frames for Review*
Medical Staff Office	60 days after all necessary documentation is received
Credentials Committee	60 days after receiving application from Department Chair
Medical Executive Committee	60 days after receiving application from the Credentials Committee
Governing Body	60 days after receiving application from the Medical Executive Committee, except when the hearing and appeal rights of Bylaws, Article 13, Hearings and Appellate Reviews, apply

B. The clinical privileges the practitioner may exercise; and

C. Any special conditions attached to the appointment.

D. If the decision is adverse, the notice to the applicant shall be by special notice, as further described in Bylaws, Section 13.3-1, Notice of Action or Proposed Action.

2.7-5 Guidelines for Time of Processing

All individuals and groups shall act on applications in a timely and good faith manner. Except when additional information must be secured, or for other good cause, each application should be processed within the following time guidelines:

These time periods are guidelines and are not directives which create any rights for a practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Chief Executive Officer.

2.8 Duration of Appointment

2.8-1 All new staff members shall be appointed to the provisional staff and subjected to a period of formal observation and review (except for those appointed to the" Consulting Staff.") Provisional appointments are not more than two consecutive one-year terms as a Provisional Staff member.

2.8-2 If an application for reappointment has been timely submitted, but has not been fully processed by the expiration date of the appointment, the practitioner may in the sole discretion of the Medical Executive Committee and the Chief Executive officer, be granted Temporary privileges for up to 120 days, within which time the processing of the reappointment application must be completed.

If the delay is due to the Member's failure to timely return the reappointment application or provide other documentation or cooperation, the appointment shall terminate as described in Section 4.4-4. Granting of the above-noted Temporary Privileges shall not be deemed to create a right for the member to be automatically reappointed.

2.9 Reappointment Process

2.9-1 Reappointments to any staff category, other than provisional, shall be for a maximum period of two years, and shall be staggered throughout the year so as to enable thorough review of each member. Changes in staff category may be requested at any time during the reappointment period after requirements of provisional status are met.

2.9-2 Schedule for Reappointment

At least 120 days prior to the expiration date of each staff member's term of appointment, the Medical Staff office shall provide the member with a reappointment form. Completed reappointment forms shall be returned to the Medical Staff office at least 90 days prior to the expiration date. Failure, without good cause, to return the form shall result in automatic suspension or resignation as described in Rule 2.9-9.

2.9-3 **Content of Reappointment Form**

A. The reappointment form shall be approved by the Medical Executive Committee and the Governing Body and, once approved, shall be considered part of these rules. The form shall seek information concerning the changes in the member's qualifications since his or her last review. Specifically, the form shall request an update of all of the information and certifications requested in the appointment application form, as described in Rule 2.2-2, with the exception of that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to whether the member requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application.

B. If the staff member's level of clinical activity at this hospital is not sufficient to permit the staff and board to evaluate his or her competence to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the staff may require.

C. In addition to completing the information requested on the reappointment form, the staff member shall submit his or her biennial dues.

2.9-4 Verification and Collection of Information

The Medical Staff shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Medical Executive Committee and/or, the Credentials Committee. The information shall address, without limitation:

A. Reasonable evidence of current ability to perform privileges that may be requested including, but not limited to, consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.
B. Participation in relevant continuing education activities.
C. Level/amount of clinical activity (patient care contacts) at the hospital.
D. Sanctions imposed or pending including, but not limited to, previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.
E. Health status including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected practitioner and staff, when requested by the Medical Executive Committee and subject to the standards set forth in Rule 2.3 pertaining to physical and mental capabilities.
F. Attendance at required Medical Staff and committee meetings.
G. Participation as a staff officer and committee member/Chair.
H. Timely and accurate completion and preparation of medical records.
I. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel and patients.
J. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.
K. Compliance with all applicable Medical Staff and hospital bylaws, rules, and policies.
L. Professional references from at least one practitioner who is familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases.
M. Any other pertinent information including the staff member's activities at other hospitals and his or her medical practice outside the hospital.
N. Information concerning the member from the state licensing board and the federal National Practitioner Data Bank.
O. Information from other relevant sources, such as but not limited to the Federation of State Medical Boards Physician Disciplinary Data Bank.

2.9-5 Credentials committee Action

The Credentials Committee shall review the application and all other relevant available information. The committee shall transmit to the Medical Executive Committee its written recommendations, which are prepared in accordance with Rule 2.7-2.

2.9-6 Medical Executive Committee Action

The Medical Executive Committee shall review the Credentials Committee's recommendations and all other relevant information available to it and shall forward to the Governing Body its favorable recommendations, which are prepared in accordance with Rule 2.7-3.

2.9-7 Reappointment Recommendations

Reappointment recommendations shall be written and shall specify whether the member's appointment should be renewed; renewed with modified membership

category and/or clinical privileges; or terminated. The reason for any adverse recommendation shall be described. The Medical Staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

2.9-8 No Extension of Appointment

Except as provided in Bylaws, Section 4.4-4, Limitations on Extension of Appointment, if the reappointment application has not been fully processed before the member's appointment expires, the staff member shall refrain from exercising his or her current membership status and clinical privileges until the reappointment review is complete.

2.9-9 Failure to File Reappointment Application

Failure to file a complete application for reappointment 90 days prior to the expiration of the appointment shall result in the automatic suspension of a practitioner's privileges and prerogatives effective on the date the member's current appointment expires, unless otherwise extended by the Medical Executive Committee with the approval of the Governing Body. Prior to suspension, the practitioner will be sent at least one letter warning of the impending suspension. If an application for reappointment is not submitted or completed as required before the appointment expires, the member shall be deemed to have resigned his or her membership in the Medical Staff, effective the date his or her appointment expires. Members who automatically resign under this rule will be processed as new applicants should they wish to reapply.

2.9-10 Relinquishment of Privileges

A staff member who wishes to relinquish or limit particular privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall send written notice to the Chief of Staff identifying the particular privileges to be relinquished or limited. A copy of this notice shall be forwarded to the Medical Staff office for inclusion in the member's credentials file.

Rule 3 Standards of Conduct

3.1 Purpose

The purpose of this Rule is to clarify the provisions of Section 2.7 of the Medical Staff Bylaws, regarding expectations of all practitioners during any and all interactions with persons at the hospital, whether such persons are colleagues, other health care professionals, hospital employees, patients and/or other individuals. This Rule is intended to address conduct which does not meet the professional standards expected of Medical Staff members. In dealing with incidents of inappropriate conduct, the protection of patients, employees, practitioners and other persons at the hospital is the primary concern. In addition, the well-being of a practitioner whose conduct is in question is also of concern, as is the orderly operation of the hospital.

3.2 Examples of Inappropriate Conduct

Examples of common inappropriate conduct include, but are not limited to, the following:

3.2-1 **Verbal abuse:** Verbal abuse is usually in the form of vulgar, profane or demeaning language, screaming, sarcasm or criticism directed at an individual, having the intent or effect of lowering the recipient's reputation or self-esteem. It is often intimidating to the recipient, and often causes the recipient or others around him or her to become ineffective in performing their responsibilities (e.g., the individuals become afraid or unwilling to question or to communicate concerns, or to notify or involve either the involved practitioner or others when problems occur). This kind of conduct becomes disruptive at the point where it reaches beyond the bounds of fair professional comment or where it seriously impinges on staff morale.

3.2-2 **Noncommunication:** Refusal to communicate with responsible persons can be extremely disruptive in the patient care setting. This kind of behavior often results from individual fighting or feuding, or lack of trust. It becomes disruptive at the point where important information should be communicated, but is not. Closely related are incomplete or ambiguous communications. This becomes disruptive when it diverts patient care resources into having to devote substantial and unnecessary time obtaining follow-up clarification.

3.2-3 **Refusal to return calls:** Refusing to return telephone calls from the facility staff can be another form of the problem. Often this type of behavior is a result of what a practitioner feels are repeated, inappropriate phone calls from the facility's staff. However, unless a phone call is returned, the practitioner cannot know the urgency of the matter. The problem becomes disruptive at the point where patient care is placed in unnecessary jeopardy, or when matters that were not initially urgent, and needn't have become urgent, become so as a result of a refusal to return calls.

3.2-4 **Inappropriate communication:** It is inappropriate to criticize the facility, its staff, or professional peers outside of official problem-solving and peer review channels. This includes written or verbal derogatory statements to an inappropriate audience, such as patients and families, or statements placed in the medical records of patients. These kinds of communications

indiscriminately undermine morale and reputation of the facility and its staff, and contribute to inaccurate perceptions of facility quality.

3.2-5 **Failure to comply:** Failure to comply with the bylaws, policies and procedures of the Medical Staff and the facility can be inadvertent, or it can be willful. Willful failure to comply — i.e., refusal to comply — with rules becomes disruptive at the point that it places the Medical Staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients and facility staff. Specific examples include:

A. Refusing to provide information or otherwise cooperate in the peer review process (e.g., refusing to meet with responsible committee members, refusing to answer reasonable questions relevant to the evaluation of patient care rendered in the facility, especially when coupled with an attitude that the responsible committee has no right to be questioning or examining the matter at hand).

B. Refusing to provide information necessary to process the facility's or a patient's paperwork. The facility, its patients and their families have a right to expect timely and thorough compliance with all requirements of the facility, third party payors, regulators, etc., as necessary to assure smooth functioning of the facility and that patients receive the benefits to which they are entitled.

C. Violating confidentiality rules — e.g., disclosing confidential peer review information outside the confines of the formal peer review process. This has the effect of undermining the peer review process, and jeopardizing important protections that often serve as inducements to assuring ongoing willingness to participate in peer review activities.

D. Refusing to comply with established protocols and standards, including, but not limited to, utilization review standards. Here, it is recognized that from time to time established protocols and standards may not adequately address a particular circumstance, and deviation is necessary in the best interests of patient care. However, in such circumstances, the member will be expected to account for the deviation, and in appropriate circumstances, to work cooperatively and constructively toward any necessary refinements of protocol or standards so as to avoid unnecessary problems in the future.

E. Refusing to participate in or meet Medical Staff obligations can be disruptive when it reaches the point that the individual's refusal obstructs or significantly impairs the ability of the Medical Staff to perform its delegated responsibilities — all of which, in the final analysis, are aimed at facilitating quality patient care.

F. Repeatedly abusing or ignoring scheduling policies, or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary delays in or hurrying of patient care services being rendered to any patient of the facility.

G. Sexual harassment — unwelcome comments or contacts of a sexual nature or characterized by sexual overtones, whether overt or covert, are both illegal and disruptive.

