SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

BOARD OF DIRECTORS MEETING

Monday, May 6, 2024
8:00 AM – 10:00 AM

Atrium Conference Room
2000 Alameda de las Pulgas, San Mateo, CA 94403

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

AGENDA

Board of Directors	Monday, May 6, 2024	8:00 AM

Atrium Conference Room, 2000 Alameda del las Pulgas, San Mateo, CA 94403

This meeting of the San Mateo Medical Center Board of Directors will be held in-person in the Atrium Conference Room, 2000 Alameda de las Pulgas, San Mateo, CA. Remote participation of this meeting will not be available. To observe or participate in the meeting, please attend in-person.
*Written public comments may be emailed to jgomez1@smcgov.org by Friday, May 3, at 4:00pm, and such written comments should indicate the specific agenda item on which you are commenting.

A. CALL TO ORDER

B. CLOSED SESSION

Items Requiring Action

1. Medical Staff Credentialing Report — Dr. Frank Trinh
2. Quality Report — Dr. Scott Oesterling

Informational Items

3. Medical Executive Committee — Dr. Frank Trinh

C. REPORT OUT OF CLOSED SESSION

D. PUBLIC COMMENT

Persons wishing to address items not on the agenda

E. FOUNDATION REPORT — John Jurow

F. CONSENT AGENDA

Approval of:

1. April 1, 2024 Meeting Minutes
2. Approval of Amended Medical Staff Office Bylaws
3. Approval of Amended Medical Staff Office Rules and Regulations

G. MEDICAL STAFF REPORT
Chief of Staff Update — Dr. Frank Trinh

H. ADMINISTRATION REPORTS
1. Workplace Violence Prevention — Robert Blake ..... Verbal
   Ava Carter, Safety Officer
   Lt. Chris Swinney, Sherriff's Office
2. Compliance Report — Gabriela Behn ..... Verbal
3. Substance Use Disorder Treatment Program — Louise Rogers ..... Verbal
   Correctional Health — Jennifer Basler, Clinical Services Manager
4. Financial Report — David McGrew…. .....TAB 2
5. CEO Report — Dr. CJ Kunnappilly…. .....TAB 2

I. COUNTY HEALTH CHIEF REPORT
County Health Snapshot — Louise Rogers…. .....TAB 2

J. COUNTY EXECUTIVE OFFICER REPORT — Mike Callagy

K. BOARD OF SUPERVISOR REPORT — Supervisor David Canepa

L. ADJOURNMENT

ADA Requests
Individuals who require special assistance or a disability-related modification or accommodation to participate in this meeting, or who have a disability and wish to request an alternative format for the meeting, should contact Janette Gomez at jgomez1@smcgov.org , as early as possible but not later than 10:00 AM on the business day before the meeting. Notification in advance of the meeting will enable the County to make reasonable arrangements to ensure accessibility to this meeting, the materials related to it, and your ability to comment.

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CONSENT AGENDA

HOSPITAL BOARD OF DIRECTORS
MEETING MINUTES
Monday, April 1, 2024
Atrium Conference Room, 2000 Alameda de las Pulgas, San Mateo, CA

Board Members Present	**Staff Present**		
Supervisor David Canepa	Amy Lam-Bonilla	Iliana Rodriguez	Priscilla Romero
Supervisor Noelia Corzo	Carlton Mills	Jacki Rigoni	Rachael Rivers
Mike Callagy	David McGrew	Jacqueline Pelka	Rebecca Archer
Louise Rogers	Donna Spillane	Janette Gomez	Rob Larcina
Dr. CJ Kunnappilly	Dr. Alpa Sanghavi	Jen Gordan	Robert Blake
Dr. Frank Trinh	Dr. Amar Dixit	John Jurow	
Dr. Scott Oesterling	Dr. Yousef Turshani	Kacie Patton	
Dr. Gordon Mak	Emily Weaver	Kimberlee Kimura	
Judith Guerrero	Gabriela Behn	Patty Cruz- Guzman	

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call to Order	Noelia Corzo called the meeting to order at 8:00 AM and the Board adjourned to Closed Session.	
Reconvene to Open Session	The meeting was reconvened at 8:11 AM to Open Session. A quorum was present (see above).	
Report out of Closed Session	Medical Staff Credentialing Report for May 6, 2024 QIC Minutes from March 26, 2024 Medical Executive Committee Minutes from April 29, 2024	Rebecca Archer reported that the Board unanimously approved the Credentialing Report and the QIC Minutes and accepted the MEC Minutes.
Public Comment	None.	
Foundation Report John Jurow	John reported that the Food Pharmacy program, with the help and support of the Samaritan House, donates hundreds of boxes of food to clinics every Monday. The Foundation has several events scheduled in the coming weeks: - A parking fundraiser is scheduled for the 4th of July. - A hot dog staff fundraiser will take place on July 17th. - The 20th Annual golf tournament will be held at the Stonebrae Country Club in Hayward.	FYI

