DOCTORS MEDICAL CENTER

# West Contra Costa Healthcare District
# Doctors Medical Center
# Governing Body
# Board of Directors

**Wednesday, October 23, 2013**

**4:30 PM**

**Doctors Medical Center**
**Auditorium**

**2000 Vale Road**

**San Pablo, CA**

DOCTORS MEDICAL CENTER

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**

**GOVERNING BODY**
**BOARD OF DIRECTORS**

**WCCHD DOCTORS MEDICAL CENTER**
**GOVERNING BODY BOARD OF DIRECTORS**
**October 23rd, 2013 – 4:30 P.M.**
**Doctors Medical Center - Auditorium**
**2000 Vale Road**
**San Pablo, CA 94806**

**1209 L Street**
**Sacramento, CA 95814**
**800-511-1465**

**Governing Body Members**
*Eric Zell, Chair*
*Supervisor John Gioia, Vice Chair*
*Irma Anderson*
*Wendel Brunner, M.D.*
*Deborah Campbell*
*Nancy Casazza*
*Sharon Drager, M.D.*
*Pat Godley*
*Richard Stern, M.D.*
*William Walker, M.D.*
*Beverly Wallace*

## AGENDA

1. **CALL TO ORDER** — E. Zell
2. **ROLL CALL**
3. **APPROVAL OF MINUTES OF SEPTEMBER 24th , 2013** — E. Zell
4. **PUBLIC COMMENTS** — E. Zell
   *[At this time persons in the audience may speak on any items not on the agenda and any other matter within the jurisdiction of the of the Governing Body]*
5. **QUALITY MANAGEMENT REPORT** — B. Ellerston
   a. Presentation
   b. Discussion
   c. Public Comment
   *d. ACTION: Acceptance of the October 2013 Quality Management Report*
6. **FINANCIALS – SEPTEMBER 2013** — J. Boatman
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Acceptance of the September 2013 Financials*

7. **PATIENT SATISFACTION PRESENTATION& RESOLUTION: EMPLOYEE RECOGNITION** B. Redlo
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Adoption of Resolution No. 2013-07*

8. **APPROVAL OF SUBSTANCE ABUSE POLICY** J. Hardy
   a. Discussion
   b. Presentation
   c. Public Comment
   d. *ACTION: Approval of Substance Abuse Policy*

9. **CEO REPORT** D. Gideon
   a. Discussion
   b. Presentation
   c. Public Comment
   d. *ACTION: For Information Only*

10. **MEDICAL EXECUTIVE REPORT** L. Hodgson, M.D.
   a. Presentation
   b. Discussion
   c. Public Comment
   d. *ACTION: Approval of the MEC report, Credentials Committee Report and Revised Medical Staff Bylaws*

**ADJOURN TO CLOSED SESSION**

A. Reports of Medical Staff Audit and Quality Assurance Matters Pursuant to Health and Safety Code Section 32155.

B. Conference with Labor Negotiators (pursuant to Government Code Section 554957.6) Agency negotiators: Bob Redlo, VP of Patient Relations, Labor Relations & Workforce Development, John Hardy, Vice President of Human Resources: California Nurses Association, NUHW, PEU Local One and Local 39.

C. Discussion involving Trade Secrets Pursuant to Health and Safety Code Section 32106. Discussion will concern new programs, services, facilities.

ANNOUNCEMENT OF REPORTABLE ACTION(S) TAKEN IN CLOSED SESSION, IF ANY.

DOCTORS
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# MINUTES
## SEPTEMBER 24, 2013

**TAB 3**

DOCTORS MEDICAL CENTER

**WCCHD DOCTORS MEDICAL CENTER**
**GOVERNING BODY BOARD OF DIRECTORS**

**September 24, 2013, 4:30 P.M.**
**Doctors Medical Center - Auditorium**
**2000 Vale Road**
**San Pablo, CA 94806**

# MINUTES

## 1. CALL TO ORDER

The meeting was called to order at 4:40 P.M.

## 2. ROLL CALL

Quorum was established and roll was called: 4:45 PM

Present:
*Eric Zell, Chair*
*Richard Stern, M.D.*
*Sharon Drager, M.D.*
*Beverly Wallace*
*Irma Anderson (via call in)*
*Supervisor John Gioia, Vice Chair*

Excused:
*William Walker, M.D.*
*Supervisor John Gioia, Vice Chair*
*Deborah Campbell*
*Pat Godley*
*Nancy Casazza*
*Wendel Brunner, M.D.*

## 3. APPROVAL OF AUGUST 24, 2013 MINUTES

***The motion made by Supervisor John Gioia and seconded by Director Beverly Wallace to approve the August 24, 2013 minutes passed unanimously.***

## 4. PUBLIC COMMENTS

No Public Comments

## 5. QUALITY MANAGEMENT REPORT

Ms. Bobbie Ellerston, Chief Nursing Officer, presented and sought acceptance of the August 2013 Quality Management Report, including Core Measures, the Patient Safety metrics for Immunizations and Stroke. Currently all Acute Myocardial Infraction (AMI) Core Measures are at 100%, and we continue with ongoing monthly meetings with physician leadership to discuss identified issues for Congestive Heart Failure (CHF). The Pneumonia and Surgical Care Improvement Project Core Measures met benchmarks.

Ms. Ellerston pointed out that a new Core Measure tab is being created in Paragon for Venous Thromboembolism Prophylaxis which will include Mechanical and or Pharmacological VTE Prophylaxis plus documentation instructions. Currently all elements of Stroke patient safety metrics are at 90-100% for the 2nd quarter of 2013.

***A motion made by Director Irma Anderson and seconded by Director Beverly Wallace to approve the September 2013 Quality Management Report passed unanimously.***

## 6. FINANCIALS

Mr. James Boatman, CFO, presented and sought acceptance of the August 2013 Financials. Doctors Medical Center had a Net Loss of $2,260,000 for the month, resulting in net income worse than budget by $ 1,357,000. Net patient revenue was under budget by $1,246,000 for the month. Inpatient and outpatient gross charges were under budget by 13.7% with patient days and discharges under budget by 1.6% and 7.6% respectively. Total outpatient visits were 8.8% under budget and total surgeries was 13.3% under budget.

Regular Managed Care days were 36.5% under budget resulting in a shortfall of $2,307,000 in gross patient revenue and a $988,000 net revenue variance. Total Medicare volume was under budget resulting in a $305,000 net revenue variance with the balance of the Medicare variance related to the 2% sequestration cuts.

Salaries and Benefits combined were under budget by $173,000 in August. Salaries were under budget by $165,000 mostly due to continued flexing in all departments. Benefits were $167,000 over budget primarily due to employee healthcare costs continue to exceed our expectations. Supplies expense was favorable to budget by $126,000 for the month. Implants and pacemakers were under budget, offset by an increase in pharmaceuticals. Professional Fees were over budget in August mostly due to a physician contract being budgeted incorrectly.

***A motion made by Director Beverly Wallace and seconded by Director Irma Anderson to accept the August 2013 Financial report passed unanimously.***

## 7. CAPITAL APPROVAL REQUEST: RADIMETRICS EXPOSURE

Mr. James Boatman, CFO sought approval for purchase of Radimetrics eXposureTM software, and authorization of the Chief Financial Officer to execute on behalf of DMC all documents necessary for execution of the purchase agreement. New Californian regulations governing radiation dose tracking and reporting (SB 1237, AB 510), and our ACR CT accreditation (a Medicare pre-requisite) require a new level of dose monitoring. Radimetrics provides cumulative dose tracking, incorporates protocol management, and generates alerts. It will keep us in compliance with the above regulations and ensure improved levels of radiation safety within the Imaging department.

***A motion made by Sharon Drager M.D. and seconded by Director Beverly Wallace to approve the capital purchase request for Radimetrics Exposure***

## 8. CEO REPORT

Ms. Dawn Gideon, Interim President and Chief Executive Officer presented an update. The Financial department continues working hard on the preparation of the budget, dealing with changes in Medicare reimbursements. The budget will be brought to the Governing Board for review and approval in November.

Flu season is approaching and it is time for vaccination. The employee health nurse will be providing flu shots for all employees. Those employees that decline the vaccination, or who are unable to produce documentation of having received the vaccine elsewhere will be required to wear a mask in all public and patient care areas beginning in November through March.

Ms. Gideon reported that this year we will start having our staff enroll patients in the new Medicaid coverage program. The financial department is presently working on the application process, and staff will be required to participate in an extensive training program. It is anticipated that the hospitals enrollment credentials will be in place by the end of the year for January enrollment.

She updated the Governing Body on the recent Joint Commission visit to our Laboratory Services, reminding the group on the scoring approach of the survey process. She reported that there were no "direct impact" issues, only relatively minor indirect impact finding.

Finally, Ms. Gideon announced that we have successfully recruited a full time medical staff and quality director who will be joining us in November.

***Information Only No Action Required***

9. **MEDICAL EXECUTIVE REPORT**

Dr. Laurel Hodgson presented and sought approval of the Medical Executive Committee and Credentials Committee report. The medical staff department has written a $ 2,500 check to Political Education Funds/CMA in support of action against changes in malpractice liability legislation.

***A motion made by Sharon Drager M.D. and seconded by Richard Stern M.D. to approve the MEC report and Credentials Report passed unanimously.***

10. **LEGISLATION UPDATE**

No Update was given.

**THE MEETING ADJOURNED TO CLOSED SESSION AT 5:45 PM**

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# QUALITY REPORT

## TAB 5

# Quality Management Report

OCTOBER 2013

# LAB REPORT

- New contract with American Red Cross
- Joint issuance of Memo by Nursing and Laboratory re: Specimen Labeling
- Lab part of Nurse Competency in September
- Creation of Stroke panel tests that are tracked on the ED monitor

# TJC UPDATES

- Measurement of Success has been accepted
- Will continue to monitor areas of pain reassessment/falls/consent
- Conducting the Intracycle Monitoring for TJC
- Stroke survey 10/17/13

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# 2013 Clinical Laboratory Quality Indicators

| INDICATOR | Goal | Q1 A | Q1 N | Q1 AVG | Q2 A | Q2 N | Q2 AVG | Q3 A | Q3 N | Q3 AVG | Q4 A | Q4 N | Q4 AVG | 2013 AVG | 2012 Summary A | 2012 Summary N | 2012 AVG |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **1.Blood Bank** | | | | | | | | | | | | | | | | | |
| RBC Wastage | <2.0% | 16 | 804 | 2.0% | 16 | 764 | 2.1% | | | | | | | | 53 | 3439 | 1.5 |
| C / T Ratio | <2.0 | 534 | 804 | 1.5 | 527 | 764 | 1.4 | | | | | | | | 3439 | 2437 | 1.41 |
| **2. False Positive Blood Culture** | | | | | | | | | | | | | | | | | |
| Overall | <3% | 48 | 1916 | 2.5% | 31 | 1693 | 1.8% | | | | | | | | | | |
| Lab | <3% | 28 | 1503 | 1.9% | 23 | 1192 | 1.9% | | | | | | | | 60 | 4787 | 1.3 |
| **3. Patient Safety Audit** (Addition of Date/Time/Initial to Collection Tubes) | | | | | | | | | | | | | | | | | |
| Overall Compliance | >95% | 349 | 491 | 71.1% | 188 | 312 | 60.3% | | | | | | | | 1242 | 1362 | 91.2 |
| RN | | 66 | 491 | 86.6% | 56 | 312 | 82.1% | | | | | | | | 630 | 681 | 92.5 |
| Lab | | 76 | 491 | 84.5% | 68 | 312 | 78.2% | | | | | | | | 612 | 681 | 89.9 |
| **4. Turn-Around-Time (TAT) [AM reported before 8AM, ER reported within 60 of receipt]** | | | | | | | | | | | | | | | | | |
| AM | >80% | | | 83.5% | | | 90.3% | | | | | | | | | | 75.8% |
| ER | >83% | 15989 | 17413 | 91.8% | 15041 | 15856 | 94.9% | | | | | | | | | | 89.6% |
| **5. Critcal Value RN Notification** | | | | | | | | | | | | | | | | | |
| Called / Total | >98% | 5069 | 5071 | 99.9% | 3773 | 3774 | 99.9% | | | | | | | | 10989 | 10992 | 99.90% |
| **6. Transfusion Documentation Audit** | | | | | | | | | | | | | | | | | |
| Arm Band Present | 95% | 88 | 90 | 98% | 88 | 90 | 98% | | | | | | | | | | |
| Consent | 95% | 88 | 90 | 98% | 88 | 90 | 98% | | | | | | | | | | |
| RN Cosigner | 95% | 90 | 90 | 100% | 88 | 90 | 98% | | | | | | | | | | |
| Start/Stop Time | 95% | 63 | 90 | 70% | 73 | 90 | 81% | | | | | | | | | | |
| Quantity Infused | 95% | 84 | 90 | 93% | 88 | 90 | 98% | | | | | | | | | | |
| Transfution Reaction | 95% | 83 | 90 | 92% | 88 | 90 | 98% | | | | | | | | | | |
| Infused W/In <4Hr | 95% | 90 | 90 | 100% | 87 | 90 | 97% | | | | | | | | | | |
| Begun W/In 30 Min. | 95% | 87 | 90 | 97% | 90 | 90 | 100% | | | | | | | | | | |
| Vitals | 95% | 90 | 90 | 100% | 89 | 90 | 99% | | | | | | | | | | |
| Temperature | 95% | 90 | 90 | 100% | 89 | 90 | 99% | | | | | | | | | | |
| **7. Code Stroke (% Reported Within 45 Minutes of Order** | | | | | | | | | | | | | | | | | |
| Overall TAT | >90% | 76 | 92 | 82.6% | 64 | 72 | 88.9% | | | | | | | | | | |
| CBC | >90% | 28 | 31 | 90.3% | 24 | 25 | 96.0% | | | | | | | | | | |
| BMP | >90% | 22 | 30 | 73.3% | 15 | 24 | 62.5% | | | | | | | | | | |
| PT/INR | >90% | 26 | 31 | 83.9% | 25 | 25 | 100.0% | | | | | | | | | | |

**KEY LEGEND: N = Total Number of Aduits, A = Number of items meeting audit criteria, TAT reported as percent of total reported within allowed time frame.**

=Met Goal | =Within 3% of Goal | =PI Alert

Reviewed and Approved by

Maureen Fitzgibbons, CLS
Clinical Laboratory Director

## EXEC SUMMARY AND ANALYSIS

**1.Blood Bank**

C/T Ratio remains excellent for facility.

**2. False Positive Blood Culture**

Nurse collected volumes of blood cultures down significantly. As facility remains well below threshold for totals, recommendation has been made to continue tracking, but stop major efforts to reduce Nursing false positives.

**3. Patient Safety Audit** (Addition of Date/Time/Initial to Collection Tubes)

Compiled data indicates that this remains a major issue at this facility.

**4. Turn-Around-Time (TAT)** (Order to Result)

Remain excellent. No action required.

**5. Critcal Value RN Notification**

Remains excellent. No action required.

**6. Transfusion Documentation Audit**

Two areas require attention: Start/Stop Time Documentation and Transfusion Completion Within 4 Hours.

**7. Code Stroke (% Reported Within 45 Minutes of Order**

Show progress for most analytes except BMP (Chemistry). Using three-fold approach: 1. Low tech immediate: pink labels for STROKE tubes to help identify them. No other tubes in centrifuge while STROKE tubes Running. Staff must remain with specimen until release. 2. Long-term: Potential replacement of current ABG instruments with analyzers that can release whole blood Chemistries in 1-2 minutes. 3. Long-term: Auto-Verification of normal Chemistry results. Requires validation. Analyzers scheduled for replacement in 2014. Best to validate at that time.

## ACTION PLAN

Wastage slightly above goal. BB Lead returned in August. Re-inforced negotiated plan with ARC for return/credit of outdating units.

Continue to monitor RN values to see if we see significant rise.

Laboratory employees have received inservice and this is one of the topics being stressed at the Nursing Competency Program in the month of September. Moving to daily audit, notification of Nursing Leadership of issues each week.

Upcoming September RN Competencies stress documentation of start/stop time and ending transfusion within 4 hours. Notification of missing data is being sent to Unit Directors for follow-up.

Reviewed and Approved by

Maureen Fitzgibbons, CLS
Clinical Laboratory Director

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# FINANCIALS
## SEPTEMBER 2013

**TAB 6**

DOCTORS MEDICAL CENTER

# Board Presentation

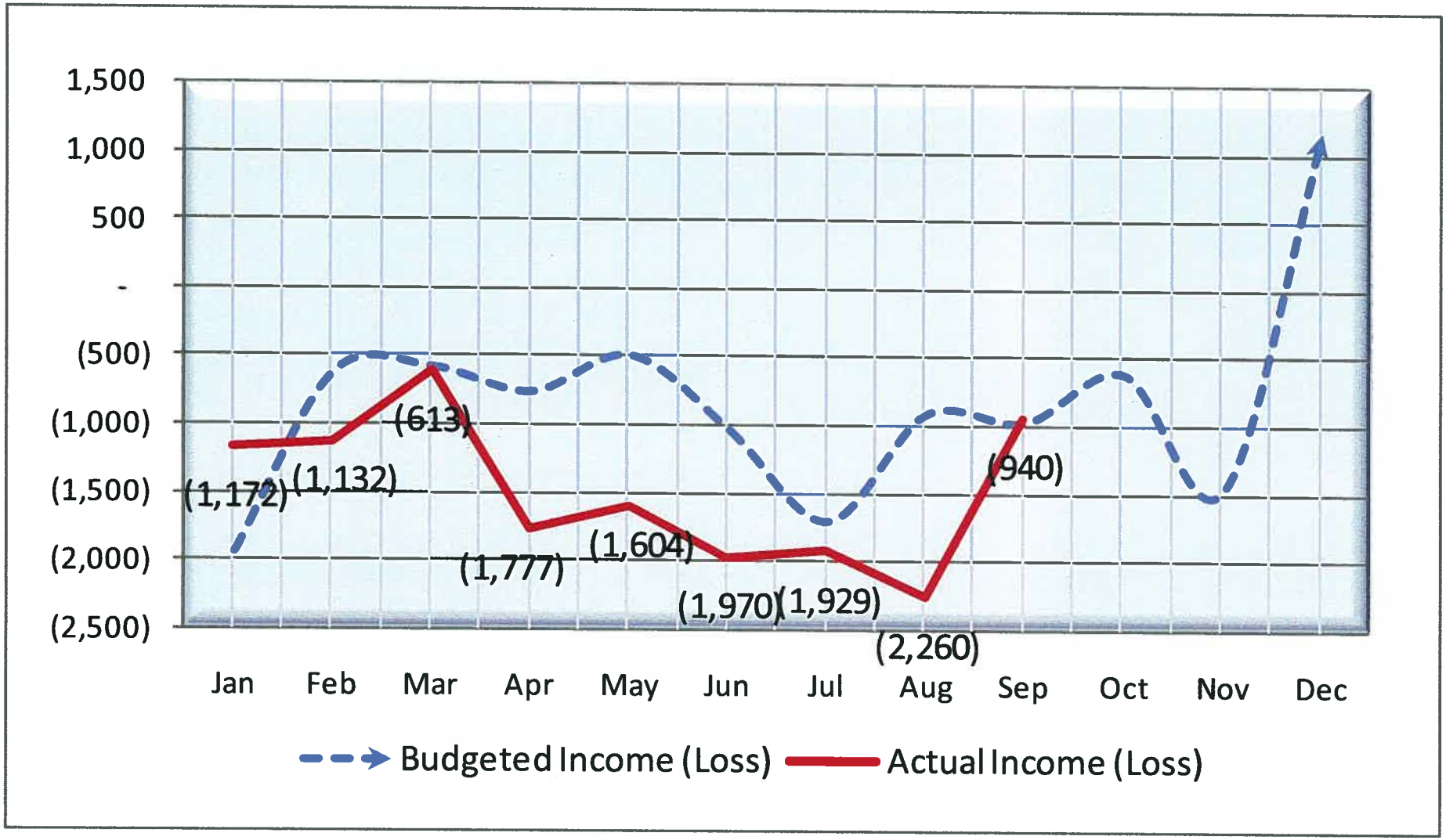
# September 2013

# Financial Report

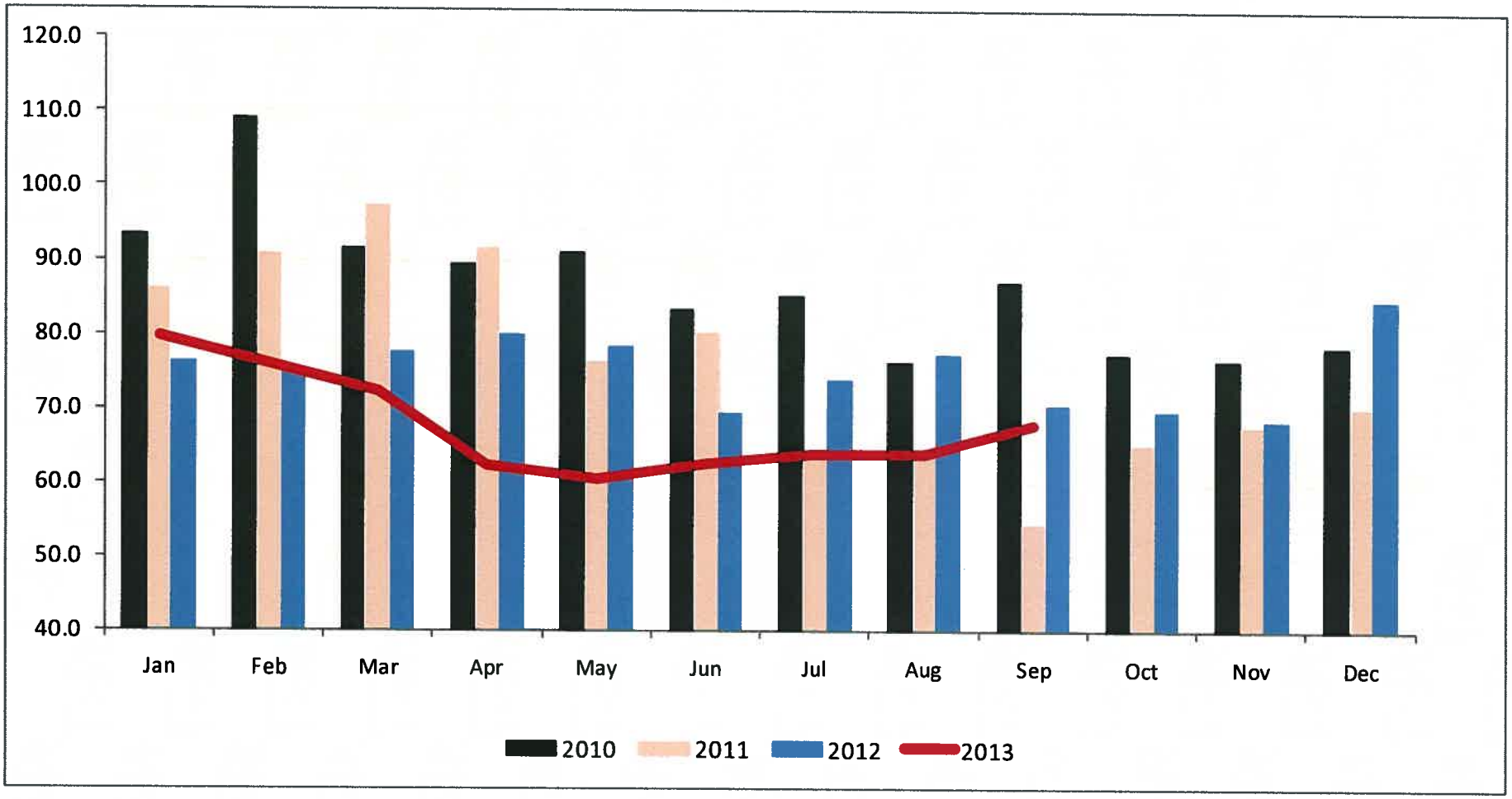
# Financial Report Key Points

- Net loss was $940K in September, $20K better than budget.
- Net patient revenue was $199K over budget.
- Operating expenses were $21K over budget.
- $1.5M IGT funding received

# Year-to-Date Income



# Average Daily Census
## Jan-10 thru Aug-13



# Statement of Activity – Summary

For the Period Ending

September 30, 2013

*(Thousands)*

| Month to Date | | | | Year to Date | | |
|---|---|---|---|---|---|---|
| Actual | Budget | Var | | Actual | Budget | Var |
| 10,093 | 9,945 | 148 | **Net Operating Revenues $** | 86,092 | 93,004 | (6,912) |
| 11,681 | 11,660 | (21) | **Total Operating Expenses $** | 106,067 | 108,630 | 2,563 |
| (1,588) | (1,715) | 127 | **Income/(Loss) from Operations $** | (19,975) | (15,626) | (4,349) |
| 648 | 755 | (107) | **Income from Other Sources $** | 6,578 | 6,731 | (153) |
| (940) | (960) | 20 | **Net Income / (Loss) $** | (13,397) | (8,895) | (4,502) |
| | | | | | | |
| 2,038 | 1,679 | 359 | **Patient Days** | 18,456 | 19,589 | (1,133) |
| 408 | 470 | (62) | **Discharges** | 4,136 | 4,417 | (281) |
| 5,919 | 6,771 | (852) | **Outpatient Visits** | 54,686 | 56,971 | (2,285) |
| 540 | 580 | 40 | **Worked FTE's** | 568 | 609 | 42 |
| 1.57 | 1.55 | 0.02 | **Medicare CMI** | 1.56 | 1.55 | 0.01 |

# Budget Variances – Net Revenue

| | |
|---|---|
| Managed Care | $ (709) K |
| Medicare<br>2% Sequestration $(73K) | $ (303) K |
| Other | $ 278 K |
| IGT | $ 1,500 K |

# Budget Variances - Expenses

- Professional Fees- $61K over budget in Physician contracts.

# Cash Position

## September 30, 2013

*(Thousands)*

| | September 30, 2013 | December 31, 2012 |
|---|---|---|
| Unrestricted Cash | $3,130 | $5,059 |
| Restricted Cash | $7,933 | $11,612 |
| Total Cash | $11,063 | $16,671 |
| Days Unrestricted Cash | 8 | 11 |
| Days Restricted | 22 | 27 |
| Total Days of Cash | 30 | 39 |

| | |
|---|---|
| California Benchmark Average | 34 |
| Top 25% | 82 |
| Top 10% | 183 |

# Accounts Receivable

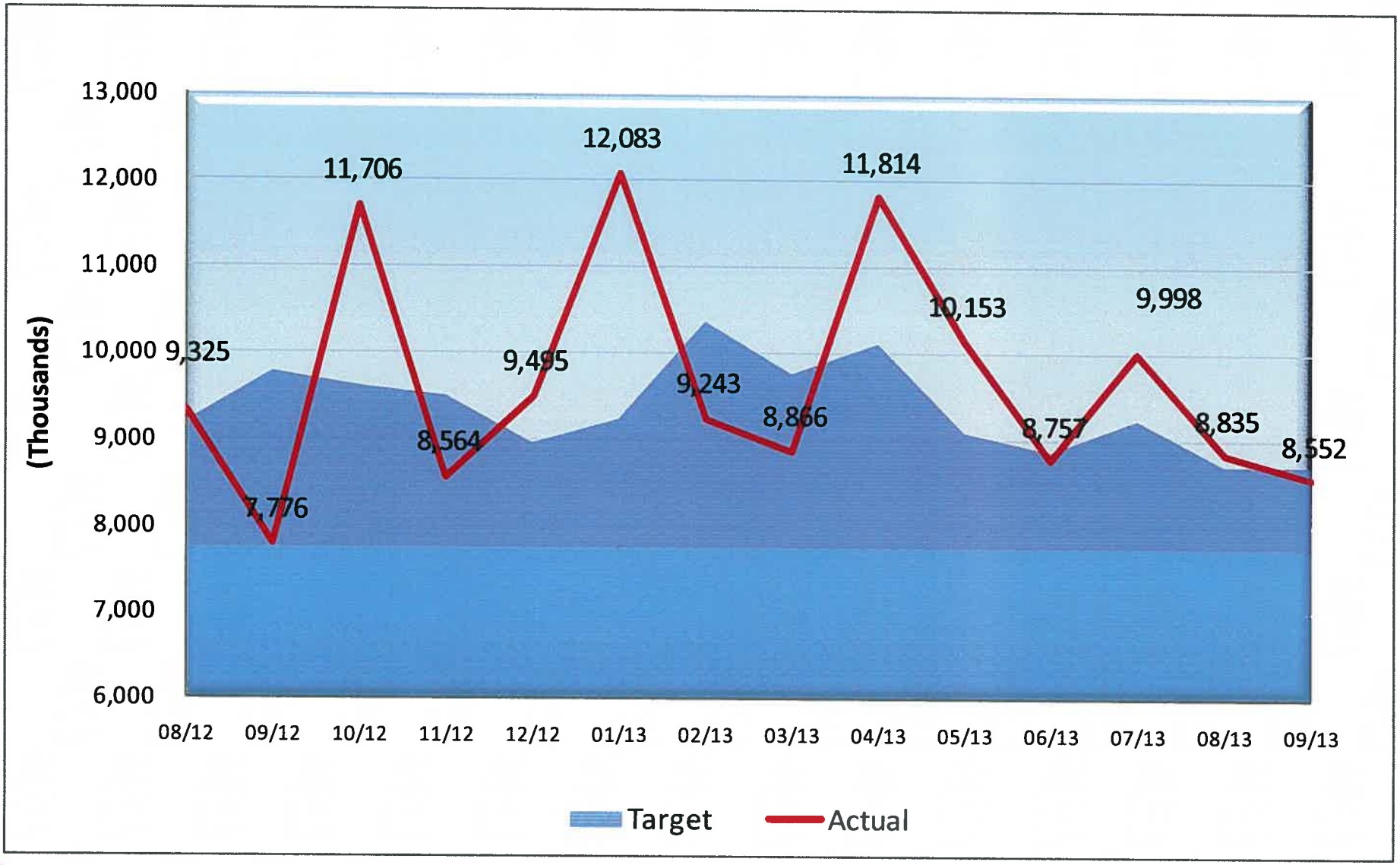
## September 30, 2013

*(Thousands)*

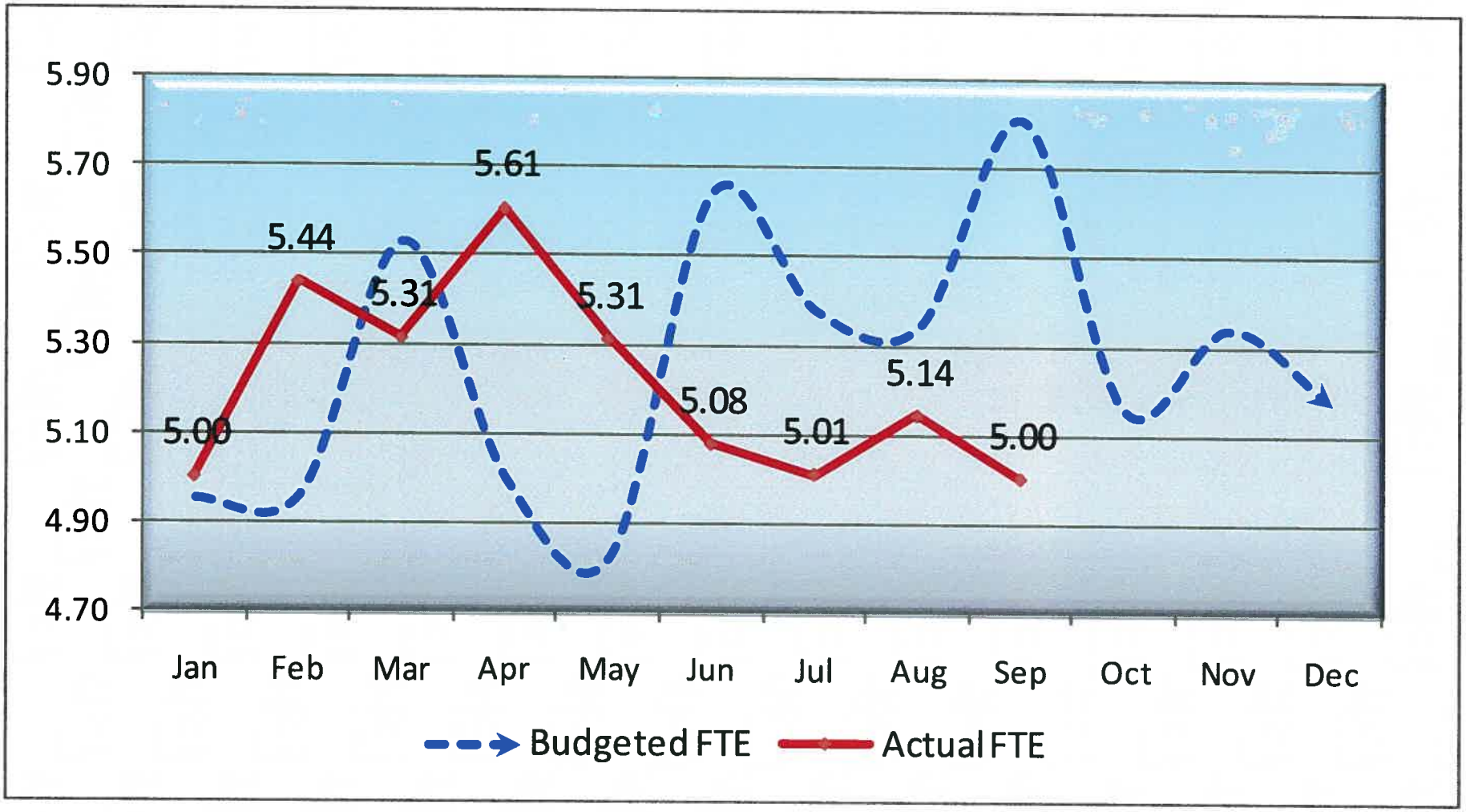
| | September 30, 2013 | December 31, 2012 |
|---|---|---|
| Net Patient Accounts Receivable | $22,195 | $31,007 |
| Net Days in Accounts Receivable | 74.8 | 92.6 |

| | |
|---|---|
| California Benchmark Average | 65.7 days |
| Top 25% | 45.2 days |
| Top 10% | 35.5 days |