3.2-6 **Physical abuse:** Offensive or nonconsensual physical contact would generally be deemed disruptive, as would intentional damage to facility premises or equipment.

3.2-7 **Threatening behavior:** Threats to another's employment or position, or otherwise designed to intimidate a person from performing his or her designated responsibilities or interfering with his or her well-being are generally disruptive. Examples include threats of litigation against peer review participants or against persons who report concerns in accordance with established reporting channels, and threats to another's physical or emotional safety or property.

3.2-8 **Combative behavior:** Combative behavior refers to that which is constantly challenging, verbally or physically, legitimate and generally recognized authority or generally recognized lines of professional interaction and communication. It becomes disruptive at the point that it results in an inability to acknowledge or to deliver constructive comments and criticism.

3.3 Procedures

3.3-1 **Reporting:** Any person may report potentially disruptive conduct in accordance with the hospital's usual reporting procedures. The Medical Staff office or other appropriate recipient of a disruptive conduct complaint shall submit each report to the Chief of Staff and Chief Executive Officer for investigation. The Chief of Staff and Chief Executive Officer may agree to delegate the investigation and any action to an appropriate committee. The Chief of Staff and Chief Executive Officer may agree to consult with the hospital's Human Resources department or other consultant as appropriate.

3.3-2 Investigation

A. The Chief of Staff and Chief Executive Officer, or designated committee, shall ensure that appropriate documentation of each incident of disruptive conduct is acquired in order to facilitate the investigation process. Such documentation should include:
   i. Date and time of the reported disruptive behavior.
   i. A statement by the reporting individual of whether the behavior involved a patient in any way, and, if so, information identifying the patient involved.
   ii. The reporter's account of the circumstances that precipitated the situation.
   iii. A factual and objective description of the reported disruptive behavior.
   iv. To the extent known to the reporter, the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations.
   v. A record of any action taken to address the situation, prior to the Medical Staff's investigation as required by the Code of Conduct, including the date, time, place, action and name(s) of those taking such an action.
      a. The Chief of Staff and Chief Executive Officer, or designated committee, shall conduct an appropriate investigation for each matter reported.
      b. If the report of inappropriate conduct is anonymous, then, the Chief of Staff and Chief Executive Officer, or designated committee, shall exercise discretion as to whether or not to investigate the matter.
      c. he investigation shall take place within 14 calendar days from receipt of a report of inappropriate conduct.

3.3-3 Action

A. **Unfounded Report:** Based on the investigation, the Chief of Staff, Chief Executive Officer, or designee shall dismiss any unfounded report by providing a

written explanation of the evidence supporting this conclusion. The report shall be maintained in the Medical Staff member's file with the original complaint. The individual who initiated the report of the decision shall be notified of the decision.

B. **Confirmed Report:** A confirmed report will be addressed as follows: The Chief of Staff and Chief Executive Officer, or designee, shall consider a number of variables to determine how best to address each incident of disruptive behavior. These variables shall include, but not be limited to:
   i. Degree of disruptiveness
   ii. Number of incidents (i.e., pattern of disruptive behavior over time)
   iii. Length of time between incidents of disruptive behavior, if multiple incidents have occurred.

C. **Plan for Addressing Disruptive Behavior:** Relying on the variables described above as well as the overall intent of Bylaws, Section 2.7, Standards of Conduct, the Chief of Staff, and Chief Executive Officer, or the designated committee, shall document a plan for addressing the disruptive behavior. The copy of the plan shall be included in the individual's file. The plan shall include item (1) below and may include any portion or all of items (2) and (3) below:
   i. The Chief Executive Officer, or designee, shall send a letter to the offending individual that describes the inappropriate conduct, explains that the behavior is in violation of Bylaws, Section 2.7, Standards of Conduct, notes any patient care or hospital operations implications, explains why the behavior in question is inappropriate, encourages the individual to be more thoughtful or careful in the future, invites the individual to respond, and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds for further disciplinary action. A copy of Bylaws, Section 2.7, Standards of Conduct, and this Rule should be included with the letter. Documentation of both the letter and the individual's response should be included in the individual's file.
   ii. he Chief of Staff, Chief Executive Officer or the designated committee, and any other number of appropriate participants from the Medical Staff and Governing Body, shall initiate a discussion with the offending individual to discuss the inappropriateness of his or her behavior and require that such behavior cease. A copy of Bylaws, Section 2.7, Standards of Conduct, and this Rule may be hand delivered to the offending individual and he or she should be advised that the Medical Staff requires compliance with the Bylaws. Each individual or a designated member of a group, (if the group meets with the offending individual), shall send a follow-up letter documenting the content of the discussion and any specific actions the offending individual has agreed to perform. The offending individual should be invited to respond. This letter and any response will be included in the individual's file.
   iii. The plan may incorporate additional components, including, but not limited to:
      a. Warning the offending individual that failure to abide by the terms of the Standards of Conduct shall be grounds for disciplinary action including,

but not limited to, suspension and/or actual termination of Medical Staff membership.

b. Notifying one or all of the following individuals of the member's disruptive behavior and any relevant history relating to the member: Chief of Staff, Medical Executive Committee and Chief Executive Officer.
c. Requiring the offending individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait (i.e., anger management), or requiring the offending individual to sign a behavior modification contract. The Chief of Staff, Chief Executive Officer or designated committee shall document any corrective action and require the offending individual to sign his or her acceptance of this plan. The plan may clearly delineate the consequences for the offending individual not successfully completing the agreed upon corrective action.
d. In appropriate circumstances, the plan may provide for immediate suspension and/or action to terminate Medical Staff membership without need of further warning or counseling.

3.3-4 **Final Warning:** If the Chief of Staff, Chief Executive Officer, or designated committee determines that the plan has been unsuccessful, the Medical Executive Committee shall be informed in writing of the offending individual's disruptive behavior, including any relevant history regarding this behavior, and advise the Medical Executive Committee to proceed with a final warning. If the Medical Executive Committee determines that the offending individual deserves a final warning, the Medical Executive Committee Chair/designee (or the Chief of Staff/designee or CEO/designee) shall meet with and advise the offending individual that the disruptive behavior in question is intolerable and must stop. The Chief of Staff/designee or CEO/designee will inform the individual that a single recurrence of disruptive behavior shall be sufficient cause to result in his/her suspension and/or termination of Medical Staff membership. This meeting shall not be a discussion, but rather will constitute the offending individual's final warning. The offender will also receive a follow-up letter that reiterates the final warning and the consequence of suspension and possible termination of Medical Staff membership and privileges.

3.3-5 **Suspension:** If after the final warning the offending individual engages in disruptive behavior that is deemed to require intervention, the individual's Medical Staff membership and privileges shall be subject to suspension consistent with the terms of the Medical Staff Bylaws and policies and procedures. Additional action may also be taken at this time. Action may be taken to revoke the individual's membership and privileges. The individual may also be found ineligible to reapply to the Medical Staff for a period of at least two years.

3.3-6 **Consequences of a Member's Failure to Comply with the Standards of Conduct:** Members who do not act in accordance with the Standards of Conduct shall be subject to corrective action and/or disciplinary action, up to

and including termination of membership and privileges, pursuant to the Bylaws. Any recommendation to restrict, or restriction of Member's membership or privileges shall entitle the member to the medical disciplinary or administrative hearing procedures set forth in the Bylaws.

3.4 Committees

The Medical Staff hereby establishes the following committees. The rules applicable to each committee are set forth in the corresponding appendix.

	See Appendix
Credentials Committee	3A
Emergency Care and Trauma Committee	3B
Ethics Committee	3C
Health Information Management/HIPA Committee	3D
Infection Control Committee	3E
Interdisciplinary Practice/Allied Health Professional Committee	3F
Medicine, Pharmacy, Therapeutics and Pain	3G
Outpatient Medical Committee	3H
Quality Improvement Committee	3I
Physician Well-Being Committee	3J
Surgical Committee	3K

Appendix 3A Credentials Committee

A. Composition

The Credentials Committee e comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the and the Director of Quality Improvement/, both of whom shall be voting members of the Committee.

B. Duties

The Credentials Committee will evaluate or coordinate the evaluation of the qualifications of all applicants for Medical Staff appointment, reappointment, or changes in Staff categories. The develop recommendations based on its evaluations of each applicant, as well as (with respect to reappointment) to the results of any Medical Staff quality assessment and improvement activities, including, but not limited to, ongoing professional performance evaluations and focused professional performance evaluations.

C. Meetings

The Credentials Committee shall meet as often as necessary.

(1) The Chairperson of the Credentials Committee shall regularly report the business of the Committee to the Medical Executive Committee.

(2) The Credentials Committee will meet on an as-needed basis.

Appendix 3B Emergency Care and Trauma Committee

A. Composition

The Emergency Care and Trauma shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the Emergency Department Manager, both of whom shall be voting members of the Committee. Other attendees may include as needed for consultation all members of the Active or Consulting Medical Staff with Emergency Medicine Privileges, a representative of Administration, represented by the Director of Quality Improvement/, the Chief Nursing Officer, the Director of Surgical Services, the Director of Pharmacy Services, and at least one RN, all of whom shall be non-voting members of the Committee.

B. Duties

Consistent with any hospital agreement for emergency medical care services, the Emergency Services Committee shall develop, implement, and maintain a plan for emergency care based on community needs and the capabilities of the Hospital that strives to assure that adequate appraisal, advice, or initial treatment shall be rendered to all ill or injured persons who present themselves at the Hospital. This plan will address not only the provisions of service in the emergency services, but also back-up specialty services that may be needed for patients who present to the hospital needing emergency medical care. This committee has oversight for unit-specific policies and procedures.

C. Meetings

The Emergency Care and Trauma Committee shall meet at least twice per year.

Appendix 3C ETHICS COMMITTEE

A. Composition

The Ethics Committee shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and a representative of Administration, represented by the Director of Quality Improvement/Risk Management/Medical Staff Services, all of whom shall be voting members of the Committee. Other attendees may include as needed for consultation the Director of Patient Care Services, one member of the clergy (if available), one medical social worker (if available) and one non-hospital local community member at large, all of whom shall be non-voting members of the Committee. Additional non-voting members may be appointed by the Chief of Staff. The Chairperson shall be a physician appointed by the Chief of Staff and the Vice-Chairperson shall be a physician selected by the Ethics Committee.

B. Duties

The purpose of the Ethics Committee is to impact positively upon the quality of health care provided by the Hospital by:

i. Providing assistance and resources in decision-making processes that have bioethical implications. The Ethics Committee shall not, however, be a decision-maker in any such processes.
ii. Educating members within the Hospital community of bioethical issues and dilemmas.
iii. Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.
iv. Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and educative guidance relating to such matters.