Consent Agenda	Approval of: 1. Hospital Board Meeting Minutes from March 4, 2024	It was MOVED, SECONDED and CARRIED unanimously to approve all items on the Consent Agenda.
Medical Staff Report Dr. Frank Trinh	The Medical Staff Office Bylaws and Rules and Regulations require revisions, including grievance procedures, to be presented at the next Hospital Board meeting. Dr. Trinh also announced that the Medical Staff Office has a new orthopedic physician, Dr. Edward Shin.	FYI
Inpatient Nursing Update. Rob Larcina Rachael Rivers	The shortage of nurses is a significant issue, worsened by the COVID-19 pandemic due to the aging population and retiring workforce. Therefore, organizations must focus on recruiting and retaining new talent. San Mateo Medical Center has taken steps to build a sustainable workforce, and leadership plays a crucial role in ensuring job satisfaction, quality of care, and job retention amidst the Retirement Tsunami. To help sow the seeds of growth within the organization, the organization must replace travel nurses with regular employees, hire and recruit new grads, optimize educational opportunities, and provide opportunities for professional advancement. San Mateo Medical Center has partnered with local schools, including San Francisco State University, College of San Mateo, and University of San Francisco, to name a few, and is currently supporting 68 nursing students. However, the department's continued challenges include competitive salaries, high cost of living, associated costs of hiring and training, and retention (sign-on bonuses, higher education incentives, opportunities for a robust clinical ladder). Despite these challenges, clinical RN educators have achieved remarkable outcomes in training due to their dedication and commitment.	FYI
Diagnostic Imaging Department. Jacqueline Pelka	The Diagnostic Imaging Department has a team of 7 Patient Services Assistants, 3 Radiology Nursing Assistants, 36 Technologists, 3 Providers, 1 Neurologist, and 18 Radiologists. The department follows regulations from the FDA, CDPH Radiologic Health Branch, and the American College of Radiology. The MRI and ultrasound departments are experiencing backlogs and wait times for screening mammograms are increasing. On August 21, the department received approval for the Mammography TOMO upgrade. The department maintains multiple equipment, such as Diagnostic Ultrasound, C-ARM, and Cardiac Ultrasound, which includes equipment upgrades, such as CT Power Injectors and Stitching. Action plans for access to care. Mammography: Pilot reducing appointment times and working with Radiology Assistant, opening Saturdays for weeks with wire localizations, and proposing utilization of Savi Scouts Markers vs Wire Localization. MRI: Opening on minor holidays, working with the vendor to open a monthly Saturday.	FYI

	Ultrasound: Increase staffing, increase volume with new hires, pilot with correctional health to start in April, and explore varied shifts to include Saturdays.	
Childhood Lead Poisoning Prevention Program (CLPPP) and Lead Paint Settlement Amy Lam-Bonilla Donna Spillane	Lead poisoning in children is a major preventable public health problem. Lead is a chemical element in heavy metals. Some sources of childhood lead poisoning in the county include lead in homes, pottery with lead glazes, lead in candies, home remedies, and much more. Lead poisoning disrupts children's growth and development and causes behavioral problems. The staff of CLPPP includes a program coordinator, a Public Health Nurse, an Environmental Health Specialist, and a Senior Community Worker. CLPPP provides comprehensive home visiting and case management services to families to encourage and monitor retesting for all children in the county who have tested positive for lead, regardless of public or private insurance. They also offer home assessments with Environmental Health Services to identify risk factors, outreach, and education to the community to provide, education around risks and prevent exposure, collaborate with community partners and providers to promote screening and early detection, provide evidence-based home visiting services, connect to resources, parenting support, and other needs. The Lead Paint Settlement took 20 years to settle and funded $11.7 million through 2025. The funding will go towards remediating lead paint in residential housing, focusing on low-income individuals, and educating the public about lead paint hazards and the remediation program. The Lead Paint Settlement led to the Rebuilding Together Peninsula (RTP) contract. Some challenges the program faces include demographics, landlord/tenant relationships, community input, relocation, and the cost and availability of labor.	FYI
Financial Report David McGrew, CFO	The FY 23/24 financial report was included in the Board packet and David McGrew answered questions from the Board.	FYI
CEO Report Dr. CJ Kunnappilly	Dr. Kunnappilly presented the CEO report which was included in the Board packet and answered questions from the Board. Dr. Kunnappilly reported the Board Survey results, and 7/9 members responded to the survey. For future agendas, include more information on staff well-being and human resources information.	FYI
County Health Chief Report Louise Rogers	Louise reported that the Sheriff's Office and Correctional Health Services have collaborated to install a new Narcan vending machine in the lobby of the Maguire Correctional Facility in Redwood City. The Narcan drug is used to reverse the effects of an opioid overdose. This vending machine is available for public use to reduce harm in the community. The vending machine also contains additional information about behavioral health services.	FYI