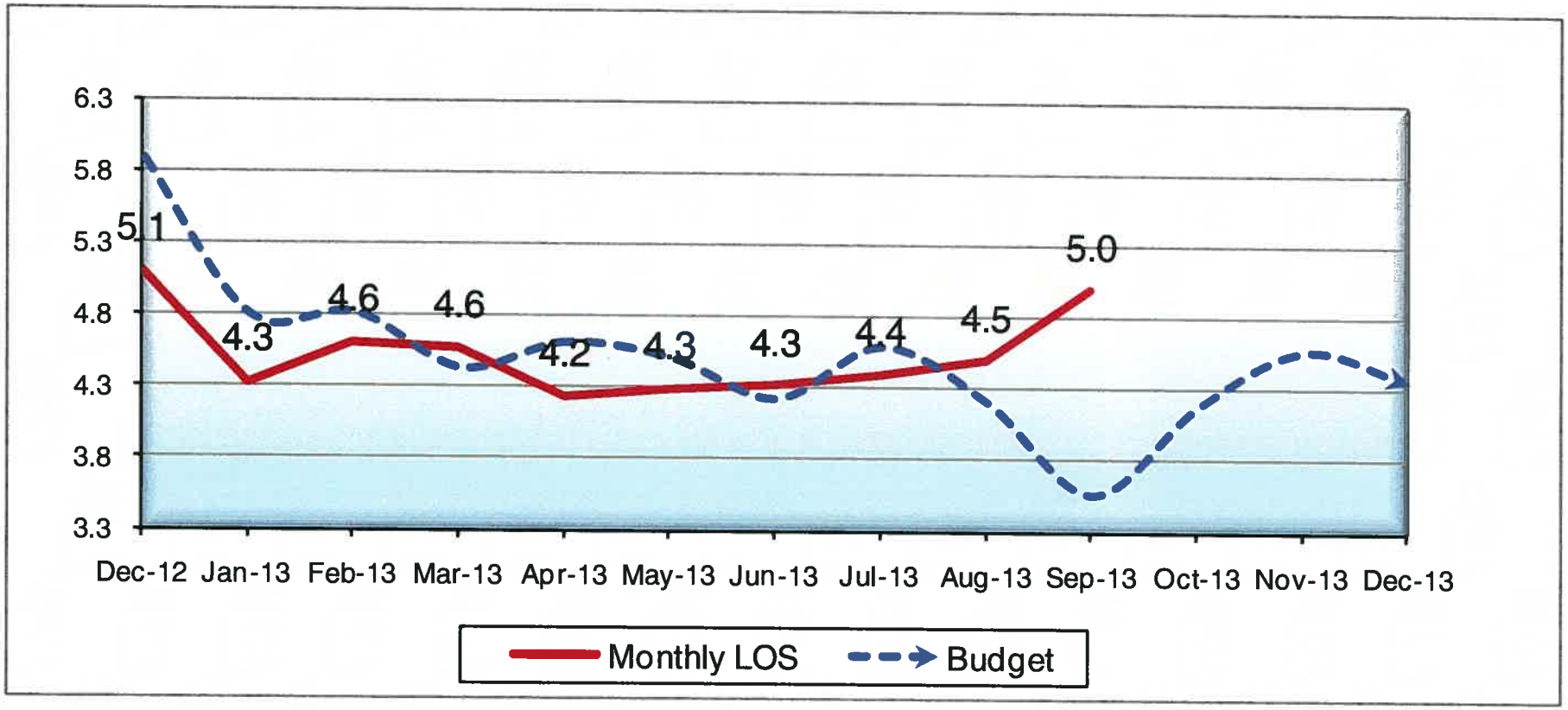
# Cash Collections

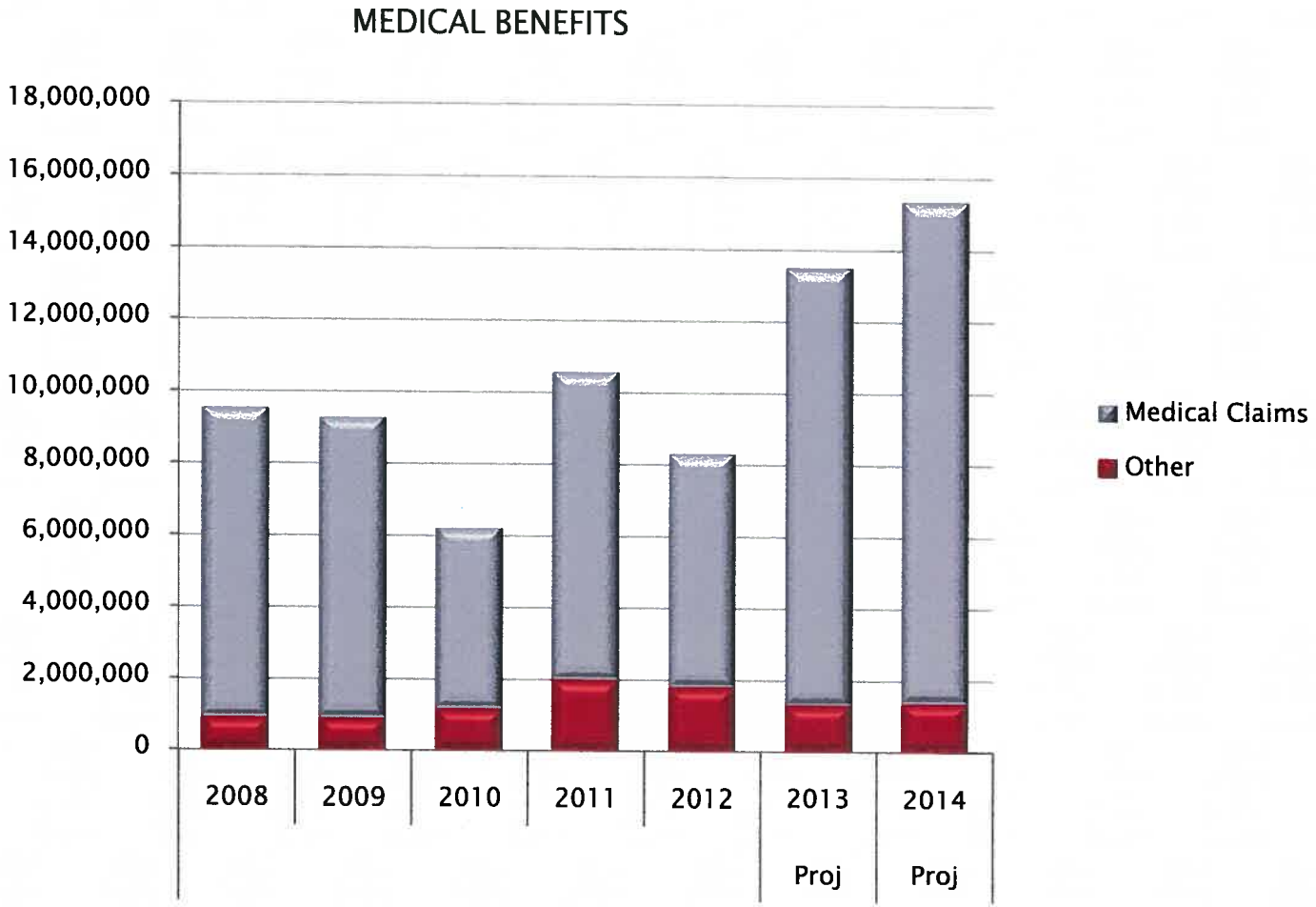


# Worked FTE / AADC

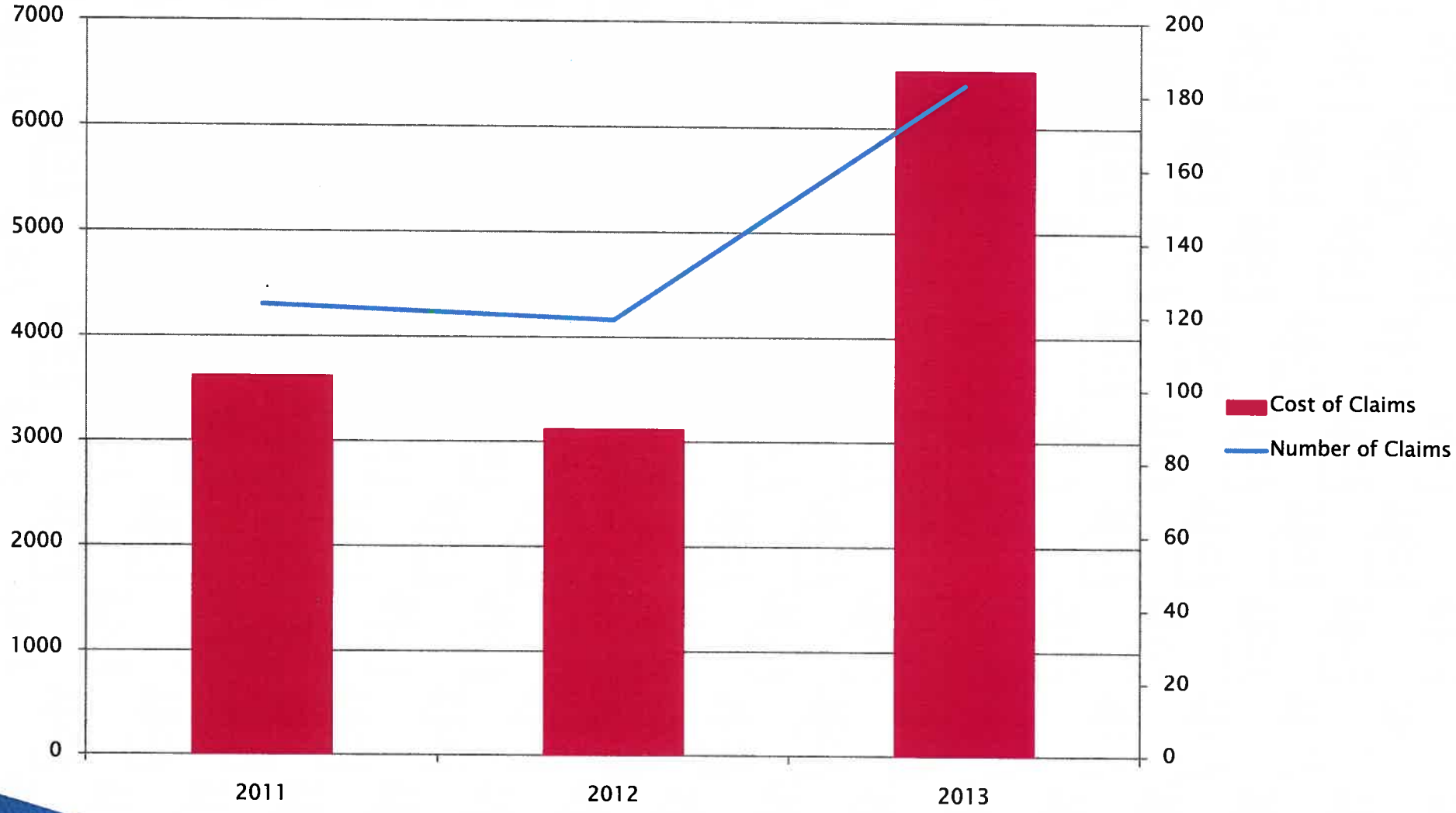


# Length of Stay

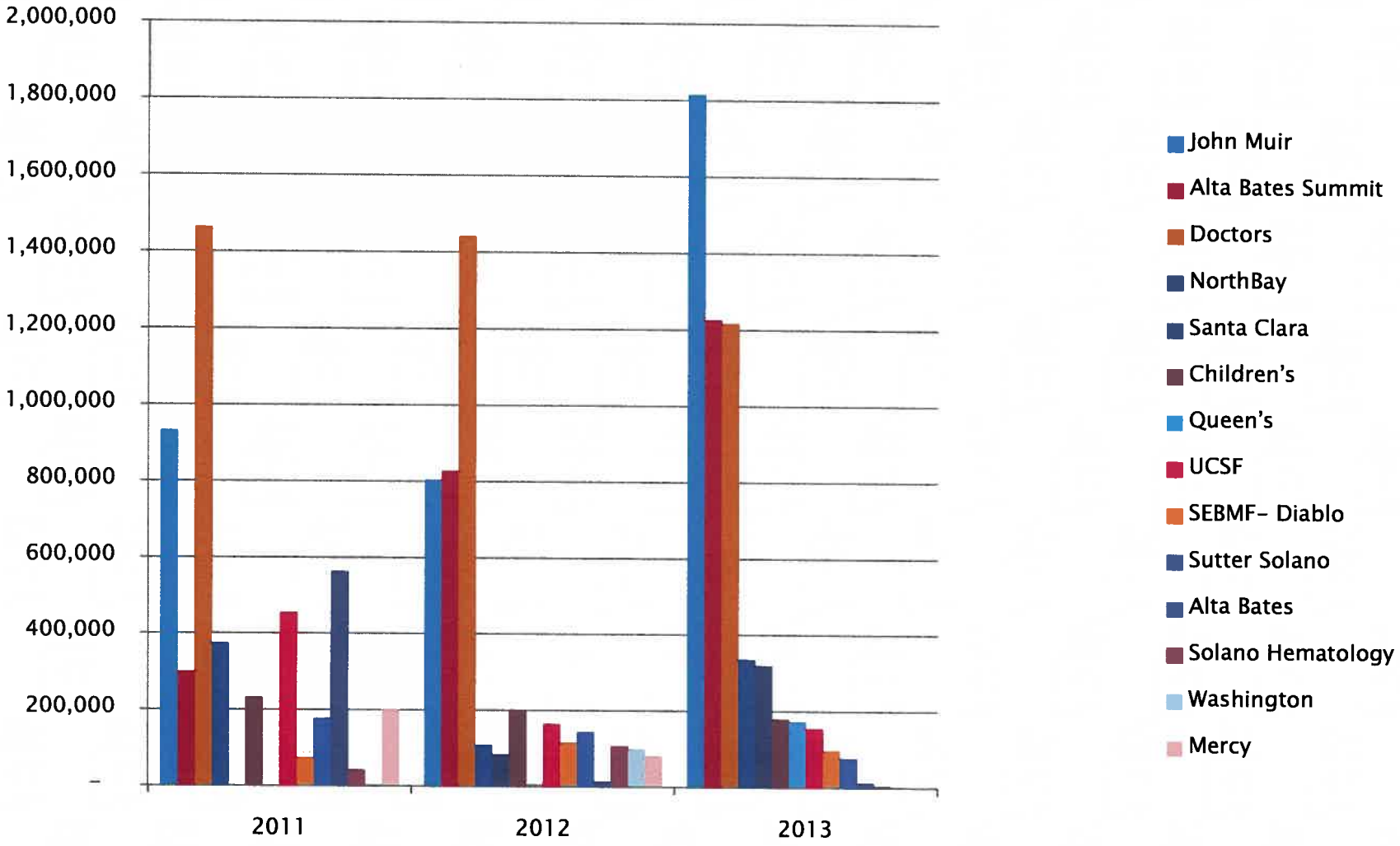



MEDICAL BENEFITS
18,000,000
16,000,000
14,000,000
12,000,000
10,000,000
8,000,000
6,000,000
4,000,000
2,000,000
0
2008
2009
2010
2011
2012
2013 Proj
2014 Proj
Medical Claims
Other

# Large Claim Frequency and Cost Over $10,000



# Total Payments over $100,000 to Providers for Health Plan



**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**
**INCOME STATEMENT**
**September 30, 2013**
(Amounts in Thousands)

| CURRENT PERIOD ACTUAL | CURRENT PERIOD BUDGET | CURRENT PERIOD VAR | CURRENT PERIOD VAR % | PRIOR YEAR ACTUAL | | CURRENT YTD ACTUAL | CURRENT YTD BUDGET | CURRENT YTD VAR | CURRENT YTD VAR % | PRIOR YEAR ACTUAL |
|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | **OPERATING REVENUE** | | | | | |
| 10,015 | 9,816 | 199 | 2.0% | 8,898 | Net Patient Service Revenue | 85,231 | 91,827 | (6,596) | -7.2% | 89,363 |
| 78 | 130 | (52) | -39.9% | 75 | Other Revenue | 861 | 1,177 | (316) | -26.8% | 1,881 |
| 10,093 | 9,945 | 148 | 1.5% | 8,973 | **Total Operating Revenue** | 86,092 | 93,004 | (6,912) | -7.4% | 91,244 |
| | | | | | **OPERATING EXPENSES** | | | | | |
| 4,633 | 4,607 | (26) | -0.6% | 5,393 | Salaries & Wages | 42,481 | 45,588 | 3,107 | 6.8% | 48,513 |
| 2,869 | 2,842 | (27) | -0.9% | 3,018 | Employee Benefits | 25,908 | 24,752 | (1,156) | -4.7% | 24,338 |
| 920 | 859 | (61) | -7.1% | 866 | Professional Fees | 8,725 | 8,266 | (459) | -5.6% | 8,610 |
| 1,434 | 1,422 | (12) | -0.9% | 1,247 | Supplies | 11,984 | 12,353 | 369 | 3.0% | 13,109 |
| 801 | 787 | (14) | -1.8% | 1,037 | Purchased Services | 7,606 | 7,582 | (24) | -0.3% | 8,236 |
| 257 | 281 | 24 | 8.7% | 237 | Rentals & Leases | 2,410 | 2,580 | 170 | 6.6% | 2,275 |
| 408 | 479 | 71 | 14.9% | 422 | Depreciation & Amortization | 3,700 | 4,096 | 396 | 9.7% | 3,625 |
| 359 | 383 | 24 | 6.3% | 378 | Other Operating Expenses | 3,253 | 3,413 | 160 | 4.7% | 3,143 |
| 11,681 | 11,660 | (21) | -0.2% | 12,598 | **Total Operating Expenses** | 106,067 | 108,630 | 2,563 | 2.4% | 111,849 |
| (1,588) | (1,715) | 127 | -7.4% | (3,625) | **Operating Profit / Loss** | (19,975) | (15,626) | (4,349) | 27.8% | (20,605) |
| | | | | | **NON-OPERATING REVENUES (EXPENSES)** | | | | | |
| - | - | - | 0.0% | - | Other Non-Operating Revenue | - | - | - | 0.0% | 1,200 |
| 1,123 | 1,133 | (10) | 0.9% | 1,123 | District Tax Revenue | 10,107 | 10,216 | (109) | 1.1% | 8,080 |
| 6 | 3 | 3 | 77.0% | 6 | Investment Income | 137 | 44 | 93 | 214.0% | 211 |
| (481) | (382) | (99) | 0.0% | (407) | Less: Interest Expense | (3,666) | (3,529) | (137) | 3.9% | (3,208) |
| 648 | 755 | (107) | -14.2% | 722 | **Total Net Non-Operating** | 6,578 | 6,731 | (153) | -2.3% | 6,283 |
| (940) | (960) | 20 | -2.1% | (2,903) | **Income Profit (Loss)** | (13,397) | (8,895) | (4,502) | 51% | (14,322) |
| | | | | | **Profitability Ratios:** | | | | | |
| -15.7% | -17.2% | 86.0% | | -40.4% | Operating Margin % | -23.2% | -16.8% | 62.9% | | -22.6% |
| -9.3% | -9.7% | 0.3% | | -32.4% | Profit Margin % | -15.6% | -9.6% | -6.0% | | -15.7% |

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**
**INCOME STATEMENT**
**September 30, 2013**
(Amounts in Thousands)

| CURRENT PERIOD ACTUAL | CURRENT PERIOD BUDGET | CURRENT PERIOD VAR | CURRENT PERIOD VAR % | PRIOR YEAR ACTUAL | | CURRENT YTD ACTUAL | CURRENT YTD BUDGET | CURRENT YTD VAR | CURRENT YTD VAR % | PRIOR YEAR ACTUAL |
|---|---|---|---|---|---|---|---|---|---|---|
| 2,315 | 2,486 | 171 | 6.9% | 2,514 | SWB / APD | 2,301 | 2,220 | (81) | -3.6% | 2,245 |
| 64.2% | 63.9% | 255.6% | | 66.8% | SWB / Total Operating Expenses | 64.5% | 64.8% | | | 65.1% |
| 3,605 | 3,892 | 286 | 7.4% | 3,766 | Total Operating Expenses / APD | 3,568 | 3,428 | (140) | -4.1% | 3,446 |
| 31,194 | 29,255 | 1,939 | 6.6% | 32,576 | I/P Gross Charges | 295,338 | 313,496 | (18,158) | -5.8% | 313,525 |
| 18,398 | 22,953 | (4,555) | -19.8% | 18,830 | O/P Gross Charges | 180,320 | 193,611 | (13,291) | -6.9% | 178,231 |
| **49,592** | **52,208** | **(2,616)** | **-5.0%** | **51,406** | **Total Gross Charges** | **475,658** | **507,107** | **(31,449)** | **-6.2%** | **491,756** |
| | | | | | **Payor Mix (IP and OP)** | | | | | |
| 51% | 50% | 1% | | 53% | Medicare % | 54% | 50% | 4% | | 53% |
| 21% | 22% | 0% | | 21% | Medi-Cal % | 20% | 22% | -1% | | 21% |
| 13% | 14% | -2% | | 12% | Managed Care | 12% | 14% | -2% | | 12% |
| 4% | 4% | 0% | | 4% | Other Government % | 3% | 4% | 0% | | 4% |
| 11% | 10% | 1% | | 10% | Self Pay % | 10% | 10% | 0% | | 10% |
| | | | | | **STATISTICS** | | | | | |
| 450 | 478 | (28) | -5.9% | 502 | Admissions | 4,209 | 4,441 | (232) | -5.2% | 4,581 |
| 408 | 470 | (62) | -13.2% | 492 | Discharges | 4,136 | 4,417 | (281) | -6.4% | 4,543 |
| 2,038 | 1,679 | 359 | 21.4% | 2120 | Patient Days | 18,456 | 19,589 | (1,133) | -5.8% | 20,691 |
| 67.9 | 56.0 | 12.0 | 21.4% | 70.7 | Average Daily Census (ADC) | 67.6 | 71.8 | (4.2) | -5.8% | 75.5 |
| 5.00 | 3.57 | (1.42) | -39.8% | 4.31 | Average Length of Stay (LOS)- Accrual Based | 4.46 | 4.43 | (0.03) | -0.6% | 4.55 |
| 30 | 30 | | | 30 | Days in Month | 273 | 273 | | | 274 |
| 649 | 839 | (190) | -22.7% | 776 | Adjusted Discharges (AD) | 6,661 | 7,145 | (484) | -6.8% | 7,126 |
| 3,240 | 2,996 | 244 | 8.1% | 3,345 | Adjusted Patient Days (APD) | 29,724 | 31,687 | (1,962) | -6.2% | 32,453 |
| 108 | 100 | 8 | 8.1% | 112 | Adjusted ADC (AADC) | 109 | 116 | (7) | -6.2% | 118 |
| 86 | 64 | 22 | 34.4% | 92 | Inpatient Surgeries | 649 | 675 | (26) | -3.9% | 684 |
| 73 | 106 | (33) | -31.1% | 70 | Outpatient Surgeries | 739 | 852 | (113) | -13.3% | 836 |
| **159** | **170** | (11) | -6.5% | **162** | **Total Surgeries** | **1,388** | **1,527** | (139) | -9.1% | **1,520** |

**WEST CONTRA COSTA HEALTHCARE DISTRICT**
**DOCTORS MEDICAL CENTER**
**INCOME STATEMENT**
**September 30, 2013**
(Amounts in Thousands)

| CURRENT PERIOD ACTUAL | CURRENT PERIOD BUDGET | CURRENT PERIOD VAR | CURRENT PERIOD VAR % | PRIOR YEAR ACTUAL | | CURRENT YTD ACTUAL | CURRENT YTD BUDGET | CURRENT YTD VAR | CURRENT YTD VAR % | PRIOR YEAR ACTUAL |
|---|---|---|---|---|---|---|---|---|---|---|
| 3,063 | 2,954 | 109 | 3.7% | 3184 | ED Outpatient Visits | 27,920 | 26,437 | 1,483 | 5.6% | 31,803 |
| 2,783 | 3,711 | (928) | -25.0% | 2981 | Ancillary Outpatient Visits | 26,027 | 29,682 | (3,655) | -12.3% | 28,476 |
| 73 | 106 | (33) | -31.1% | 70 | Outpatient Surgeries | 739 | 852 | (113) | -13.3% | 836 |
| **5,919** | **6,771** | (852) | -12.6% | **6,235** | **Total Outpatient Visits** | **54,686** | **56,971** | (2,285) | -4.0% | **61,115** |
| 393 | 428 | (35) | -8.1% | 460 | Emergency Room Admits | 3,816 | 3,975 | (159) | -4.0% | 4,200 |
| 12.8% | 14.5% | | | 14.4% | % of Total E/R Visits | 13.7% | 15.0% | | | 13.2% |
| 87.3% | 89.5% | | | 91.6% | % of Acute Admissions | 90.7% | 89.5% | | | 91.7% |
| 540 | 580 | 40 | 6.9% | 644 | Worked FTE | 568 | 609 | 42 | 6.8% | 627 |
| 644 | 695 | 51 | 7.3% | 754 | Paid FTE | 673 | 709 | 36 | 5.0% | 730 |
| 5.00 | 5.81 | 0.81 | 13.9% | 5.78 | Worked FTE / AADC | 5.22 | 5.25 | 0.03 | 0.7% | 5.30 |
| 5.96 | 6.96 | 0.99 | 14.3% | 6.76 | Paid FTE / AADC | 6.18 | 6.11 | (0.08) | -1.2% | 6.16 |
| 3,091 | 3,276 | (185) | -5.6% | 2,660 | Net Patient Revenue / APD | 2,867 | 2,898 | (31) | -1.1% | 2,754 |
| 15,306 | 17,424 | (2,118) | -12.2% | 15,366 | I/P Charges / Patient Days | 16,002 | 16,004 | (1) | 0.0% | 15,153 |
| 3,108 | 3,390 | (282) | -8.3% | 3,020 | O/P Charges / Visit | 3,297 | 3,398 | (101) | -3.0% | 2,916 |
| 1,430 | 1,538 | 108 | 7.0% | 1,612 | Salary Expense / APD | 1,429 | 1,439 | 10 | 0.7% | 1,495 |
| 4.77 | 4.72 | (0.05) | -1.1% | 5.00 | Medicare LOS - Discharged Based | 4.78 | 5.07 | 0.30 | 5.8% | 4.89 |
| 1.57 | 1.55 | 0.02 | 1.0% | 1.63 | Medicare CMI | 1.56 | 1.55 | 0.01 | 0.5% | 1.55 |
| 3.05 | 3.04 | 0.00 | 0.1% | 3.07 | Medicare CMI Adjusted LOS | 3.06 | 3.27 | (0.21) | -6.3% | 3.17 |
| 5.00 | 3.57 | (1.42) | -39.8% | 4.31 | Total LOS - Discharged Based | 4.47 | 4.43 | (0.04) | -0.8% | 4.57 |
| 1.52 | 1.44 | 0.08 | 5.5% | 1.55 | Total CMI | 1.52 | 1.48 | 0.04 | 2.6% | 1.49 |
| 3.29 | 2.48 | 0.81 | 32.5% | 2.78 | Total CMI Adjusted LOS | 2.95 | 3.00 | (0.05) | -1.7% | 3.07 |

Footnote:
a) Reclassed budget of $56K in July from Admin Salaries to Admin Consulting for the CEO,CNO and COO.
b) Reclassed budget of $9K in July from Admin Employee Benefits to Admin Consulting for the CEO,CNO and COO.
c) Moved budget of $79K in July Admin Salaries, Benefits and Recruitment to Admin Consulting for the CEO,CNO and COO.
d) Reclassed budget of $14K in July from Admin Recruitment to Admin Consulting for the CEO,CNO and COO.