C. Meetings

The Ethics Committee will meet on an as-needed basis.

Appendix 3D Health Information Management and HIPAA Committee

A. Composition
The Health Information Management Committee shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the Chief Financial Officer over Health Information Management and the Director of Quality and Compliance, all of whom shall be voting members of the Committee. Other attendees may include as needed for consultation, the staff of the Health Information Management Department.

B. Duties
The Health Information Management Committee assures that all patient records are complete, accurate, legible, contain sufficient information to justify the diagnosis and treatment, and that they are completed within the time period required by State law. The Committee will also address all HIPAA rules, regulations and related compliance issues.

C. Other
The Health Information Management Committee Chairperson may require correction of medical record deficiencies by Medical Staff Members and may recommend discipline of Medical Staff Members.

D. The HIM/HIPAA Committee meets on an as needed basis.

Appendix 3E Infection Control Committee

A. Composition

i. The Infection Control Committee shall consist of one representative from each department, one Practitioner who specializes in infectious disease, a nurse whose responsibilities primarily involve infectious disease, and the pharmacy director who shall be voting members. The employee health nurse, a representative of nursing administration, a surgical services representative and director of central supply, and a representative of hospital administration shall be ex officio members.

ii. Representatives from housekeeping, laundry, dietary services and engineering and maintenance shall be available on a consultative and ad hoc basis.

B. Duties

The Infection Control Committee shall develop and monitor the Hospital's infection control program, and the Staff's treatment of infectious disease, including review of the clinical use of antimicrobials. The Committee shall ensure that the hospital's infection control plan links with external support systems and with communitywide agencies as they relate to reduction of risk from the environment. The committee shall ensure that appropriate resources are available for infection control activities. The committee shall also assure that the results of infection control studies and reviews are incorporated into the hospital's educational programs and into the hospital's quality assessment and improvement activities. At least every three years, the committee shall review and approve all policies relating to the infection control program. The Chair or his or her designee shall be available for on-the-spot interpretation of applicable rules.

C. Meetings

The Infection Control Committee shall meet at least quarterly.

Appendix 3F Interdisciplinary Practices/Allied Health Professionals Committee

A. Composition

The Interdisciplinary Practice Committee (IDP/AHP) shall be comprised of one member of the Active or Consulting staff or an Allied Health Professional, in the capacity of the Chairperson and a representative from nursing administration. In addition, representatives of the categories of Allied Health Professionals (AHPs) granted privileges in the hospital should serve as consultants on an as-needed basis and shall participate, when available, in the committee proceedings when a member of the same specialty is applying for privileges.

B. Duties

i. Standardized Procedures

a. The IDP/AHP shall develop and review standardized procedures that apply to nurses or AHPs; identify functions that are appropriate for standardized procedures and initiate such procedures; and review and approve standardized procedures.

b. Standardized procedures can be approved only after consultation with the Medical Staff and by affirmative vote of the administrative representatives, a majority of physician members, and a majority of nurse members.

ii. Credentialing Allied Health Professionals

a. The IDP/AHP shall recommend policies and procedures for expanded role privileges for assessing, planning and directing the patients' diagnostic and therapeutic care.

b. The IDP/AHP shall review AHPs' applications and requests for privileges and forward its recommendations and the applications on to the Medical Executive Committee

c. The IDP/AHP shall participate in AHP peer review and quality improvement. It may initiate corrective action when indicated against AHPs in accordance with the Medical Staff Bylaws, these Rules or guidelines governing AHPs.

d. The IPC shall serve as liaison between AHPs and the Medical Staff.

C. Meetings

The IPC shall meet on an as needed basis.

Appendix 3G Medicine, Pharmacy, Therapeutics And Pain Management Committee

A. Composition

The Medicine, Pharmacy, Therapeutics and Pain Management Committee shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the Director of Pharmacy Services, both of whom shall be voting members of the Committee. Other attendees may include as needed for consultation the Director of Quality Improvement, the Chief Nursing Officer, the Infection Control Practitioner, the Director of Surgical Services, the Director of Outpatient Medical Services, the Laboratory Services Manager and the Radiology Services Manager, all of who shall be nonvoting members of the Committee.

B. Duties

The Medicine, Pharmacy, Therapeutics and Pain Management Committee is to develop, implement and monitor professional policies regarding evaluation, selection, and procurement of drugs comprising the Hospital formulary, distribution, administration, safety, and effect (including reactions and interactions) of drug usage, patient education and other matters pertinent to drug use in the Hospital. The Medicine, Pharmacy, Therapeutics and Pain Management Committee has overall responsibility for the Mayers Memorial Hospital District Organizational-wide Pain Management Program. The Committee develops and implements policies and procedures relative to the care of medical patients.

C. Meetings

The Medicine, Pharmacy, Therapeutics And Pain Management Committee shall meet at least quarterly.

Appendix 3H Outpatient Services Committee

A. Composition

Outpatient Services Committee shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the Outpatient Department manager, all of whom shall be voting members of the Committee. Other attendees may be included, as needed for consultation

B. Duties

The Outpatient Services Committee are to develops, implements and monitors policy and procedures that ensure delivery of patient care that is up to the current standards of practice, and, meets patient safety requirements utilizing the latest technologies and advances in wound care, and infusion therapy practices.

C. Meetings

The Outpatient Services Committee will meet at least semi-annually, and on an as needed basis.

Appendix 3I Quality Improvement/Risk Management/Utilization Review Committee

A. Composition

The Quality Improvement committee shall consist of a Medical Staff Officer or an Allied Health Professional, Chairs of Infection Control, Director of Quality, Health Information Management manager, and Director of Pharmacy. The Chair shall be the Chief of Staff or designee from Medical Staff.

B. Duties

The Quality Improvement/Risk Management/Utilization Review committee shall be responsible to provide leadership in measuring, assessing and improving medical care rendered in the hospital including, but not limited to, oversight of Ongoing Professional Practice Evaluation activities and on its own behalf or in concert with other Medical Staff committees oversight of Focused Professional Practice Evaluations to assess members' general competencies, medical assessment and treatment, use of medications, use of blood and blood components operative and other procedures, efficiency of clinical practices patterns, monitoring of significant departures from established clinical patterns, patients' and families' education, coordination of care with other practitioners, and hospital personnel. Subcommittees that report to the Quality Improvement/Risk Management/Ethics/Utilization Review committee may be appointed, using the procedure described in the Medical Staff Bylaws, when necessary to carry out these functions

i. Quality Improvement

a. Develop, review annually and revise as needed, a quality improvement plan that is appropriate for the hospital and Medical Staff and that meets regulatory requirements, including, but not limited to, assessing the hospital's general competencies and all major areas of patient care, including Ongoing Professional Practice Evaluations and on its own behalf or in concert with other Medical Staff committees, Focused Professional practice Evaluations. This shall specifically include, but is not limited to, providing leadership in measuring, assessing and improving: medical assessment and treatment, use of medications, use of blood and blood components, operative and use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process, other procedures, appropriateness of clinical practice patterns, significant departures from established clinical pattern, and the use of developed criteria for autopsies. The quality improvement plan may also include mechanisms for:

1) Establishing objective criteria;
2) Measuring actual practice against the criteria;
3) Analyzing practice variations from criteria by peers;
4) Taking appropriate action to correct identified problems;
5) Following up on action taken; and
6) Reporting the findings and results of the audit activity to the

Medical Staff, the Chief Executive Officer and the Governing body.

b. Utilize at least sentinel event data and patient safety data in measuring and assessing performance improvement.
c. Review and act upon, on a regular basis, factors affecting the quality, appropriateness and efficiency of patient care provided in the hospital, including review of surgical and other invasive procedures, mortality, use of medications, including antibiotics, blood and blood components usage, admissions and continued hospitalizations and fulfillment of consultation requirements.
d. Coordinate the findings and results of committee and staff patient care review activities, utilization review activities, continuing education activities, reviews of medical record completeness, timeliness and clinical pertinence; and other staff activities designed to monitor patient care practices.
e. Submit quarterly reports to the Medical Executive Committee on the overall quality, appropriateness and efficiency of medical care provided in the hospital, and on the committee, and staff patient care review, utilization review and other quality review, evaluation and monitoring activities.
f. On at least an annual basis, evaluate the coordination of patient care and formulate policy recommendations for dietary services, equipment standardization, home health, physical therapy and social services
g. At least once a year, evaluate and revise as needed the hospital-wide quality improvement program to assess the effectiveness of the monitoring and evaluation activities and to recommend improvement

ii. Surgical Case Review Duties

Review the monthly review of all surgical cases, including those in which a tissue specimen was not removed. All surgical cases must be reviewed except that when surgical case review consistently supports the justification and appropriateness of surgical procedures performed by individual practitioners, an adequate sample of cases may be reviewed. The review should address:

a. Selecting appropriate procedures;
b. Preparing the patient for the procedure;
c. Performing the procedure and monitoring the patient; and
d. Providing post procedure care.

iii. Death and Tissue Review

Review all deaths and review all removed tissue when the tissue is found to be normal or not consistent with the clinical diagnosis, and develop and implement measures to correct any problems discovered.

iv. Medication Administration and Usage Duties

Develop, implement and monitor professional policies regarding evaluation, selection and procurement and storage of drugs comprising the hospital formulary; preparing and dispensing medications; distribution, administration, safety, and effect (including reactions and interactions) of drug usage; patient education; and other matters pertinent to drug use in the hospital.

v. Blood and Blood Components Usage Review Duties
    a. Provide for at least a quarterly review of blood usage. This includes evaluating all or a sample of cases involving transfusion; all confirmed transfusion reactions; the adequacy of transfusion services in meeting patient needs; ordering practices; distributing, handling and dispensing, and administration of blood and blood components.
    b. Provide for review of policies governing blood usage.
vi. Medical Records Function
    a. Provide for at least quarterly review of medical records for clinical pertinence and timely completion.
    b. Provide for the quarterly review by a multidisciplinary team (including Medical Staff members, nursing, health information management service staff and administration) a sample of records to determine whether they reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and the condition of the patient at discharge.
    c. Review summary reports concerning timely completion of medical records
    d. Approve a standardized medical record format, forms used in the record and electronic data processing and storage systems.
    e. Recommend solutions for problems identified during review and monitor effectiveness of these interventions.

C. Meetings

The committee shall meet at least quarterly.

Appendix 3JPhysician Well-Being Committee

A. Composition

The Physician Well-Being Committee shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the Chief Executive Officer, all of whom shall be voting members of the Committee. Other attendees may include as needed for consultation the Director of Quality Improvement, the Director of Risk Management, the Medical Staff Coordinator, and other Active or Consulting medical staff members who shall be non-voting members of the Committee.