	Louise also gave an update on the Cordilleras Behavioral Health Facilities' transition. The residents and patients from the old building will be moved to the new building, which will house four 16-bed mental health rehabilitation centers and co-house many residents.	
County Executive Office Iliana Rodriguez	Iliana from the County Executive's office reported the approved budget for homeless and emergency response proposals under Measure K funding.	FYI
Board of Supervisors Supervisor David Canepa	Supervisor Canepa continues prioritizing the domestic violence task force, including the Keller Center. The Board of Supervisors has recently approved Women's History Month and the California Equal Pay Pledge. The Bay Area Housing Authority is reviewing the potential billion-dollar cost of constructing more housing in the county and increasing transportation support for services like BART and SamTrans.	FYI

Supervisor Canepa adjourned the meeting at 9:36 AM. The next Board meeting will be held on May 6, 2024.

Minutes recorded by:
Janette Gomez, Executive Secretary (WOC)

Minutes approved by:
Dr. Chester Kunnappilly, Chief Executive Officer

MEDICAL STAFF BYLAWS

2024 PROPOSED REVISIONS

Current Language	2024 Proposed Changes
8.3 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. Suspensions cumulatively totaling thirty (30) days in any twelve (12) month period shall be reported to the Medical Board of California.	**8.3 AUTOMATIC SUSPENSION** In the following instances where patient safety and quality of care are not directly implicated such that corrective action is not undertaken for a medical cause or reason, the member's privileges or membership may be administratively suspended or limited as described without a right to hearing or further review. Administrative suspensions that remain in effect for a period in excess of fourteen (14) days shall be reported to the Medical Board of California or equivalent State licensing agency.

Current Language	2024 Proposed Changes
8.3.1 Licensure a) Revocation and Suspension: Whenever a member's license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and clinical 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 clinical 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	**8.3.1 Licensure** When a member's license to practice in the State is revoked, restricted, suspended, surrendered or made subject to any probationary provisions by the State's medical board or licensing agency, the member's Medical Staff membership and clinical privileges shall be automatically suspended. Fair hearing and appeal rights shall not apply. A medical staff member shall promptly inform the Chief Executive Officer and Chief of Staff of any change in licensure status or entry into an order with any licensing board whether public, non-public, private or non-disciplinary. Upon petition of the physician, reinstatement of Medical Staff membership and clinical privileges shall be subject to the recommendations of the Medical Executive Committee taking into account any

manner, as of the date such action becomes effective and throughout its term. c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical 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. d) Failure to provide evidence of current valid licensure to the Credentials Committee when requested so as to maintain continuous valid Medical Staff status as defined in Article 3, will result in suspension of all privileges and membership.	recommendations of the Credentialing Committee and additionally subject to the approval of the Governing Board.
Current Language 8.3.2 Controlled Substances a) Whenever a member's Drug Enforcement Administration (DEA) certificate is 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. 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. c) Failure to provide evidence of current valid certification shall result in suspension of the right to prescribe controlled drugs or medications.	**2024 Proposed Changes** **8.3.2 Controlled Substances** Upon receipt by the hospital of notice that a member's right to prescribe or obtain controlled substances or medications has been suspended, revoked, or placed on probation, stayed, or otherwise restricted by the applicable governmental agency, such actions and terms shall automatically apply to the member's ability to prescribe controlled substances in the hospital. Whenever a member's DEA registration expires, the member's right to prescribe medications shall be automatically suspended until the DEA registration is renewed. Fair hearing and appeal rights shall not apply.