# WEST CONTRA COSTA HEALTHCARE DISTRICT
## DOCTORS MEDICAL CENTER
## BALANCE SHEET
## September 30, 2013
(Amounts in Thousands)

| | Current Month | Dec. 31, 2012 |
|---|---|---|
| **ASSETS** | | |
| Cash | 3,130 | 5,059 |
| Net Patient Accounts Receivable | 22,195 | 31,007 |
| Other Receivables | 6,830 | 464 |
| Inventory | 1,646 | 1,731 |
| Current Assets With Limited Use | 7,933 | 11,612 |
| Prepaid Expenses and Deposits | 1,417 | 1,621 |
| **TOTAL CURRENT ASSETS** | **43,151** | **51,494** |
| **Assets With Limited Use** | **642** | **642** |
| **Property Plant & Equipment** | | |
| Land | 12,120 | 12,120 |
| Bldg/Leasehold Improvements | 29,433 | 29,432 |
| Capital Leases | 10,926 | 10,926 |
| Equipment | 45,010 | 43,579 |
| CIP | 644 | 860 |
| Total Property, Plant & Equipment | 98,133 | 96,917 |
| Accumulated Depreciation | -57,418 | -53,887 |
| **Net Property, Plant & Equipment** | **40,715** | **43,030** |
| **Intangible Assets** | **1,408** | **1,454** |
| **Total Assets** | **85,916** | **96,620** |

| | | Current Month | Dec. 31, 2012 |
|---|---|---|---|
| | **LIABILITIES** | | |
| 96 | Current Maturities of Debt Borrowings | 1,311 | 1,613 |
| 97 | Accounts Payable and Accrued Expenses | 12,445 | 16,509 |
| 98 | Accrued Payroll and Related Liabilities | 18,098 | 17,512 |
| 99 | Deferred District Tax Revenue | 3,086 | 3,091 |
| 100 | Estimated Third Party Payor Settlements | 2,732 | 1,868 |
| 101 | **Total Current Liabilities** | **37,672** | **40,593** |
| | **Other Liabilities** | | |
| 102 | Other Deferred Liabilities | 9,670 | 2,804 |
| | **Long Term Debt** | | |
| 103 | Notes Payable - Secured | 60,323 | 61,242 |
| 104 | Capital Leases | 1,012 | 1,647 |
| 105 | Less Current Portion LTD | -1,311 | -1,613 |
| 106 | **Total Long Term Debt** | **60,024** | **61,276** |
| 107 | **Total Liabilities** | **107,366** | **104,673** |
| | **EQUITY** | | |
| 108 | Retained Earnings | -8,053 | 9,667 |
| 109 | Year to Date Profit / (Loss) | -13,397 | -17,720 |
| 110 | **Total Equity** | **-21,450** | **-8,053** |
| 111 | **Total Liabilities & Equity** | **85,916** | **96,620** |

| | | |
|---|---|---|
| Current Ratio (CA/CL) | ***1.15*** | ***1.27*** |
| Net Working Capital (CA-CL) | ***5,479*** | ***10,901*** |
| Long Term Debt Ratio (LTD/TA) | ***0.70*** | ***0.63*** |
| Long Term Debt to Capital (LTD/(LTD+TE) | ***1.56*** | ***1.15*** |
| Financial Leverage (TA/TE) | ***-4.0*** | ***-12.0*** |
| Quick Ratio | **0.67** | **0.89** |
| Unrestricted Cash Days | **8** | **11** |
| Restricted Cash Days | **22** | **27** |
| Net A/R Days | **74.8** | **92.6** |

DOCTORS MEDICAL CENTER

# September 2013 Executive Report

Doctors Medical Center had a Net Loss of $ 940,000 for the month of September. As a result, net income was $20,000 better than budget. The following are the factors leading to the Net Income variance for the month:

| | |
|---|---|
| Managed Care | $ (709) K |
| Medicare<br>2% Sequestration $(73K) | $ (303) K |
| Other | $ 278 K |
| IGT | $ 1,500 K |

Net patient revenue was over budget by $199,000 for September mainly due to receipt of IGT funding of $1,500,000. Inpatient gross charges were over budget by 6.6% with patient days over budget by 21.4% and discharges under budget by 13.2%. Although ED visits were 3.7% better than budget, total outpatient volume was 12.6% under budget for September and outpatient surgeries were 6.5% under budget.

In September, regular Managed Care volume was 11.1% under budget resulting in a shortfall of $1,599,000 in patient revenue and $709,000 in total Managed Care. Regular Medicare outpatient volume and reimbursement rate were lower than expected resulting in $255,000 variance.

**Expenses**

**Professional Fees**- Physician fees were $61,000 over budget due to a miscalculation of a contract during the budget process.

DOCTORS
MEDICAL CENTER

# PATIENT SATISFACTION PRESENTATION & EMPLOYEE RECOGNITION RESOLUTION #2013-07

**TAB 7**

DOCTORS MEDICAL CENTER

# PATIENT SATISFACTION PROGRAM UPDATE

## PATIENT EXPERIENCE PROGRAM and PATIENT SATISFACTION COMMITTEE

- Press Ganey will continue assisting project with quarterly pulse checks and updates
- PSC will maintain oversight of initiatives and steering of project
- Patient Satisfaction Committee (PSC) continues to meet quarterly and has expanded to include frontline staff in their membership
- Increased involvement of Physicians as Leaders in the process
- Communication Boards updated directly by Department Managers
- Continued emphasis on a Patient-Centered Program

## ALL PATIENT EXPERIENCE TRAINING MODULES HAVE BEEN COMPLETED

- All modules of training have been completed and will be reviewed on an ongoing basis
- Key Take-A-Ways will be used to reinforce learning at the front line
- Training included in annual nursing competencies

## UNIT BASED PERFORMANCE IMPROVEMENT TEAMS

- All teams have selected initiatives to impact overall facility goals to improve communication and teamwork
- Team facilitators/managers continue to provide presentations of selected initiatives to identified committees to demonstrate best practices and to capture tracking and trending

## EMPLOYEE RECOGNITION PROGRAM

- The employee recognition program will continue with nominations on a quarterly basis
- Winner's photo will be posted in the main entrance for viewing and recognition

**WEST CONTRA COSTA HEALTHCARE DISTRICT**

**RESOLUTION NO. 2013-07**

**RESOLUTION EMPLOYEE RECOGNITION**

WHEREAS, Sharri Steiert has demonstrated commitment to the mission, vision and values of Doctors Medical Center;

WHEREAS, Sharri Steiert has dedicated her career to Doctors Medical Center, our patients, and the surrounding community;

WHEREAS, Sharri Steiert has voluntarily participated in community outreach and educational programs on behalf of Doctors Medical Center, promoting community health education and disease prevention;

WHEREAS, Sharri Steiert has shown outstanding leadership in problem solving positively impacting her department and patient satisfaction;

WHEREAS, Sharri Steiert has contributed to the learning and growth of her department through leadership and exemplification of professional service behaviors;

WHEREAS, Sharri Steiert has been voted Employee of the 2nd Quarter through nomination by peers who value her work and contribution to Doctors Medical Center and;

NOW, THEREFORE, BE IT RESOLVED that the West Contra Costa Healthcare District Board of Directors Governing Body recognizes and thanks Sharri Steiert for her dedication to the community, this hospital and the many patients we serve.

**PASSED AND ADOPTED** by the Governing Body Board of Directors of the West Contra Costa Healthcare District on this 23rd day of October, 2013, by the following vote:

AYES:

NO:

ABSTAIN:

_____

Eric Zell, Chair of Board of Directors

_____

Nancy Casazza, Secretary of Board of Directors

DOCTORS MEDICAL CENTER

# Approval of Substance Abuse Policy

**TAB 8**

# APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

**All items marked with † must be completed, and or required routing**

| | |
|---|---|
| †**TITLE: SUBSTANCE ABUSE** | †**CHECK ONE:** ☐ **New** ☒ **Reviewed** ☒ **Revised :** ☒ **Major** ☐ **Minor** |
| † ☐ **Administrative** ☐ **Clinical** ☒ **Department** **HUMAN RESOURCE** | |
| †**SUBMITTED BY**: BOB REDLO | |
| †**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other | |
| †**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES**: The title formally known as Drug and Alcohol was changed to Substance Abuse. Instructions on the process to be followed in the event of reasonable suspicion were added to revised policy, as well as who to contact in the event a employee is suspected of substance abuse. This information can be found on the new Attachment D. | |

| | MEETING DATE | APPROVAL |
|---|---|---|
| ☒ **Manager or Department Director**† | 9/24/13 | |
| ☐ **Medical Staff Department(s):** | | |
| ☐ Cancer Committee ☐ CV Surgery Committee | | |
| ☐ Infection Control Committee ☐ IDP Committee | | |
| ☐ Medical Ethics Committee ☐ Patient Safety Committee | | |
| ☐ Radiation Safety Committee ☐ P&T Committee | | |
| ☐ Respiratory/Critical Care/ED Committee | | |
| ☐ Quality Improvement Team: ☐ EM Committee | | |
| ☐ EOC/Safety Committee ☐ Other: | | |
| ☐ **Nursing Department:** ☐ Nursing Practice: | | |
| ☐ **Forms Committee** (as applicable) | | |
| ☐ **Administrative Policy Review Committee (APRC)**† | | |
| ☒ **Executive Leadership** | 10/1/2013 | |
| ☐ **Medical Executive Committee (MEC)** (as applicable) | | |
| ☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)* | | |

**DOCTORS MEDICAL CENTER**

| | |
|---|---|
| **Manual: HOSPITAL WIDE** | **Sub Folder: HUMAN RESOURCES** |
| **Title: Substance Abuse Policy** | **Reviewed: Revised: John Hardy, Human Resource Vice President** |
| **Effective Date: July 30, 2013** | **Page 1 of 16** |

## PURPOSE:

This policy establishes Doctors Medical Center's ("DMC's" or the "Hospital's") commitment to providing a healthy and safe working environment for its employees and patients free from employees under the influence of alcohol and/or a controlled substance. It is DMC's intent to provide a drug and alcohol free, healthy and safe workplace. Substance abuse in the workplace can also cause a number of other work-related problems, including absenteeism and tardiness, substandard job performance, increased workloads for co-workers, behavior that disrupts other employees, and threats to patient safety.

To further its interest in avoiding accidents and to promote and maintain safety, employees are required to report for work in appropriate mental and physical condition to enable them to perform their jobs in a safe and satisfactory manner.

## POLICY:

It is the policy of Doctors Medical Center to maintain a safe, healthy, and efficient work environment free of alcohol and substance abuse for its employees, customers, and visitors. The hospital takes immediate corrective action to protect its employees, customers and the public when an individual employed by the hospital is known to be impaired.

A. It is a violation of hospital policy for an employee to:

1. Use, possess, distribute, sell, or be under the influence of illegal substances.
2. Engage in the unlawful distribution, manufacture, dispensing, possession or use of illegal drugs.

The prohibitions of this section apply whenever the interests of the Hospital may be adversely affected, including any time an employee is:

1. On Hospital premises;
2. Conducting or performing Hospital business, regardless of location.
3. Operating or responsible for the operation, custody, or care of Hospital equipment or other property; or
4. Responsible for the safety of others in connection with, or while performing, Hospital-related business.

B. The legal use of prescribed drugs is permitted on the job only if: (1) the prescribed drugs are utilized for the purpose for which they were prescribed or manufactured; (2) in a quantity, frequency and manner in which they were prescribed; and (3) if they do not impair an employee's ability to perform the essential functions of the job effectively and in a safe manner, and/or do not endanger other individuals in the workplace.

C. Employees must report to the Employee Health Nurse any prescription medication that could prevent or impair their ability to perform their duties in a safe manner, prior to reporting to work while taking such medication. If it is determined that the medication may endanger the employee or someone else, pose a risk of significant damage to Hospital property or substantially interfere with the employee's job performance, the employee may not be permitted to report to work. The Hospital will reasonably accommodate qualified disabled employees who must take legal drugs because of their disability.

D. Failure of an employee to comply with this policy or consent to "for cause" and/or pre-placement testing may result in termination of employment or withdrawal of an employment offer. Any attempt to adulterate, dilute, or substitute a test specimen and/or a failure to provide an adequate test specimen absent a valid medical explanation will be considered a "refusal-to-test."

E. This Policy is not intended to regulate off-the-job conduct so long as the employee's off-the-job use of alcohol or drugs does not result in the employee being under the influence of or impaired by the use of alcohol or drugs in violation of this Policy.

**DEFINITIONS:**

A. "Legal Drug" includes prescribed drugs and over-the-counter drugs, which have been legally obtained and are being used for the purpose for which they are prescribed or manufactured.

B. "Illegal Substance" means any drug which is not legally obtainable, or which is legally obtainable, but has not been legally obtained. In addition, the term refers to a drug or substance that has been legally obtained but is being sold or distributed unlawfully. The term includes prescribed drugs not legally obtained and prescribed drugs not being used for prescribed purposes.

C. "Reasonable Suspicion" includes a suspicion that is based on specific personal observations such as an employee's manner, disposition, muscular movement, appearance, behavior, speech or breath odor; information provided to management by an employee, by law enforcement officials, by a security service or by other persons believed to be reliable; or a suspicion that is reasonably based on other surrounding circumstances, including, but not limited to, sudden changes

in the employee's work performance, excessive absenteeism or tardiness, or exhibition of additional evidence of substance abuse.

D. An employee is "Under the Influence" of an illegal substance, alcohol, or legal substance that interferes with an employee's ability to perform their duties, if any measurable amount of a substance, or a metabolite of that substance, is detected in the employee's circulatory system through a blood analysis, urine screen, or saliva test, or breath.

**GENERAL:**

DMC employees have the responsibility to report any unusual or suspicious employee behavior to their immediate supervisor. Employees who observe unusual behavior should in no way try to approach or otherwise have contact with the suspected employee. Behavior should be immediately reported in a confidential manner to the nearest manager/supervisor. Managers/Supervisors also have the responsibility to be on the lookout for workplace substance abuse and to address such concerns where suspected behavior is observed. All steps will be taken to protect workers' privacy and confidentiality rights.

Reasonable suspicion is determined by supervisors/designated staff that has been trained to utilize guidelines in the recognition of symptoms and behavior indicating drug and alcohol use. Any reported behavior is to first be evaluated by trained individuals before action is determined. Symptoms such as behavior, appearance, speech, or breath odor will be evaluated objectively to determine whether intervention is necessary.

In the event an accident has occurred, and the life of the employee may be in question, or a serious injury has resulted, the employee will be sent to DMC Emergency Department (ED). In such circumstances, a determination of reasonable suspicion of substance abuse may be appropriate and the supervisor/manager can refer the employee for immediate testing and/or treatment in the ED.

In cases when there is reasonable suspicion an employee has participated in the unauthorized use or possession of, or is under the influence of, drugs and/or alcohol, the following procedure is to be implemented:

A. Doctors Medical Center will make every effort to protect the confidentiality of drug test results. In particular, any test results will be treated confidentially to the maximum extent possible and will not be revealed to managers or supervisors unless there is a strict work-related reason to do so.

B. Non-Compliance with a manager's direction to submit to a medical screening, disclose and/or explain the nature of any suspicious substance, or to leave (or remain in) a work area or the hospital for reasons related to the purposes of this policy will be viewed as insubordination and is subject to appropriate disciplinary action.

C. Employees, who voluntarily self-disclose and request assistance, or a leave for treatment of alcohol and/or drug dependency prior to a request for a drug test, may be granted leave at the discretion of Doctors Medical Center.

   Employees who are provided leave to voluntarily enroll in an alcohol and/or drug dependency program must:

   1. Show proof of successful completion of the treatment or rehabilitation program prior to return to work; and

   2. Comply with post-rehabilitation testing protocol (which may include random testing) and may last up to 12 months.

D. Pursuant to this policy, employees and job applicants will be asked to provide body substance samples including but not necessarily limited to blood, breath, urine, hair and/or saliva, to test for the use of drugs and/or alcohol in violation of this policy.

E. Employees, their possessions, and DMC issued equipment, containers under employee control are subject to search, and surveillance at all times while on DMC premises or while conducting DMC business.

F. Violation of this policy may lead to corrective action, up to and including immediate termination of employment.

G. All test results will be reviewed by the Medical Review Officer at the lab performing the test, to ensure that any positive test results were not caused by legitimate use of prescription medication.

H. Test results will not be revealed to outside agencies except where required by law. DMC does report positive "for cause" results, to all licensing agencies subject to mandatory reporting.

## TESTING REQUIREMENTS

1. Pre-employment testing- As a pre-qualification to assuming any position, employees to whom a contingent offer of employment have been made will be required to provide a body substance sample for drug testing as part of a pre-employment physical examination. In the event of a confirmed positive test result, the applicant will not be considered further for employment.

2. Post-Accident Testing- Any current employee who is involved in a serious accident while on duty, whether on or off the employer's premises, may be asked to provide a body substance sample.

3. Reasonable Suspicion Testing - Such testing may be required if significant and observable changes in employee performance, appearance, behavior, speech, etc. provide reasonable suspicion of being under the influence of drugs and/or alcohol, or otherwise call into question the employee's ability to safely perform the essential functions of his or her position.

4. Random Testing - An employee who tests positive and who successfully completes a rehabilitation program will be subject to unscheduled testing for a 12-month period following reinstatement.

**TESTING PROCEDURE:**

Testing of Applicants:

As part of the Hospital's employment screening process, any applicant to whom a contingent offer of employment is made must pass a test for controlled substances. Initial or continued employment is conditioned on a negative test result.

Testing of Employees:

The following procedure will apply to employees who are reasonably suspected of being under the influence of drugs or alcohol while on duty and/or who are involved in a serious accident while on duty.

1. Inform the employee of the policy

2. Relieve the employee of duty

3. Remove and Interview:

A. The employee should leave the work floor immediately escorted by Manager/Supervisor to Employee Health/Human Resources (EH/HR). If EH/HR is closed remove the employee from the work area to a private space. Security may be called if desired by the Manager/Supervisor.

B. With a representative, inform the employee of what was observed and why the possibility of being under the influence is being questioned.

C. DO NOT accuse the employee of being "drunk" or "on drugs" or make any similar accusations.

D. Allow the employee an opportunity to tell their side of the story.

E. If the employee's story does not rationally explain what has been observed, or if the employee still does not appear able to work, inform the employee that DMC is concerned about whether they can properly/safely perform their assigned duties.

I. Observe and Document:

A. Complete the Manager's Evaluation Report Form (ATTACHMENT A) and Observation Checklist (ATTACHMENT B).

B. Review the facts of the situation with Human Resources, Employee Health or designee and determine if the employee should be examined by the Employee Health Physician/Nurse and/or tested for drugs or alcohol.

C. Consult with Employee Health to determine if prescribed drug use claimed by an employee may be affecting an employee's ability to work safely and properly.

II. Confirm Assessment:

A. Obtain the assistance of Human Resources, Employee Health or, if not operational, another supervisor, security officer or manager to review the completed Manager' Evaluation Report Form and Observation Checklist and to assist with the assessment. Assessment should focus on whether to request Drug and/or Alcohol Test. Call Security if a Drug and/or Alcohol Test are indicated.

B. Do not discuss the employee's condition or your suspicions with anyone other than Human Resources, Employee Health, Administration, or, if not operational, another manager or supervisor. Notify the Administrator on call.

III. Ask to Submit to Drug and/or Alcohol Test:

A. If you have a reasonable suspicion that the employee is working in an impaired condition or otherwise engaging in conduct that violates this policy, the employee should be asked to submit drug and/or alcohol test.

B. Inform the employee of the reasons they are being asked to submit to testing.

C. Inform the employee that refusal violates the DMC Alcohol and Substance Abuse Policy and is grounds for disciplinary action, up to and including termination of employment.

IV. Refusal to Consent:

A. If the employee refuses to undergo testing, ask the employee to sign the Refusal to Submit to Testing Form (ATTACHMENT C).

B. If the employee refuses to sign the Refusal to Submit to Testing Form, write across the bottom of the form that the employee refuses to sign.

C. Have the Refusal to Submit to Testing Form witnessed by you and the person assisting with the assessment. Give copy to employee. Send duplicate to EH/HR in sealed envelope.

D. Inform the employee that they are being placed on an immediate administrative leave pending completion of the investigation.

E. Retrieve the employee badge, keys, pager, and other company property.

F. Do not allow the employee to return to the worksite. Call Security if not done so already.

G. Arrange for transportation home through family members, friends or, if this is not possible, a taxi.

H. Remain with the employee at all times until they leave with the appropriate transportation.

I. Do not allow the employee to drive. In the event that they refuse transportation and insist on operating their vehicle, inform them that the local police will be notified of their decision.

If an employee refuses to cooperate with the administration of a drug and/or alcohol test, the refusal may be handled in the same manner as a positive test result.

V. Consents to Testing:

A. If the employee consents to a drug and/or alcohol test, Employee Health and/or its designee will contact the testing facility and advise them that an employee will be tested for drugs and/or alcohol. (ATTACHMENT D).

B. The involved Manager/Supervisor and/or EH/HR (if present) is responsible for the testing and documentation thereof. Security will accompany the employee to the testing area. Employee is to be escorted at all times by Security.

C. After the testing process is completed, the supervisor will:

1. Inform the employee that they are being placed on immediate administrative leave pending completion of the investigation.

2. Retrieve the employee badge, keys, pager, and other company property.

3. Arrange for transportation home through family members, friends or, if this is not possible, a taxi.

4. Do not allow the employee to drive or return to the worksite.

5. In the event that the employee refuses transportation and insists on operating their vehicle, inform them that the local police will be notified of their decision.

6. Remain with the employee at all times until they leave with the appropriate transportation.

D. All positive drug findings must be confirmed by a NIDA approved laboratory. The Hospital will receive only a pass or fail report from the medical clinic or laboratory. The employee will remain on administrative leave until it is determined whether or not the employee can return to work. Laboratory reports shall be made available to the employee upon request.

E. After consulting with EH/HR, the involved Manager/Supervisor is responsible for communicating to the employee Return to Work (RTW) instructions, if any. Employees must report to EH/HR before reporting to their work station/floor.

F. Test results will be retained in a separate file in EH.

**Consequences of a Positive Drug Test**

DMC prefers to avoid severe penalties by preventing workplace substance abuse in the first place and by responding comprehensively as soon as a problem is identified.

Before corrective action is imposed, employees will be given the opportunity to explain positive test results.

- An employee's statement regarding drug or alcohol use should, whenever practical, be documented prior to initial testing.

- DMC's Employee Assistance Program or "EAP" provides confidential counseling and referral services to employees. Examples of informal resources also available include Alcoholics or Narcotics Anonymous. The first time an employee tests positive for drugs and/or alcohol, at DMC's sole discretion, he/she may be referred to EAP and given additional informal resource information. If an employee is given an opportunity to participate in a rehabilitation program in lieu of discipline, any such employee will be required to provide proof of successful completion of the alcohol abuse or drug rehabilitation program.

- An employee's participation in DMC's EAP will not necessarily affect appropriate corrective action for a violation of company policy, performance that is below DMC expectations, misconduct, safety violations or other infractions.

- An employee who has been allowed to return to work after testing confirmed positive normally will be discharged immediately for a confirmed positive result on any subsequent alcohol or drug test.

- An employee who tests positive and who successfully completes rehabilitation will be subject to unscheduled testing for a 12-month period following reinstatement.

Employees with drug and/or alcohol problems that have not resulted in corrective action may request approval to take unpaid time off to participate in a rehabilitation or treatment program. Such unpaid leave may be granted if the employee agrees to abstain from the use of the problem substance(s), abides by all DMC policies, rules, and prohibitions relating to conduct in the workplace, and if granting the leave will not cause facility any undue hardship.

**PROCEDURAL STEPS FOR NEGATIVE TEST RESULTS**

If the test is negative for drugs or alcohol, the employee will return to their workstation with Manager/Supervisor or HR Designee. The employee will normally be paid for all lost time, if applicable, including any missed overtime and other benefits.

**PROCEDURAL STEPS FOR TESTING DUE TO POSSESSION OF PHYSICAL EVIDENCE**

Testing may also be required if an employee is found to be in possession of physical evidence, i.e., drugs, alcohol or paraphernalia possibly connected with the use of an illicit drug. Testing may also be required if illicit drugs and/or alcohol are found in the employee's immediate work area. However, it should be emphasized that possession of drugs and /or alcohol is prohibited whether or not it is determined the employee used such substances.

**DETERMINATION STEPS**

All substance abuse incidents will be reviewed individually. Prior to any employee being requested to consent to drug and/or alcohol testing, THE ADMINISTRATOR ON DUTY MUST BE NOTIFIED. Administration will also make the final decision regarding accommodation requests and discipline pending input from the Department Director/Designee and the Vice President of Human Resources, if deemed necessary.

## CONVICTION

DMC employees convicted of any criminal drug statute are required to notify their supervisor in writing within five (5) calendar days of the conviction. Any individual so convicted or who fails to report the conviction may be subject to disciplinary action up to and including termination and/or be required to enroll in and successfully complete an approved treatment program.

The employee and/or DMC will make notification to the appropriate state board of licensing and diversion board for any licensed medical professional when a drug/alcohol dependency has been determined.

## REHABILITATION

Rehabilitation may be offered to an employee on a one-time basis only. An employee who enters rehabilitation may be granted a leave of absence provided that it does not result in an undue hardship to the Hospital. Sick time will be integrated with State Disability Insurance, if available. An employee may return to work after successful completion of a Doctors Medical Center approved rehabilitation program.

Disclosures made by employees to DMC management concerning their participation in any drug or alcohol rehabilitation program will be treated confidentially.

## AUTHORIZATION TO OBTAIN MEDICAL INFORMATION AND TO SUBMIT TO DRUG AND/OR ALCOHOL TESTING (APPLICANT)

I understand that I have been offered a position contingent on the results of a drug or alcohol screen (or both). I have received a copy of the Hospital's drug and alcohol policy. I authorize the drug and alcohol screen, and the release of the results to the Hospital with the following understanding and agreement:

- The testing and release of medical information relating to the testing is voluntary. I may refuse to submit to testing or the release of information. I may revoke this authorization by written notice. A refusal or revocation may be considered a voluntary withdrawal of my employment application.

- The drug and alcohol screen will be paid for by the Hospital and administered by a physician, medical clinic, or laboratory selected by the Hospital.

- The drug and alcohol screen may require samples of urine and blood.

- The results of the drug and alcohol screen will be released to the Hospital and considered by the Hospital in determining whether to hire me.

- To the extent that I wish to dispute or explain the test results, I will contact the Hospital for that purpose.

- If the Hospital retains a copy of the test or examination results, the copy will be maintained separately from any personnel file and will be treated as confidential medical information.

- This authorization shall remain valid for 6 months or for the duration of my employment with Doctors Medical Center, whichever is longer.

- I am entitled to receive a copy of this Authorization and the results of any tests and medical information released to the Hospital.

With full knowledge of the foregoing, and of my own free will and accord, I hereby voluntarily AGREE to submit to drug and alcohol testing and to release the test information to the Hospital. I release the Hospital (including predecessors, successors, subsidiaries, past and present officers, directors, agents, servants, employees, and assigns) from any and all claims, responsibilities, and matters related to my submission to drug testing and the release of medical information that might arise, grow out of, or be incident to such testing.

Date: _____ Signature: _____

Printed Name: _____

## AUTHORIZATION TO OBTAIN MEDICAL INFORMATION AND TO SUBMIT TO DRUG AND/OR ALCOHOL TESTING (EMPLOYEE)

I understand that I have been involved in a serious accident in the workplace and/or that the Hospital has reasonable suspicion that I may be consuming drugs and/or alcohol, which is impairing my ability to do my job. I understand that I am being asked to submit to a drug and/or alcohol screen. I have received a copy of the Hospital's drug and alcohol policy. I authorize the drug and alcohol screen, and the release of the results to the Hospital with the following understanding and agreement:

- The testing and release of medical information relating to the testing is voluntary. I may refuse to submit to testing or the release of information. I may revoke this authorization by written notice. A refusal or revocation may be considered a voluntary withdrawal and may be considered in any corrective action taken by the Hospital concerning me or my employment at Doctors Medical Center.

- The drug and alcohol screen will be paid for by the Hospital and administered by a physician, medical clinic, or laboratory selected by the Hospital.

- The drug and alcohol screen may require samples of urine and blood.

- The results of the drug and alcohol screen will be released to the Hospital and considered by the Hospital in determining whether to continue to employ me and/or whether to take corrective action in relation to my employment at Doctors Medical Center.

- To the extent that I wish to dispute or explain the test results, I will contact the Hospital for that purpose.

- If the Hospital retains a copy of the test or examination results, the copy will be maintained separately from any personnel file and will be treated as confidential medical information.

- This authorization shall remain valid for 6 months or for the duration of my employment with Doctors Medical Center, whichever is longer.

- I am entitled to receive a copy of this Authorization and the results of any tests and medical information released to the Hospital.

With full knowledge of the foregoing, and of my own free will and accord, I hereby voluntarily AGREE to submit to drug and alcohol testing and to release the test information to the Hospital. I release the Hospital (including predecessors, successors, subsidiaries, past and present officers, directors, agents, servants, employees, and assigns) from any and all claims, responsibilities, and matters related to my submission to drug testing and the release of medical information that might arise, grow out of, or be incident to such testing.

Date: _____ Signature: _____

Printed Name: _____

## Attachment A

## Manager's Evaluation Report Form

**Directions**: Check pertinent items based on your visual observation of the employee. This should be done with the assistance of Human Resources, Employee Health or, another supervisor / manager. This section must be completed regardless of the outcome of the interview conducted.

| | |
|---|---|
| 1. Walking | __Normal __Stumbling __Staggering __Falling<br>__Swaying __Unsteady __Holding On |
| 2. Standing | __Normal __Stumbling __Staggering __Falling<br>__Swaying __unsteady __Holding On |
| 3. Speech | __Normal __Shouting __Silent __Whispering<br>__Slow __Rambling/Incoherent __Slurred _Slobbering |
| 4. Demeanor | __Normal __Sleepy __Crying __Silent _Talkative<br>__Excited __Fighting |
| 5. Personal Conduct | __Normal __Resisting Communication __Fighting __Threatening<br>__Drowsy __Hostile __Profanity __Hyperactive __Erratic |
| 6. Eyes | __Normal __Bloodshot __Watery __Dilated Pupils __Glassy<br>__Droopy __Pinpoint Pupils |
| 7. Face | __Normal __Flushed __Pale __Sweaty |
| 8. Appearance Clothing | __Normal __Unruly __Messy __Dirty<br>__Partially Dressed __Bodily Excrement Stains<br>__Stains on Clothing |
| 9. Breath | __Normal __Alcoholic Odor<br>__No alcoholic odor |
| 10. Movements | __Normal __Fumbling __Jerky __Slow __Nervous<br>__Hyperactive |
| 11. Eating/Chewing | __Gum __Candy __Mints<br>__Other (Identify) _____ |
| 12. Other observations:<br>_____<br>_____<br>_____ | |

***Attachment B***

**Observation Checklist**

***Questions for Suspected Substance Abuse***

With another supervisor present, please ask the employee who is suspected of substance abuse the following questions in the order listed. **Please refer to Substance Abuse Policy for list of necessary steps to follow.**

1. Are you feeling ill? __Yes __No
   If yes, what are your symptoms? _____
   _____

2. Do you have a cold? __Yes __No

   If yes, are you taking any medicine for the cold?
   Comments: _____
   _____

3. Are you using any type of non-prescribed (over the counter) drug?
   __Yes __No

   If yes, what kind of drug? _____
   Comments: _____
   _____

4. Did you drink alcohol or an alcoholic beverage during or prior to work?
   __Yes __No

   If yes, what did you drink? _____
   Comments (When? Where? With Whom? How Much?):

   _____
   _____

5. Any other information you would like to provide.
   _____
   _____

**Attachment C**

**Refusal to Submit to Drug and/or Alcohol Screen**
**By Breath Blood and/or Urine Test**

I hereby refuse to authorize any testing for alcohol or drugs. I understand that my refusal means that I cannot complete a medical exam and such refusal will require a review of the facts by management, which may necessitate discipline, up to and including termination.

_____ _____

Signature of Employee Witness

_____

Date

Employee was offered transportation home:

_____Accepted

_____Rejected

## Attachment D

When an employee consents to drug testing the Employee Health Nurse and/or its designee will contact USA Mobile Drug Testing to dispatch a mobile unit to DMC to administer drug test. Our contact person is listed below.