B. Purpose

i. The purpose of the Physician Well-Being Committee shall be to improve the quality of care, promote the competence of the Medical Staff and address disruptive behavior by attempting to resolve matters relating to Medical Staff members' health, well-being, disruptive behavior or impairment prior to development of significant patient care problems.
   a. The Physician Well-Being Committee shall develop a process that provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of Practitioners who suffer from a potentially impairing condition. These processes should include mechanisms for the following:
   b. Educating the Medical Staff and Hospital staff about illness and impairment recognition issues specific to Practitioners.
   c. Self-referral by a Practitioner, and referral by other Medical Staff and Hospital staff.
   d. Upon its own initiative, upon request of the involved Practitioner, or upon request of a Medical Staff Committee, providing such advice, counseling, or referrals to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.
   e. Evaluating the credibility of a complaint, allegation, or concern, including such investigation as reasonably deemed necessary.
   f. Monitoring the affected Practitioner and the safety of patients until the rehabilitation or any corrective action process is complete.
   g. Confidentiality; however, if the Physician Well-Being Committee receives information that demonstrates that the health or impairment of a Medical Staff member may pose a risk of harm to Hospital patients (or prospective patients), that information shall be referred to the Chief of Staff, who will determine whether corrective action is necessary to protect patients.

ii. The Physician Well-Being Committee shall review responses from applicants concerning physical or mental disabilities, and recommend what, if any, reasonable accommodations may be indicated to assure that the Practitioner will provide care in accordance with the Hospital and Medical Staff's standard of care. The timing of these assessments shall be closely coordinated so that the Medical Executive Committee does not consider the issue of physical or mental disabilities until after an applicant has been otherwise determined to be

qualified for Medical Staff membership. The Committee shall also perform this function during a member's term, upon request from the Medical Executive Committee.

C. Accountability and Relationships
   i. The Physician Well-Being Committee shall be accountable to its Chairperson.
   ii. The Chairperson of the Physician Well-Being Committee shall be accountable to the Medical Executive Committee and the Chief of Staff.
   iii. The Chairperson of the Physician Well-Being Committee shall regularly report the general business of the Committee to the Medical Executive Committee. (The Physician Well-Being Committee shall maintain only such records of its proceedings as it deems advisable, and shall provide general reports on its activities on a routine basis to the Medical Executive Committee.)
   iv. The Physician Well-Being Committee will meet on an as-needed basis.

Appendix 3K Surgical Committee

A. Composition
The Surgical Committee shall be comprised of one member of the Active or Consulting medical staff or an Allied Health Professional who shall be the Chairperson and the Director of Nursing, both of whom shall be voting members of the Committee. Other attendees may include as needed for consultation the, the Certified Registered Nurse Anesthetist, nurses and technicians from the surgical team, PAR nurse, any staff related to Outpatient Surgical services, and any PA/Surgical Assistant (as applicable) who shall be non-voting members of the Committee.

B. Duties
The Surgical Committee shall be responsible to oversee processes related to the use of surgical and other invasive procedures, including: selecting appropriate procedures; preparing the patient for the procedure; equipment availability; safety of the environment; performing the procedure and monitoring the patient; and providing postprocedural care.

C. Meetings
The Surgical Committee shall meet on an as-needed basis.

Rule 4 Allied Health Professionals

4.1 Overview

4.1-3 The credentialing process for Allied Health Professionals (AHPs) is similar to that for credentialing Medical Staff members. However, the Interdisciplinary Practices Committee (IPC), rather than the Credentials Committee, is responsible for overseeing the credentialing of AHPs. The credentialing process for AHPs is summarized in Rule 4.3.

4.1-4 Rule 4.4 reflects the basic requirements that all AHPs must meet, and Appendices 4A through 4E set forth requirements that specific types of AHPs must meet in addition to the basic requirements.

4.1-5 Until the AHP has been granted privileges, an AHP should not be practicing within the hospital.

4.1-6 This Rule 4 applies to AHPs who practice independently, as well as AHPs who are employees or independent contractors of a Medical Staff member.

4.2 Categories of AHP's Eligible to Apply for Practice Privileges

4.2-1 The types of AHPs allowed to practice in the hospital will be ultimately determined by the Governing Body, based upon the comments of the Medical Executive Committee and such other information as may be available to the Governing Body.

4.2-2 The types of AHPs currently eligible to apply for practice privileges are:
Licensed Clinical Psychologists
Licensed Clinical Social Workers
Nurse Anesthetists
Nurse Practitioners
Physician Assistants

A. When an AHP in a category that has not been approved as eligible to apply for clinical privileges under Bylaws, Article 6, Allied Health Professionals, requests privileges, the IPC may begin to process an application at the same time the request for recognition of the profession is processed; however, no right to practice in the hospital is thereby created or implied.

4.3 Processing the Application

4.3-1 Applications shall be submitted and processed in a manner parallel to that specified for Medical Staff applicants in Rule 2, Appointment and Reappointment, except that the applications shall be submitted to the IDP/AHP rather than the Credentials Committee.

4.3-2 Once the application is determined to be complete as defined in Medical Staff Rule 2, Section 2.5, it will be forwarded to the IDP/AHP for consideration. The IDP/AHP may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The IDP/AHP shall evaluate the AHP based upon the standards set forth in Rule 2, Appointment and Reappointment and Rule 4.4. The IDP/AHP will also ascertain that appropriate monitoring mechanisms are in place through the Quality Improvement Committee. Whenever possible, the IDP/AHP shall include practitioners in the same AHP category when

conducting its evaluation. The IDP/AHP shall forward its recommendations to the department to which the AHP would be assigned.

4.3-3 Thereafter, the application shall be processed by the Medical Executive Committee and Governing Body in accordance with the procedures set forth in Rule 2.7-2 through Rule 2.7-3.

4.4 Credentialing Criteria

4.4-1 Basic Requirements

A. The applicant must belong to an AHP category approved for practice in the hospital by the Governing Body.

B. If required by law, the applicant must hold a current, unrestricted state license or certificate.

C. In addition, hospital independent contractors shall meet all conditions of their contract with the hospital.

D. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the hospital, and that he or she is qualified to exercise clinical privileges within the hospital.

E. The applicant must maintain in force professional liability insurance or its equivalent for the privileges exercised in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.

F. The applicant must submit a minimum of two references from either licensed physicians or adequately trained professionals in the appropriate field and who are familiar with his or her professional work and have demonstrated competency.

G. The applicant must have actively practiced for an average of at least 20 hours per week in his or her field for eighteen of the previous 24 months. If applicant is working in an independent setting, he or she must have completed one year of clinical practice outside of his or her training program.

H. The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the Medical Staff.

4.4-2 Specific Requirements

In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his or her category of AHP, as set forth in the applicable appendix:

	See Appendix
Licensed Clinical Psychologists	4A
Nurse Anesthetists	4B
Nurse Midwives	4C
Nurse Practitioners	4D
Physician Assistants	4E

4.4-3 Supervising Practitioner Responsibilities

A. A supervising practitioner or group which employs or contracts with the AHP agrees that the AHP is solely his, her or its employee or agent and not the hospital's employee or agent. The supervising practitioner or group has full and sole responsibility for paying the AHP, and for complying with all relevant laws, including federal and state income tax withholding laws, overtime laws and workers' compensation insurance coverage laws.

B. A supervising practitioner or group which employs or contracts with the AHP agrees to indemnify the hospital against any expense, loss or adverse judgment it may incur as a result of allowing an AHP to practice at the hospital or as a result of denying or terminating the AHP's privileges.

4.5 Provisional Status

All AHPs initially shall be appointed to a provisional status for at least 12 months. Advancement from the provisional status will be based upon whether the professional's performance is satisfactory, as determined by IDP/AHP (when its review is necessary for the privileges), the Medical Executive Committee and the Governing Body.

4.6 Duration of Appointment and Reappointment

4.6-3 AHPs shall be granted practice privileges for no more than 24 months. Reappointments to the AHP staff shall be processed every other year, in a parallel manner to that specified in the Rule 2, Appointment and Reappointment for Medical Staff members.

4.6-4 Applications for renewal of the AHP's privilege and the supervising practitioner's approval must be completed by the AHP and supervising practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Rules.

4.7 Observation

4.7-1 All new AHPs shall be subject to a performance evaluation and monitoring, consistent with the provisions of Bylaws, Article 7, Performance Evaluation and Monitoring as adapted to the scope of practice and privileges of the AHP.

4.7-2 The proctor or evaluator should be a member in good standing of the Medical Staff who exercises appropriate clinical privileges. Whenever possible, the proctor/evaluator should not be the sponsoring or supervising practitioner of the AHP being observed.

4.7-3 The Governing Body may approve alternative observation procedures for employee or Contract AHPs.

4.8 Exception to Credentialing Process – Contract Allied Health Professionals

4.8-1 On occasion, the hospital may determine that the interests of patient care are best served by entering into a contract with an entity that provides AHPs to work within the hospital. These AHPs are neither employees nor independent contractors of the hospital, nor are they independent professionals working in their own private practice. Rather, they are employees or independent

contractors of an entity that has agreed to provide certain health services to the hospital's patients. For purposes of these rules, these persons shall be referred to as Contract AHPs and the entity employed or contracting with them shall be referred to as the Contracting Entity.

4.8-2 Ordinarily, Contract AHPs must complete the full AHP credentialing process prior to being permitted to render patient care within the hospital. However, the Contracting Entity may be responsible for credentialing the Contract AHPs pursuant to the terms of the contract with the hospital. Formal credentialing as described in these guidelines may be waived for Contract AHPs whom the Contracting Entity warrants to be adequately qualified to perform the patient care activities described in the contract.

4.8-3 Whether the Contracting Entity is responsible for credentialing, the Contract AHPs will be determined by hospital administration and shall be made a part of the written contract between the hospital and the Contracting Entity. If the Contracting Entity will credential the Contract AHPs, the following shall apply:

A. The Contracting Entity shall provide a written description of the activities to be performed by the Contract AHPs. This description may be contained in the contract itself or in a separate job description.

B. The hospital Chief Executive Officer may ask the appropriate medical staff department and the IDP/AHP to review the job descriptions or contract provisions describing the activities of the Contract AHPs for completeness, accuracy and appropriateness.

4.8-4 Where the contract does not provide for the Contracting Entity to perform the evaluation, each Contract AHP shall be subject to all of the credentialing procedures of these rules.