8.3.3 Professional Liability Insurance **8.3.4 Failure to Pay Medical Staff Dues** **8.3.5 Medical Records**	**[no changes made to 8.3.3 or 8.3.4]** **[8.3.5 Medical Records moved/changed to 8.3.9]**

	2024 Proposed Changes **[new sections proposed to be added/renumbered]** **8.3.5 Felony Conviction** Conviction, or a plea of "guilty" or "no contest", to a felony in any jurisdiction shall result in automatic suspension upon conviction or entry of the plea. The Medical Executive Committee and the Governing Board may, but is not required, to consider action to reinstate the physician upon application following conviction or entry of the plea without right to any hearing or appeal. **8.3.6 Exclusion from Federal or State Health Care Programs** A physician who is excluded or debarred under the Medicare or Medicaid programs, by any governmental licensing agency, or convicted of any offense related to health care, or listed by a federal or state agency as being debarred, excluded, or otherwise ineligible for federal or state program participation shall be automatically suspended. The suspension shall be effective immediately upon debarment, exclusion, sanction, conviction or listing regardless of whether an appeal is filed and shall remain in effect. The Medical Executive Committee and the Governing Board may, but is not required, to consider action to reinstate the physician following debarment without right to any hearing or appeal. **8.3.7 Failure to Enter Legible Orders** Admitting privileges and surgical or procedure privileges may be suspended for illegible orders. Illegible orders occur when three other individuals cannot read the orders. Suspension will occur automatically after the member has been notified in writing on three separate occasions regarding legibility. Privileges shall be reinstated if the member demonstrates to the reasonable satisfaction of the Medical Executive Committee that sufficient remedial measures have been taken.

	2024 Proposed Changes **8.3.8 Behavioral Suspension [*Please note this is new language with the purpose to have increased flexibility without a hearing for Chief of Staff and/or CEO to respond to disruptive behavior that doesn't directly affect or interfere with patient care]*** The Chief of Staff or designee, on behalf of the Medical Executive Committee and following consultation with the Chief Executive Officer, may summarily suspend a member **for up to** 7 days when information is discovered that shows the member has engaged in behavior that is contrary to the hospital's Code of Conduct or County policies concerning conduct in the workplace. The Chief of Staff may extend the suspension for an additional 7 days upon approval by Medical Executive Committee or a subset of MEC members or a similarly designated behavioral committee, which shall consider the facts and circumstances of the behavioral suspension in closed session without notice or hearing rights to the physician whose behavior is the subject of examination. A behavioral suspension under this section shall be for the purpose of investigating the need for further disciplinary action, sanctions, or requirements imposed by the Chief of Staff, subject to the advice and consent of the Medical Executive Committee, Medical Staff Office Manager (or equivalent behavioral committee), to correct the physician's behavior. Additional disciplinary action, sanctions, or requirements for correcting physician behavior may include but are not limited to requiring participation in anger management counseling, documentation of additional education or training concerning behavior in the workplace, referral to the hospital's well-being committee (if active and functioning), or similar orders that reasonably address the physician's behavior, which shall be recommended by the Medical Executive Committee and MSO (or equivalent behavioral committee) prior to imposition by the Chief of Staff. Any additional disciplinary actions, sanctions, or suspension based on the discovery of information that implicates or relates to the physician's medical competence or any medical cause or reason shall

	be administered in accordance with the notice, hearing, and appeal procedures set forth in Article 9, below.
Current Language **8.3.5 Medical Records** Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Board on recommendation of the Medical Records/Utilization Committee through the Medical Executive Committee. 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 his designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacations 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 medical record completion is current and the member is removed from suspension by the Chief of Staff or his designee.	**2024 Proposed Changes** **8.3.9 Medical Records** Suspension shall be imposed for failure to complete medical records within the time frames for completion specified in the Rules and Regulations. Clinical privileges shall be reinstated upon confirmation that the medical record(s) at issue have been completed. Failure to complete the medical records at issue within seven (7) weeks of suspension shall be deemed a voluntary resignation from the Medical Staff and the voluntary relinquishment of all clinical privileges. Accumulation of more than three (3) medical record suspensions in any consecutive twelve (12) month period shall also be deemed to constitute a voluntary resignation from the Medical Staff and voluntary relinquishment of all clinical privileges. Fair hearing and appeal rights shall not apply.
Current Language 8.3.6 Executive Committee Deliberation	**2024 Proposed Changes** **[renumbered to 8.3.10—no changes]**

At the next regular meeting or no longer than sixty (60) days after action is taken or warranted as described in Section 8.3.1, or Sections 8.3.2., 8.3.3., 8.3.4, 8.3.5, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure set forth in Article 9. For actions of less than two years' duration, the member's membership status and clinical privileges can automatically be reinstated subject to approval by the Hospital Board of Directors upon the recommendation of the Medical Executive Committee. For actions of greater than two years' duration, formal application for appointment in accordance with Article 6 must be made subject to approval by the Hospital Board of Directors upon the recommendation of the Medical Executive Committee.	
Current Language 8.3.7 Failure to Satisfy Special Appearance Requirement A member who fails without good cause to appear and satisfy the requirements of Section 8 shall automatically be suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that section. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee.	**[renumbered to 8.3.11—no changes]**