**Kevin Wiedeman**
Owner
USA Mobile Drug Testing of the East Bay
**925-336-1397**

kwiedeman@usamdt.com
http://www.usamdt.com/eastbay

DOCTORS MEDICAL CENTER

# MEDICAL EXECUTIVE REPORT

## TAB 10

# MEDICAL EXECUTIVE COMMITTEE
# REPORT TO THE BOARD

**MEC DATE:** October 14, 2013

**BOARD DATE**: October 23, 2013

| TOPIC | Comment (S) |
|---|---|
| Kathy White, Interim COO provided the following report:<br>• Susan Komen Walk was a success. DMC had a group of 50 people who participated in the walk.<br>• The DMC Employee Recognition Committee selected the Second Employee of the Quarter. | No action required by the Board |
| Laurel Hodgson, Chief of Staff:<br>• Bylaws Amendments were approved with a majority of the returned affirmative ballots received.<br>• Dr. Drager presented the results and answered questions regarding mean, percentages vs. percentile, and trends on physician satisfaction scores. | Approval<br>No action required by the Board |
| Policy, Procedures, Forms:<br>• Pronouncements of Death by RN Policy<br>• CVAD Flush and Maintenance Table | Approval<br>Approval |
| Credentials Committee<br>• Credentials Report: September 2013 | Approval |

# APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

**All items marked with † must be completed, and or required routing**

| | |
|---|---|
| †**TITLE: Bylaws Amendments** | †**CHECK ONE:** ☐ **New** ☐ **Reviewed** ☒ **Revised :** ☒ **Major** ☐ **Minor** |
| † ☐ **Administrative** ☐ **Clinical** ☐ **Department** MEDICAL STAFF | |
| †**SUBMITTED BY:** | |
| †**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☒ New Regulation: CMS CDPH (TJC) Other | |
| †**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** | |

| | MEETING DATE | APPROVAL |
|---|---|---|
| ☐ **Manager or Department Director**† | | |
| ☐ **Medical Staff Department(s):** | | |
| ☐ Cancer Committee ☐ CV Surgery Committee | | |
| ☐ Infection Control Committee ☐ IDP Committee | | |
| ☐ Medical Ethics Committee ☐ Patient Safety Committee | | |
| ☐ Radiation Safety Committee ☐ P&T Committee | | |
| ☐ Respiratory/Critical Care/ED Committee | | |
| ☐ Quality Improvement Team: ☐ EM Committee | | |
| ☐ EOC/Safety Committee ☐ Other: **BYLAWS COM.** | **05/29/2013** | |
| ☐ **Nursing Department:** ☐ Nursing Practice: | | |
| ☐ **Forms Committee** (as applicable) | | |
| ☐ **Administrative Policy Review Committee (APRC)**† | | |
| ☐ **Executive Leadership** | | |
| ☐ **Medical Executive Committee (MEC)** (as applicable) | **10/14/2013** | **10/14/2013** |
| ☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)* | **10/23/2013** | **10/23/2013** |

**BYLAWS EXECUTIVE SUMMARY**
**DOCTORS MEDICAL CENTER, San Pablo, CA**

| Article/Section # | Article/Section Title | Page # |
|---|---|---|
| 1.2 | Purpose<br>*Eliminate language that could create liability. Joint Commission and California Business and Professions Code language regarding roles of medical staff and governing board.* | 4 |
| 2.5n | Under Section 2.5 - Basic Responsibilities of Medical Staff Membership<br>*Notification to medical staff from member of significant adverse events to be reviewed by medical staff to help limit negligent credentialing claims.* | 7 |
| 3.1 thru 3.1-12 | Categories of Membership<br>• moved from R&Rs<br>*Joint Commission requirement.* | 10 – 15 |
| 4.5-1 | Under Section 4.5 – Application for Initial Appointment and Reappointment<br>*Joint Commission* | 16 – 17 |
| 4.8-1 thru 4.8-7 | Under Section 4.8 – Processing the Application for Initial Appointment and Renewal<br>• moved from R&Rs<br>*Avoid duplication and inconsistency between bylaws and rules* | 19 - 22 |
| 4.13-2 | Termination of Leave<br>*Documentation confirms process* | 24 |
| 5.2-4 | Criteria for "cross-Specialty" Privileges within the Hospital<br>*Create process for controversial/cross-department situations.* | 25 |
| 5.2-5 | History and Physical Privileges<br>*CMS and Joint Commission.* | 26 |
| 5.4-1 | Admissions<br>*California law and regulation regarding scope of practice and prohibitions on discrimination and Joint Commission* | 27 |
| 5.5 | Telemedicine Privileges<br>*CMS, Joint Commission and California law and regulation* | 27 |
| 5.6 | Temporary Privileges (5.6-1 thru 5.6-3)<br>*Joint Commission* | 28-30 |
| 5.8 | Disaster Privileges<br>*Joint Commission* | 30-31 |
| 5.10 | Automatic Withdrawal of Application<br>*Document process to address situation without triggering hearing.* | 32 |
| 6.2-5 | MEC Action<br>*Remove language that may undermine medical staff* | 34 |

| Article/Section # | Article/Section Title | Page # |
|---|---|---|
| 7.9 | Expungement of Disciplinary Action<br>*Establish requirements to assure medical staff not undermined by premature expungement.* | 54 |
| 8.1-5 | Term of Elected Office<br>*Allow for possibility of a second year of office* | 56 |
| 9.6-2 | Selection<br>*Establish process to resolve controversial situation.* | 61 |
| 9.6-5 | Duties<br>*Joint Commission* | 61 |
| 11.3 | Special Meetings<br>*Deleted language that contrary to theory of medical staff self-governance.* | 68 |
| 11.4-2 | Notice of Meetings<br>*Create a feasible standard to enable MEC to timely convene when necessary.* | 69 |
| 11.6 | Mandatory Attendance Requirement<br>*Create an effective process to address situation that not trigger hearings.* | 70 |
| 11.9 | Manner of Action<br>Create a flexible process to facilitate conducting meetings. | 71 |
| 13.1 | Rules & Regulations<br>*Joint Commission* | 76 |
| 13.2 | Policies<br>*Create feasible option to establish processes and standards consistent with Bylaws and Rules.* | 76 |
| 13.3 | Active Staff Petition to Medical Executive Committee<br>*Joint Commission* | 76 |
| 13.4 | Notice of Amendments to Rules & Regulations<br>*Joint Commission* | 77 |
| 13.13-1 | Insertion of Adverse Information<br>*Clarify existing processes and eliminate potential inconsistent provisions.* | 78 |
| 13.13-2 | Review of Adverse Information at the time of Reappraisal and Reappointment<br>*Create a feasible process consistent with actual processes that not undermine medical staff.* | 78-79 |
| 13.13-3 | Confidentiality<br>*Create a feasible process consistent with actual processes that not undermine or unduly burden medical staff.* | 79-80 |
| 14.1-1 | Initiation of Bylaws Amendments – Procedure<br>*Joint Commission* | 81 |

DOCTORS
MEDICAL CENTER

*2000 Vale Road*
*San Pablo, CA 94806*
*Tel. 510-970-5000*

# DOCTORS MEDICAL CENTER MEDICAL STAFF

## BYLAWS

**October 22, 2013**

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## BYLAWS

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## PROSCRIPTION

These Bylaws will become effective upon ratification by the Medical Staff and approval by the Governing Body.

# BYLAWS OF THE MEDICAL STAFF OF DOCTORS MEDICAL CENTER

## PREAMBLE

These bylaws are adopted in order to provide for the organization of the Medical Staff of Doctors Medical Center and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. 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. Therefore, the physicians, dentists, and podiatrists in this hospital hereby organize themselves into a Medical Staff in conformity with these bylaws.

## DEFINITIONS

1. ALLIED HEALTH PROFESSIONALS (AHP) - 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 Board, 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 rules adopted by the Governing Body, these Bylaws, and the Rules and Regulations. AHP's are not eligible for Medical Staff membership. Examples of AHP include:

   Nurse Practitioner,
   Physician Assistant,
   C.R.N.A. (Certified Nurse Anesthetist), and
   Psychologist.

2. APPLICANT: Any physician, dentist, or podiatrist who has applied for membership on the Medical Staff of Doctors Medical Center.

3. ATTENDING: The admitting physician, dentist, or podiatrist until a patient's care has been transferred to and accepted by another physician, dentist, or podiatrist and upon such transfer and acceptance, the subsequent physician, dentist, or podiatrist shall be deemed the attending.

4. AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE: The individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

5. CHIEF EXECUTIVE OFFICER (CEO): The individual appointed by the Governing Body to serve in an administrative capacity in overall management of the hospital.

6. GOVERNING BODY/BODY: The Governing Body of the hospital.

7. CHIEF OF STAFF: The chief officer of the Medical Staff elected by members of the Medical Staff.

8. DENTIST: An individual who holds a valid Dentist license issued by the State of California.

9. DOCTOR: An appropriately licensed physician, dentist, or podiatrist.

10. ELECTRONIC MEDICAL RECORD (EMR): System in place to document patient care and/or treatment.

11. EX OFFICIO: Serves as a member of any committee identified in these bylaws by virtue of an office or position held and, unless otherwise expressly provided, means without voting rights.

12. HOSPITAL: Doctors Medical Center, San Pablo.

13. IN GOOD STANDING: In good standing means a member is currently not under suspension ~~or,~~ serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations or policy of the medical staff, and not subject to a pending Medical Staff recommendation or action which is cause for requesting a Medical Staff hearing.

14. INVESTIGATION: A process specifically instigated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff. An investigation is ongoing until either formal action is taken or the investigation is closed. An investigation does not include activity of the Physician Well-Being Committee.

15. LIMITED LICENSE PRACTITIONERS: Dentists and podiatrist.

16. MAIL: includes U.S. mail service, U.S. mail by certified return receipt requested, hand delivery via courier service with signed receipt, hand delivery, hand delivery with written confirmation from the person making delivery, courier service, courier service with confirmation of delivery. Mail shall be deemed delivered regardless of whether the practitioner of the office personnel accept or refuse to accept it. Refusal to accept delivery by the practitioner or office personnel shall be considered equivalent to the delivery and receipt. Mail also is deemed to include electronic mail and/or facsimile, which will be deemed received upon transmission.

17. MEDICAL DISCIPLINARY CAUSE OR REASON (MDCR): Disciplinary action taken based upon an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care (California Business and Professions Code Section 805).

18. MEDICAL EXECUTIVE COMMITTEE: The Executive Committee of the Medical Staff which shall constitute the governing body of the Medical Staff as described in these bylaws. This committee represents the Medical Staff in matters with these bylaws that require Medical Staff approval.

19. MEDICAL RECORD: Patient's record of care and/or treatment via EMR or hard copy.

20. MEDICAL STAFF or STAFF: Those physicians, dentists, and podiatrists, who have been granted recognition as members of the Medical Staff pursuant to the terms of these bylaws.

21. MEDICAL STAFF YEAR: For the purpose of these bylaws, the Medical Staff year commences on the first day of January and ends on the 31st day of December each year.

22. MEMBER: A physician, dentist, or podiatrist who has applied for and has been granted membership on the Medical Staff of Doctors Medical Center in any staff category.

23. MONITORING: The observation of medical procedures, concurrent review of patient care and management, and/or retrospective chart review.

24. ORAL SURGEON: Dentist with specialized training in oral surgery.

25. PHYSICIAN: An individual with an M.D. or D.O. degree or their equivalent. "Their equivalent" shall mean any degree (i.e., foreign) recognized by the licensing boards in the State of California to practice medicine.

26. PODIATRIST: Individual with D.P.M. degree or equivalent.

27. PRACTITIONER: Unless otherwise expressly limited any physician, dentist, or podiatrist applying for, or exercising privileges in the Hospital.

28. PREROGATIVE: A participatory right granted, by virtue of staff category or otherwise, to a Medical Staff member and exercisable subject to the conditions set forth in these bylaws.

29. PRIVILEGES: The permission granted to Medical Staff members or AHP to provide specific patient.

30. PROCTORING: The process of monitoring the performance of Medical Staff members.

31. PSYCHOLOGIST: An individual who holds a valid Psychologist license issued by the State of California.

32. TELEMEDICINE: Telemedicine involves the use of electronic communication or other communication technologies to provide or support clinical care to patients located at an originating distant site by a practitioner at a distant site.

33. TELEMEDICINE PRACTITIONER: Any licensed and appropriately credentialed practitioner who prescribes, renders a diagnosis or otherwise provides clinical treatment to a patient who has expressly applied for and been granted telemedicine privileges.

34. VICE PRESIDENT MEDICAL STAFF AFFAIRS: Physician approved by Medical Staff and Administration and hired by the Governing Body to act as a liaison among the Medical Staff, Administration and the Board. The Vice President Medical Staff Affairs may be delegated to act on the behalf of the Chief of Staff as appropriate. This position may be vacant, as not a required position.

## ARTICLE 1 - NAME AND PURPOSES

### 1.1 NAME

The name of this organization is the Medical Staff of Doctors Medical Center - San Pablo.

### 1.2 PURPOSES

These bylaws are adopted in order to provide for the organization of the Medical Staff and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. 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 members of the Medical Staff. The organized Medical Staff both enforces and complies with these Medical Staff bylaws.

These bylaws recognize that the organized Medical Staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital-wide policy, involving the oversight of care, treatment, and services provided by members and others in the hospital. The Medical Staff is involved with all aspects of delivery of health care within the hospital including, but not limited to, setting standards for the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review.

These bylaws acknowledge that the provision of quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the hospital Governing Body for the proper performance of their respective obligations. To that end, 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 supporting the Medical Staff's self- governance and 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.

## ARTICLE 2 - MEMBERSHIP

### 2.1 NATURE OF MEMBERSHIP

No physician, dentist, or podiatrist, including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide direct or indirect medical or health-related services to patients in the hospital unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been granted in accordance with these bylaws.

### 2.2 QUALIFICATIONS FOR MEMBERSHIP

#### 2.2-1 General Qualifications

Only physicians, dentists, or podiatrists who meet the following qualifications, except in the case of retired or honorary members or administrative members in which case these criteria shall only apply as deemed individually applicable by the Medical Staff, shall be eligible to apply for Medical Staff membership.

a. Each applicant for membership must have:

(1) Valid licensure in the state of California,
(2) An appropriate degree with adequate experience, education, and training,
(3) Current professional competence,
(4) Good judgment, and
(5) Adequate physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care, and
(6) Professional liability insurance with no less than $1 million/$ 3 million limits of liability as, from time to time, may be jointly determined by the Governing Body and Medical Executive Committee;

b. Applicants must be determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, and (3) to be willing to in assume and to properly discharge those responsibilities as determined by the Medical Staff;

#### 2.2-2 Particular Qualifications

a. Physicians. An applicant for physician membership in the Medical Staff must hold an M.D. or D.O. or their equivalent degree issued by a medical or osteopathic school approved at the time of the issuance of such degree by the Medical Board of California or the Board of Osteopathic Examiners of the State of California and must also hold a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purpose of this section, "or their equivalent" shall mean only degree (i.e., foreign) recognized by the Medical Board of California and the Board of Osteopathic Examiners.

b. Limited License Practitioners.

(1) Dentists. An applicant for dental membership in the Medical Staff must hold a D.D.S. or equivalent degree issued by a dental school approved at the time of the issuance of such degree by the Board of Dental Examiners of California and must also hold a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.

(2) Podiatrists. An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree conferred by a school approved at the time of issuance of such degree by the Medical Board of California of the State of California and must hold a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California of the State of California.

2.2-3 Waiver of Qualifications and Responsibilities

In unusual situations, particularly in which an individual only is providing limited non-clinical services, a qualification or responsibility may be waived in the discretion of the Governing Body upon a recommendation from the Medical Executive Committee. Such waiver must be based upon a determination that such waiver will serve the best interests of the patients and of the Hospital. Such waiver must be in writing. No individual has the right to a waiver and there is no right to a fair review, hearing or Governing Body appeal as the result of a refusal to grant a requested waiver. Notwithstanding and not to limit the foregoing, Administrative Staff, who are performing peer review and quality assessment/improvement activities, may be excused from having a California license, professional liability insurance, a DEA certificate, and any other requirements the Chief of Staff or designee determines are in the best interests of the Hospital, given the functions the Administrative staff will be performing.

## 2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff merely because that person 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 such person had, or presently has, staff membership or privileges at another health care facility. Medical Staff membership or clinical privileges shall not be conditioned on or determined by the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation or other organization, or in contracts with a third party which contracts with this hospital.

## 2.4 NONDISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, sexual orientation, race, age, creed, color or national origin, or physical or mental impairment that does not pose a threat to the quality of patient care.

## 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

The ongoing responsibilities of each member of the Medical Staff, except those specifically excluded within these bylaws, shall include:

a. Providing patients with quality care by meeting the professional standards of the Medical Staff of this Hospital;

b. Abiding by the Medical Staff Bylaws and Medical Staff Rules and Regulations;

c. Discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;

d. Preparing and completing in a timely fashion medical records for all the patients to whom the member provides care in the Hospital, and preparing any other records as required by the Medical Staff and/or the Hospital;

e. Abiding by the ethical principles of the California Medical Association or member's professional association;

f. Abiding by applicable laws of governmental agencies and complying with applicable standards of Joint Commission and other accrediting bodies;

g. Aiding in any Medical Staff-approved educational programs for medical students, interns, resident physicians, resident dentists, staff members, nurses and other personnel;

h. Working cooperatively with members, nurses, Hospital administration and others so as not to adversely affect patient care or Hospital operations;

i. Retaining responsibility within the member's area(s) of professional competence for the continuous care and supervision of each patient in the Hospital for whom the member is providing services, or arranging for a qualified substitute to provide such care and supervision;

j. Refusing to engage in improper inducements for patient referral;

k. Participating in continuing education programs as determined by the Medical Staff;

l. Participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff; the Medical Executive Committee and/or the member's department(s) chair;

m. Discharging such other staff obligations which may be established from time to time by the Medical Staff or the Medical Executive Committee;

n. Notifying the Medical Staff Office in writing within five (5) working days after (i) the individual's membership, participation or clinical privileges in another peer review body (hospital Medical Staff, licensed outpatient clinic, health plan or practice group) are suspended for more than fourteen (14) days, denied, restricted or terminated based on MDCR, (the foregoing shall be deemed to apply to any action that is reported to the National Practitioner Data Bank or the Medical Board of California pursuant to B&P §805), (ii) the member's license or DEA registration expires, is terminated, surrendered, limited or put on probation, (iii) any changes in the individual's professional liability insurance, or (iv) the filing of any criminal misdemeanor or felony charges, including but not limited to DUI charges. In addition, the individual shall timely inform the Medical Staff Office of any significant changes in the information required on appointment or reappointment.

o. Providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.1-3, and those which are the subject of a hearing pursuant to Article 7;

p. To keep as confidential, as required by law, all information or records received in the physician-patient relationship.

q. Treating employees, patients, visitors and other physicians in a courteous and dignified manner, work cooperatively with others, and adhere to the Medical Staff's Standards of Conduct as set forth in Section 2.6 of these Bylaws (and such rules and policies as may be adopted by the Medical Executive Committee to further illustrate and implement procedures to address reported inappropriate behavior)

to help assure that inappropriate conduct does not adversely affect patient care or the Hospital's operations.

r. Having a mental and/or physical examination, which may include body fluid testing, at any time there is a reasonable suspicion regarding a member's health status, as determined by the Medical Executive Committee or by the Chief of Staff (or designee) with the concurrence of the Department Chair (or designee) as the representatives of the Medical Executive Committee.

s. Complying with the applicable requirements for timely completing and recording a history and physical as specified in Section 5.2-4.

t. Acquire and document a patient's informed consent for all procedures and treatments identified in the Medical Staff Rules and/or policies as requiring informed consent.

u. Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these Bylaws. A member may be required by the Medical Executive Committee to demonstrate continuing satisfaction of any of the requirements in these Bylaws.

## 2.6 STANDARDS OF CONDUCT

Members of the Medical Staff are expected to adhere to the Medical Staff Standards of conduct, including but not limited to the following:

### 2.6-1 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 Medical Staff approved Hospital rules 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 to 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 payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

### 2.6-2 Conduct Guidelines

a. Upon receiving Medical Staff membership and/or privileges at the hospital, the member enters 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 and 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 non-demeaning manner, and through official Medical Staff channels.

e. Cooperation and adherence to the Medical Staff approved rules of the Hospital and the rules of 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.

g. No Member of the Medical Staff shall intimidate, harass or threaten an individual in order to deter the individual from reporting unprofessional conduct or intimidate, harass, or retaliate against an individual for reporting or participating in a review or investigation of unprofessional conduct.

2.6-3 Adoption of Rules and/or Policies

The Medical Executive Committee may promulgate rules and/or policies to further illustrate and implement the purposes of this Section 2.6, including but not limited to, examples of inappropriate conduct, procedures for investigating and addressing incidents of perceived misconduct, progressive remedial measures, including, when necessary, disciplinary action. Not to limit the foregoing, as part of progressive discipline, members may be issued a warning and/or reprimand, and can be required to write apologies, have medical, psychiatric and/or drug evaluations, be subject to body fluid testing, undergo counseling, participate in programs specific to the behavior trait (such as anger management or professional boundaries classes), and/or to sign behavior modification contracts. No member shall be entitled to progressive discipline. The nature and severity of the conduct is to be evaluated in determining the discipline. As part of such rules and/or policies, applicants and members may be required to sign statements agreeing to comply with the Medical Staff's Standards of Conduct as a condition to being appointed or reappointed to the Medical Staff.

## ARTICLE 3 - CATEGORIES OF MEMBERSHIP

### 3.1 CATEGORIES

The categories of the Medical Staff shall include the following: active, courtesy, provisional, affiliate active, affiliate associate, honorary, retired, temporary and administrative. Each time membership is granted or renewed, the member's staff category shall be determined.

### 3.2 ACTIVE STAFF

3.2-1 Qualifications

The active staff shall consist of members who:

(a) meet the general qualifications for membership set forth in Section 2.2;

(b) have offices or residences which, in the opinion of the medical executive committee, are located closely enough to the hospital to provide appropriate continuity of quality care;

(c) regularly care for patients in this hospital or are regularly involved in medical staff functions, as may be specified in Medical Staff policy; and

(d) have satisfactorily completed their designated term in the provisional staff category.

3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an active medical staff member who is in good standing shall be to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V;

(b) attend and vote on medical staff bylaws and amendments and all other matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed; and

(c) hold staff, division, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law.

3.2-3 Transfer of Active Staff Member

After two consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

### 3.3 COURTESY STAFF

3.3-1 Qualifications

The courtesy medical staff shall consist of members who:

(a) meet the general qualifications set forth in subsections (a)-(b) of Section 3.2-1;

(b) do not regularly care for more than 25 patients annually or are not regularly involved in medical staff functions as determined by the medical staff;

(c) are members in good standing of the active or associate medical staff of another California licensed hospital, although exceptions to this requirement may be made by the medical executive committee for good cause; and

(d) have satisfactorily completed their designated term in the provisional category.

3.3-2 Prerogatives

Except as otherwise provided, the courtesy medical staff member shall be entitled to:

(a) admit patients to the hospital with the limitations of Section 3.3-1(b) and exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend meetings of the medical staff and the department and committees to which the member is duly appointed , including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Courtesy staff members shall not be eligible to hold office in the medical staff.

3.3-3 Limitation

Courtesy staff members who admit more than 25 patients annually or regularly care for patients at the hospital shall, upon review of the medical executive committee, be obligated to seek membership in the appropriate staff category.

## 3.4 PROVISIONAL STAFF

3.4-1 Qualifications

The provisional staff shall consist of members who:

(a) meet the general medical staff membership qualifications set forth in Sections 3.2-1(a) and (b); and

(b) immediately prior to their application and grant of membership were not members (or were no longer members) in good standing of this medical staff.

3.4-2 Prerogatives

The provisional staff member shall be entitled to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Provisional staff members shall not be eligible to hold office in the medical staff organization or chair committees, but may serve on committees.

3.4-3 Observation of Provisional Staff Member

Each provisional staff member shall undergo a period of observation by designated monitors as described in Section 5.3. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair to the credentials committee. Such observation, including any continuation of it during the term of the member's provisional staff status in order to assess the member's qualifications, is not corrective action that would be grounds for the procedures described in Article VII of these bylaws.

3.4-4 Term of Provisional Staff Status

A member shall remain in the provisional staff for a period of 12 months, unless that status is extended by the medical executive committee for an additional period of up to 12 months upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.4-5 Action at Conclusion of Provisional Staff Status

(a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy, or other applicable staff category as appropriate, upon recommendation of the medical executive committee; and

(b) In all other cases, the appropriate department shall advise the credentials committee which shall make its report to the medical executive committee which, in turn, shall make its recommendation to the Governing Body regarding a modification or termination of clinical privileges or termination of medical staff membership.

## 3.5 AFFILIATE STAFF

3.5-1 Affiliate Active Staff

Affiliate Active Staff shall consist of members who meet all of the criteria for membership but do not admit or treat patients and only have privileges to perform histories and physicals. Affiliate Active Staff must:

(a) complete the same application as other applicants who are requesting clinical privileges,
(b) meet the general qualifications for membership set forth in Bylaws Section 2.2,
(c) demonstrate clinical competence for performing histories and physicals,
(d) complete a provisional term, and
(e) fulfill the basic responsibilities of Medical Staff membership

Affiliate Active Staff shall have the same rights to vote as members of the Active Staff.

3.5-2 Affiliate Associate Staff

Affiliate Associate Staff shall consist of members who meet all of the criteria for membership but who may not meet the requirements for privileges and/or may not have the level of clinical activity to qualify for another staff category, but who appear likely to provide a distinct service to the Hospital, Medical Staff or Hospital patients. Affiliate Associate Staff:

(a) do not admit or treat patients in the hospital
(b) do not have any clinical privileges
(c) do not complete provisional term,
(d) do not have the right to vote
(e) are not obligated to serve on medical staff committees
(f) the medical executive committee may adopt a modified application that requires more limited information and does not require proof of current competence for privileging

3.5-3 Prerogatives

Affiliate Active and Affiliate Associate Staff are entitled to:

(a) attend CME and serve on committees, with or without vote, at the discretion of the chairperson of
the involved committee and upon concurrent of the Chief of Staff
(b) order outpatient laboratory, physical therapy and radiology services for their patients
(c) unless otherwise instructed by the patient, shall have access to the medical records of their current patients.

## 3.6 TELEMEDICINE STAFF

3.6-1 Qualifications

The Telemedicine Staff shall consist of practitioners who only provide services via telemedicine link from a site other than the Hospital. Telemedicine Staff must apply for appointment and reappointment and have completed provisional status.

3.6-2 Prerogatives

The prerogatives of a Telemedicine Staff member shall be as follows:

(a) to exercise such telemedicine privileges as are granted to him/her pursuant to Article V.

(b) Telemedicine Staff shall not be eligible to vote or hold office in this Medical Staff.

(c) Telemedicine Staff are obligated to have malpractice insurance, pay application fees and pay dues in such amounts as established by the Medical Staff. The Medical Staff may establish an application for individuals who only seek telemedicine privileges and may adopt a policy that includes an alternative credentialing process for those who only request telemedicine privileges.

3.6-3 Responsibilities

Telemedicine Staff shall be required to discharge the basic responsibilities specified in Section 2.5.

## 3.7 HONORARY AND RETIRED STAFF

3.7-1 Qualifications

(a) The Honorary Staff

The honorary staff shall consist of physicians, dentists and podiatrists who do not actively practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct.

(b) The Retired Staff

The retired staff shall consist of members who have retired from active practice and, at the time of their retirement, were members in good standing of the active medical staff for a period of at least five continuous years, and who continue to adhere to appropriate professional and ethical standards.

3.7-2 Prerogatives

Honorary, and retired staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote or hold office in this medical staff organization, but they may serve on committees with or without vote at the discretion of the medical executive committee. They may attend staff and department meetings, including open committee meetings and educational programs.

## 3.8 TEMPORARY STAFF

3.8-1 Qualifications

The temporary staff shall consist of physicians, dentists and podiatrists who do not actively practice at the hospital but are important resource individuals for medical staff quality assessment and improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff. Temporary Staff may be appointed to the Medical Staff by the chief of Staff or the Medical Executive Committee, are not required to complete the application process described in these bylaws, or to pay Medical Staff dues.

3.8-2 Prerogatives

Temporary medical staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and improvement functions. They shall have no privileges. They may not admit patients to the hospital or hold office in the medical staff organization. They may, however, serve on designated committees with or without vote at the discretion of the medical executive committee. They may attend medical staff meetings outside of their committees, upon invitation.

## 3.9 ADMINISTRATIVE STAFF (INCLUDES VICE-PRESIDENT OF MEDICAL STAFF AFFAIRS)

3.9-1 Selection, Review and Removal of Vice President of Medical Staff Affairs (VPMA)
The Medical Executive Committee and Governing Body shall jointly determine if there is a need to employ a Chief Medical Officer. In addition, the job description for VPMA must be reviewed and approved by the Medical Executive Committee prior to the position being filled in order to prevent encroachment upon medical staff self-governance and to maximize effectiveness of the administrative position and cooperation between administrative staff and the medical staff. The Chief Executive Officer shall coordinate candidate interviews with representatives of medical staff leadership, who shall participate in the interview and review of candidates for position of Chief Medical Officer in the hospital. The Medical Executive Committee shall also approve or veto the selection of any such candidate, with any veto being binding upon the hospital.

The Medical Executive Committee shall provide the Chief Medical Officer and the Governing Body with an annual performance review of its Chief Medical Officer within sufficient time to permit the Chief Medical Officer to discuss the results of such review with each administrative staff member.

An individual in a chief medical officer position shall be terminated upon the request of the Medical Executive Committee or by a majority vote of the entire medical staff for cause. Prior to removing an individual from a member of the administrative staff, the CEO shall meet and discuss the action with the Medical Executive Committee.

3.9-2 Selection, Review and Removal of Medical Directorships
A listing of all medical directorship positions in the hospital shall be made available to any medical staff member upon request.

The Medical Executive Committee shall review the job descriptions (e.g., qualifications, responsibilities and reporting relationships) for all medical directorships in the hospital to both assure their adequacy for medical staff purposes and to avoid a conflict of duties between the medical director and any medical staff leader. The Medical Executive Committee shall also participate in the interview and review of candidates for the position of a medical director and approve or veto the selection of any such candidate, with any veto being binding upon the hospital. In addition, the Medical Executive Committee shall review the performance of each of the medical directors periodically and transmit the results of that review to the Governing Body for its consideration.

An individual in a medical director position shall be terminated upon the request of the Medical Executive Committee or by a majority vote of the entire medical staff for cause. Prior to removing an individual from a member of the administrative staff, the CEO shall meet and discuss the action with the Medical Executive Committee.

3.9-3 Qualifications
Administrative staff category membership shall be held by any physician, who is not otherwise eligible for another staff category and who is retained by the hospital or medical staff solely to perform ongoing medical administrative activities.

The administrative staff shall consist of members who:

(a) are charged with assisting the medical staff in carrying out medical-administrative functions;

(b) document their (1) current licensure, (2) adequate experience, education and training, (3) current professional competence, (4) good judgment, and (5) current physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent to exercise their duties;

(c) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect their judgment in carrying out the quality assessment and improvement functions, and (3) to be willing to participate in and properly discharge those responsibilities determined by the medical staff.

3.9-4 Prerogatives

All administrative staff shall be entitled to:
Attend open meetings of the medical staff and various departments and educational programs.
Administrative staff members shall not be eligible to hold office in the medical staff organization, admit patients or exercise clinical privileges.

## 3.10 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws or by the medical staff rules and regulations or policies.