4.9 General

4.9-1 Duties

Upon appointment, each AHP shall be expected to:

A. Consistent with the privileges granted to him or her, exercise independent judgment within his or her areas of competence and, if applicable, within the limits of an approved standardized procedure, provided that a Medical Staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

B. Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable standardized procedures, and by the privileges granted by the Governing Body.

C. Write orders to the extent established by any applicable Medical Staff or department policies, rules or standardized procedures and consistent with privileges granted to him or her.

D. Record reports and progress notes on patient charts to the extent determined by the appropriate department, and in accordance with any applicable standardized procedures.

E. Assure that records are countersigned as follows: (i) the supervising practitioner, if any, shall countersign all entries except routine progress notes; (ii) unless otherwise specified in the rules or specific supervision protocols, all chart entries

that require countersignatures must be countersigned within fourteen days after the entry is made.

F. Consistent with the privileges granted to him or her, perform consultations as requested by a Medical Staff member.

G. Comply with all Medical Staff and hospital bylaws, rules and policies.

4.9-2 Prerogatives and Status

AHPs are not members of the Medical Staff, and hence shall not be entitled to vote on Medical Staff or department matters. They are expected to attend and actively participate in the clinical meetings, to the extent consistent with rules.

4.10 Standardized Procedures

4.10-1 Definition

Standardized procedures means the written policies and protocols for the performance of standardized procedure functions, and which have been developed in accordance with the requirements of state law.

4.10-2 Functions Requiring Standardized Procedures

Standardized procedures are required whenever:

A. Any registered nurse (including, but not by way of limitation, Nurse Anesthetists, Nurse Practitioners and Nurse Midwives) practices beyond the scope of practice taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

B. Any hospital pharmacist furnishes self-administered hormonal contraceptives in accordance with California Business and Professions Code Section 4052.3.

4.11 Development of Standardized Procedures

A. Standardized procedures may be initiated by the affected AHPs, or sponsoring or supervising practitioners.

B. The IPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Representatives of the category of AHPs that will be practicing pursuant to the standardized procedures shall be involved in developing the standardized procedures.

C. Each standardized procedure for registered nurses shall:

i. Be in writing and show the date or dates of approval by the IPC.

ii. Specify which standardized procedure functions registered nurses may perform and under what circumstances.

iii. State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

iv. Specify any experience, training and/or education requirements for performance of standardized procedure functions.

v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

vi. Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

vii. Specify the nature and scope of review and/or supervision required for performance of standardized procedure functions; for example, whether the functions must be performed under the immediate supervision of a physician.
viii. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.
ix. State the limitations on settings, if any, in which standardized procedure functions may be performed.
x. Specify patient recordkeeping requirements.
xi. Provide for a method of periodic review of the standardized procedures.

D. Standardized procedures must be approved by the IDP/AHP, the Medical Executive Committee and the Governing Body.

Appendix 4A Licensed Clinical Psychologists

A. Licensure

Licensed Clinical Psychologists shall be currently licensed by the Board of Psychology of the Department of Consumer Affairs.

B. Scope of Practice

i. Licensed Clinical Psychologists may receive privileges to perform the following professional services at the hospital pursuant to a Medical Staff member's order:
   a. Conduct psychological testing and diagnostic procedures;
   b. Render a psychological diagnosis;
   c. Provide appropriate psychotherapy;
   d. Write orders regarding patient activity within the hospital and nursing management of a patient's behavior problems;
   e. Document, in a patient's medical record, information detailing the patient's response to psychological treatment; and
   f. Participate in decisions regarding discharge and psychological follow-up treatment.
   g. Perform hypnosis, if the Licensed Clinical Psychologist:
      1) Can demonstrate experience in the clinical use of hypnosis; and
      2) Has had course work in hypnosis from qualified instructors and has experience in a clinical setting using hypnosis under supervision.

ii. Licensed Clinical Psychologists shall not:
   a. Prescribe drugs, perform surgery, administer electroconvulsive therapy or otherwise practice medicine;
   b. Use biofeedback instruments that pierce or cut the skin;
   c. Knowingly undertake any therapy or other professional activity in which the characteristics of his or her own personality may likely interfere with the professional services rendered or which may result in harm to the patient or client; or
   d. Perform services that are outside his or her education, training and experience.

iii. Every patient being treated by a Licensed Clinical Psychologist at the hospital shall at all times be under the general care of a physician on the Medical Staff, who shall have responsibility for the patient's overall medical condition. Such physician shall perform the admitting history and physical on any patient treated by the Clinical Psychologist at the hospital.

iv. Licensed Clinical Psychologists shall at all times identify himself or herself as a psychologist when engaged in any therapy or other professional activity.

Appendix 4B Nurse Anesthetists

A. Licensure and Certification
Nurse Anesthetists shall be currently licensed as a registered nurse in California and currently certified as a Nurse Anesthetist by the California Board of Registered Nursing and the American Association of Nurse Anesthetists.

B. Scope of Practice
   i. Nurse Anesthetists may administer anesthesia only upon the direct order of a qualified physician, dentist or podiatrist who:
      a. Is a current member in good standing of the Medical Staff of the hospital;
      b. Is acting within the scope of his or her licensure and privileges; and
      c. Has personally evaluated the patient in question.

C. Nurse Anesthetists may receive privileges to perform the following professional services at the hospital:
   i. Perform a preanesthesia evaluation of the patient, which may involve:
      a. Review of the patient's medical records, x-rays, previous experience with anesthesia, and history and physical examination conducted by a physician;
      b. Performance of a physical examination;
      c. Assessment of the patient's emotional status; and
      d. Choice of anesthetic agent;
   ii. Record the preanesthetic evaluation in the patient's record;
   iii. Administer regional, local or general anesthesia upon appropriate order *[and under the supervision of the operating or supervising practitioner]*;
   iv. Initiate orders to registered nurses and other hospital staff as required for care of the patient;
   v. Provide pain management services and emergency procedures including:
      i. Endotracheal intubation;
      ii. Injection of anesthetic or narcotic substances into epidural, subdural or subarachnoid spaces; and
      iii. Injection of somatic or sympathetic nerves with anesthetic agents;
   vi. Perform postanesthetic evaluation of the patient;
   vii. Authorize release of an inpatient from the recovery area to a nursing unit pursuant to either the order of a qualified licensed independent practitioner or rigorously-applied criteria approved by the Medical Staff; and
   viii. Perform other functions according to standardized procedures adopted by the hospital.

D. Nurse Anesthetists shall consult with the physician, dentist or podiatrist responsible for the anesthesia, the Chief of the Surgical Department or other qualified physician, when necessary or appropriate.

Appendix 4C Nurse Practitioners

A. Licensure and Certification
Nurse Practitioners shall be currently licensed as a registered nurse in California and currently certified as a Nurse Practitioner by the California Board of Registered Nursing.

B. Scope of Practice
Nurse Practitioners may receive privileges to perform the following professional services at the hospital:

i. Perform tasks or functions which fall within the customary scope of nursing practice; and
ii. Furnish or order drugs or devices (other than controlled substances) to patients under the following conditions:
   a. The drug or device is furnished or ordered pursuant to a standardized procedure or protocol which is promulgated by the hospital in accordance with legal requirements;
   b. The drug or device furnished or ordered is consistent with the Nurse Practitioner's educational preparation or established (and maintained) clinical competency.
   c. The drug or device is furnished or ordered under the supervision of the attending physician, who:
      1) Collaborated in the development of the standardized procedure;
      2) Approved the standardized procedure;
      3) Is available by telephone at the time of patient examination by the Nurse Practitioner; and
      4) Supervises no more than four Nurse Practitioners at one time.
   d. The drug or device is furnished or ordered pursuant to certification from the Board of Registered Nursing that the Nurse Practitioner has completed:
      1) At least six months of physician-supervised experience in the furnishing of drugs or devices; and
      2) A course in pharmacology covering the drugs and devices to be furnished.
   e. The drug or device is furnished or ordered under a number issued by the Board of Registered Nursing to the Nurse Practitioner, to be included on all transmittals of orders for drugs or devices.
   f. The Nurse Practitioner is registered with the United States Drug Enforcement Administration.

C. Furnish or order Schedule IV or Schedule V controlled substances if, in addition to the conditions above at (b) being met, the drugs or devices are further limited to those drugs agreed upon by the Nurse Practitioner and the supervising physician and specified in the standardized procedure.

D. Furnish or order Schedule III controlled substances if, in addition to the conditions above at ii and iii being met, the drugs or devices are furnished in accordance with a patient-specific protocol approved by the treating or supervising physician.

E. Furnish or order Schedule II controlled substances if, in addition to the conditions above at ii, iii, and iv being met, the following conditions are met:
   i. The provision in the protocol for furnishing Schedule II controlled substances addresses the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished; and
   ii. The Nurse Practitioner completes, as part of his or her continuing education requirements, a course including Schedule II controlled substances that meets the standards of the Board of Registered Nursing.
   iii. The term "furnish" shall include
      a. Ordering a drug or device in accordance with the standardized procedure; and
      b. Transmitting an order of a supervising physician.

F. Perform tasks or functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in standardized procedures, promulgated by the hospital in accordance with Rule 4.10.

G. The supervising physician shall review, countersign, and date a minimum sample of ten percent of medical records of patients treated by the Nurse Practitioner functioning under these protocols within 24 hours. The supervising physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.

Appendix 4D Physician Assistants

A. Requirements

Physician Assistants shall be currently licensed by the Physician Assistant Committee of the Medical Board of California.

Physician Assistants shall perform all services at the hospital under the direction of a qualified supervising physician.

B. Scope of Practice

i. Physician Assistants may receive privileges to perform the following professional services at the hospital pursuant to a delegation and protocols where present:

a. Take a history, perform a physical examination, assess the patient, make a diagnosis, and record the pertinent data in a manner meaningful to the supervising physician;

b. Order, transmit an order for and perform or assist in performing laboratory screening and therapeutic procedures, provided that the procedures are consistent with the supervising physician's practice and with the patient's condition;

c. Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy and nursing services;

d. Recognize and evaluate situations which call for the immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient;

e. Administer or provide medication to patient or transmit orally or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication to the patient, subject to the following conditions:

1) Any prescription transmitted by the Physician Assistant shall be based either on a patient-specific order by the supervising physician or on a written practice-specific formulary and protocol approved by the supervising physician which specifies all criteria for the use of a specific drug or device and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued.

2) The supervising physician must countersign and date within seven days the medical record of any patient cared for by the Physician Assistant for whom the Physician Assistant's Schedule II drug order has been issued, transmitted or carried out;

3) Physician Assistants may not administer, provide or issue a prescription for controlled substances listed in Schedules II through V inclusive without a patient-specific order by the

supervising physician unless the Physician Assistant has completed an education course that covers controlled substances and meets all legal requirements set forth in California Business & Professions Code section 3502.1.