San Mateo Medical Center
A County System of Healthcare

MEDICAL STAFF BYLAWS

Revised 06/10/1998; 06/09/1999; 06/28/2000, 07/10/2003; Reviewed 5/24/2004; Revised 5/10/2005; Reviewed 6/20/2006; Reviewed 5/22/2007; Revised 05/27/2008; Reviewed 05/26/2009; Revised 05/25/2010; Revised 05/24/2011; Reviewed 05/02/2012; Revised 06/04/2013; Reviewed 06/05/2014; Revised 07/02/2015; Revised 12/08/2015: Reviewed 10/14/2016; Revised 4/11/2017; Revised 05/15/2019; Reviewed 10/06/2021—County counsel review ongoing as of January 2022-Reviewed 5/24/2023; REVISED 05/15/2024

SAN MATEO MEDICAL CENTER
MEDICAL STAFF BYLAWS

PREAMBLE

The Bylaws are adopted in order to provide for the organization of the Medical Staff of San Mateo Medical Center[1] and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving effective and efficient quality 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, and accountability to the Board of Directors, and relations with applicants and members of the Medical Staff.

DEFINITIONS

1. **Administrator** means the Chief Executive Officer of San Mateo Medical Center.[2]

2. **Affiliate to the Medical Staff** or **AMS**: An individual, other than a licensed physician, dentist, clinical psychologist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Directors, the Medical Staff, and the applicable State Practice Acts; who is qualified to render direct or indirect medical, dental, psychiatric, 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 practice privileges and prerogatives in conformity with the rules adopted by the Board of Directors, these Bylaws, and the Medical Staff Rules and Regulations. AMS's are not eligible for Medical Staff membership.

3. **Authorized Representative** means the individual designated by the Medical Center's Board of Directors[3] to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

4. **Chief of Staff** means the chief officer of the Medical Staff elected by members of the Medical Staff.

5. **Clinical Privileges** or **Privileges** means the permission granted to a Medical Staff member or affiliate, in accordance with these Bylaws, to render specific patient services.

6. **Governing Body** shall mean the operational group known as the Hospital Board of Directors who perform the ongoing functions of governance as defined and specified in the Governing Body Bylaws.

7. **Hospital** means San Mateo Medical Center[4] and includes all inpatient and outpatient locations and services operated under the auspices of the hospital's license.[5]

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1 May 2003

2 May 2003

3 05/15/03

4 May 2003

5 May 2011

8. **Investigation** means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff, and does not include activity of the Medical Staff Aid Committee.

9. **Medical-Administrative Officer** shall mean a practitioner, employed by or otherwise serving the Hospital on a full or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and include the supervision of professional activities of practitioners and affiliates under his direction.

10. **Medical Executive Committee** means the Executive Committee of the Medical Staff which shall govern the Medical Staff with respect to the professional work performed in the Hospital and shall act on behalf of the Medical Staff in the intervals between annual Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.

11. **Medical Staff** or **Staff** means the formal organization of physician (MD or DO or their equivalent as defined in Section 3.2.2), dentist, podiatrist, and clinical psychologist who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.

12. **Member** means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 3.2.2), dentist, podiatrist, and clinical psychologist holding a current license to practice within the scope of that license, who is a member of the Medical Staff.

13. **Medical Staff Year** means the period from July 1st to June 30th.[6]

14. **Physician** means an individual with an M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

15. **Prerogative** shall mean a participating right granted by virtue of staff category or otherwise, to a Medical Staff member or affiliate, which is exercisable subject to, and in accordance with, the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules, regulations, or policies.

16. **Resident** is a physician in training who works under the supervision of a Medical Staff member. Resident may be a licensed physician and qualified to obtain privileges in a particular area of medicine but is training in another area of medicine. A resident must seek appointment to the Medical Staff at such time as he/she intends to function as a member of the Medical Staff and is duly licensed and trained.

17. **Telemedicine** is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.[7]

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[6] May 2003

[7] May 2008

ARTICLE 1 - NAME

The name of this organization is the Medical Staff of San Mateo Medical Center.

1.1 DESCRIPTION[8]

1.1.1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a staff category depending upon the nature and tenure of practice at the hospital. All new members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the staff categories described in Article 4.

1.1.2 Members are also assigned to departments depending upon their specialties. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.