## 3.11 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members:

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and the scope of their licensure, and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

## 3.12 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a written request by a member with any supporting documentation requested by the Medical Staff, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

## ARTICLE 4 - APPOINTMENT AND REAPPOINTMENT
(Including Telemedicine Services)

### 4.1 GENERAL

Except as otherwise specified herein, no person, including persons engaged by the hospital in administratively responsible positions, shall exercise privileges in the hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these bylaws. By applying to the Medical Staff for appointment or reappointment or, in the case of members of the honorary and retired staff and temporary staff, by accepting an appointment to that category, the applicant acknowledges responsibility to first review these bylaws and agrees that throughout any period of membership that person will comply with the responsibilities of Medical Staff membership and with the Bylaws and Rules and Regulations of the Medical Staff as they exist and as they may be modified from time to time. Appointment to the Medical Staff shall confer on the appointee only such privileges as have been granted in accordance with these bylaws.

### 4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, advancement, or transfer, the applicant shall have the burden of producing information the Medical Staff deems necessary for an adequate evaluation of the applicant's qualifications and suitability for the privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. This burden may include submission to a medical or psychological examination, if deemed appropriate by the Medical Executive Committee which may select the examining physician and shall be at the applicant's expense. If a third party requires the applicant sign a release/authorization and pay for production of information and documents, the applicant shall have the burden of satisfying such third party's requirements, including payment of such amounts in order for the Medical Staff to obtain such information and documents.

### 4.3 APPOINTMENT AUTHORITY

Appointments, denials and revocations of appointments to the Medical Staff shall be made as set forth in these bylaws and the Rules and Regulations, but only after there has been a recommendation from the Medical Executive Committee and approval of the Governing Body, or as set forth in these bylaws.

### 4.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these bylaws, appointments to the Medical Staff shall be for a period of up to two (2) years. Reappointments shall be for a period of up to two years.

### 4.5 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

4.5-1 Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions fulfilled or accompanied by an explanation of why answers are unavailable, and signed by the applicant. The form shall require detailed information which shall include, attestations regarding whether certain events have occurred and requires detailed information for certain attestation responses. The form also shall require, but not be limited to, detailed information concerning:

(a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration (if required for the requested privileges or if the applicant wants the right to prescribe medications for which a DEA certificate is required), certification of CPR training, and continuing medical education information related to the clinical privileges to be exercised by the applicant;

(b) peer references familiar with the applicant's professional competence and ethical character;

(c) requests for membership categories, departments, and clinical privileges;
(d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction for relinquishment of medical staff membership or privileges or any licensure or registration, and related matters; current physical and mental health status;
(e) final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending;
(f) professional liability coverage,
(g) any past, pending or current exclusion from a federal health care program; and.
(h) ability to perform privileges requested.

When an applicant requests an application form, that person shall be given a copy of these Bylaws, the Medical Staff Rules and Regulations, and summaries of other applicable policies relating to practice in the hospital, if any.

An applicant is responsible for assuring the information submitted on the application is accurate and complete. An application will automatically be withdrawn if, during the processing or review of an application for appointment or reappointment, it is determined that (i) an applicant's response to an attestation question was false, (ii) the required detailed information for certain attestation responses was incomplete as omitting information that would have been a cause for that attestation response, e.g. disclosed discipline at one hospital but omitted discipline at another hospital, and/or (iii) omits professional liability claims that resulted in a payment, including but not limited to a settlement, arbitration award of judgment. If the inaccuracy or omission is identified after the individual was appointed, the appointment will automatically terminate. Although the individual applicant or member is not entitled to a hearing, fair review or appeal to review this automatic withdrawal of the application or automatic termination, if the applicant or member believes the information was disclosed as required, the applicant or member has the right and obligation within thirty (30) days of notice of the automatic withdrawal or automatic termination to submit a statement that explains why the required information was complete and accurate.

The applicant is required to immediately notify the Medical Staff of any changes to the information on the application.

4.5-2 Effect of Application

In addition to the matters set forth in Section 4.1, by applying for appointment to the Medical Staff each applicant:

(a) signifies willingness to appear for interviews in regard to the application;
(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;
(c) consents to inspection of records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
(d) releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
(e) releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or Medical Staff may have, and releases the Medical Staff and hospital from liability for so doing to the fullest extent permitted by law;

(g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment. Medical Staff dues are due and payable February 1st of each year. Failure to pay dues by April 1st will result in loss of staff membership.

(h) pledges to provide for continuous quality care for patients.

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing continuous care of his or her patients, seeking consultation whenever necessary, refraining from providing unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(j) agrees to supply evidence of any malpractice claims or proceedings; and

(k) pledges to be bound by the Medical Staff Bylaws, Rules and Regulations, and policies.

## 4.6 BASIS FOR APPOINTMENT AND REAPPOINTMENT

Recommendations for appointment and reappointment to the Medical Staff and for granting and renewal of privileges shall be based upon the applicant or member's professional performance at this hospital and in other settings, upon whether the applicant or member meets the qualifications and can carry out all of the responsibilities specified in these Bylaws the Rules and Regulations and policies of the Medical Staff.

## 4.7 PROCESSING THE APPLICATION FOR INITIAL APPOINTMENT AND RENEWAL

If the individual meets the criteria to have the application processed, the following procedures will be followed:

### 4.7-1 Verification of Information

a. The Medical Staff Office or its designee shall, in timely fashion, collect and verify professional licenses with primary source, and collect and verify from the primary source whenever feasible the references, relevant practitioner specific data which are compared to aggregate data whenever possible, and other qualification evidence submitted. The Medical Staff Office shall also request information concerning the applicant from the applicable licensing Board and the National Practitioner Data Bank. The Medical Staff Office shall notify the applicant of any problems in obtaining the information required, and the applicant will be obliged to assure the required information is submitted to the Medical Staff Office. If the Medical Staff Office identifies information that the Medical Staff Office determines needs further clarification, explanation and/or documentation, the Medical Staff Office will notify the applicant and the applicant will be required to timely provide the specified clarification, explanation and/or information. If the verification discloses that the individual did not meet the criteria for applying, the Medical Staff will proceed as described in Section 4.6.

b. An application automatically shall be deemed voluntarily withdrawn if an applicant does not provide any required information and/or documentation within thirty (30) days after it is requested, unless the applicant submits within said thirty (30) days information that the Department Chair deems "good cause" for the additional time to respond. An applicant whose application is not completed within six (6) months after it was received by the Medical Staff Office shall be automatically deemed voluntarily withdrawn unless the Department Chair determines the delay should be excused for good cause as delayed by the Medical Staff and beyond the control or responsibility of the applicant; provided, however, (a) applicant then may be required to confirm in writing that all of the information on the application continues to be complete and correct, and (b) the deadline only will be extended for such period as delayed by the Medical Staff.

c. The Medical Staff Office may, but is not required to, review the application with the Department Chair prior to verifying the information. Such "pre-review" is for the purpose of advising the Medical Staff Office regarding additional documents or information to be obtained during the collection and verification process.

d. When collection and verification is accomplished, the Medical Staff Office shall transmit the application and all supporting materials to the credentials committee and each Department Chair in which the applicant seeks privileges.

e. A Department Chair or Committee responsible for review of an application may determine the application was not complete and return it to the Medical Staff Office with instructions regarding completion of the application.

4.7-2 Department Action

After receipt of the application, the chair or appropriate committee of each department to which the application is submitted, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at the chair's or committee's discretion. The chair or appropriate committee shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, the applicant's clinical and technical skills and any relevant data available from hospital performance improvement activities, and the reapplicant's participation in relevant continuing education and shall transmit to the credentials committee a written report and recommendation as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair may also request deferral of action on the application.

4.7-3 Credentials Committee Action

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chair's report and recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report and its recommendations as to membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the membership. The committee may also recommend deferral of action on the application.

4.7-3 Medical Executive Committee Action

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. The medical executive committee may request additional information, return the matter to the credentials committee for further review, return the matter to the department for further review and/or elect to interview the applicant. The medical executive committee shall immediately forward to the Governing Body a written report and recommendation as to medical staff membership and, if membership is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the membership. The medical executive committee may also defer action on the application. The reasons for each recommendation shall be stated.

4.7-4 Effect of Medical Executive Committee Action

(a) Favorable Recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the Governing Body.

(b) Adverse Recommendation: When a final recommendation of the medical executive committee is adverse to the applicant, the Governing Body and the applicant shall be promptly informed by written notice. The applicant shall then be entitled to procedural rights as provided in Article VII.

4.7-5 Action on the Application

The Governing Body may accept the recommendation of the medical executive committee or may refer the matter back to the medical executive committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

(a) If the medical executive committee issues a favorable recommendation, the Governing Body shall affirm the recommendation of the medical executive committee if the medical executive committee's decision is supported by substantial evidence.

(1) If the Governing Body concurs in that recommendation, the decision of the board shall be deemed final action.

(2) If the tentative final action of the is unfavorable and would be grounds for procedural rights under Article VII, (i) the Chief Executive Officer shall give the applicant written notice of the tentative adverse recommendation and (ii) the applicant shall be entitled to the procedural rights set forth in Article VII. If procedural rights are waived by the applicant, the decision of the Governing Body shall be deemed final action.

(b) In the event the recommendation of the medical executive committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VII shall apply.

(1) If procedural rights are waived by the applicant, the recommendations of the medical executive committee shall be forwarded to the Governing Body for final action, which shall affirm the recommendation of the medical executive committee if the medical executive committee's decision is supported by substantial evidence.

(2) If the applicant requests a hearing following the adverse medical executive committee recommendation pursuant to Section 4.8-5 (b) or an adverse Governing Body tentative final action pursuant to 4.8-5 (a) (2), the Governing Body shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the board shall make a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is supported by substantial evidence, following a fair procedure. The board's decision shall be in writing and shall specify the reasons for the action taken.

4.7-6 Notice of Final Decision

(a) Notice of the final decision shall be given to the chief of staff, the medical executive and the credentials committees, the chair of each department concerned, the applicant and the Chief Executive Officer.

(b) A decision and notice to grant or renew membership shall include, if applicable: (1) the staff category to which the applicant becomes a member; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the membership.

4.7-7 Timely Processing of Applications

Applications for staff membership shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. While special or unusual circumstances may constitute good cause and warrant exceptions, the following maximum time periods provide a guideline for routine processing of applications:

(a) evaluation, review, and verification of application and all supporting documents by the medical staff office:45 days from receipt of all necessary documentation;

(b) review and recommendation by department(s): 45 days after receipt of all necessary documentation from the medical staff office;

(c) review and recommendation by credentials committee: 45 days after receipt of all necessary documentation from the department(s);

(d) review and recommendation by executive committee: 45 days after receipt of all necessary documentation from the credentials committee; and

(e) final action: 240 days after receipt of all necessary documentation by the medical staff office, or 7 days after conclusion of hearings.

4.7.8 Reapplication After Adverse Appointment Decision

An applicant who has received a final adverse decision regarding appointment shall not be eligible to reapply to the Medical Staff for a period of two years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists. For purposes of this section, the two years shall be calculated from the date the applicant completed any and all hearings, appeals and court actions to challenge such adverse action. If the applicant withdrew his/her application after the applicant was on notice of a pending adverse decision, the two years shall be calculated from the date the application was withdrawn.

4.7.9 Effect of Application

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 4.5-2.

4.7.10 Standards and Procedure for Review

When a staff member submits the first application for reappointment, and every two years thereafter, or when the member submits an application for modification of staff status or privileges, the member shall be subject to an in-depth review generally following the procedures set forth in these bylaws, the Rules and Regulations and policies.

4.7.11 Failure to File Reappointment Application

Applications for reappointment shall be sent six months in advance of the practitioner's or AHP's reappointment expiration date via mail or e-mail. Reappointment materials are due back in the Medical Staff Services office within thirty (30) days. A second notice will be sent by certified mail two (2) weeks prior to the thirty (30) day deadline. If the reappointment materials are not received within the thirty (30) days deadline, the Practitioner's privileges or AHP's prerogatives shall be automatically suspended, except with respect to his/her patients already inpatients at the hospital. If the Practitioner/AHP returns the completed reappointment materials to the Medical Staff Services office within the next thirty (30) days, the Practitioner/AHP will be taken off automatic suspension and the reappointment process will continue. If the Practitioner does not return the completed application materials within those thirty (30) days, the individual will remain suspended and will be deemed to have voluntarily resigned at the end of the current reappointment period. Notwithstanding the foregoing, if a Practitioner or AHP notifies the Medical Staff in writing that he or she is resigning all clinical privileges and prerogatives after the expiration of the current appointment period, the individual's clinical privileges and prerogatives shall not remain automatically suspended pursuant to this Section. In the event clinical privileges are automatically suspended or membership or clinical privileges are deemed resigned for the reasons set forth herein, the member shall not be entitled to any hearing, review or Governing Body appeal.

4.8 LEAVE OF ABSENCE

4.8-1 Leave Status

At the discretion of the Medical Executive Committee, a Medical Staff member may obtain a voluntary leave of absence (LOA) from the staff upon submitting a written request to the Chief of Staff or designee stating the approximate period of leave desired, which may not exceed one year. For good cause, with submission of a written request, the LOA may be extended for an additional year. 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.

4.8-2 Termination of Leave

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the Medical Staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee or its designee. The staff member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests and may be required to submit a completed application for reappointment. The Medical Executive Committee shall make a recommendation concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in this Article IV for reviewing an application for reappointment shall be followed. A member who is reinstated may be subject to monitoring and/or proctoring, which shall not be deemed corrective or disciplinary action that triggers hearing rights under Article 7.

4.8-3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article 7 for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, or otherwise. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

4.8-4 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice from the member and review by the Medical Executive Committee. Notwithstanding the provisions of Sections 4.7, reactivation of membership and clinical privileges previously held shall be granted upon the member's written request to terminate the leave, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee. During the period of the leave, the member shall not exercise clinical privileges at the Hospital, and membership rights and responsibilities shall be inactive. The obligation to pay dues shall accrue and be paid prior to reinstatement, unless waived by the Medical Executive Committee.

4.9 RESIGNATION FROM MEDICAL STAFF

a. Any practitioner who desires to resign from the Medical Staff must submit a letter of resignation to the Chief of Staff, stating such request. Resignations shall be reported to the Medical Executive Committee and Governing Body.

b. An individual who has outstanding obligations to the hospital or medical staff shall be notified that the individual will be recorded as having resigned while not in good standing. Subsequent application for Medical Staff membership or clinical privileges will not be processed insofar as outstanding obligations remain or are no longer able to be completed. This status will be reported to any requests for references.

## ARTICLE 5 - PRIVILEGES

### 5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, or the Rules and Regulations, a member providing clinical services including but not limited to telemedicine services at this hospital shall be entitled to exercise only those privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the Rules and Regulations of the clinical department and the authority of the department chair and the Medical Staff.. Medical Staff privileges may be granted, continued, modified or terminated by the governing body of this hospital only upon recommendation of the Medical Staff, only for reasons directly related to quality of patient care and other provisions of the Medical Staff Bylaws, and only following the procedures outlined in these Bylaws and the Rules and Regulations.

### 5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. Telemedicine practitioners must submit an application for telemedicine privileges. A request by a member for a modification of privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 Basis for Privileges Determination

Requests for privileges shall be evaluated on the basis of the member's education, training, experience, any required references, demonstrated professional competence and judgment, clinical performance, the documented results of patient care and other quality review and monitoring which the Medical Staff deems appropriate, including an appraisal by the Chair of the Department or major clinical service in which such privileges are sought, and health status as it may affect the practitioner's ability to exercise the privileges granted. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises privileges.

5.2-3 Unavailable Clinical Privileges

Notwithstanding any other provisions of these bylaws, to the extent that any requested clinical privileges are not available at the hospital (whether because of exclusive contract, lack of facilities, policy decision of the Governing Body or otherwise), the request therefore shall be rejected. Because such a rejection is unrelated to the applicant's qualifications, an applicant whose request is so rejected shall not be entitled to the procedural rights provided in Article 7.

5.2-4 Criteria for "Cross-Specialty" Privileges within the Hospital

Any request for clinical privileges that are either new to the Hospital or that overlap more than one department shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or services. The MEC shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the MEC may establish an ad-hoc committee with representation from all appropriate Departments.

5.2-5 History and Physical Privileges

A medical history and physical examination is completed and documented by a physician or an oral maxillofacial surgeon member of the Medical Staff, or other qualified licensed individual with privileges to perform a history and physical. The history and physical must be available in the medical

record within 24 hours of a patient's admission and prior to any surgery/procedure requiring moderate or deep sedation or anesthesia.

a. The history and physical and any updates to the history and physical must be performed by a member who has privileges to perform the history and physical.

b. The initial history and physical can be completed up to 30 days prior to the patient's admission or surgery/procedure. However, if the initial history and physical was completed more than 24 hours prior to the surgery/procedure or admission, an updated medical record entry must be documented by the member within 24 hours of the admission and prior to the procedure. The entry must reflect an examination of the patient and indicate any changes in the patient's condition.

c. If there is no change in the patient's condition, the member must document in the medical record that the initial history and physical was reviewed, the patient was examined, and 'no change' has occurred since the initial history and physical was completed.

d. A member responsible for administering anesthesia may, if granted those privileges, perform the pre-surgical updated history and physical.

## 5.3 PROCTORING

### 5.3-1 General Provisions

Except as otherwise determined by the Medical Executive Committee, all initial appointees to the Medical Staff and all members granted new privileges shall be subject to a period of proctoring. Each appointee or recipient of new privileges shall be assigned to a department where performance on an appropriate number of cases as established by the Medical Executive Committee, or the department as designee of the Medical Executive Committee, shall be observed by the chair of the department, or the chair's designee, during the period of proctoring specified in the department's rules and regulations, to determine suitability to continue to exercise the privileges granted in that department. The exercise of privileges in any other department shall also be subject to direct observation by that department's chair or the chair's designee. The member shall remain subject to such proctoring until the Medical Executive Committee notifies the member in writing that proctoring has been satisfactorily completed. The Medical Executive Committee must receive the following in order to determine whether proctoring has been satisfactorily completed:

a. A report and recommendation signed by the chair or the assigned designee of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualification for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and

b. A report and recommendation signed by the chair or the assigned designee of the other department(s) in which the appointee may exercise privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has satisfactorily demonstrated the ability to exercise the privileges initially granted in those departments.

### 5.3-2 Failure to Obtain Certification of Completion of Proctor Program

If an initial appointee fails within the time of provisional staff membership to furnish the certification required, or if a member exercising new privileges fails to furnish such certification within the time allowed by the department, an additional 12 months may be granted to allow completion of certification. The total period that an individual can be on the provisional staff cannot exceed 24 months. If certification is not granted within the additional time allotted, those specific privileges shall automatically terminate. If the basis for not being granted such certification is a medical disciplinary cause or reason, as defined in Article 7, the member shall be entitled to a hearing upon request, pursuant to Article 7. If the basis is not a medical disciplinary cause or reason, the member is not entitled to a hearing.

5.3-3 Medical Staff Advancement

The failure to obtain certification for any specific privileges shall not, of itself, preclude advancement in Medical Staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period.

## 5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 Admissions

Subject to demonstrating appropriate training, experience and current clinical competence, podiatrists, and dentists who are members of the Medical Staff may be granted privileges to perform a history and/or physical. If a dentist or podiatrist does not have the privilege to perform a history and/or physical, a physician member of the Medical Staff with this privilege must promptly conduct and directly supervise the admitting history and physical (except for the portion related to dentistry or podiatry). A physician member of the Medical Staff must assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization that are outside of the limited license practitioner's lawful scope of practice.

5.4-2 Surgery

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of the department of surgery or the chair's designee.

5.4-3 Medical Appraisal

All patients admitted for care in a hospital by a dentist or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member 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 appropriate department(s).

## 5.5 TELEMEDICINE PRIVILEGES

The Medical Staff policy may permit the Medical Staff to recommend the granting of telemedicine privileges to telemedicine practitioners in reliance on information provided by the distant site hospital or telehealth entity. In order to qualify for telemedicine privileges, the practitioner must meet all of the standards and requirements in the bylaws, rules and policies for privileges that are applicable to telemedicine services.

## 5.6 TEMPORARY PRIVILEGES

5.6-1 Circumstances

a. Care of a Specific Patient

Temporary privileges may be granted where good cause exists to a physician, dentist, podiatrist, for the care of a specific patient (but not more than five (5) patients during a calendar year) provided that the procedure described in Section 5.6-2 has been completed.

b. Locum Tenens

Temporary privileges may be granted to a person serving as a locum tenens for a current member of the Medical Staff, provided that the procedure described in Section 5.6-2 has been completed. Such person may attend only patients of the member(s) for whom that person is providing coverage, for a period not to exceed 120 days, unless Medical Executive Committee recommends a longer period for good cause.

c. Other Important Patent Care Needs

Temporary clinical privileges may be granted to allow a physician, dentist or podiatrist to fulfill an important patient care treatment or service need provided that the procedure described in Section 5.6-2 has been completed.

d. Pending Application for Membership
Temporary privileges may be granted to a person during pendency of that person's application for membership and privileges, provided that the procedure described in Section 5.6-2 has been completed, and that the applicant has a current license, relevant training or experience, documented current competence, demonstrated ability to perform the privileges requested, a query and evaluation of the NPDB information, a complete application, no current or previously successful challenge to professional licensure or registration, not subject to involuntary termination of medical staff membership at any other organization, and not subject to involuntary limitation, reduction, denial or loss of clinical privileges. Such persons may only attend patients for a period not to exceed 120 days.

e. Temporary Membership and Temporary Privileges not Co-Extensive
Temporary members of the Medical Staff pursuant to Section 5.6 are not, by virtue of such membership, granted temporary privileges.

f. Not Right to Temporary Privileges
No individual has the right to temporary privileges.

5.6-2 Review Required

a. Upon receipt and review of a completed application for membership and clinical privileges that has all of the required supporting documentation from a physician, dentist, or podiatrist authorized to practice in California, an applicant for membership and privileges or member who has applied for additional clinical privileges may be granted temporary privileges if the individual appears to have qualifications, ability and judgment, consistent with Section 2.2-1, but only after:

(1) the appropriate department chair or designee has contacted or received a reference letter from at least one person who:

(a) has recently worked with the applicant;

(b) has directly observed the applicant's professional performance over a reasonable time; and

(c) provides reliable information regarding the applicant's current professional competence, ability to perform the privileges requested, ethical character, health status, and ability to work well with others so as not to adversely affect patient care.

If the applicant requests temporary privileges in more than one department, each department chair or designee in which temporary privileges are requested must obtain the required verifications for the privileges requested in such department.

(2) Query and evaluation of the hospital's authorized representative has queried the National Practitioner Data Bank regarding the applicant for temporary privileges.

(3) Verification of a valid and unrestricted California license applicable to practice.

(4) Verification of current malpractice insurance.

(5) Current DEA registration (if required).

(6) Verification of any specialty training claimed.

b. The Chief of Staff or designee shall confirm that the requirements for temporary privileges have been satisfied. The Chief Executive Officer or designee may grant temporary privileges only if recommended by the Chief of Staff or designee.

c. The applicant's file, including the appropriate reference will be processed through the procedures required in these Bylaws for membership and privileges.

d. The names of applicants granted temporary privileges will be forwarded to the Governing Body.

5.6-3 General Conditions

a. If granted temporary privileges, the applicant shall act under the supervision of the department chair to which the applicant has been assigned, and shall ensure that the chair, or the chair's designee, is kept closely informed as to his or her activities within the hospital.

b. Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles 6 or 7 of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.6-2.

c. Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be determined by the Chief of Staff after consultation with the departmental chair or his designee.

d. Temporary privileges may at any time be terminated by the Chief of Staff with the concurrence of the chair of the department or their designees, subject to prompt review by the Medical Executive Committee. In such cases, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.

e. All persons requesting or receiving temporary privileges shall be bound by, and must acknowledge receipt of, the Bylaws and Rules and Regulations of the Medical Staff.

f. Temporary Medical Staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assurance functions. They cannot hold office in the Medical Staff organization. They may, however, serve on designated committees with or without vote at the discretion of the Medical Executive Committee. They may attend Medical Staff meetings outside of their committees, upon invitation.

## 5.7 EMERGENCY PRIVILEGES

a. In the case of an emergency, any member of the Medical Staff, to the degree permitted by the scope of the member's license and regardless of department, staff status, or privileges, shall be permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the Medical Staff with appropriate privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the hospital.

b. In the event of an emergency, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

## 5.8 DISASTER PRIVILEGES

5.8-1 Granting of Disaster Privileges

a. Disaster privileges may be granted when the emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs.

b. During a disaster in which the emergency management plan has been activated, the CEO, Chief of Staff or the designee(s) of either has the option to grant disaster privileges on a case-by-case basis at his/her discretion upon presentation of a valid picture identification issued by the State of California or Federal agency (example driver's license or passport) and at least one of the following:

(i) Current license to practice issued by the State of California, or

(ii) Current hospital picture identification card, or

(iii) A picture identification which indicates that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professions (ESAR-VHP), or other recognized state or federal response organization or group, or

(iv) picture identification which indicates that the individual has been granted authority to render patient care in emergency circumstances, or

(v) confirmation by a licensed independent practitioner currently privileged by the hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

In addition, the Medical Staff shall obtain the name of current hospital affiliation where the practitioner maintains medical staff membership, if applicable, and current malpractice insurance coverage information

5.8-2 Review After Disaster Privileges Granted

a. The Medical Staff will oversee performance of those holding disaster privileges by medical record reviews unless another method is specified at the time, such as direct observation or mentoring.

b. Primary source verification of all information shall be performed upon the earlier of (i) as soon as the immediate situation is under control by the Medical Staff Office, or (ii) within 72 hours. If extraordinary circumstances make it not possible to complete primary source verification within 72 hours, the Medical Staff will document the reasons it could not be performed within this time, evidence or the individual's demonstrated ability to continue to provide care, and evidence of attempts to perform primary source verification as soon as possible. Based upon its oversight, within 72 hours the Medical Staff shall determine whether to continue the practitioner's disaster privileges. A written record of this information shall be retained in the Medical Staff Office with a copy of the temporary privilege form. Notwithstanding the foregoing, primary source verification is not required if the volunteer did not provide care, treatment or services under disaster privileges.

## 5.9 MODIFICATION OF PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the appropriate Privileges and Credentials Committee, or pursuant to a request under the Rules and Regulation, the Medical Executive Committee may recommend a change in the privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1.

## 5.10 AUTOMATIC WITHDRAWAL OF APPLICATION

If a Medical Staff member requesting a modification of privileges or department assignments fails to furnish within 90 days the information necessary to evaluate the request or if the application is not complete within 6 months after it was submitted, the application shall automatically be withdrawn and the applicant shall not be entitled to the procedures described in Article 7.

## ARTICLE 6 - CORRECTIVE ACTION

### 6.1 OPPE, FPPE AND ALTERNATIVES TO CORRECTIVE ACTION

The Medical Staff performs ongoing professional practice evaluations ("OPPE") of all members' privileges in accordance with the Medical Staff Bylaws, rules and policies. OPPE includes but is not limited to processes whereby the Medical Staff recommends methods and criteria to be used in the conduct of such ongoing monitoring. The Medical Staff has a focused professional practice evaluation process (FPPE") that includes proctoring all initially granted privileges and from time to time performing focused professional practice evaluations of a member competency. The FPPE process shall be implemented in accordance with the Medical Staff Bylaws, rules and policies.

The Departments and Committees and their chairs are responsible for carrying out delegated peer review and quality assurance review functions. As part of these functions, they may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) 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 Department or Committee. These alternatives to corrective action shall be documented in the member's file but shall not be deemed final disciplinary action. Rather, they are measures to guide, educate and monitor. Medical Executive Committee approval is not required for these 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, fair review or appeal rights under Article 7.

### 6.2 CORRECTIVE ACTION

#### 6.2-1 Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the Medical Staff Bylaws or Rules and Regulations; (4) below applicable professional standards; a request for an investigation or action against such member may be submitted to the Chief of Staff, a department chair, or the Medical Executive Committee.

#### 6.2-2 Initiation

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recordation of the reasons.

#### 6.2-3 Notice to Chief Executive Officer

The Chief of Staff or designee shall promptly notify the Chief Executive Officer of each request for corrective action received by the Medical Executive Committee and the date of its receipt, and shall keep the Chief Executive Officer informed of all communication, meetings, and other actions taken in connection with each request.

#### 6.2-4 Investigation

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff department, or standing or ad hoc committee of the Medical Staff. Should circumstances warrant, the Medical Executive Committee, in its discretion, may appoint practitioners who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary privileges under Section

5.6. If the investigation is delegated to an officer of a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner 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. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved. However, such investigation shall not constitute a "hearing" as that term is used in Article 7, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Staff shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension (pursuant to Section 6.3), termination of the investigative process, or other action.

6.2-5 Medical Executive Committee Action

As soon as practicable, and in any event not longer than sixty (60) days after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

a. determining that no corrective action be taken;
b. deferring action for a reasonable time where circumstances warrant;
c. issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member shall have no right to a hearing and the member's only rights are to appear before the appropriate department to discuss the matter and to make a written response which shall be placed in the member's file.
d. 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;
e. recommending reduction, modification, suspension or revocation of privileges;
f. recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
g. recommending suspension, revocation or probation of Medical Staff membership; and
h. taking other actions deemed appropriate under the circumstances.

Actions taken by the Medical Executive Committee shall be based on preponderance of evidence.

6.2-6 Subsequent Action

a. If corrective action as set forth in Section 6.2-5(d)-(h) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Governing Body subject to the member's rights to the processes in Article 7, if any.
b. So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article 7.

6.2-7 Initiation by Governing Body

If the Medical Executive Committee fails to investigate or take disciplinary action, and the Medical Executive Committee's decision is not supported by substantial evidence, the Governing Body may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that Governing Body direction, the Governing Body may initiate corrective action after written notice to the Medical Executive Committee, but this corrective action and disciplinary process must comply with Articles 6 and 7 of these Medical Staff Bylaws.

## 6.3 SUMMARY RESTRICTION OR SUSPENSION

### 6.3-1 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient, or other person, the chief of staff, the Medical Executive Committee, or the head of the department or designee in which the member holds privileges may summarily restrict or suspend the Medical Staff membership or privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Governing Body, the Medical Executive Committee and the Chief Executive Officer. In addition, the affected Medical Staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.2-2 below. The summary restriction or suspension 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 restriction or suspension, the member's patients shall be promptly assigned to another member by the Department Chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

### 6.3-2 Written Notice of Summary Suspension

Within one working day of imposition of a summary suspension, the affected member shall be provided with verbal notice of such suspension, to be followed by written notice within three working days. This written notice shall include a statement of facts demonstrating that the suspension was reasonable and warranted to protect the life or well-being of patient (s) or the substantial and imminent likelihood of significant impairment of the life, health, safety of any patient, prospective patient. The notice shall be copied to the Medical Executive Committee and constitute a request for a corrective action investigation. The notice may be supplemented by other information identified during the corrective action investigation and is in addition to, the notice required under Section 7.4-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.4-1 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.

### 6.3-3 Medical Executive Committee Action

The Medical Executive Committee or a subcommittee appointed by the Chief of Staff shall be promptly convened to review and consider the summary suspension. The member shall be notified of the meeting and given the opportunity to appear. Upon the Medical Executive Committee's or member's request, the member shall attend and answer questions 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 Article 7, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two (2) working days of the meeting. The member's failure to attend any Medical Executive Committee meeting upon request shall not constitute a waiver of the member's rights under Article 7.

### 6.3-4 Procedural Rights

If the Medical Executive Committee votes to continue the summary suspension beyond fourteen days or to continue a summary restriction so that it extends beyond 30 days, the member shall be offered the procedural rights afforded by Article 7.