4) Any drug order issued by a Physician Assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician's practice.
5) All Physician Assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration.

f. Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as medications, diets, social habits, family planning, normal growth and development, aging and understanding and managing their diseases;
g. Assist the supervising physician by arranging admissions, making appropriate entries in the patient's medical record, reviewing and revising treatment and therapy plans, ordering, transmitting orders for, performing, or assisting the performance of radiology services, therapeutic diets, physical therapy treatment, ordering occupational therapy treatment, ordering respiratory care services, and providing continuing care to patients following discharge;
h. Facilitate the supervising physician's referral of patients to the appropriate health facilities, agencies and resources of the community;
i. Perform, outside the personal presence of the supervising physician, surgical procedures which are customarily performed under local anesthesia, which the supervising physician has determined the Physician Assistant has training to perform, and for which the Physician Assistant has privileges to perform; and
j. Act as a first or second assistant in surgery under the supervision of the supervising physician.

ii. Physician Assistants shall not:
a. Perform any task or function that requires the particular skill, training, or experience of a physician, dentist or dental hygienist;
b. Determine eye refractions or fit glasses or contact lenses; or
c. Prescribe or use any optical device for eye exercises, visual training or orthoptics (this does not, however, preclude administering routine visual screening tests).

iii. Supervision
a. Physician Assistants shall perform all services at the hospital under the direction of a supervising physician who:
1) Is currently licensed by the State of California;
2) Is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting supervision or employment of a Physician Assistant;

3) Is a current member in good standing of the Medical Staff and practices actively at the hospital; and
4) Meets the requirements set forth in this Appendix 4D.

b. Before the Physician Assistant is permitted to perform services at the hospital, the supervising physician shall submit a signed, written request which describes the tasks and functions that the Physician Assistant would be performing. Those tasks and functions shall be consistent with the supervising physician's specialty, with the supervising physician's usual and customary practice, and with the patient's health and condition.

c. The supervising physician shall establish the following in writing, together with any necessary documentation:
    1) That the supervising physician accepts full legal and ethical responsibility for the performance of all professional activities of the Physician Assistant;
    2) Those specific duties and acts, including histories and physical examinations, that the Physician Assistant would be permitted to perform outside of the supervising physician's immediate supervision and control;
    3) That the supervising physician is covered by professional liability insurance with limits as determined by the governing board, for acts or omissions arising from supervision of the Physician Assistant (the supervising physician shall verify such coverage in a form acceptable to the Medical Staff Executive Committee); and
    4) That the supervising physician is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or the employment of a Physician Assistant.

d. The supervising physician shall agree in writing in a form acceptable to the hospital that:
    1) He or she shall notify the hospital and its Medical Staff immediately in the event that he or she becomes subject to any disciplinary condition, or an action to impose a disciplinary condition, by the Medical Board of California; and
    2) He or she shall comply with all Medical Board of California regulations regarding supervision of the Physician Assistant.

e. No supervising physician shall have a supervisory relationship with more than four Physician Assistants at any one time. (Notwithstanding the foregoing, an emergency physician may have a supervisory relationship with more than four emergency care Physician Assistants at any one time, provided that the emergency physician does not oversee the work of more than four such Physician Assistants while on duty at any one time.)

f. The supervision of the Physician Assistant by the supervising physician shall include all of the following:
    1) Availability of the supervising physician in person or by

electronic communication when the Physician Assistant is caring for patients;

2) Observation or review of the Physician Assistant's performance of all tasks and procedures that the supervising physician will delegate to the Physician Assistant until the supervising physician is assured of competency;
3) Establishment of written transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the Physician Assistant's scope of practice for such times when the supervising physician is not on the premises;
4) Establishment of written guidelines for the adequate supervision of the Physician Assistant.
   A) This requirement may be satisfied by the supervising physician adopting protocols for some or all of the tasks performed by the Physician Assistant. These protocols shall comply with all of the following:
      - The minimum content for any such protocol governing diagnosis and management shall include the presence or absence of symptoms, signs and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient and education to be given the patient.
      - For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care.
      - Protocols shall be developed by the supervising physician, adopted from, or referred to, texts or other sources.
      - Protocols shall be signed and dated by the supervising physician and the Physician Assistant.

   B) Alternatively, the requirement of adequate supervision of the Physician Assistant may be satisfied by alternative mechanisms established by the Medical Board of California.
5) The supervising physician shall review, countersign, and date a minimum sample of five percent of medical records of patients treated by the Physician Assistant functioning under these protocols within 24 hours. The supervising physician shall select for review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient.
6) On-site supervision by the supervising physician of any surgery requiring anesthesia other than local anesthesia; and
7) Responsibility on the part of the supervising physician to follow the progress of the patient and to make certain that the Physician Assistant does not function autonomously.

Rule 5 Immunization And Communicable Diseases

Medical Staff members and AHPs are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others at the Hospital, and to comply with all reasonable precautions established by Hospital and/or Medical Staff policy respecting safe provision of care and services in the Hospital. Additionally, Medical Staff members and AHPs are expected to comply with Hospital policies regarding the testing for communicable diseases and regarding immunizations.

Mayers Memorial Healthcare District Skilled Nursing Quality Assurance Performance Improvement (MMHD SNF QAPI)

PURPOSE:

The purpose of the Quality Assurance and Performance Improvement Plan (QAPI) is to provide a framework for promoting and sustaining performance improvement in the Mayers Memorial Healthcare District Skilled Nursing Facility, in order to improve the quality of care and enhance organizational performance. The goals are to proactively reduce risk to our residents by eliminating or reducing factors that contribute to unanticipated adverse events and/or outcomes and provide high quality care and services to ensure a perfect care experience for our residents and their families. This will be accomplished through the support and involvement of the Board of Directors, Administration, Medical Staff, Management, and employees, in an environment that fosters collaboration and mutual respect. This collaborative approach supports innovation, data management, LEAN process and performance improvement, proactive risk assessment, commitment to customer satisfaction, and use of the Just Culture model to promote and improve awareness of patient safety. Mayers Memorial Healthcare District has an established mission, vision, values statement, and utilizes a foundation of excellence model, which are used to guide all improvement activities.

POLICY:

MISSION STATEMENT

Leading rural healthcare for a lifetime of wellbeing

VISION STATEMENT

Build the healthiest rural community through exceptional and accessible care

VALUES STATEMENT

Our vision and mission is supported by our values. I-RESPECT:

Integrity

Reliability

Excellence

Stewardship

Partnership

Equity

Compassion

Teamwork

PERFORMANCE IMPROVEMENT INITIATIVES

The 2025 performance improvement priorities are based on the following priorities:

- Improving the resident care experience (including quality and satisfaction);
- Improving the quality of life for our resident population; and
- Reducing harm in the resident population.

Priorities identified include:

- Achieve and maintain 4-Star Overall CSM Star Rating.
- Support Patient and Family Centered Care through engagement.
- Sustain a Just Culture philosophy that promotes patient safety, openness, & transparency
- Promote LEAN principles to improve processes, reduce waste, and eliminate inefficiencies
- Optimize technology to integrate medical services at all levels of the organization
- Facilitate integrated continuum of care
- Ensure resident safety

Mayers Memorial Healthcare District's vision will be achieved through these strategic priorities. Each strategic priority is driven by leadership oversight and a quality team developed to ensure improvement and implementation.

ORGANIZATION FRAMEWORK

Processes cross many departmental boundaries and performance improvement requires a planned, collaborative effort between all hospital-based departments, services, and outside Mayers Memorial Healthcare District Skilled Nursing, including third-party payors and other physician groups. Though the responsibilities of this plan are delineated according to common groups, it is recognized that true process improvement and positive outcomes occur only when each individual works cooperatively and collaboratively to achieve improvement.

<u>Governing Board</u>

The Board of Directors (BOD) of Mayers Memorial Healthcare District has the ultimate responsibility for the quality of care and services provided throughout the system. The BOD assures that a planned and systematic process is in place for measuring, analyzing and improving the quality and safety of the Health System activities.

The Board:

- Delegates the responsibility for developing, implementing, and maintaining performance improvement activities to administration, medical staff, management, and employees.
- Recognizes that performance improvement is a continuous, cyclical process, and therefore they will provide the necessary resources to carry out this philosophy.
- Provides direction for the organization’s improvement activities through the development of strategic initiatives.
- Evaluates the organization’s effectiveness in improving quality through reports from the various

board committees, Medical Executive Committee and Board Quality Committee.

Executive Leadership Team

The Executive Leadership Team creates an environment that promotes the attainment of quality and process improvement through the safe delivery of resident care, quality outcomes, and resident satisfaction. The Executive Leadership Team sets expectations, develops plans, and manages processes to measure, assess, and improve the quality of the Health System's governance, management, clinical and support activities. The Executive Leadership Team ensures that clinical contracts contain quality performance indicators to measure the level of care and service provided.

The Executive Leadership Team has developed a culture of safety by embracing the Just Culture model and has set behavior expectations for providing no less than Safe, Timely, Effective, Efficient, Equitable, Patient Centered Care. They ensure compliance with regulatory, statutory and contractual requirements.

Board Quality Committee

The Board Quality Committee is to provide oversight for the District QAIP and set expectations of quality care, patient safety, environmental safety, and performance improvement throughout the organization. The committee will monitor the improvement of care, treatment and services to ensure that it is safe, timely, effective, efficient, equitable and patient-centered. They will oversee and be accountable for the organization's participation and performance in national quality measurement efforts, accreditation programs, and subsequent quality improvement activities. The committee will assure the development and implementation of ongoing education focusing on service and performance excellence, risk-reduction/safety enhancement, and healthcare outcomes.

Medical Executive Committee

The Medical Executive Committee shares responsibility with the BOD Quality Committee and senior management for the ongoing quality of care and services provided within the Health System.

The Medical Executive Committee provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of patient care and the medical performance of all individuals with delineated clinical privileges. These mechanisms function under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved.

The Medical Executive Committee delegates some the oversight responsibility for performance improvement activity monitoring, assessment, and evaluation of patient care services provided throughout the system to the Board Quality Committee. Other functions such as peer-review remain with Med Staff Quality Committee which meets in conjunction with Medical Executive Committee.

Committees Chairs of the Medical Staff

The Committees Chairs:

- Provide a communications channel to the Medical Executive Committee.
- Monitor ongoing professional performance evaluation and focused professional performance evaluation and make recommendations regarding reappointment based on data regarding quality of care.
- Maintain all duties outlined by appropriate accrediting bodies.