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

1.1.4 Overseeing all of this is the Medical Executive Committee, comprising the elected officials of the Medical Staff, department chairs, and representatives elected at large.

[8] May 2011: The Joint Commission Standard (TJC) MS 01.01.01, EP12

ARTICLE 2 - PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Staff are:

a) To be the formal organizational structure through which:

1) The benefits of staff membership may be obtained by individual practitioners, and

2) The obligations of staff membership may be fulfilled.

3) Clinical privileges are delineated for all members and AMS's to exercise in the Hospital.

b) To serve as the primary means for accountability to the Board of Directors for the appropriateness of professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at quality and efficiency levels, and that there will be a high level of professional performance by all providers granted clinical privileges.

c) To provide a means or method by which members of the Medical Staff can formulate recommendations for the Hospital's policy-making and planning processes, and through which such policies and plans are communicated to and observed by each member of the Staff.

d) To constitute a professional collegial body which provides its members educational activities and professional support in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

e) To exercise its rights and responsibilities in a manner that does not jeopardize the hospital's license, Medicare and Medi-Cal provider status, accreditation, or tax-exempt status.[9]

2.2 RESPONSIBILITIES

To effect the stated purposes, it is the obligation and responsibility of the organized Medical Staff:

a) To participate in the Hospital's quality management program by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, including, without limitation:

1) Evaluating individual and institutional performance through valid and reliable measurement systems based on objective, clinically-sound criteria.

2) Engaging in the ongoing monitoring of critical aspects of care and enforcement of Medical Staff and Hospital policies.

3) Evaluating physician credentials for initial and continued membership in the Medical Staff organization and for the delineation of clinical privileges for each member and

[9] May 2011

Affiliate to the Medical Staff in the Hospital.

4) A continuing education program, fashioned at least in part on the needs demonstrated through the patient care review and other quality management programs.

5) A utilization review program to allocate inpatient and outpatient medical and health services based upon patient-specific determination of individual medical, social, and emotional needs.

b) To recommend to the Governing Body action concerning appointments, reappointments, staff category, departmental assignments, clinical privileges, and corrective action.

c) To account to the Governing Body for the quality and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation, and results of the patient care review and other quality management activities.

d) To initiate and pursue corrective action with respect to members and Affiliates to the Medical Staff, when warranted.

e) To administer and seek compliance with these Bylaws, through the development and implementation of Rules and Regulations of the Staff, department-specific Rules and Regulations, and other patient care-related Hospital policies.

f) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

g) To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.

h) To provide access to, and cooperation with, the Hospital and Governing Body towards maintaining an effective mechanism for communication of issues with all parties.

i) To notify in writing the Department Chair of any medical absence from practice of 30 days or longer.

ARTICLE 3 - MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

No member, including those in a medical-administrative position by virtue of employment or a contract with the Hospital, shall admit or provide 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 clinical privileges and prerogatives as have been granted in accordance with these Bylaws. Medical Staff membership or clinical privileges shall not be conditioned or determined on 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.

3.2 QUALIFICATIONS OF MEMBERSHIP

3.2.1 General Qualifications

Only physicians, dentists, podiatrists and clinical psychologists shall be deemed to possess basic qualifications for membership in the Medical Staff, except for the honorary and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the Medical Staff, and who:

a) document and continuously maintain their (1) current California licensure [telemedicine providers who are not licensed in California must be registered as a telemedicine provider with the Medical Board of California[10]], (2) 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 to exercise clinical privileges within the Hospital, and that patients treated by them can reasonably expect to receive quality medical care;

b) can be available within reasonable proximity to the Hospital so that patients treated by them will receive effective, efficient, and continuous quality medical care;

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 patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities addressed in these Bylaws, (5) to accomplish these ends within the resources of the Hospital and with regard to the needs of the patient, and (6) have an approved membership history;

d) who maintain, in force, professional liability insurance in not less than one million dollars ($1,000,000) from a carrier acceptable to the Hospital Governing Body. However, the Medical Executive Committee, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary or discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:

[10] May 2008, per California Business/Professions Code §2052.5 & §2060

1) whether the member has applied for the requisite insurance;

2) whether the member has been refused insurance, and if so, the reasons for such refusal;

3) whether insurance is reasonably available to the member, and if not, the reasons of its unavailability;

e) be eligible to receive payments from the federal Medicare and state Medicaid [Medi-Cal] programs;[11]

shall be deemed to possess basic qualifications for membership in the Medical Staff, except for the Honorary and Retired Staff categories, in which case these criteria shall only apply as deemed individually applicable by the Medical Staff and as approved by the Governing Body.