6.3-5 Initiation by Governing Body

If the Chief of Staff, members of the Medical Executive Committee and the head of the department (or designee) in which the member holds privileges are not available to summarily restrict or suspend the member's membership or privileges, the Governing Body (or designee) may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any patient, prospective patient, or other person, provided that the Governing Body (or designee) made reasonable attempts to contact the chief of staff, members of the Medical Executive Committee and the head of the department (or designee) before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.3 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred.

6.4-1 Licensure

a. Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this state is expired, revoked or suspended, 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 the member has been granted at the hospital which are within the scope of said 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, 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.

6.4-2 Controlled Substances

a. Whenever a member's DEA certificate is expired, revoked, limited, or suspended, 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. Notwithstanding the foregoing, if a Department requires that its members have a DEA certificate to have privileges in that Department or have a DEA certificate for particular privileges, the member's privileges shall automatically be deemed resigned in accordance with the Department rule.

b. Probation: Whenever a member's DEA 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.

6.4-3 Failure to Satisfy Special Appearance Requirement

Failure of a member without good cause to appear and satisfy the requirements of Section 11.6 shall result in the automatic suspension of all of the member's clinical privileges until such time as the practitioner satisfies the attendance requirement, except that a member who remains on suspension for six months for failure to satisfy an attendance requirement shall automatically be deemed resigned.

6.4-4 Medical Records

a. Members of the Medical Staff are required to complete medical records within 14 days after discharge to comply with State Law. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff or designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the Chief of Staff or designee (also see Rules and Regulations).

b. Any member who accumulates more than ninety (90) days of suspension for failure to timely complete medical records during any twelve month period or who is suspended for failure to timely complete medical records for sixty (60) consecutive days shall be deemed to have voluntarily resigned his/her medical staff membership and all privileges.

6.4-5 Failure to Pay Dues/Assessments

Failure as required by Section 13.2 shall be deemed a voluntary resignation from the Medical Staff.

6.4-6 Failure to Carry Liability Insurance

Failure to carry professional liability insurance with the required amount of coverage, shall immediately result in automatic suspension of all of the member's privileges. If a member has professional liability insurance but it does not have the required coverage for all of the member's privileges, any privilege for which there is inadequate coverage will immediately be automatically suspended. The suspension shall remain in place until the member provides evidence that the member secured the required coverage and a tail or nose to assure continuous coverage. If a member fails to provide the required evidence of coverage within six months after the failure to maintain the coverage, the member's membership and privileges automatically shall be deemed resigned. If only certain privileges were suspended for failure to adequately insure such privileges, those privileges shall be deemed resigned if the member fails to provide the required coverage for such privileges.

6.4-7 X-ray Operator/Supervisor and Fluoroscopy Certificate

If a practitioner fails to maintain required X-ray Operator/Supervisor and Fluoroscopy Certificate or fails to provide evidence of same, the practitioner's clinical privileges requiring fluoroscopy shall be automatically suspended and shall remain so suspended until the practitioner provides evidence to the Medical Executive Committee that he or she has secured the required X-ray Operator/Supervisor and Fluoroscopy Certificate. If after sixty (60) days the Certificate is not provided, those privilege(s) requiring fluoroscopy will be voluntarily relinquished.

6.4-8 Felony Conviction or Exclusion from Federal or State Healthcare Programs

A practitioner who has been convicted or pled "guilty" or "no contest" or its equivalent to a felony in any jurisdiction or who has been excluded from a Federal or State Healthcare Program shall be automatically terminated from the Medical Staff. Such termination shall become effective immediately upon such criminal conviction or plea regardless of whether an appeal is filed. A practitioner who is ineligible for payment for the Medicare and/or Medi-Cal program shall not treat or order services for a Hospital patient covered by the program(s) for which s/he is ineligible, and shall be automatically terminated from the Medical Staff for violating the foregoing prohibition.

6.4-9 Exclusive Contracts

A practitioner's clinical privileges automatically shall be deemed voluntarily resigned to the extent such privileges are the subject of an exclusive contract if such practitioner is no longer affiliated with the group which has the exclusive contract; provided, however, if a new group has been selected and the practitioner shall be providing services in affiliation with the new group, then the practitioner's clinical privileges shall not automatically be deemed voluntarily resigned, the practitioner also automatically shall be deemed to have voluntarily resigned his membership. Notwithstanding the foregoing, if the member meets the eligibility requirements to apply for clinical privileges that are not subject to the exclusive contract and has a pending application for such clinical privileges, the practitioner will remain a member of the medical staff pending the review of such an application for such clinical privileges

6.4-10 Loss of Alternative Coverage

Each practitioner must at all times have at least one covering practitioner. The covering practitioner must have substantially the same clinical privileges as the individual who is being covered and agree to provide coverage for all of the patients of the practitioner for whom coverage is being provided; however, if there is no other practitioner in the same specialty or with substantially the same privileges and the Medical Executive Committee determines the specialty is required, the Medical Executive Committee may permit an alternative arrangement for coverage or coverage by someone who does not have substantially the same privileges. At any time, the Medical Staff can require that a practitioner with clinical privileges immediately provide the name of his/her covering practitioner. If a practitioner fails to promptly provide this information or the covering practitioner fails to confirm that s/he has agreed to provide coverage, all of the clinical privileges of the practitioner who cannot document coverage by another practitioner will be automatically suspended pending the Medical Staff's receipt of coverage information and verification of the required coverage. The Department Chair, Chief of Staff or a designee may recommend and the CEO may agree that an applicant who is applying for temporary privileges to meet an important patient care be excused from securing coverage for such temporary privileges.

6.4-11 Failure to Respond to Member-Specific Request for Information

Each member shall respond in a timely manner to a request for information from the Chief of Staff, the member's Department Chair, or a chair (or the chair's designee) of a committee that is reviewing member-specific information. Letters that require a timely response shall specify the deadline for responding and be sent by a receipted form of delivery. If the member does not respond within thirty (30) days of the delivery of the letter, the member shall be sent a second written request. If the member fails to respond to the second letter within fifteen (15) days of the delivery of the letter, the Chief of Staff on behalf of the Medical Executive Committee shall be notified. A final notice will be sent to the member that advises the member that he or she will be automatically terminated from the Medical Staff if no response is received within fifteen (15) days of the member's receipt of the final letter. If the member submits a response that fails or refuses to

respond to the question(s) asked in the request for information, the member's response will be treated as a failure to respond.

6.4-12 Medical Executive Committee Deliberation

As soon as practicable after action is taken or warranted as described in Section 6.4-1(b) or (c), Section 6.342, 6.3-3, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate in accordance with these bylaws.

## 6.5 NOTIFICATION OF CORRECTIVE ACTION

6.5-1 The Medical Executive Committee may from time to time receive confidential peer review information from another peer review body at another hospital or health care entity that an investigation is pending, or that a disciplinary action has been imposed against a member of this Medical Staff. The receipt of such information may, at the discretion of the Medical Executive Committee, constitute sufficient grounds for initiating an investigation of the Medical Staff member or summarily suspending pending further investigation at this hospital.

## ARTICLE 7 - HEARINGS AND APPELLATE REVIEWS

### 7.1 GENERAL PROVISIONS

#### 7.1-1 Exhaustion of Remedies

If adverse action described in Section 7.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

#### 7.1-2 Application of Article

For purposes of this Article, the term "member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated. (In addition to Medical Staff members and applicants, who are providing or applying to provide professional services in the hospital, but are not members of the Medical Staff, are entitled to the hearing rights specified in this article.)

#### 7.1-3 Timely Completion of Process

Each of the parties shall cooperate in order for the hearing and appeal process to be completed within a reasonable time.

#### 7.1-4 Final Action

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final action by the Governing Body.

#### 7.1-5 Substantial Compliance

Technical, insignificant or non-prejudicial deviations from the procedures set forth in these bylaws shall not be grounds for invalidating the action taken.

#### 7.1-6 Medical Disciplinary Cause or Reason (MDCR)

MDCR refers to disciplinary action taken based upon an aspect of a practitioner's competence or professional conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

### 7.2 GROUNDS FOR HEARING

The taking or recommending of any one or more of the following actions by the Medical Executive Committee for a MDCR, shall constitute grounds for a hearing pursuant to this Article:

a. denial of initial appointment to the Medical Staff;
b. denial of staff reappointment;
c. restriction of staff membership or clinical privileges for thirty (30) days or more in any twelve (12) month period;
d. termination of staff membership;
e. denial or termination of clinical privileges, including temporary privileges;
f. involuntary reduction in clinical privileges;
g. summary suspension of clinical privileges for more than fourteen (14) consecutive days; or
h. significant consultation or co-admitting requirements which restrict the practitioner's exercise of clinical privileges, other than routinely imposed in compliance with the processes set forth in the Medical Staff bylaws, rules and regulations or departmental rules and regulations, such as incidental to provisional status, upon the granting of a new privilege, or upon return to from a leave of absence.

## 7.3 NO HEARING OR FAIR REVIEW RIGHTS

The taking or recommending of one or more of the following actions does not afford a hearing right or fair review right. Note that this list is not all-inclusive:

a. denial or termination of privileges based upon closed staff or exclusive use policy (see 7.8-1);
b. denial or termination of allied health professional staff membership or privileges, unless taken or recommended against a, for reasons that are reportable to the applicable licensing board;
c. denial of membership or privileges for failure to file a completed application or to submit necessary information for the processing of an application for membership or privileges;
d. failure to complete medical records (unless it is reportable to the Medical Board of California) subject to review of the Medical Executive Committee;
e. failure to maintain individual malpractice insurance as required;
f. termination or restriction of membership or privileges for failure to meet minimum activity requirements, as defined by these bylaws, the Medical Staff's rules, policies or privilege delineation forms, or for failure to pay annual Medical Staff dues, subject to review by the MEC;
g. letter of reprimand, provided a practitioner shall be given the opportunity to submit a written response that will be retained in the credentials file with the letter of reprimand;
h. routine proctoring requirement for new applicants or new privileges;
i. denial or reduction in privileges to prescribe or obtain controlled substances based on the action of the DEA, as described in Section 6.3;
j. denial or reduction in privileges or membership due to suspension, revocation or probation of a member's license to practice in this state (see 7.7-2);
k. failure to request reinstatement after a leave of absence as described in 4.7-3; or
l. an automatic action imposed pursuant to 6.4.

## 7.4 REQUESTS FOR HEARING

### 7.4-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or the National Practitioner Data Bank, if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Section 7.4-2, and that such a hearing must be requested within 30 days; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws. If the recommendation or final proposed action is reportable to the Medical Board of California and/or the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

Each notice given in connection with the provisions of this Article shall be in writing and shall be deemed to have been received on the earliest of the following:

(a) on the date on which it is delivered personally;
(b) on the date shown to have been accepted by return receipt from the Post Office, or
(c) five (5) days after it has been deposited in the United States Mail, postage prepaid, and addressed to the party at its last known address.

### 7.4-2 Request for Hearing

The member shall have 30 days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Governing Body. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.4-3 Time and Place for Hearing

Upon receipt of a request for hearing, the Medical Executive Committee shall schedule a hearing and, within 30 days, give notice to the member of the time, place and date of the hearing. Unless extended by the judicial review committee or by agreement of the member and the Medical Executive Committee, the date of the commencement of the hearing shall be not less than 60 days, nor more than 90 days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed 60 days from the date of receipt of the request.

7.4-4 Notice of Hearing

Together with the notice stating the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged and a list of the charts in question, and a list of any the witnesses expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 7.5-1.

7.4-5 Judicial Review Committee

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee which shall be composed of not less than five (5) members of the Medical Staff 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 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 Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the active Medical Staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chair. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. If there is not a member of the medical staff in the same specialty who is willing and able to serve, it is not feasible to require the Medical Staff to pay someone not on the medical staff in order to have someone in the same specialty. All other members shall be physicians.

7.4-6 Failure to Appear or Proceed

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and a waiver of the member's hearing rights. If a member believes the member has good cause for not personally attending and proceeding, the member must promptly assert such cause or be deemed to have waived a claim of good cause that excused such failure to attend and proceed.

7.4-7 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 by the hearing officer on a showing of good cause, or upon agreement of the parties.

7.4-8 Resignation or Withdrawal of Application

Notwithstanding any other provision of these bylaws, whenever the affected practitioner unconditionally (a) resigns from the medical staff; (b) resigns and relinquishes the privileges that are the subject matter of a hearing; (c) withdraws the application that is the subject matter of a hearing; (d) amends an application or request so as to remove the items that are the subject matter of a hearing; or (e) consents in writing to the action or recommendation that prompted the hearing and there are no other issues before the hearing and appellate review proceedings with respect to said practitioner, his privileges or application, as the case may be, shall terminate as of the first day after such resignation, withdrawal, amendment, or consent. Once so terminated, the proceedings shall not be reopened except when ordered by the Governing Body, after receiving a written request from, or giving notice to, the affected practitioner, and determining that good cause exists for such reopening. A practitioner who resigns or takes a leave of absence as a result of or while disciplinary actions are pending is reportable to the Medical Board of California.

7.4-9 Settlements

If a proposed settlement of the subject matter is agreed upon between the affected practitioner and the Medical Executive Committee, such proposed settlement may be submitted in writing directly to the Governing Body for its rejection or approval. If the Governing Body approves such a submitted settlement, it shall render its final decision in the matter in accordance with the settlement and the decision shall be effective immediately and shall not be subject to further hearing or review. Failure of the Governing Body to reject or approve such a settlement within thirty (30) days after its submission to the Governing Body shall be deemed a final decision by the Governing Body to approve it. If the terms of the settlement are reportable to the Medical Board of California or the National Practitioner Data Bank, they shall be reported. All deadlines shall be stayed while a matter is awaiting Governing Body review and approval.

7.4-10 Confidentiality of Proceedings

Except as otherwise authorized in these Bylaws or by law, all parties, participants, and attendees shall keep the hearing and appellate review proceedings and the contents thereof confidential, and no one shall disclose or release any information from or about the proceedings to any person or the public. Any party or participant who is damaged by a violation of this Section may enforce this Section by court order upon request for injunctive or other appropriate relief.

7.4-11 Governing Body Decision Prompts Hearing

In the unusual situation in which the Governing Body is the body whose adverse decision prompts the hearing or fair review, the medical executive committee shall have the option of designating the Governing Body to fulfill any or all of the duties assigned to the medical executive committee or the Chief of Staff when the Medical Executive Committee was the body whose decision prompted the hearing. This may include but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling at the hearing, providing the notice of hearing and statement of charges, designating the judicial review committee, presenter and witnesses, and presenting evidence in the hearing.

7.5 HEARING PROCEDURE

7.5-1 Prehearing Procedure

a. If either side to the hearing requests in writing a list of witnesses or copies of evidence expected to be introduced in the hearing, within 30 days of such request, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is

reasonably known or anticipated, who are anticipated to give testimony and copies of all documents expected to be introduced at the hearing. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least 10 days before the commencement of the hearing shall constitute good cause for a continuance. The member and the Medical Executive Committee shall have the right to receive all evidence which will be made available to the Judicial Review Committee.

b. The member shall have the right to inspect and copy at the member's expense, documentary information relevant to the charges which the Medical Executive Committee has in its possession or under its control, as soon as practicable after the Medical Staff's receipt of the practitioner's request for a hearing. The Medical Executive Committee shall have the right to inspect and copy, at its expense, documentary information relevant to the charges which the member has in his or her possession or control as soon as practicable after receiving the Medical Executive Committee's request. The failure by either party to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

c. The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

(1) whether the information sought may be introduced to support or defend the charges;

(2) the exculpatory or inculpatory nature of the information sought, if any;

(3) the burden imposed on the party in possession of the information sought, if access is granted; and

(4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

d. The member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the hearing officer. Challenges to the impartiality of any Judicial Review Committee member or the hearing officer shall be ruled on by the hearing officer.

e. It shall be the duty of the member and the Medical Executive Committee or its designee 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 prehearing decisions may be succinctly made at the hearing.

7.5-2 Representation

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character. Accordingly, neither the member nor the Medical Executive Committee shall be by legal counsel in the judicial review hearing, unless the judicial review committee determines there are special circumstances that are good cause to have attorneys present or unless the member and the Medical Staff agree that attorneys should be present. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice medicine in the state of California who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative

who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the member is not so represented. The foregoing shall not be deemed to deprive any party of its right to the assistance of legal counsel for the purpose of preparing for the hearing.

7.5-3 The Hearing Officer

The CEO shall appoint a hearing officer to preside at the hearing; provided, however, if the Medical Executive Committee and physician agree on another proposed hearing officer, that mutually agreeable hearing officer may then replace the hearing officer who had been designated by the CEO. The hearing officer may be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney from a firm regularly utilized by the hospital, the Medical Staff or the involved Medical Staff member or applicant for membership, for legal advice 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. 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. 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, which may include but not be limited to asking the judicial review committee to determine if the practitioner shall be deemed to have waived his/her right to a hearing. If requested by the Judicial Review Committee, the hearing officer may participate in the deliberations of such committee-be a legal advisor to it and assist with the drafting of the judicial review committee's decision. The hearing officer shall not be entitled to vote.

7.5-4 Record of the Hearing

A shorthand 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 shorthand reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee 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.

7.5-5 Rights of the Parties

Within reasonable limitations, both sides at the hearing may 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, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

7.5-6 Miscellaneous Rules

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 this Article. 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. The Judicial Review Committee may interrogate the witnesses or request additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments. The hearing

process shall be completed within a reasonable time after notice of the action is received, unless the hearing officer issues a written decision that the member or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

No person shall disrupt any hearing. Any person in attendance (whether a party or any other person) who disrupts a hearing shall be warned by the hearing officer to cease such disruption. If the disruption continues, the hearing officer may exclude such person from the hearing. If the disruptive person is the affected practitioner and the disruption continues after the warning, the judicial review committee may determine the disruption shall be deemed a waiver of the member's right to a hearing and that the member then is deemed to have accepted the Medical Staff's recommendation.

7.5-7 Burdens of Presenting Evidence and Proof

a. At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

b. An applicant for membership or additional privileges shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

c. Except as provided above for applicants for membership or additional privileges, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted as required by California Business and Professions Code Section 809.3(b)(3).

7.5-8 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. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

7.5-9 Basis for Decision

The decision of the Judicial Review Committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the Judicial Review Committee shall be subject to such rights of appeal as described in these bylaws, but shall otherwise be affirmed by the Governing Body as the final action if it is supported by substantial evidence, following a fair procedure.

7.5-10 Decision of the Judicial Review Committee

Within 30 days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be 15 days after final adjournment. The hearing shall not be deemed finally adjourned until the Judicial Review Committee has completed its deliberation. A copy of said decision also shall

be forwarded to the Chief Executive Officer, the Governing Body, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the Governing Body as the final action if it is supported by substantial evidence, following a fair procedure.

## 7.6 APPEAL

### 7.6-1 Time for Appeal

Within 30 days after receipt of the decision of the Judicial Review Committee, either the member 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 party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Governing Body as the final action if it is supported by substantial evidence, following a fair procedure.

### 7.6-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; and/or (b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.6-5.

### 7.6-3 Time, Place and Notice

If an appellate review is to be conducted, the appeal board shall, within 45 days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than 45 nor more than 75 days from the date of such notice of the time, place and date of appellate review, provided, however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held within 45 days from the date the notice of time, place and date of appellate review. The time for appellate review may be extended by the appeal board for good cause.

### 7.6-4 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 (3) 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 firm to assist in the proceeding, but that attorney firm shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Governing Body shall not be the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney firm who assisted the hearing panel, which served as hearing officer or assisted the committee.

### 7.6-5 Appeal Procedure

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review 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 to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the Judicial Review 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, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. 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. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the Governing Body its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Review Committee decision consistent with the standard set forth in Section 7.6-6, or remand the matter to the Judicial Review Committee for further review and decision.

7.6-6 Decision

a. Except as provided in Section 7.6-6 (b), within 30 days after the conclusion of the appellate review proceedings, the Governing Body shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure. The decision shall be in writing, shall specify the reasons for the action taken and shall be sent to the Chief of Staff, the Medical Executive, the subject of the hearing, and the Chief Executive Officer.

b. Should the Governing Body determine that the Judicial Review Committee decision is not supported by substantial evidence, the board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Governing Body. Subject to the availability of the Judicial Review Committee, this further review and the time required to report back shall not exceed 30 days in duration except as the parties may otherwise agree or for good cause as jointly determined by the hearing officer of the Governing Body and the Judicial Review Committee.

7.6-7 Right to One Hearing

Except in circumstances where a new hearing is ordered by the Governing Body or a court because of procedural irregularities, no member 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.

7.7 FAIR REVIEW

7.7-1 Grounds for Fair Review

Except as expressly required to be in compliance with the Medical Staff bylaws, rules and regulations or policies or a policy decision of the hospital (such as the closing of a department, changes in physical plant or equipment, granting an exclusive contract), the taking or recommending of any one or more of the following actions by the Medical Executive Committee for reasons other than a MDCR (except as provided in item i below) shall constitute grounds for a Fair Review.

a. Denial of Medical Staff membership
b. Denial of reappointment
c. Suspension of Medical Staff membership or clinical privileges
d. Termination of Medical Staff membership

e. Denial of requested clinical privileges, other than temporary privileges
f. Reduction in clinical privileges
g. Termination of privileges, other than temporary privileges
h. Denial of membership in requested Medical Staff category or involuntary change in Medical Staff category
i. Summary suspension or restriction of clinical privileges, other than temporary privileges, for fourteen (14) consecutive days or less, for a MDCR

7.7-2 Notice of Adverse Action or Recommended Action. Whenever any of the actions constituting grounds for a Fair Review under Section 7.7-1 above, has been taken or recommended, the Medical Executive Committee shall give written notice to the affected practitioner. The notice shall:

a. Describe what action has been taken or recommended
b. State the reasons for the action or recommendation
c. State that the practitioner is entitled to a Fair Review pursuant to Section 7.7 of the Bylaws, which must be requested in writing, and that the request must be received by the CEO within thirty (30) days after the practitioner's receipt of the notice of adverse action or recommended action

7.7-3 Fair Review

The procedure for requesting, arranging for and conducting a fair review shall be the same as for hearings except that, (1) there is no right to discovery, (2) the CEO shall appoint an arbitrator who shall fulfill the responsibilities of both the hearing officer and the judicial review committee; provided however, if the Medical Executive Committee and physician agree on another proposed arbitrator, that mutually agreeable arbitrator may then replace the arbitrator who had been designated by the CEO with pre-procedural rights of voir dire to confirm the proposed arbitrator is qualified and not biased, (3) the parties must exchange documents and witness lists at least five (5) working days prior to the fair review, and testimony of witnesses and copies of evidence not timely exchanged may be barred, (4) the body whose decision prompted the fair review has the initial burden of producing evidence to support its action or recommendation, with the burden then shifting to the affected practitioner to produce evidence and demonstrate that the decision was unreasonable, and (5) either party may request that the Governing Body review the decision of the arbitrator, the Governing Body to establish the procedure to be followed.

## 7.8 EXCEPTIONS TO FAIR REVIEW, HEARING AND APPEAL RIGHTS

In addition to other exceptions set forth in these bylaws, the fair review, hearing and appeal rights under these bylaws are not applicable under the following circumstances:

7.8-1 Closed Departments/Exclusive Contracts

The hearing and appeal rights under these bylaws do not apply to a practitioner whose application for Medical Staff membership and privileges was denied, or whose membership and/or privileges were terminated or affected on the basis that the privileges he or she seeks are granted only pursuant to a closed staff, exclusive use policy, or exclusive contract.

7.8-2 Medico-Administrative Practitioner

The fair review, hearing and appeal rights under these bylaws do not apply to those persons serving the hospital in a medico-administrative capacity. Termination of such persons' rights to practice in the hospital shall instead be governed by the terms of their individual contract with the hospital.

However, the hearing and appeal rights of these bylaws shall apply to the extent that membership status or clinical privileges, which are independent of the practitioner's contract, are also removed or suspended, unless the contract includes a specific provision establishing alternative procedural rights

applicable to such decisions. Notwithstanding the foregoing, if an action is reportable pursuant to California Business and Professions Code Section 805 or the National Practitioner Data Bank, the affected practitioner shall have the right to a Medical Staff hearing and Governing Body appeal pursuant to this Article IX.

7.8-3 Automatic Suspension or Termination of Membership or Privileges

Notwithstanding other provisions of these Bylaws, the fair review, hearing and appeal rights under these bylaws are not granted if a member's Medical Staff membership and/or clinical privileges are automatically suspended or terminated or automatically deemed resigned in accordance with these bylaws.

7.8-4 Hospital Policy Decision

The fair review, hearing and appeal rights of these bylaws are not available if the hospital makes a decision in consultation with the Medical Executive Committee to have a moratorium on providing certain services, discontinue a service at the Hospital, or to make physical plant changes that adversely affects the staff membership or clinical privileges of any member or applicant.

7.8-4 Minimum Activity Requirements

The fair review, hearing and appeal rights in these bylaws are not available if membership or privileges are denied, restricted or terminated or staff categories are changed or not changed because of a failure to meet the minimum activity requirements set forth in the Medical Staff bylaws, rules, policies or privilege criteria. Notwithstanding the foregoing, if the individual believes the activity count is erroneous and that individual has met the minimum activity requirements, within thirty days of notification of actions taken based upon the failure to meet minimum activity requirements, the individual can submit to the Medical Staff Office a list of his or her activity to demonstrate satisfaction of such requirements. The Medical Staff then will review the list submitted by the individual to ascertain if there was an error in the Medical Staff's calculations.

7.9 EXPUNGEMENT OF DISCIPLINARY ACTION

Upon petition, the Medical Executive Committee, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation; provided; however, the discipline must have been imposed more than five (5) years ago and can only be removed if the type of concern that was the basis for such discipline did not recur after such discipline.

7.10 NATIONAL PRACTITIONER DATA BANK REPORTING

7.10-1 Adverse Actions

The authorized representative shall report an adverse action to the National Practitioner Data Bank when required by the applicable law and regulation. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

7.10-2 Dispute Process

If no hearing was requested, a member who was the subject of an adverse action report may request an informal meeting to discuss the report filed. The meeting shall not constitute a hearing and shall be limited to the issue of whether the intended report is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the Chair of the subject's department, and the hospital's Authorized Representative, or their respective designee.

## 7.11 PRIVILEGE RETORATION AND RESTRICTION REMOVAL

Any privilege denial, revocation or restriction may be removed only upon formal application by the practitioner unless the privilege is granted, restored or the restriction removed by the Medical Executive Committee, prior to final decision by the Governing Body, or by the Governing Body in its final decision. However, no such application may be submitted within two (2) years. For purposes of this section, the two years shall be calculated from the date the applicant completed any and all hearings, appeals and court actions to challenge such adverse action. If the applicant withdrew his/her application for such privileges after the applicant was on notice of a pending adverse decision, the two years shall be calculated from the date the applicant was withdrawn. Such practitioner, his application, and the processing thereof shall comply with the provisions of these bylaws applicable to first-time applicants for the denial, revoked or restricted privileges.

# ARTICLE 8 - OFFICERS

## 8.1 OFFICERS OF THE MEDICAL STAFF

### 8.1-1 Identification

The officers of the Medical Staff shall be the Chief of Staff, Chief of Staff-Elect, immediate past Chief of Staff, and Secretary-Treasurer.

### 8.1-2 Qualifications

Officers are limited to those who are physicians holding unrestricted licenses and must be members of the active Medical Staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

### 8.1-3 Nominations

a. Nominations shall be made by a nominating committee. The nominating committee shall consist of three (3) members of the Active Medical Staff appointed by the Chief of Staff subject to approval of a majority of the Medical Executive Committee. The nominating committee shall convene at least sixty (60) days prior to the December meeting of the Medical Staff and shall submit to the Medical Staff Coordinator one or more qualified nominees for each office at least forty five (45) days prior to the December meeting to consider the nominations. The nominees shall be for the offices of Chief of Staff-Elect, Secretary-Treasurer, and two-members at large of the Medical Executive Committee.

b. Further nominations may be made for any office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least ten percent (10%) of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chairman of the nominating committee as soon as reasonably practicable, but at least ten (10) days prior to the date of the December meeting of the Medical Staff.

c. Nominations may be made from the floor at the time of the December meeting of the Medical Staff. The nominee must be present or have provided written consent to have his or her name placed in nomination.

d. The voting members of the Medical Staff shall be advised of the Nominating Committee's decision by notice delivered or mailed at least thirty (30) days prior to the December Meeting, at which time the election will be held. This may also serve as a written ballot.

### 8.1-4 Elections

The Chief of Staff-Elect, Secretary-Treasurer and two Members at Large of the Medical Executive Committee shall be elected at the December meeting of the medical Staff. Election shall be by oral vote or showing of hands unless written ballot is requested by two (2) or more eligible voters.

Voting by absentee ballot is permitted. In order to be counted, absentee ballots must be requested within fifteen days prior to the election and received by the medical staff coordinator prior to the election. Absentee ballots shall include handwritten signatures on the envelope for authentication. Voting by proxy shall not be permitted. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a

run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

8.1-5 Term of Elected Office

Each officer shall serve a one (1) year term, commencing on the first day of the Medical Staff year following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff and the Chief of Staff-Elect shall automatically assume the office of Chief of Staff. Notwithstanding the foregoing, the nominating committee may nominate the Chief of Staff to serve a second year, subject to Chief of Staff's agreement to continue for a second term and re-election by the active staff. If the Chief of Staff is elected to serve a second year, the nominating committee may nominate the Chief of Staff-Elect and Secretary-Treasurer to serve a second term.

8.1-6 Recall of Officers

Any Medical Staff officer and member at large whose election is subject to these bylaws may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a Medical Staff officer or member at large may be initiated by the Medical Executive Committee or may be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff officers who actually cast votes at the special meeting in person or by mail ballot.

8.1-7 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, the officer's loss of membership or status in good standing on the Medical Staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, then the Chief of Staff-Elect shall serve out that remaining term and shall immediately appoint an ad hoc Nominating Committee to decide promptly upon nominees for the office of Chief of Staff-Elect. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall occur at the next regular staff meeting. If there is a vacancy in the office of Chief of Staff-Elect, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

8.2 DUTIES OF OFFICERS

8.2-1 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 and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where 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 calling, presiding at, and being responsible for the agenda of all meetings thereof;

d. serving as an ex officio member of all other staff committees without vote, unless the membership in a particular committee is required by these bylaws;

e. interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the Hospital;

f. appointing, in consultation with the Medical Executive Committee, committee members for all standing Medical Staff, liaison, and multi-disciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;

g. representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer;

h. being a spokesperson for the Medical Staff in external professional and public relations;

i. performing such other functions as may be assigned to the Chief of Staff by these bylaws, the Medical Staff, or by the Medical Executive Committee;

j. serving on liaison committees with the Governing Body and Administration, as well as outside licensing or accreditation agencies;

k. appointing ad hoc committees as are necessary to assist the Medical Executive Committee and the Chief of Staff to fulfill their respective functions, and to designate the Chair of such committees; and

l. acting on behalf of the Medical Executive Committee by performing Medical Executive Committee functions that the Chief of Staff reasonably believes must be performed prior to the next regular or special meeting.

8.2-2 Chief of Staff-Elect

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

8.2-3 Immediate Past Chief of Staff

The immediate past Chief of Staff shall be a member of the Medical Executive Committee and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these bylaws, or by the Medical Executive Committee.