Medical Staff

The medical staff is expected to participate and support performance improvement activities. The medical staff provides effective mechanisms to monitor, assess, and evaluate the quality and appropriateness of resident care and the clinical performance of all individuals with delineated clinical privileges. These mechanisms are under the purview of the medical staff peer review process. Consistent with this process, performance improvement opportunities are addressed, and important problems in patient care or safety are identified and resolved. Annually, the Skilled Nursing Facility will determine critical indicators/performance measures consistent with strategic and performance improvement priorities and guidelines.

The Director of Quality provides leadership that creates a vision and direction for clinical quality and patient safety throughout the Health System. The Director, in conjunction with the medical staff and Health System leaders, directs and coordinates quality, patient safety, and performance improvement initiatives to enhance the quality of care provided to our patients. The Director communicates patient safety, best practices, and process improvement activities to the medical staff and engages them in improvement activities. The Director sits the Medical Staff Quality Committee.

Hospital Management (Directors, Managers, and Leads)

Management is responsible for ongoing performance improvement activities in their departments and for supporting teams chartered by the Board Quality Committee. Many of these activities will interface with other departments and the medical staff. They are expected to do the following:

- Foster an environment of collaboration and open communication with both internal and external customers.
- Participate and guide staff in the patient advocacy program.
- Advance the philosophy of Just Culture within their departments.
- Utilize LEAN principles and FOCUS-PDCA (Find, Organize, Clarify, Understand, Select – Plan, Do, Check, Act) process improvement activities for department-specific performance improvement initiatives.
- Establish performance and patient safety improvement activities in conjunction with other departments.
- Encourage staff to report any and all reportable events including “near-misses”.
- Participate in the investigation and determination of the causes that underlie a “near-miss” / Sentinel/Adverse Event/Error or Unanticipated Outcome as recommended by the Just Culture model and implement changes to reduce the probability of such events in the future.

Employees

The role of the individual employee is critical to the success of a performance improvement initiative. Quality is everyone’s responsibility, and each employee is charged with practicing and supporting the Standards of Business Conduct: Health System Code of Conduct and Chain of Command for Medical Care Issues policies. All employees must feel empowered to report, correct, and prevent problems.

The Nursing Quality and Peer Review Council consist of registered nurses from each service area. This Council is an integral part of reviewing QAIP data, evaluating processes, providing recommendations, and communicating their findings with peers to improve nursing practice.

Employees are expected to do the following:

- Contribute to improvement efforts, including reporting Sentinel/Adverse Event/Error or Unanticipated Outcomes, to produce positive outcomes for the patient and ensure the perfect

care experience for patients and customers.
- Make suggestions/recommendations for opportunities of improvement or for a cross-functional team, including risk reduction recommendations and suggestions for improving patient safety, by contacting their Manager, the Director of Nursing over our nursing facility, the Director of Quality, the Medical Director, or an Executive Leadership Team Member.

PERFORMANCE IMPROVEMENT STRUCTURE

Medical Staff Quality Committee

With designated responsibility from the Medical Executive Committee, the Medical Staff Quality Committee is responsible for prioritizing the performance improvement activities in the organization, chartering cross-functional teams, improving processes within the Health System, and supporting the efforts of all performance improvement activities. The Med Staff Quality Committee is an interdisciplinary committee led by the Medical Director of Quality, which meets monthly in conjunction with the Board Quality Committee. The committee has representatives from each Medical Staff department, Health System leadership, nursing, and ancillary and support services ad hoc.

The Medical Staff Quality Committee:

- Annually review and approve the Medication Error Reduction Plan (MERP), Infection Control Plan, Alternate Life Safety Measures Plan, Utilization Review Plan, Risk Management Plan, and the Patient Safety Plan.
- Regularly reviews progress to the aforementioned plans.
- Reviews quarterly quality indicators to evaluate patient care and delivery of services and takes appropriate actions based on patient and process outcomes.
- Reviews recommendations for performance improvement activities based on patterns and trends identified by the proactive risk reduction programs and from the various Health System committees.
- Elicits and clarifies suspected or identified problems in the provision of service, quality, or safety standards that may require further investigation.
- Reviews progress reports from chartered teams and assists to address and overcome identified barriers.
- Reviews summaries and recommendations of Root Cause Analysis (RCA) and Failure Mode Effects Analysis (FMEA) activities.
- Oversees the radiation safety program, including nuclear medicine and radiation oncology and evaluates the services provided and make recommendations to the MEC.

Quality Improvement Committees (QIC)

The Board Quality Committee provides direct oversight for the QICs. The QICs are executive committees with departmental representatives, within the Mayers Memorial Healthcare District, presenting their QA/PI findings as assigned. There are two QICs at the moment - one that drives improvement in our Skilled Nursing Facility; one that drives improvement in our Acute care setting. The goal of this committees is to achieve optimal patient outcomes by making sure that all staff participates in performance improvement activities. Departmental Directors or their designee review assigned quality metrics biannually at the PIC. Performance improvement includes collecting data, analyzing the data,

and taking action to improve. The Director of Quality is responsible for processes related to this committee.

The Quality Improvement Committee will:

- Oversee the Performance Improvement activities of MMHD including data collection, data analysis, improvement, and communication to stakeholders
- Set performance improvement priorities and provide the resources to achieve improvement
- Reviews requests for chartered Performance Improvement Teams. Requests for teams may come from committees, department or individual employees. Not all performance improvement efforts require a chartered team;
- Report the committee's activities quarterly to the Medical Staff Quality Committee.

SCIENTIFIC METHOD FOR IMPROVEMENT ACTIVITIES

Mayers Memorial Healthcare District utilizes FOCUS-PDCA Rapid Cycle Teams (Find, Organize, Clarify, Understand, Select – Plan, Do, Check, Act). The BOD, Executive Leadership Team Members, or the Medical Staff Quality Committee charter formal cross-functional teams to improve current processes and design new services, while each department utilizes tools and techniques to address opportunities for improvement within their individual areas.

Performance Improvement Teams

Teams are cross-functional and multidisciplinary in nature. The priority and type of team are based on the strategic initiatives of the organization, with regard to high risk, high volume, problem prone, and low volume.

Performance Improvement Teams will:

- Follow the approved team charter as defined by the BOD, Executive Leadership Team Members, or Board Quality.
- Establish specific, measurable goals and monitoring for identified initiatives.
- Report their findings and recommendations to key stakeholders, and Board Quality.

PERFORMANCE IMPROVEMENT EDUCATION

Training and education are essential to promote a culture of quality within the Mayers Memorial Healthcare District. All employees and Medical Staff receive education about performance improvement upon initial orientation. Employees receive additional annual training on various topics related to performance improvement.

A select group of employees have received specialized manager training in using the Just Culture coaching and investigation process utilizing statistical data tools for performance improvement. These facilitators may be assigned to chartered teams at the discretion of the PIC, MSQC and Executive Leadership Team Members.

Annual evaluation of the performance improvement program will include an assessment of needs to target future educational programs. The Director of Quality is responsible for this evaluation.

PERFORMANCE IMPROVEMENT PRIORITIES

Improvement activities must be data driven, outcome based and updated annually. Careful planning, testing of solutions and measuring how a solution affects the process will lead to sustained improvement or process redesign. Improvement priorities are based on the mission, vision, and strategic plan for Mayers Memorial Healthcare District. During planning, the following are given priority consideration:

- Processes that are high risk, high volume, or problem prone areas with a focus on the incidence, prevalence, and severity of problems in those areas
- Processes that affect patient safety and outcomes
- Processes related to patient advocacy and the perfect care experience
- Processes related to the National Quality Forum (NQF) Endorsed Set of Safe Practices
- Processes related to patient flow
- Processes associated with near miss Sentinel/Adverse Event/Error or Unanticipated Outcome

Because Mayers Memorial Healthcare District is sensitive to the ever-changing needs of the organization, priorities may be changed or re-prioritized due to:

- Identified needs from data collection and analysis
- Unanticipated adverse occurrences affecting patients
- Processes identified as error prone or high-risk regarding patient safety
- Processes identified by proactive risk assessment
- Changing regulatory requirements
- Significant needs of patients and/or staff
- Changes in the environment of care
- Changes in the community

DESIGNING NEW AND MODIFIED PROCESSES/FUNCTIONS/SERVICES

Mayers Memorial Healthcare District designs and modifies processes, functions, and services with quality in mind. When designing or modifying a new process the following steps are taken:

An individual with the appropriate expertise within the organization is assigned the responsibility of developing the new process.

- Key individuals, who will own the process when it is completed, are assigned to a team led by the responsible individual.
- An external consultant is utilized to provide technical support, when needed.
- The design team develops or modifies the process utilizing information from the following concepts:
  - ✓ It is consistent with our mission, vision, values, and strategic priorities and meets the needs of individual served, staff and others
  - ✓ It is clinically sound and current
  - ✓ Current knowledge when available and relevant i.e. practice guidelines, successful practices, information from relevant literature and clinical standards

- ✓ It is consistent with sound business practices
- ✓ It incorporates available information and/or literature from within the organization and from other organizations about potential risks to patients, including the occurrence of sentinel/near-miss events, in order to minimize risks to patients affected by the new or redesigned process, function, or service
- ✓ Conducts an analysis and/or pilot testing to determine whether the proposed design/redesign is an improvement and implements performance improvement activities, based on this pilot
- ✓ It incorporates the results of performance improvement activities
- ✓ It incorporates consideration of staffing effectiveness
- ✓ It incorporates consideration of patient safety issues
- ✓ It incorporates consideration of patient flow issues

- Performance expectations are established, measured, and monitored. These measures may be developed internally or may be selected from an external system or source. The measures are selected utilizing the following criteria:
  - ✓ They can identify the events it is intended to identify
  - ✓ They have a documented numerator and denominator or description of the population to which it is applicable
  - ✓ They have defined data elements and allowable values
  - ✓ They can detect changes in performance over time
  - ✓ They allow for comparison over time within the organization and between other entities
  - ✓ The data to be collected is available
  - ✓ Results can be reported in a way that is useful to the organization and other interested stakeholders

PROACTIVE RISK ASSESSMENTS

- Risk assessments are conducted to proactively evaluate the impact of buildings, grounds, equipment, occupants, and internal physical systems on patient and public safety. At least one Failure Effect Mode Analysis will be completed every 18 months.
- The Medical Staff Quality Committee and other leadership committees will recommend the processes chosen for our proactive risk assessments based on literature, errors and near miss events, sentinel event alerts, and the National Quality Forum (NQF) Endorsed Set of Safe Practices.
  - ✓ The process is assessed to identify steps that may cause undesirable variations, or “failure modes”.
  - ✓ For each identified failure mode, the possible effects, including the seriousness of the effects on the patient are identified and the potential breakdowns for failures will be prioritized.