3.2.2 Particular Qualifications

Physicians: An applicant for physician membership in the Medical Staff, except for the Honorary Staff, must hold an M.D. or D.O. degree or their equivalent and 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 the equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners.

Dentists: An applicant for dental membership in the Medical Staff, except for Honorary Staff, must hold a D.D.S. or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Board of Dental Examiners of California.

Podiatrists: An applicant for podiatric membership on the Medical Staff, except for the Honorary Staff, must hold a D.P.M. degree and a valid and unsuspended certificate to practice podiatry issued by the Medical Board of California.

Clinical Psychologists: An applicant for clinical psychologist membership on the Medical Staff must hold a clinical psychologist degree and a valid, unsuspended certificate to practice clinical psychology issued by the Medical Board of California and either (1) not less than two years of documented clinical experience in a medical facility or (2) be listed in the latest edition of the National Register of Health Care Providers in Psychology.

3.3 EFFECT OF OTHER AFFILIATIONS

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

[11] May 2011

3.4 NON-DISCRIMINATION

No aspect of Medical Staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, or national origin or physical or mental impairment that does not pose a threat to the quality of patient care; nor shall they be denied on the basis of any criterion unrelated to the delivery of quality patient care in the Hospital setting, to professional qualifications, the Hospital's purposes, needs, and capabilities, or community needs.

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for the Honorary and Retired Staff, the ongoing responsibilities of each member of the Medical Staff and each practitioner exercising temporary privileges include:

a) providing all patients with the quality of care meeting the professional standards of the community and the Medical Staff of this Hospital;

b) monitoring the quality of care provided by its members and Affiliates;

c) abiding by the Medical Staff Bylaws, Rules and Regulations; and holding to specific contractual relations with the Hospital, if any, as they relate to patient care, reporting to Administration or the Governing Body on other Hospital-related activities;

d) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership or personal, department, committee, and/or Hospital functions, including peer review, utilization review, and participating in emergency call coverage or consultation panels and backup functions, for which he or she is responsible by virtue of staff category assignment, election, utilization of Affiliates of the Medical Staff, or exercise or privileges, prerogatives, or other rights in the Hospital, or as may be determined by the Medical Staff.

e) preparing and completing in a timely fashion medical and other required records for all the patients to whom the member provides care in the Hospital;

f) abiding by the lawful ethical principles of the California Medical Association or equivalent association for other practitioners;

g) aiding the Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, podiatrists, nurses, and other personnel;

h) working cooperatively with members, Affiliates, nurses, Hospital Administration, and others so as not to adversely affect patient care;

i) making appropriate arrangements for coverage for his or her patients when required in a way that provides for continuous effective and efficient care and supervision of each patient;

j) refusing to engage in improper inducements for patient referral;

k) attending or participating in continuing education programs that relate, in part, to the clinical privileges granted and to documenting this participation so that it can be considered at the time of reappointment and/or renewal of revision of individual clinical privileges;

l) abiding by all applicable laws and regulations of governmental agencies; and

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

n) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;

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 8.1.3, and those, which are the subject of a hearing pursuant to Article 9.

p) assuring a medical history and physical examination is completed and documented for each patient no more than 30 days before or 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. There must be a complete H&P and an update, if applicable, in the medical record of each patient prior to surgery or procedure requiring anesthesia services, except in emergencies. In the case of emergencies, the H&P must be recorded immediately following the procedure and the practitioner must sign, date, and time a statement of the emergency circumstances in the patient's medical record.[12]

The medical history and physical examination must be completed and documented by a physician, nurse practitioner or physician assistant who is credentialed and privileged to perform an H&P. Dentists, clinical psychologists, and podiatrists shall be responsible for those portions of the history and physical examination and progress notes relative to the specialty.

At a minimum, the H&P must contain the following elements for both inpatients and outpatient procedures requiring an H&P: (1) chief complaint, (2) history of present problem, (3) past medical history, (4) relevant social and family history, (5) current medications and allergies, (6) review of systems, (7) physical examination, and (8) impression/ plan.

When a medical history and physical examination has been completed within 30 days of admission (or registration), a patient examination and updated medical record entry must be completed and documented in the patient's medical record within 24 hours after admission or registration. The examination must be conducted by a licensed practitioner who is credentialed and privileged to perform an H&P. In all cases, the update must take place prior to surgery or a procedure requiring anesthesia services. The update note must document an examination for any changes in the patient's condition that might be significant for the planned course of treatment.