8.2-4 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 general Medical Staff meetings;

c. calling meetings on the order of the Chief of Staff or Medical Executive Committee;

d. attending to all appropriate 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 - CLINICAL DEPARTMENTS AND SECTIONS

### 9.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND SECTIONS

The Medical Staff may be divided into clinical departments. Each department shall be organized as a separate component of the Medical Staff and shall have a chair selected and entrusted with the authority, duties, and responsibilities specified in Section 9.6. A department may be further divided, as appropriate, into sections which shall be directly responsible to the department within which it functions, and which shall have a section chief selected and entrusted with the authority, duties and responsibilities specified in Section 9.7. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or sections.

### 9.2 ASSIGNMENT TO DEPARTMENTS

a. The Medical Executive Committee shall, after consideration of the request of the practitioner and the recommendations of the clinical departments, as submitted through the Credentials and Privileging Committee, recommend initial departmental assignments for all Medical Staff members and all other approved practitioners with privileges. No staff member may belong to more than one department at any given time.

b. A member of any department may obtain privileges in any other department upon application to that department after establishing his qualifications for those privileges.

c. It is the intention of these bylaws that a practitioner belongs to a department of his choosing in which he is active. His choice of department is not necessarily fixed and may be changed on an annual basis upon application to the Medical Executive Committee.

### 9.3 ADDITIONAL DEPARTMENTS

It is not the intention of these bylaws to limit the number of clinical departments. At any time, if thirty or more members of the same specialty or discipline vote by a 2/3 majority to establish a separate department, this may be accomplished by amendment to the Rules and Regulations, which amendment shall not require amendment of the Bylaws.

### 9.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

a. conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department as required by State, Federal and licensing and accrediting bodies (e.g., The Joint Commission). The department shall collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all aspects of care performed under the jurisdiction of the department, regardless of whether the member whose work is subject to such review is a member of that department;

b. recommending to the Medical Executive Committee guidelines for the granting of privileges and the performance of specified services within the department;

c. evaluating and making appropriate recommendations regarding the qualifications of applicants seeking appointment or reappointment and privileges within the department;

d. conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

e. reviewing and evaluating departmental adherence to:

(1) Medical Staff Bylaws, Rules, policies and procedures and

(2) sound principles of clinical practice;

f. coordinating patient care provided by the department's members with nursing and ancillary patient care services;

g. submitting written reports to the Medical Executive Committee concerning:

(1) the department's review and evaluation activities, actions taken thereon, and the results of such action;

(2) recommendations for maintaining and improving the quality of care provided in the department and the hospital, as outlined in the overall hospital Performance Improvement Plan; and

(3) any department analyses of patient care.

h. meeting at least quarterly and as needed for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions;

i. establishing such committees or other mechanisms as necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;

j. taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;

k. accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department;

l. appointing such committees as may be necessary or appropriate to conduct department functions;

m. formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff; and

n. assuring that all medical records meet the highest standards of patient-care usefulness and of historical validity.

## 9.5 FUNCTIONS OF SECTIONS

Subject to approval of the Medical Executive Committee, each section shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, concurrent/retrospective patient care reviews, evaluation of patient care practices, credentials review and privileges delineation, and continuing education programs. The section shall transmit regular reports to the department chair on the conduct of its assigned functions.

## 9.6 DEPARTMENT CHAIRS

### 9.6-1 Qualifications

Each department shall have a chair who shall be a member in good standing of the active Medical Staff and shall be qualified by training, experience and demonstrated ability in at least one of the clinical areas covered by the department. Department Chairs must be certified by an appropriate specialty board.

### 9.6-2 Selection

Department Chairs shall be elected every one (1) year by those members of the department who are eligible to vote for general officers of the Medical Staff. For the purpose of this election, each Department Chair shall appoint a nominating committee of three (3) members at least 60 days prior to the meeting at which election is to take place. The recommendations of the Nominating Committee of one or more nominees for Chair shall be circulated to the voting members of each department at least 20 days prior to the election. Nominations also may be made from the floor when the election meeting is held, as long as the nominee is present and consents to the nomination or has filed a written consent. Election of Department Chairs shall be subject to ratification by the Medical Executive Committee. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt. If there is a dispute regarding the election process, the outcome or a tie-vote that remains after a run off between the top two nominees, the dispute or outcome, as applicable, will be resolved by the Medical Executive Committee.

### 9.6-3 Term of Office

Each Department Chair shall serve a minimum one (1) year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or privileges in that department. Department officers shall be eligible to succeed themselves.

### 9.6-4 Removal

After election and ratification, removal of Department Chairs from office may occur for cause by a two-thirds vote of the Medical Executive Committee or a two-thirds vote of the department members eligible to vote on departmental matters who cast votes.

### 9.6-5 Duties

Each Chair shall oversee the clinically related activities of the department and oversee the administratively related activities of the department that are not provided by the Hospital and shall have the following authority, duties and responsibilities and shall assume all of them and shall otherwise perform such duties as may be assigned:

a. act as presiding officer at departmental meetings;

b. report to the Medical Executive Committee and to the Chief of Staff regarding all clinical and administrative activities within the department;

c. continuously assess and improve the quality of care, treatment and services including monitoring the quality of patient care and professional performance rendered by members with privileges in the department through a planned and systematic process; and overseeing the effective conduct of the patient care, evaluation, and monitoring functions delegated to

the department section by the Medical Executive Committee as outlined in the overall hospital Performance Improvement Plan;

d. develop and implement departmental programs for concurrent/retrospective patient care review, on-going monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement;

e. be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and hospital and make specific recommendations and suggestions regarding the departments including but not limited to recommendations for a sufficient number of qualified and competent persons to provide care, treatment and services and recommendations regarding space and other resources needed by the department;

f. transmit to the Medical Executive Committee the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for privileges, monitoring of specified services, and corrective action with respect to persons with privileges in the department;

g. endeavor to enforce the Medical Staff bylaws, rules, policies and regulations within the department;

h. implement within the department appropriate actions taken by the Medical Executive Committee;

i. participate in every phase of administration of the department, including cooperation with the nursing service and the hospital administration in matters such as personnel, supplies, special regulations, standing orders and techniques;

j. assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;

k. recommend delineated privileges for each member of the department and determine the qualifications and competence of those within the department who are not licensed independent practitioners but who provide patient care, treatment and services;

l. provide such oversight as is required to help assure the integration of the department into the primary functions of the Hospital and coordination and integration of interdepartmental and intradepartmental services;

m. prepare a call list if required for Emergency Room specialty back up;

n. assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or organization;

o. provide for orientation and continuing education of all persons in the department or service;

p. appoint ad hoc committees as are necessary to assist the department and the Chair to fulfill their respective functions, and to designate the Chair of such committees;

q. develop and implement policies and procedures that guide and support the provision of services; and

r. perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the Medical Executive Committee; and

## 9.7 COMMITTEE/SECTION CHAIRS

### 9.7-1 Qualifications

Each section/committee may have a Chair who shall be a member of the active Medical Staff and a member of the division which he or she is to head, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the section/committee.

### 9.7-2 Selection

Absent an applicable Medical Staff policy, each section/committee Chair shall be selected or elected with such mechanism as such section/committee may adopt. Vacancies due to any reason shall be filled for the unexpired term by the Department Chair.

### 9.7-3 Term of Office

Each section/committee chair shall serve one term which coincides with the Medical Staff year or until her a successor is chosen, unless the Chair shall sooner resign or be removed from office or lose Medical Staff membership or privileges in that section/committee. Chairs shall be eligible to succeed themselves.

### 9.7-4 Removal

After appointment and ratification, a section/committee chair may be removed by the Department Chair or the Medical Executive Committee.

### 9.7-5 Duties

Each section/committee chair shall:

a. act as presiding officer at meetings;

b. assist in the development and implementation, in cooperation with the Department Chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the section as outlined in the overall hospital Performance Improvement Plan;

c. evaluate the clinical work performed in the section;

d. conduct reviews and submit reports and recommendations to the Department Chair regarding the privileges to be exercised within the section by members of or applicants to the Medical Staff; and

e. perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the Chief of Staff, or the Medical Executive Committee.

## ARTICLE 10 - COMMITTEES

### 10.1 DESIGNATION

Medical Staff committees shall include, but not be limited to, the Medical Staff meeting as a committee of the whole, meetings of departments and sections, meetings of committees established under this Article and in the Rules and Regulations, and meetings of special or ad hoc committees created these Bylaws. The committees described in this Article and in the Rules and Regulations shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or others who are authorized to do so under these Bylaws. 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.

### 10.2 GENERAL PROVISIONS

#### 10.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of one year, and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

#### 10.2-2 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or if the Medical Executive Committee determines other good cause exists, that member may be removed by the Medical Executive Committee.

#### 10.2-3 Vacancies

Unless otherwise specifically provided, 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 is removed for cause, a successor may be selected by the Medical Executive Committee.

### 10.3 EXECUTIVE SESSION

Executive session is a meeting of a Medical Staff committee, which only voting Medical Staff committee members may attend, unless others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

### 10.4 MEDICAL EXECUTIVE COMMITTEE

#### 10.4-1 Composition

The Medical Executive Committee shall consist of the following persons:

a. the officers of the Medical Staff;

b. the department chairs; and

c. four at-large members of the of the active Medical Staff who shall be nominated and elected for a two-year term in the same manner and at the same time as provided in Sections 8.1-3

through 8.1-5 for the nomination and election of officers and may be removed as provided in Section 8.1-6.

d. Non-voting members will include the Chief Executive Officer, Associate Administrator, the Performance Improvement Committee Chair, and VP of Patient Care.

e. Additional ex officio members can be appointed at the discretion of the Medical Executive Committee.

10.4-2 Duties

The duties of the Medical Executive Committee shall include, but not be limited to:

a. representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these bylaws;

b. coordinating and implementing the professional and organizational activities and policies of the Medical Staff;

c. receiving and acting upon reports and recommendations from Medical Staff departments, divisions, committees, and assigned activity groups;

d. recommending actions to the Governing Body on matters of a medical-administrative nature;

e. recommending Bylaws, Rules and policies regarding the structure of the Medical Staff, the mechanisms to review credentials and delineate individual privileges, the organization of quality assessment and improvement activities, the mechanisms of termination of Medical Staff membership and fair hearing procedures, and other matters relevant to the operation of an organized Medical Staff;

f. evaluating the medical care rendered to patients in the hospital as outlined in the overall hospital Performance Improvement Plan that has been approved by the Medical Executive Committee;

g. participating in the development of all Medical Staff and hospital policy, practice, and planning;

h. reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Governing Body regarding staff appointments and reappointments, assignments to departments, privileges, and corrective action;

i. taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in Medical Staff corrective or review measures when warranted;

j. taking reasonable steps to develop continuing education activities and programs for the Medical Staff;

k. designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff and approving or rejecting appointments to those committees by the Chief of Staff;

l. reporting to the Medical Staff at each regular staff meeting;

m. assisting in the obtaining and maintenance of accreditation;

n. developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

o. appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;

p. reviewing the quality and appropriateness of services provided by contract physicians as outlined in the overall hospital Performance Improvement Plan that has been approved by the Medical Executive Committee;

q. reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;

r. approving policies and procedures necessary for assuring a roster of specialty physicians available for providing consultation to the Emergency Department; and

(1) The Medical Executive Committee shall consider the following factors: availability of adequate physician resources, frequency of emergency cases for each specialty, and other factors deemed appropriate by the Medical Executive Committee.

(a) Each member of the Medical Staff shall participate in such emergency coverage or consultation panels as may be required by the Medical Executive Committee. Participation may be voluntary in a given specialty if:

1) it is not a condition of the hospital's Basic Emergency Medical Service licensing permit that a roster of physicians in that specialty be available for consultation at all times; or

2) the Medical Executive Committee determines that the specialty can be covered adequately and fairly on a voluntary basis.

(b) The Medical Executive Committee may exempt individual physicians from participation in such a panel, in any specialty, upon a showing of good cause.

(c) Failure to comply with these policies and procedures shall constitute grounds for corrective or disciplinary actions pursuant to provisions in the Medical Staff Bylaws, Rules and Regulations.

s. establishing a mechanism for dispute resolution between Medical Staff members (including limited license practitioners) involving the care of a patient.

10.4-3 Meetings

The Medical Executive Committee shall meet as often as necessary, but not less than 10 meetings each year and shall maintain a record of its proceedings and actions.

## ARTICLE 11 - MEETINGS

### 11.1 ANNUAL MEETING

The annual meeting of the Medical Staff shall be the business meeting in December of each year. At this meeting, the retiring officers and committees shall make reports to the staff, including review and evaluation of the work done in clinical departments during the previous year; the Chief of Staff-Elect and Secretary-Treasurer shall be elected for the ensuing year, and two members-at-large of the Medical Executive Committee shall be elected to serve for two year terms. The Medical Executive Committee will organize the members-at-large to serve staggered two-year terms.

### 11.2 REGULAR MEETINGS

Meetings of the Medical Staff shall be held semi-annually, in June and December, at a time and place decided by the Medical Executive Committee and announced to the staff at least two weeks in advance of the meeting.

11.2-1 The presence of 12 members of the Active Staff at any regular or special meeting in person or through authenticated written ballot as described in these Bylaws shall constitute a quorum for the purpose of amending these bylaws of the medical staff or for the election or removal of medical staff officers. The presence of 12 members of the active staff of the members of the Active Medical Staff shall constitute a quorum for all other actions.

### 11.3 SPECIAL MEETINGS

a. Special meetings of the Medical Staff may be called at any time by the Chief of Staff. The Chief of Staff shall call special meetings within 30 days after receipt of a written request for a special meeting, signed by not fewer than ten members of the active staff.

b. The Medical Executive Committee shall designate the time and place of any special meeting. At any special meeting, no business shall be transacted excepting that stated in the notice calling the meeting.

c. Written or printed notices stating the place, day and hour of a special meeting shall be delivered, either personally or by mail, to each member of the active staff at least 10 days before the date of such meeting by, or at the direction of, the Chief of Staff or other persons authorized to call the meetings. If mailed, the notice of meetings shall be deemed delivered when deposited, postage pre-paid, in the United States mail, addressed to each staff member at his address as it appears on the records of the hospital. The attendance of a member of the Medical Staff at a meeting shall constitute a waiver of notice of such meeting.

### 11.4 COMMITTEE MEETINGS

11.4-1 Regular Meetings

Except as otherwise specified in these Bylaws, the chairs of committees may establish the times for holding of regular meetings.

11.4-2 Notice of Meetings

Written or oral notice stating the place, day and hour of any special meeting or of any regular meeting (except those determined by resolution) shall be given to each member of the committee not less than three days before the time of such meeting by the person or persons calling the meeting; except that special meetings of the Medical Executive Committee may be called upon twenty-four hours' notice (subject to satisfying quorum requirements).

11.4-3 Quorum

For committees other than the Medical Executive Committee, a quorum shall consist of the lesser of a majority of the number of voting members on the committee or three (3) voting members of the committee. A quorum for the Medical Executive Committee shall be five members, and five affirmative votes will be required to pass any Medical Executive Committee action.

11.4-4 Committee Functions

Committees shall have such powers of action as delegated to them through the Medical Staff Bylaws or Rules and Regulations or by the Medical Executive Committee.

11.4-5 Member of Committees

Committee membership may be modified by the Chief of Staff with the recommendation of the chair of the committee at any time during the Medical Staff year. Each member of the Medical Staff should make every effort to attend meetings of the committees to which the member has been appointed.

11.4-6 Minutes

Minutes of each regular and special meeting of a committee shall be prepared and shall include a record of the attendance of members and the vote taken on significant matters. Minutes shall be reviewed and maintained in a permanent file.

11.5 DEPARTMENT MEETINGS

11.5-1 Regular Meetings

Departments shall hold regular meetings as often as necessary but at least quarterly for purposes of review of clinical experience of practitioners with privileges in the department. The emphasis will be on clinical disease, morbidity and mortality, and will be relevant to patient care within the hospital.

11.5-2 Special Committees

At the discretion of the Chair of the Department, members of the department may be appointed to sub-committees to carry out the various aspects of review and evaluation of the clinical work conducted in the department or the administrative activities of the department.

11.5-3 Special Meetings

Special meetings of any department may be called by or at the request of the Chair thereof, the Chief of Staff or one-third of the members of the active staff in that department.

11.5-4 Notice of Meetings

Written or oral notice stating the place, day and hour of any meeting shall be given to each member of the department not less than three (3) days before the time of such meeting by the person or persons calling the meeting.

11.5-5 Quorum

For meeting of the department, a quorum shall consist of at least three (3) voting members.

## 11.6 MANDATORY ATTENDANCE REQUIREMENTS

A practitioner whose conduct or patient's clinical course is scheduled for discussion at a department or committee shall be notified and shall be expected to attend such meeting. The department, committee or its chair may mandate a practitioner's attendance. If attendance is mandatory, a notice of mandatory attendance will be sent to the practitioner by mail. Failure by a practitioner to attend the meeting for which attendance is mandatory shall result in the automatic suspension of the practitioner's privileges, unless the practitioner has submitted facts that demonstrate the practitioner should be excused for good cause that are accepted as good cause by the committee or department chair and then ratified by the Medical Executive Committee at its next meeting.

## 11.7 MINUTES

Except as otherwise specified in the Medical Staff Bylaws or Rules and Regulations, minutes of each regular and special meeting of the department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes will be presented at the next meeting for review and approval. If no changes are advised, the minutes will be forwarded to the Medical Executive Committee.

## 11.8 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

## 11.9 MANNER OF ACTION

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. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Upon the Chair's agreement, Committee action may be conducted by telephone or video conference which shall be deemed to constitute a meeting for the matters discussed in that telephone or video conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least 2/3 of the members entitled to vote. Appearance at a meeting is deemed a waiver of notice of such meeting.

## ARTICLE 12 - CONFIDENTIALITY, IMMUNITY AND RELEASES

### 12.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising privileges within this hospital, an applicant:

a. authorizes representatives of the hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

b. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;

c. agrees to be bound by the provisions of this article and to waive all legal claims against any representative of the Medical Staff or the hospital who acts in accordance with the provisions of this article; and

d. acknowledges that the provisions of this article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of privileges at this hospital.

### 12.2 CONFIDENTIALITY OF INFORMATION

#### 12.2-1 General

Records and proceedings of all Medical Staff committees, having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the Medical Staff, meetings of departments and sections, meetings of standing, special and ad hoc committees and 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.

#### 12.2-2 Breach of Confidentiality

As effective 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, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, sections, or committees, except in conjunction with other health facility, professional society, or licensing authority, and except as required by law, is outside appropriate standards of conduct for this Medical Staff, violates the Medical Staff Bylaws, 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. Voluntary disclosure of peer review information will not be made except to persons who are authorized to receive such information in the conduct of Medical Staff affairs.

#### 12.2-3 Medical Staff Peer Review Activity Confidentiality Agreement

All Medical Staff members will be required to sign an affidavit regarding the following:

I acknowledge that as a member of the Medical Staff of the San Pablo Campus and/or the San Pablo Campus, I may be required to perform, provide input or otherwise be involved in the evaluation and improvement of the quality of care rendered at either or both Campuses. I further acknowledge that confidentiality is vital to the free and candid discussion necessary to effective Medical Staff peer review activities. Accordingly, I agree to respect and maintain the confidentiality of all discussions,

deliberations, records and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of Medical Staff affairs.

I further understand that my participation in quality assurance activities is in reliance on my belief that the confidentiality of these activities will be preserved by all other individuals involved. I therefore understand and agree that the Medical Staff shall be entitled to take such action as it deems appropriate to ensure that this confidentiality is maintained including action necessitated by a breach or threatened breach of this provision by any person, including myself.

## 12.3 IMMUNITY FROM LIABILITY

### 12.3-1 For Action Taken

Each representative of the Medical Staff and hospital shall be immune, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or hospital.

### 12.3-2 For Providing Information

Each representative of the Medical Staff and hospital and all third parties shall be immune, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise privileges or provide services at this hospital.

## 12.4 ACTIVITIES AND INFORMATION COVERED

### 12.4-1 Activities

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

a. applications for appointment, reappointment, or privileges;

b. corrective action, including summary suspension;

c. hearings and appellate reviews;

d. medical care evaluations;

e. utilization reviews;

f. other hospital, department, section, or committee activities related to quality patient care and professional conduct; and

g. queries and reports concerning peer review organizations, Medical Board of California and similar reports and National Practitioner Data Bank Report.

## 12. 5 INDEMNIFICATION

12.5-1 Scope of Indemnification.

The Hospital shall indemnify, defend and hold harmless the Medical Staff, its members and representatives from and against losses and expenses (including attorney(s) 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, witness for or representative of the Medical Staff, a department, service, committee or hearing panel;

b. As a member, witness for or representative of the Hospital Governing Body or any Hospital task force, group or committee: and

c. As a person providing information to the Medical Staff, Hospital or Governing Body, or a committee, group, officer, representative, or employee of the Medical Staff, Hospital or Governing Body for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member, AHP, or an applicant.

The Medical Staff or individual may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, and any available insurance or otherwise and in any sequence the member or Medical Staff determines. Payment of any losses or expenses by the Medical Staff or individual is not a condition precedent to the Hospital's defense and indemnification. Although the Hospital shall consult with the Medical Staff and individual, if requested, regarding the qualifications and selection of the counsel and shall assure that the attorney(s) selected are qualified and experienced in the type of matters that are the subject of the action, the Hospital shall have the right to select and manage the defense.

12.5-2 Exception to Indemnification.

Notwithstanding Section 12.5-1:

a. The Hospital shall not be obligated to indemnify, defend and hold harmless those individuals and/or the Medical Staff who a judge or jury determines acted in bad faith and with malice or motivation of personal gain or if the Medical Staff or individuals fail to notify the Hospital, notification to either be delivered or addressed to the Hospital CEO, of a summons, lawsuit or other legal or equitable action in a reasonable timely manner so that the Hospital has an opportunity to timely respond in order to provide a defense.

b. If the Hospital alleges that the Medical Staff or individuals acted in bad faith and with malice or motivation of personal gain, then from and after the time the Hospital alleges such bad faith, malice or inappropriate motivation, the Medical Staff or individuals who are the subject of such allegations shall have the right to be represented at the Hospital's expense by counsel separate from the Hospital, but shall repay the Hospital for any and all losses and expenses (including attorneys' fees, judgments, settlements and other costs) advanced by Hospital in providing such separate defense only if a judge or jury determines the Medical Staff acted in bad faith and with malice or motivation of personal gain.

## 12.6 CUMMULATIVE EFFECT

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

## ARTICLE 13 - GENERAL PROVISIONS

### 13.1 RULES AND REGULATIONS

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall periodically review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations shall be submitted to the Medical Executive Committee for review and approval. Following notice to members of the active staff of proposed adoption, amendment or repeal of the Rules and Regulations, the Medical Executive Committee may recommend proposed Rules and Regulations to the Governing Body for approval. Such Rules and Regulations shall be effective following approval of the Governing Body, which approval shall not be withheld unreasonably. If the Governing Body fails to act within ninety (90) days after the Medical Executive Committee submitted Rules and Regulations to the Governing Body for approval, the Governing Body will be deemed to have approved such Rules and Regulations. Applicants and members of the Medical Staff shall be governed by such rules and regulations as are properly initiated and adopted. If there is conflict between the Bylaws and the Rules and Regulations, the Bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

a. These shall relate to the proper conduct of the Medical Staff organization activities as well as to the level of practice that is to be required of each practitioner in the hospital.

b. Such rules and regulations shall be a part of these bylaws, except that, following notice to the members of the active staff, Rules may be amended (i) upon approval by two-thirds vote of the Medical Executive Committee and Governing Body approval, or (ii) at any regular meeting of the Medical Staff at which a quorum is present or at any special meeting on notice by a majority vote of the members of the medical staff who are present and eligible to vote and subject to Governing Body approval.

c. Notwithstanding the foregoing, the Medical Executive Committee, with the approval of the Governing Body, may adopt amendments to general medical staff rules or department rules provisionally without notice to the active medical staff upon a documented need for an urgent amendment to comply with applicable law or regulation. Following notice of such action, members of the active staff, by petition signed by at least one-third of such members, may ask the medical executive committee to reconsider such changes.

### 13.2 POLICIES

Policies shall be developed as necessary to implement more specifically the general principles found within these bylaws and the Medical Staff rules. The policies may be adopted, amended or repealed by majority vote of the Medical Executive Committee, subject to approval by the Governing Body. Such policies shall not be inconsistent with the Medical Staff or hospital bylaws, rules or other policies.

### 13.3 ACTIVE STAFF PETITION TO MEDICAL EXECUTIVE COMMITTEE

If members of the active staff, by written petition signed by at least one-third of such members, ask the Medical Executive Committee to reconsider any Rule, policy or action (other than a recommendation or action taken with respect to a particular individual, e.g. recommendation for appointment, reappointment, disciplinary action), the Medical Executive Committee shall promptly schedule a meeting with up to three individuals representing those who have signed the petition to discuss the request.

13.4 NOTICE OF AMENDMENTS TO RULES AND POLICIES

After Governing Body approval, members of the Medical Staff shall be notified of adoption or amendment of Rules and policies. The method of such notice shall be as determined by the Medical Executive Committee, which may include but not be limited to a notice posted in a location used by the doctors or an intranet posting.

13.5 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, and to determine the manner of expenditure of such funds received. Staff dues are due and payable February 1st of each year. Failure to pay by April 1st will automatically result in loss of staff membership.

13.6 FINES

Subject to the approval of the Governing Body, the Medical Executive Committee from time to time may approve fines or monetary penalties to promote compliance with the Medical Staff's bylaws, rules or regulations.

13.7 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both sexes wherever either term is used.

13.8 AUTHORITY TO ACT

Any member or members who act 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.

13.9 DIVISION OF FEES

Any division of fees (as defined by Business and Professions Code 650) by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

13.10 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted shall be sent by mail, e-mail or facsimile. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof, shall be addressed as follows:

> Name and proper title of addressee, if known or applicable; name of department, division, or committee; (c/o Medical Staff Coordinator, Chief of Staff); Doctors Medical Center, 2000 Vale Road, San Pablo, California 94806.

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the Medical Staff or the hospital.

## 13.11 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairs, or the Medical Executive Committee shall, at least 20 days prior to the date of 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 which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

## 13.12 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as Medical Staff representatives to local, state and national hospital Medical Staff sections should be filled by such selection process as the Medical Staff may determine. Nominations for such positions shall be made by a nominating committee appointed by the Medical Executive Committee.

## 13.13 MEDICAL STAFF CREDENTIALS FILES

### 13.13-1 Insertion of Adverse Information

The following applies to actions relating to requests for insertion of adverse information into the Medical Staff member's credentials file, other than in the course and scope of the credentialing, performance improvement, OPPE, FPPE and corrective actions processes as described in the Bylaws, Rules and policies of the Medical Staff and the hospital's Performance Improvement process:

a. Any person may provide information to the Medical Staff about the conduct, performance or competence of its members.

b. When a request is made for insertion of adverse information into the Medical Staff member's credentials file, a subcommittee of the Medical Executive Committee shall review such a request.

c. After such a review a decision will be made by the subcommittee of the Medical Executive Committee to:

(1) not insert the information;

(2) notify the member of the adverse information by a written summary and offer the member the opportunity to rebut this assertion before it is entered into the member's file; or

(3) request the Medical Executive Committee to initiate an investigation as outlined in Section 6.1-2 of these bylaws.

d. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

### 13.13-2 Review of Adverse Information at the Time of Reappraisal and Reappointment

The following applies to the review of adverse information in the Medical Staff member's credentials file at the time of reappraisal and reappointment.

a. Prior to recommendation on reappointment, the appropriate Privileges and Credentials Committee, as part of its reappraisal function, shall review any adverse information in the credentials file pertaining to a member.

b. Following this review, the appropriate Privileges and Credentials Committee shall determine whether documentation in the file warrants further action~~.~~, including but not limited to whether to recommend investigation and/or adverse action to the Medical Executive Committee.

c. The procedures set forth in these Bylaws shall be followed if the Medical Executive Committee commences an investigation or recommends adverse action.

13.13-3 Confidentiality

The following applies to records of the Medical Staff and its Committees responsible for the evaluation and improvement of patient care:

a. The records of the Medical Staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

b. Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.

c. Information which is disclosed to the governing body of the hospital or its appointed representatives -- in order that the governing body may discharge its lawful obligations and responsibilities -- shall be maintained by that body as confidential.

d. Information contained in the credentials file of any member may be disclosed with the member's consent, or to any Medical Staff or professional licensing board, or as required by law. However, any disclosure outside of the Medical Staff that is not required by law shall require the authorization of the Chief of Staff and the concerned department chair and notice to the member.

e. A Medical Staff member shall be granted access to his/her own credentials file, subject to the following provisions:

(1) timely written notice of such shall be made by the member to the Chief of Staff or the Chief of Staff's designee; and

(2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member.

f. In the event a Notice of Charges is filed against a member, access to the member's own credentials file shall be governed by Section 7.5-1.

## 13.14 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Staff shall review and make recommendations to the Governing Body regarding quality of care issues related to exclusive arrangements for physician and/or professional services, prior to any decision being made, in the following situations:

a. the decision to execute an exclusive contract in a previously open department or service;

b. the decision to renew or modify an exclusive contract in a particular department or service;

c. the decision to terminate an exclusive contract in a particular department or service.

## ARTICLE 14 - ADOPTION AND AMENDMENTS OF BYLAWS

### 14.1 PROCEDURE

14.1-1 Initiation of Bylaws Amendments

The (i) Medical Executive Committee, (ii) the Chief of Staff, (iii) the Bylaws Committee after approval by the Medical Executive Committee, or (iv) a written petition signed by at least ten percent (10%) of the members in good standing who are entitled to vote, may submit proposed Bylaws or a Bylaws amendment. All proposed amendments will be submitted to the Medical Executive Committee. If the Medical Executive Committee disagrees with the substance of an amendment proposed by the petitioners, the Medical Executive Committee will schedule a meeting with at least 3 of the members who signed the petition to discuss the Medical Executive Committee's objections. If the Medical Executive Committee and the individuals representing the petitioners cannot agree regarding the proposed Bylaws amendments, and if the amendment is not in violation of any applicable laws, regulations or accreditation standards, the amendment and the Medical Executive Committee's objections will be submitted to active staff for vote in accordance with this Article. The Medical Executive Committee may decide to send proposed Bylaws or amendments to the Governing Body for review prior to approval.

14.1-2 Action on Bylaw Change

If a quorum is present at a duly noticed meeting for the purpose of enacting a bylaw change as outlined in these Bylaws, the change shall require an affirmative vote of 2/3 of the members voting in person or by written ballot.

14.1-3 Approval Process

Proposed Bylaws or amendments to the Bylaws may be approved by the Medical Staff through either of the following processes. The Medical Executive Committee shall determine which of the following two processes shall be used to approve the proposed Bylaws or Bylaws amendments:

a. The proposed Bylaws or amendments to the Bylaws and a ballot shall be mailed to all of the Medical Staff members who are entitled to vote. The notice shall include the exact wording of the existing Bylaws and the proposed change. The notice shall inform members that they have thirty (30) days to return their ballots to the Medical Staff Office. The affirmative vote of a majority of the returned ballots received within the foregoing thirty (30)days are required for the Medical Staff to approve the proposed Bylaws or amendments to the Bylaws, or

b. The proposed Bylaws or amendments to the Bylaws may be approved by a majority of the Medical Staff members who are entitled to vote at either (i) a regular meeting if such changes were offered at a prior Medical Staff meeting or the notice of the regular meeting included the exact wording of the existing Bylaws and the proposed change, or (ii) a special meeting if such changes were offered at a prior Medical Staff meeting or the notice of the special meeting included the exact wording of the existing Bylaws and the proposed change.