- ✓ Potential risk points in the process will be closely analyzed including decision points and patient's moving from one level of care to another through the continuum of care.
- ✓ For the effects on the patient that are determined to be "critical", a root cause analysis is conducted to determine why the effect may occur.
- ✓ The process will then be redesigned to reduce the risk of these failure modes occurring or to protect the patient from the effects of the failure modes.
- ✓ The redesigned process will be tested and then implemented. Performance measurements will be developed to measure the effectiveness of the new process.
- ✓ Strategies for maintaining the effectiveness of the redesigned process over time will be implemented.

- Ongoing hazard surveillance rounds including Environment of Care Rounds and departmental safety hazard inspections are conducted to identify any trends and to provide a comprehensive ongoing surveillance program.
- The Safety Committee review trends and incidents related to the Safety Management Plans. The EOC Safety Committee provides guidance to all departments regarding safety issues.
- The Infection Control Practitioner and Environment of Care Safety Officer complete a written infection control and preconstruction risk assessment for interim life safety for new construction or renovation projects.

DATA COLLECTION

Mayers Memorial Healthcare District chooses processes and outcomes to monitor based on the mission and scope of care and services provided and populations served. The goal is 100% compliance with each identified quality metric. Data that the organization considers for the purpose of monitoring performance includes, but is not limited to, the following:

- Medication therapy
- Infection control surveillance and reporting
- Surgical/invasive and manipulative procedures
- Data management
- Discharge planning
- Utilization management
- Complaints and grievances
- Restraints/seclusion use
- Mortality review
- Medical errors including medication, surgical, and diagnostic errors; equipment failures, infections, blood transfusion related injuries, and deaths due to seclusion or restraints
- Needs, expectations, and satisfaction of individuals and organizations served, including:

- ✓ Their specific needs and expectations
- ✓ Their perceptions of how well the organization meets these needs and expectations
- ✓ How the organization can improve patient safety
- ✓ The effectiveness of pain management

- Resuscitation and critical incident debriefings

- In addition, the following clinical and administrative data is aggregated and analyzed to support patient care and operations:
  - ✓ Quality measures delineated in clinical contracts will be reviewed annually
  - ✓ Pharmacy transactions as required by law and to control and account for all drugs
  - ✓ Information about hazards and safety practices used to identify safety management issues to be addressed by the organization
  - ✓ Reports of required reporting to federal, state, authorities
  - ✓ Performance measures of processes and outcomes, including measures outlined in clinical contracts
- Summaries of performance improvement actions and actions to reduce risks to patients

These data are reviewed regularly by the PIC, MSQC, and the BOD with a goal of 100% compliance. The review focuses on any identified outlier and the plan of correction.

AGGREGATION AND ANALYSIS OF DATA

Mayers Memorial Healthcare District believes that excellent data management and analysis are essential to an effective performance improvement initiative. Statistical tools are used to analyze and display data. These tools consist of dashboards, bar graphs, pie charts, histograms, Pareto charts, control charts, fishbone diagrams, and other tools as appropriate. All performance improvement teams and activities must be data driven and outcome based. The analysis includes comparing data within our organization, with other comparable organizations, with published regulatory standards, and best practices. Data is aggregated and analyzed within a time frame appropriate to the process or area of study. Data will also be analyzed to identify system changes that will help improve patient safety and promote a perfect care experience.

Data is analyzed in many ways including:

- Using appropriate performance improvement problem solving tools
- Making internal comparisons of the performance of processes and outcomes over time
- Comparing performance data about the processes with information from up-to-date sources
- Comparing performance data about the processes and outcomes to other hospitals and reference databases

Intensive analysis is completed for:

- Levels of performance, patterns or trends that vary significantly and undesirably from what was expected
- Significant and undesirable performance variations from the performance of other operations

- Significant and undesirable performance variations from recognized standards
- A sentinel event which has occurred
- Variations which have occurred in the performance of processes that affect patient safety
- Hazardous conditions which would place patients at risk
- The occurrence of an undesirable variation which changes priorities

The following events will automatically result in intense analysis:

- Significant confirmed transfusion reactions
- Significant adverse drug reactions
- Significant medication errors
- All major discrepancies between preoperative and postoperative diagnosis
- Adverse events or patterns related to the use of sedation or anesthesia
- Hazardous conditions that significantly increase the likelihood of a serious adverse outcome
- Staffing effectiveness issues
- Deaths associated with a hospital acquired infection
- Core measure data, that over two or more consecutive quarters for the same measure, identify the hospital as a negative outlier

REPORTING

Results of the outcomes of performance improvement and patient safety activities identified through data collection and analysis, performed by medical staff, ancillary, and nursing services, in addition to outcomes of performance improvement teams, will be reported to the Board Quality Committee on a quarterly basis. Results of the appraisal of performance measures outlined in clinical contracts will be reported to the Board Quality Committee and Medical Staff annually.

The MSQC will provide their analysis of the quality of patient care and services to the Medical Executive Committee on a quarterly basis. The Medical Executive Committee, Quality Medical Director, or the Director of Quality will report to the BOD at least quarterly relevant findings from all performance improvement activities performed throughout the System.

Mayers Memorial Healthcare District also recognizes the importance of collaborating with state agencies to improve patient outcomes and reduce risks to patients by participating in voluntary quality reporting initiatives.

CONFIDENTIALITY AND CONFLICT OF INTEREST

All communication and documentation regarding performance improvement activities will be maintained in a confidential manner. Any information collected by any Medical Staff committee, the Administrative Council, or Health System department in order to evaluate the quality of patient care, is to be held in the strictest confidence, and is to be carefully safeguarded against unauthorized disclosure. Access to peer review information is limited to review by the Medical Staff and its designated committees and is confidential and privileged. No member of the Medical Staff shall participate in the review process of any case in which he/she was professionally involved unless specifically requested to

participate in the review. All information related to performance improvement activities performed by the Medical Staff or Health System staff in accordance with this plan is confidential and are protected by disclosure and discoverability through California Evidence Code 1156 and 1157.

ANNUAL ASSESSMENT

The Quality Improvement Program and the objective, structure, methodologies, and results of performance improvement activities will be evaluated at least annually. The evaluation includes a review of patient care and patient related services, infection control, medication administration, medical care, and the Medical Staff. More specifically, the evaluation includes a review of the utilization of services (including at least the number of patients served and volume of services), chart review (a representative sample of both active and closed clinical records), and the Health System policies addressing provision of services.

The purpose of the evaluation is to determine whether the utilization of services is appropriate, policies are followed, and needed changes are identified. The Quality Assurance program evaluates the quality and appropriateness of diagnoses, treatments furnished, and treatment outcomes. An annual report summarizing the improvement activities, and the assessment will be submitted to the Medical Staff Quality Committee, the Medical Executive Committee, and the Board of Directors.

PLAN APPROVAL

The Quality Improvement Plan will be reviewed, updated, and approved annually by the Board Quality Committee, the Medical Executive Committee, and the Board of Directors.

2025 FOCUS SUCCESS MEASURES

Medication Error Reduction Program

Gradual Dose Reduction Program

2025 FUTURE SUCCESS MEASURES

Hand Hygiene

UTI Response

Attachment A

Mayers Memorial Hospital District Skilled Nursing 2025 QAIP Reporting Measures

SKILLED NURSING FACILITY	Responsible	Benchmark	1st QTR	2nd QTR	3rd QTR	4th QTR
Percentage of residents who experience a UTI						
Percentage of residents who experience significant weight loss						
Percentage of residents whose need for help with activities of daily living has increased						
Percentage of residents whose ability to move independently has worsened						
Percentage of high risk residents with pressure ulcers (sores)						
Percentage of residents who have/had a catheter inserted and left in their Blatter						
Percentage of residents experiencing one or more falls with major injury						
Percentage of residents who self-report moderate to severe pain						
Percentage of residents who receive antipsychotic medications						
Number of resident visits to the emergency department						
Percentage of catheter related UTI's						
RN hours resident days						
Total Nursing hours per resident day						
Rate of COVID-vax Administered						
Rate of Flu-vax Administered						
Rate of Pneumovax Administered						
QUALITY	**Responsible**	**Benchmark**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Resident Safety Index Detail						
Medication error rate						
Percentage of residents that develop pressure ulcers						
Resident falls						
Long Term Care						
Percent of residents who develop pressure ulcers						
Residents with a urinary tract infection percentage						
Percent of residents who experience unplanned weight loss						

Attachment A

Mayers Memorial Hospital District Skilled Nursing 2025 QAIP Reporting Measures

Percentage of Falls						
SNF 5-Star Quality Rating						
RISK	**Responsible**	**Benchmark**	**1st QTR**	**2nd QTR**	**3rd QTR**	**4th QTR**
Total number of resident safety events						
FALLS						
Total # non-resident (visitor) falls						
Total # of resident falls						
Rate of resident falls with injury						
Skin breakdown / deceits						
Total # of hospital-acquired pressure ulcers						

Attachment B

Quality Improvement Indicator Definitions 2025

Indicator Title	CMS Core Measure #	Inclusive Of	Measurement Explanation
Skilled Nursing Facility	LTC1 LTC4 LTC5 LTC6 LTC7	• Percent of residents who develop pressure ulcers • Residents with a urinary tract infection percentage • Percent of residents who experience unplanned weight loss • Percentage of Falls • SNF 5-Star Quality Rating	Rate calculated per CMS.

Attachment C

2025 External Reporting

	Title	Acronym	Sponsor	Indicators
	Minimum Data Sets (MDS) http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/MDSPubQIandResRep/index.html	MDS	CMS	The MDS Quality Indicator (QI) Report summarizes, by state, the average percentage of nursing home residents who activate (trigger) one of 24 quality indicators (32 with subcategories) during a quarter. QIs are triggered by specific responses to MDS elements and identify residents who either have or are at risk for specific functional problems needing further evaluation. QIs are aggregated across residents to generate facility level QIs, which is the proportion of residents in the facility with the condition.
	National Healthcare Safety Network http://www.cdph.ca.gov/programs/hai/Pages/NHSNGuidanceSpecifictoCaliforniaHospitals.aspx	NHSN	CDPH	Statewide Indicators: • Central Line-associated Bloodstream Infection (CLABSI) • Methicillin-resistant Staphylococcus aureus (MRSA) Bloodstream Infection (BSI) • Vancomycin-resistant Enterococci (VRE) Bloodstream Infection (BSI) • Clostridium difficile infection (C. difficile, C. diff, CDI, CDAD) • Surgical Site Infection (SSI)