14.1-4 Adoption

Bylaws amendments and new Bylaws approved by the Medical Staff in accordance with Article 14 shall be effective upon approval by the Governing Body. Neither the Medical Staff nor the Governing Body may unilaterally amend the bylaws. Medical Staff members will be provided with copies of the revisions to the Bylaws using such mechanism as is determined by the Medical Executive Committee.

14.1-5 Exclusive Mechanism

The mechanism described herein shall be the sole method for initiation, approval, amendment or adoption of the Medical Staff Bylaws.

## 14.2 EFFECT OF THE BYLAWS

Upon adoption and approval of Bylaws, each applicant, individual with clinical privileges and Medical Staff member, the Medical Staff and Governing Body is subject to and agrees to comply with such Bylaws.

## 14.3 SUCCESSOR IN INTEREST

These bylaws, and privileges of individual members of the Medical Staff accorded under these bylaws, will be binding upon the Medical Staff, and the Governing Body of any successor in interest in this hospital, except where hospital medical staffs are being combined.

In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Governing Body or its successor in interest. Until such time as the new bylaws are approved, the existing bylaws of each institution will remain in effect.

## 14.4 AFFILIATIONS

Affiliations between the hospital and other hospitals, health care systems, or other entities shall not, in and of themselves, affect these bylaws.

## ARTICLE 15 – MEDICAL STAFF SELF GOVERNANCE

Subject to the applicable provisions for adoption and amendment, all policies, procedures, protocols, criteria, standards or guidelines related to Medical Staff self-governance activities shall be set forth in the bylaws, rules and regulations of the Medical Staff or other documents which shall be deemed to be a part of the bylaws, rules and regulations upon approval by the Medical Staff and Governing Body. Such self-governance activities include, but are not limited to, standards and criteria for Medical Staff membership, standards and criteria for clinical privileges, procedures for enforcement of such standards and criteria, quality improvement, utilization management, and review and analysis of patient medical records.

The Chief Executive Officer (CEO) shall immediately inform the Chief of Staff or designee for review by the Medical Staff of (i) any unusual occurrences that have affected or pose a significant risk of affecting the quality of patient care or patient safety, and (ii) any reports to the Department of Health Services of an "adverse event" as defined in California Health and Safety Code Section 1279.1, as it may be amended from time to time.

Except in emergency situations in which the Hospital must immediately act to prevent imminent danger, the Hospital shall consult with the Medical Executive Committee before entering into contracts or other arrangements whereby practitioners and/or AHP's provide patient care to Hospital patients and before deciding to add or delete Hospital services or departments. The Governing Body shall uphold the MEC's determination regarding quality of care issues unless the Governing Body finds that the Medical Staff has failed to fulfill a substantive duty or responsibility.

Notwithstanding any other term or condition of these Bylaws or Rules and Regulations, the Medical Staff does not waive and shall at all times retain its rights of self-governance as specified in California Business and Professions Code Section 2282.5, as the foregoing may be amended by the legislature or interpreted by the courts from time to time.

**APPROVAL SIGNATURE PAGE**

ADOPTED by the Medical Staff on March 10, 2012

_____

Laurel A. Hodgson M.D, Chief of Staff

_____

Denise Ricker, Secretary-Treasurer

APPROVED by the Governing Body on _____

_____

Deborah Campbell, Chair
West Contra Costa Healthcare District Board of Directors

# APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

**All items marked with † must be completed, and or required routing**

| | |
|---|---|
| †**TITLE: Pronouncement of Death** | †**CHECK ONE:** ☐ **New** ☐ **Reviewed** x☐ **Revised :** ☐ **Major** ☐ **Minor** |
| † ☐ **Administrative** x☐ **Clinical** ☐ **Department** _____ **Nursing** _____ | |
| †**SUBMITTED BY:** | |
| †**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other | |
| †**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:** Including regulations and all supervisors . | |

| | MEETING DATE | APPROVAL |
|---|---|---|
| x☐ **Manager or Department Director**† Bobbie Ellerston, Int CNO | | |
| ☐ **Medical Staff Department(s):** | | |
| ☐ Cancer Committee ☐ CV Surgery Committee | | |
| ☐ Infection Control Committee ☐ IDP Committee | | |
| ☐ Medical Ethics Committee ☐ Patient Safety Committee | | |
| ☐ Radiation Safety Committee ☐ P&T Committee | | |
| ☐ Respiratory/Critical Care/ED Committee | | |
| ☐ Quality Improvement Team: ☐ EM Committee | | |
| ☐ EOC/Safety Committee x☐ Other: MSPI | 10/7/13 | |
| x☐ **Nursing Department:** ☐ Nursing Practice: | 9/19/13 | 9/19/13 |
| ☐ **Forms Committee** (as applicable) | | |
| ☐ **Administrative Policy Review Committee (APRC)**† | | |
| ☐ **Executive Leadership** | | |
| ☐ **Medical Executive Committee (MEC)** (as applicable) | 10/14/13 | |
| x☐ **Board of Trustees** *(automatic from MEC)* *(as applicable)* | 10/23/13 | |

**DOCTORS MEDICAL CENTER**

| | |
|---|---|
| **Manual: NURSE ADMINISTRATION** | **Sub Folder:** |
| **Title: Pronouncement of Death by RN** | **Reviewed: 05/2013**<br>**Revised:** |
| **Effective Date: 11/2010** | **Page 1 of 5** |

**PURPOSE:**
This policy delineates the Standardized Procedure to be used by the Registered Nurse for the Pronouncement of death.

**POLICY:**

A. It is the responsibility of the physician to write an order for the RN to pronounce death.

B. Registered Nurses who have successfully completed training and annual competency testing, may pronounce death on all patients who:
- Patients who are Do Not Resuscitate
- Expected deaths

C. Registered Nurses who have successfully completed training and annual competency testing, may pronounce death of all patients with the *exception of*:
- Patients who are a **full or limited code blue.**
- Patients who require physician confirmation of brain death.
- Patients currently on a ventilator
- Coroner Cases (see section G below)
- Death that is reportable to CMS (e.g., occurs while patient is in restraints or 24 hours after the removal of restraints).

D. It is the responsibility of the physician to notify the family and coroner, complete and sign the death certificate, and, when appropriate, as defined in the Medical Staff policy, obtain permission to perform an autopsy.

E. The physician may delegate to the RN: notification of the family and notification of the coroner.

F. RN to contact Nursing Admin for all deaths.

G. REPORTABLE DEATHS

Situations in which the law requires patient deaths to be reported to the Coroner's office:

1. If the deceased's injuries or accident occurred in another county, contact the Coroner's Office in that county for their procedures and forms.
2. Section 27491 of the California Government Code, as amended by statute (27491.2, 2011) directs, "the coroner to inquire into and determine the circumstances, manner and cause of the following deaths which are immediately reportable".

Reportable deaths are:

a. All violent, sudden and unusual deaths;
b. Unattended deaths;
c. Deaths wherein the deceased has not been attended by either a physician or a registered nurse, who is a member of a hospice care interdisciplinary team, as defined by subdivision (e) of Section 1746 of Health and Safety Code in the 20 days before death;
d. Deaths related to or following known or suspected self-induced or criminal abortion;
e. Deaths related to known or suspected homicide, suicide, or accidental poisoning;
f. Deaths known or suspected as resulting in whole or in part from or related to accident or injury either old or recent;
g. Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration or where the suspected cause of death is sudden infant death syndrome;
h. Death in whole or in part occasioned by criminal means.
i. Deaths associated with a known or alleged rape or crime against nature;
j. Deaths that occur in prison or while under sentence;
k. Deaths known or suspected as due to contagious disease and constituting a public hazard;
l. Deaths from occupational diseases or occupational hazards.
m. Deaths of patients in state mental hospitals serving the mentally disabled and operated by the State Department of Developmental Services;
n. Deaths under such circumstances as to afford a reasonable ground to suspect that the death was caused by the criminal act of another; and
n. Any deaths reported by physicians or other persons having knowledge of death for inquiry by the Coroner.

3. In addition to the above provisions of the Government Code, the Health and Safety Code adds another category of coroner's cases, namely, "if a physician is truly unable to state the cause of death, he may refer the case to the Coroner." In this situation, the physician must speak to the Coroner.
4. Also in Contra Costa County, the Coroner may assume jurisdiction and investigate any death which occurs under the following conditions:
    a. Where the procedure being performed is considered by others in the profession to be relatively minor and the patient dies unexpectedly.
    b. Where a patient does not regain full consciousness following the performance of any procedure which involves the administration of any anesthetic substance.
    c. Where the patient suddenly develops a fatal sensitivity, or other reaction, following the administration of a medication, whole blood, blood extenders, or a serum.
    d. Where the death of the patient occurs during the performance of a procedure, or during the immediate postoperative period, and

the patient's condition was not considered to be terminal in nature prior to the initiation of the procedure.

e. Where a patient remains comatose until death and the symptom cannot be readily related by complete diagnostic work-up prior to death as being due to the condition for which the physician is treating the patient.

f. Where the death apparently has occurred as the result of an accident, error, or negligence of any person associated with performance of the procedure; or where equipment, medication lies were faulty.

5. If the patient is a suspected Coroner's Case:
   a. Leave all tubes and drains in place. Remove IV tubing to the extension clave and cap. Tape all tubes in place.
   b. Detach external pacemaker from electrodes and tape electrodes to skin surface. Temporary pacemakers are retumed to SPD.
6. Once the coroner accepts a case, the hospital may release copies of the medical record, x-rays and blood/tissue samples, or forensic evidence to the coroner after signing the "Property Evidence Release" forms. A subpoena is not necessary.
7. If the coroner releases the case, document the name of the coroner, release number and ate and time of phone call. They physician retains the responsibility to complete the need for autopsy attestation as defined by the Medical Staff policy.
8. Full cooperation with the coroner's investigation is required by law. In order not to destroy evidence, the decedent shall remain undisturbed until the coroner has been notified. Do not destroy decedent's clothing or disturb tubes, lines, etc.
   a. EXCEPTION - In the Emergency Department, in order to provide care to others, the decedent may be moved after notifying the coroner, either to:
      1) The Medical Center morgue.
      2) Another private ED room if:
         a) Coroner wishes body to remain in the ED for imminent pick-up by coroner's Deputy and/or;
         b) Viewing by a family member, if permission granted by coroner. If so, a Medical Center employee is to stay in the room to assure nothing is disturbed.
         c) Decedent shall be in a room where no movement or disturbance of decedent can occur unless approved by the coroner.
         d) Valuables may be removed and given to next-of-kin if permission is granted by the coroner.

G. OTHER SPECIAL CIRCUMSTANCES

The following special circumstances should be considered for each death:

1. In order to comply with AB 631, all deaths in the Medical Center should be considered for possible anatomical donation, and must

be reported less than 59 minutes of death. (See **Organ Donation After Cardiac Death (DCD)** policy)

2. If, at the time of death, the patient had a reportable/communicable disease, nursing must document this on the Mortuary Release form.
3. Advance Directives – DNR in the Operating Room:
   a. Patients with Advance Directives, DNR orders, have the right to have their wishes carried out during surgical procedures.
   b. When a patient with an Advance Directive or DNR order is scheduled for surgery, there should be a reconsideration of such a decision.
   c. There should be a discussion with the surgeon, primary care physician, and anesthesiologist, patient and/or family members. Explanation of special circumstances related to anesthesia should be made.
   d. The risks and options of the anesthesia should be discussed. The patient's and/or family's exact wishes should be established before the procedure.
   e. The results of this discussion should be documented in the record. The patient's and/or family's exact wishes should be documented.
   f. The operative and anesthetic permit should indicate that the patient or duly authorized patient's representative has had the opportunity to discuss and reconsider any advance directive.
   g. Once a decision is made regarding the interpretation of patient's advance directive:
      1. The condition of advance directive are conveyed to members of the OR team.
      2. Any team member that objects to complying with the patient's advance directive may withdraw from the case and a replacement will be found.

**DEFINITION/OVERVIEW:**

*Pronouncement of Death by Registered Nurse:*

A. The process by which a Registered Nurse may pronounce death in the absence of a physician.

*RN Competency:*

A. Successful completion of the education module is required of each RN prior to pronouncement of death.
B. Each RN to print the certificate of successful completion of the module.
C. Competency testing on initial certification and annually thereafter.
D. A list of competent RNs will be maintained in the Education Department and in the Nursing Administration Office.

*Reportable Death:*

A death that fits criteria outlined in Item G. and must be reported to the Coroner.

**PROCEDURE:**

A. PRONOUNCEMENT OF DEATH

1. Notify the attending physician of the expiration. Verifies there is an order for the RN to pronounce. If patient meets the criteria for RN Pronouncement (outlined above in Policy), the RN may obtain a physician order and enter the order in the Electronic Medical Record.
2. To determine that death has occurred, establish all of the following during the assessment:
    a. Apical pulse absent, confirmed by absence of apical heart tones upon auscultation of the chest.
    b. Respirations absent, confirmed by absence of chest wall movement and absence of breath sounds upon auscultation
    c. No blood pressure detected by palpation or auscultation.
    d. No pupillary response to light
    e. No response to noxious stimuli
3. Immediately after completing the assessment, the RN will notify the attending physicians of the assessment findings and, if applicable, the pronouncement of death.

**DOCUMENTATION:**

A. RN to document assessment and pronouncement of death in the electronic Medical Record including assessment findings, and date of time of assessment in the Pronouncement of Death tab or the form during downtime (Addendum A).

B. The nurse completing the form will sign electronically and obtain an electronic signature of RN witness.
    a. The pronouncing nurse presses *control/shift/"u"* keys in document to get the 'cosign' box for the witness to sign in electronically.
    b. The RN witness signs in electronically.

C. Pronouncement of Death form (Addendum A) to be completed and signed by the RN who pronounced during downtime. This form is an addendum to the Progress Notes and is to be placed as the final Progress Note.

C. Search for Next of Kin Documentation

**REFERENCES:**

**Reference / Regulations:**
BRN–NPR-B-44 09/2002
Revised-2/05, 4/05

**ATTACHMENTS:**
Addendum A – downtime Pronouncement of Patient Death Form
Addendum B – screen shot of pronouncement tab in electronic records.

## Addendum A

PRONOUNCEMENT OF PATIENT DEATH

DATE_____ TIME_____

DIAGONOSIS_____

**1. Confirm both of the following:**

No code order written by the physician. _____
*Date of order*

Physician order for nurse to pronounce patient death.

_____
*Date of order*

**2. Patient Assessment:** Date: _____ Time Noted: _____
*(All items below must be checked in order to pronounce patient's death)*

Apical pulse absent for 60 seconds
Respirations absent for 60 seconds
No audible breath sounds for 60 seconds
No blood pressure detected by palpation or auscultation
Pupils not reactive to light
Physician notified _____*(name of physician)*
Next of kin notified _____*(name of next of kin)*
Hospital Supervisor notified _____*(name of Supervisor)*

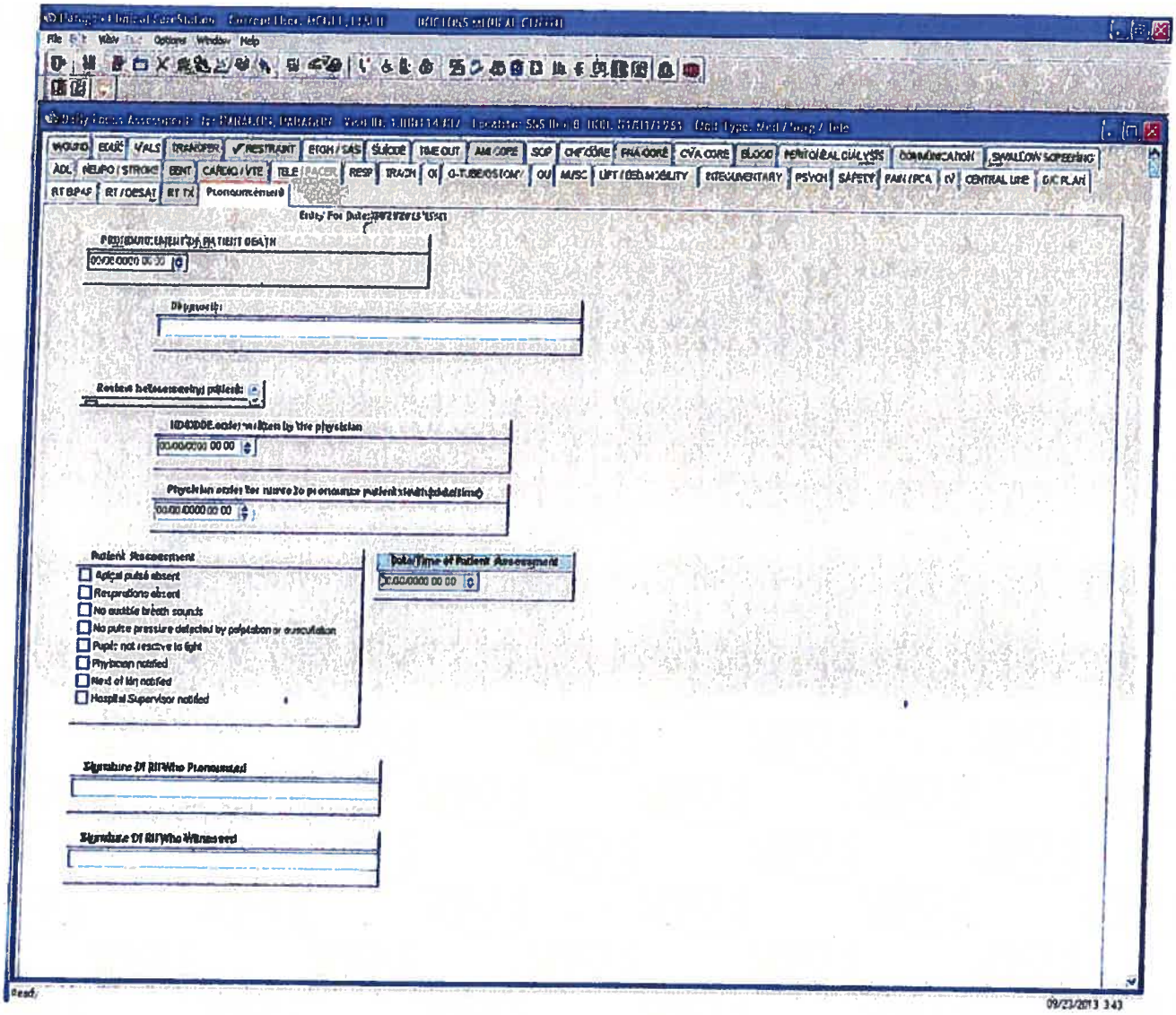
_____
Signature RN who pronounced

_____
Signature of RN witness

Pronouncement of Patient Death

*Retained as part of the permanent medical record*

| | |
|---|---|
| **Responsible for review/updating (Title/Dept)** | Title Dept |


WOUND
EKG
VALS
TRANSFER
RESTRAINT
ETOH / SAS
SUICIDE
TIME OUT
AM CORE
SCP
CHF CORE
PNA CORE
CVA CORE
BLOOD
PERITONEAL DIALYSIS
COMMUNICATION
SWALLOW SCREENING
ADL
NEURO / STROKE
BENT
CARDIO / VTE
TELE
PACER
RESP
TRACH
GI
G-TUBE/OSTOMY
GU
MISC
LIFT / BED MOBILITY
INTERMENTARY
PSYCH
SAFETY
PAIN / PCA
IV
CENTRAL LINE
D/C PLAN
RT BIPAP
RT / OBSAT
RT TX
Pronouncement
Patient Assessment
Apical pulse absent
Respirations absent
No audible breath sounds
Pupil: not reactive to light
Physician notified
Next of kin notified
Hospital Supervisor notified
Date/Time of Patient Assessment
Signature Of RN Who Pronounced
Signature Of RN Who Witnessed
Read

DOCTORS MEDICAL CENTER **Employee Name:** _____ **Date:** _____

**Skill:** **Pronouncement of Death by RN**

| Skill | Mode of Validation | Competent | Observer Initials |
|---|---|---|---|
| Pronouncement of Death | | C = Competent<br>NC = Not competent | |
| 1. Notifies the attending physician of the expiration of patient. Completes Pronouncement of Death tab:<br>a. Verifies there is an order for RN to pronounce patient's death. If none, obtains one.<br>b. Verifies there is a Do Not Resuscitate order. | verbal | ☐ C ☐ NC | |
| 2. Requests a second RN (Nurse assigned to patient) to witness the pronouncement and signs the death record. | verbal | ☐ C ☐ NC | |
| 3. Determines that death has occurred by establishing the absence of the following during the assessment and documents findings in the patient's medical record<br>a. Apical pulse – confirms absence of apical heart tones by auscultation of the chest.<br>b. Respirations– confirms absence of chest wall movement and absence of breath sounds by looking at the chest and auscultation.<br>c. Blood pressure - confirms absence by palpation or auscultation.<br>d. Pupillary response to light – confirms absence by shining light on the eyes. | demonstration | ☐ C ☐ NC | |
| 4. Contacts the Spiritual Care Department or Social Services to support staff and/or family during the pronouncement of death process. | verbal | ☐ C ☐ NC | |
| 5. Documents date and time death was pronounced and by whom in the patient's medical record | | | |
| 6. Performs post-mortem care per procedure. | verbal | ☐ C ☐ NC | |

| Comments | Further Actions |
|---|---|
| | ☐ Competent ☐ Other<br>☐ Remediation needed (See "Education Referral") |

_____ **Employee Signature**

_____/_____ **Observer Signature/Title**

# APPROVAL ROUTING SHEET FOR POLICIES AND PROCEDURES

DOCTORS MEDICAL CENTER

**All items marked with † must be completed, and or required routing**

| | |
|---|---|
| †**TITLE:** CVAD flush and maintenance table | †**CHECK ONE:** ☐ New ☐ Reviewed<br>X Revised : X Major ☐ Minor |
| † ☐ Administrative X Clinical ☐ Department _____ | |
| †**SUBMITTED BY:** Eileen Scott RN, OCN | |
| †**NEW POLICY - REASON FOR SUBMISSION:** ☐ Change in Law ☐ New Regulation: CMS CDPH TJC Other | |
| †**REVIEWED OR REVISED - SUMMARY OF POLICY / PROCEDURE CHANGES:**<br>Based on Infusion Nurses Society recommendations:<br>Change in standard of care for heparin concentration from 100 units per ml to 10 units per ml when used in flushing central lines. Other than implantable ports which remains Heparin 100 units per ml.<br><br>Removed flushing verbiagefor Q8 hours as it was confusing and redundant to flushing before and after medication administration. See attached table. | |

| | MEETING DATE | APPROVAL |
|---|---|---|
| ☐ **Manager or Department Director**† | | |
| ☐ **Medical Staff Department(s):** | | |
| ☐ Cancer Committee ☐ CV Surgery Committee | | |
| ☐ Infection Control Committee ☐ IDP Committee | | |
| ☐ Medical Ethics Committee ☐ Patient Safety Committee | | |
| ☐ Radiation Safety Committee X P&T Committee | 9/27/13 | Yes |
| ☐ Respiratory/Critical Care/ED Committee | | |
| ☐ Quality Improvement Team: ☐ EM Committee | | |
| ☐ EOC/Safety Committee ☐ Other: | | |
| ☐ **Nursing Department:**<br>☐ Nursing Practice: | | |
| ☐ **Forms Committee** (as applicable) | | |
| ☐ **Administrative Policy Review Committee (APRC)**† | | |
| ☐ **Executive Leadership** | | |
| ☒ **Medical Executive Committee (MEC)** (as applicable) | 10/14/13 | 10/14/13 |
| ☑ **Board of Trustees** *(automatic from MEC)* *(as applicable)* | 10/23/13 | |

MEDICAL CENTER

# Central Vascular Access Devices (CVAD) FLUSH AND MAINTENANCE TABLE

| All CVAD Devices | FLUSHING | Blood Sampling | Needleless Connector / Tubing Change | Dressing Change |
|---|---|---|---|---|
| | • Use at least 10 ml size syringe only<br>• Use Pulsatile (start and stop) Method to flush<br>• *Do Not* flushing against resistance<br>• Use manual positive pressure technique and/or use positive fluid displacement needleless connectors (PDNC)<br>  ○ If using PDNC, flush, remove syringe then clamp<br>  ○ Manual positive pressure :<br>  ➢ Clamp cath while concurrently continuing to flush the last 0.5 ml of solution or<br>  ➢ Remove syringe while cont. to flush last 0.5 ml of sol. | • Stop all infusions before procedure, including other lumen(s)<br>• **Before sampling: Flush with 10 ml normal saline (NS) (20 ml if from TPN line)**<br>• *Do Not* discard blood for blood culture (if ordered to be drawn from CVAD) | • Administration sets being used to administer lipid-based infusates should be DEHP free. | • Use Biopatch if IV is to be used longer than 24 hours.<br>• For cleaning: Chlorhexidine; If allergic to it - tincture of iodine, povidone iodine, or 70% alcohol.<br>• Allow solution to air dry before applying dressing. |
| **Non-tunneled, Non Valved (open ended tip):**<br>• **PICC**<br>• **Power PICC**<br>• **Subclavian/jugular**<br>• **Midline (is not a central line):** *Do not use* for TPN / PPN, blood draws, vesicant infusion. | **Before and after each medication administration:**<br>• 10 ml normal saline (NS)<br>**If using only Q 12 hrs:**<br>• 10 ml NS then 3 ml of 10 units/ml Heparin<br>**If not in use, flush Q 12 hours with**<br>• 10 ml NS then 3 ml of 10 units/ml Heparin | **Discard:**<br>• 3-5 ml<br>**After sampling, flush with:**<br>• 20 ml NS<br>• Followed by Heparin if not to be used immediately: 3 ml of 10 units/ml | **Connectors:**<br>• Weekly with dressing change<br>• Signs of cracks, leaking, non intact septum<br>• When it's removed<br>• If there is blood or debris within the connector<br>• Prior to drawing for blood culture through connector<br>• Upon contamination<br>• After each blood sampling through connector<br>**Primary Adm. set**<br>• **Non-lipid** – q 96 hrs<br>• **Lipid, TPN** – q 24 hrs<br>**Secondary adm. Set used intermittently:**<br>• Every 24 hours<br>**Blood /Blood products**<br>• **IV set: Q** 4 hours | **Initial insertion:**<br>• Do not change unless it's soiled, loose, bleeding or with drainage (PRN) or per MD's order<br>**Transparent Semipermeable Membrane (TSM) and Biopatch:**<br>• weekly and PRN<br>**Gauze & Biopatch:**<br>• Q 48 hrs and PRN<br>• Use Gauze dressing for pts who are allergic to TSM, diaphoretic, site is oozing or bleeding, or TSM is not sticking onto the skin.<br>• TSM with gauze underneath that is covering insertion/exit site is considered as a gauze dressing<br>• Assess catheter external length to determine if catheter has migrated out |
| **n-tunneled, Valved catheters:**<br>• **Power PICC Solo** | **Before and after medication administration:**<br>• 10 ml normal saline<br>**Not in Use:**<br>• Flush weekly with 10 ml NS | **Discard:** 3-5 ml<br>**After sampling, flush with:**<br>• Flush with 20 ml NS | | |
| **Tunneled, Non Valved (open ended tip):**<br>• **Hickman**<br>• **Implantable Port** | **Before and after each medication administration:**<br>• Implantable port: 10 ml NS<br>• Hickman/Leonard: 10ml NS<br>• Broviac: 2 ml NS<br>**If using only Q 12 hrs:**<br>**Port:** 10 ml NS then 5ml of 100 units/ml of Heparin<br>**Hickman/Leonard:** 10 ml NS then 3 ml of 10 units/ml Heparin<br>**Broviac:** 2 ml NS then 1.5 ml of 10 units/ml Heparin<br>**If not in use:**<br>**Port:** ***Monthly*** 10 ml NS then 5ml of 100 units/ml of Heparin<br>**Hickman/Leonard:** ***Daily*** 10 ml NS then 3 ml of 10 units/ml Heparin<br>**Broviac:** ***Daily*** 2 ml NS then 1.5 ml of 10 units/ml Heparin | **Discard:** 5 ml<br>**After sampling, flush w/ :**<br>Port - 20 ml NS<br>Hickman/Leonard - 20 ml NS<br>Broviac – 5 ml NS<br>Followed by Heparin if not to be used immediately:<br>Port: 5 ml of 100units/ml<br>Hickman/Leonard: 3 ml of 10 units/ml<br>Broviac: 1.5 ml of 10 units/ml | | |
| **Tunneled, Valved:**<br>• **Groshong chest catheter** | **Before and after each medication administration:**<br>• 10 ml normal saline (NS)<br>**If not in use:**<br>• Flush weekly with 10 ml NS | **Discard:** 5 ml<br>**After sampling, flush with:** 20 ml NS | | |

| MEDICAL STAFF COMMITTEE RECOMMENDATIONS | DATE |
|---|---|
| CREDENTIALS COMMITTEE | September 24, 2013 |
| MEDICAL EXECUTIVE COMMITTEE | October 14, 2013 |
| BOARD OF DIRECTORS APPROVAL | October 23, 2013 |

# DOCTORS MEDICAL CENTER
# CREDENTIALS REPORT
# OCTOBER 2013

## INITIAL APPOINTMENTS

*The following practitioners have applied for membership and/or clinical privileges at DOCTORS MEDICAL CENTER. This summary includes factors that determine status of membership, licensure, professional liability insurance, required certifications (if applicable), etc. Factors that determine current competence include medical/professional education, training (internship/residencies/fellowship) and experience, board certification (if applicable), current and previous hospital and other institutional affiliations, physical and mental health status, peer references, and past or pending professional disciplinary action.*

| NAME | DEPARTMENT/SPECIALTY | CATEGORY | APPOINTMENT TERM | RECOMMENDATION |
|---|---|---|---|---|
| Sue, Clara, MD | Med./Family Practice/Internal Medicine | Provisional | 10/23/2013 – 09/30/15 | Approval |

## REAPPOINTMENTS

*The following practitioners have applied for reappointment to the Medical Staff. This summary includes factors that determine membership; licensure, DEA, professional liability insurance, required certifications (if applicable), etc. Qualitative/quantitative factor, developed through on-going professional performance evaluation, include peer review, quality performance, clinical activity, privileges, competence, technical skills, behavior, health, medical records, blood review, medication usage, litigation history, utilization and continuity of care.* ***Membership requirements are met, unless specified below.***

| NAME | DEPARTMENT/SPECIALTY | CATEGORY | REAPPOINTMENT TERM | RECOMMENDATION |
|---|---|---|---|---|
| Anton, Steven, MD | Medicine/Cardiology | Active | 11/20/13 – 9/30/15 | Approval |
| Berman, Ronald H., MD | Medicine/Internal Medicine | Active | 11/20/13 – 9/30/15 | Approval |
| Jones, Sharon, MD | Medicine/Internal Medicine | Active | 11/20/13 – 9/30/15 | Approval |
| Katler, Ernest, MD | Medicine/Rheumatology | Active | 11/20/13 – 9/30/15 | Approval |
| Ricker, Denise, MD | Medicine/Nephrology | Active | 11/20/13 – 9/30/15 | Approval |
| Delaney, Leslie, MD | Surgery/Pain Management | Courtesy | 11/20/13 – 9/30/15 | Approval |
| Khan, Junaid, MD | Surgery/Cardiothoracic Surgery | Courtesy | 11/20/13 – 9/30/15 | Approval |
| Ross, Joel, MD | Surgery/HEENT | Active | 11/20/13 – 9/30/15 | Approval |