If, upon examination, the licensed practitioner finds no significant changes in the patient's medical condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. [13]

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[12] May 2008, per Title 22/CMS Medical Conditions of Participation; December 2015 updated revision

[13] May 2008, per Title 22/CMS Medical Conditions of Participation; December 2015 updated revision

q) acquiring a patient's informed consent for all procedures and treatments identified in the Bylaws, Article 15 General Provisions, and abiding by the procedures for obtaining such informed consent.[14]

r) preparing and completing, in a timely and accurate manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital, including compliance with such electronic health record policies and protocols as have been implemented by the hospital.[10]

s) actively participating in and regularly cooperating with the Medical Staff in assisting the hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement, peer review, utilization management, quality evaluation, ongoing and focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.[15]

t) adherence to Medical Staff Policies as outlined in Section V of the Medical Staff Rules and Regulations.[16]

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14 May 2008, per CMS Interpretive Guidelines to 42 CFR §482.13(b)(2)

15 May 2008, sections r) & s) added to accommodate Joint Commission Standards MS.3.10 and MS.4.40

16 May 2011

ARTICLE 4 - CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

The categories of the Medical Staff shall include the following: Active, Courtesy, Provisional, Telemedicine,[17] Honorary and Retired. At each appointment and reappointment, the member's staff category shall be evaluated and re-determined.

4.2 ACTIVE STAFF

4.2.1 Qualifications

The Active Staff shall consist of members who:

a) meet the general qualifications for membership set forth in Article 3;

b) have offices or residences which in the opinion of the Medical Executive Committee are located closely enough to the Hospital to provide continuity of quality of care;

c) regularly care for a minimum of one hundred (100) outpatients/inpatients at this Hospital annually or regularly provide non-clinical professional services to the Hospital or Medical Staff;

d) at the discretion of the Governing Body; and

e) except for good cause, as determined by the Medical Staff and approved by the Governing Body, have satisfactorily completed their designated term in the Provisional Staff category.

4.2.2 Prerogatives

Except as otherwise provided, the prerogatives of an active Medical Staff member shall be to:

a) admit and/or treat patients and/or exercise such clinical privileges as are granted pursuant to Article 7;

b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member; and

c) hold Staff, division, or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

4.2.3 Responsibilities

[17] May 2008

Each Active Medical Staff member shall:

a) meet the basic responsibilities set forth in Section 3.5;

b) actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital in fulfilling its obligations related to patient care, including, but not limited to: emergency service and backup function, providing consultation to other staff members consistent with his or her delineated privileges; patient care audit, peer review, utilization review, quality evaluation, and related monitoring activities required of and by the Medical Staff; in supervising and proctoring initial appointees and/or Affiliates of the Medical Staff; consistent with his or her delineated privileges and discharging such other functions as may be required from time to time; and

c) pay all staff dues and assessments promptly as outlined in Article 15.

4.3 COURTESY STAFF

4.3.1 Qualifications

The Courtesy Staff shall consist of members who:

a) meet the general qualifications set forth in subsections a), b), c), and d) of Section 3.2.1;

b) do not regularly care for patients in or at the Hospital or are not regularly involved in the Medical Staff functions as determined by the Medical Staff;

c) are members in good standing of an Active Medical Staff of another JCAHO accredited and California licensed hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause subject to approval by the Board of Directors; and

d) have satisfactorily completed appointment in the Provisional category.

4.3.2 Prerogatives

Except as otherwise provided, the Courtesy Medical Staff members shall be entitled to:

a) admit and/or treat patients to the Hospital within the limitations of Section 4.3.1 b) and exercise such clinical privileges as are granted pursuant to Article 7; and

b) attend, in a non-voting capacity, meetings of the Medical Staff and the department of which he or she 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.

Courtesy Staff members shall not be eligible to hold office in the Medical Staff.

4.3.3 Responsibilities

Each Courtesy Staff member shall meet the basic responsibilities set forth in Section 3.5 but shall not be required to pay medical staff dues.

4.3.4 Limitation

Courtesy Staff members who meet requirements of Active Staff and have more than ten (10) patient contacts per year at the Hospital shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.

4.4 PROVISIONAL STAFF

4.4.1 Qualifications

The Provisional Staff shall consist of members who:

a) meet the qualifications specified for members of the Active or Courtesy Staff, except that they have not yet satisfactorily completed the proctoring or observation requirements specified in Article 7, have been Medical Staff members for less than one year; and/or have not fulfilled such other requirements as may be set forth in the Bylaws, the Medical Staff, and Department Rules and Regulations, or Hospital policies; and

b) immediately prior to their application and appointment were not members or were no longer members in good standing of this Medical Staff.

4.4.2 Prerogatives

The Provisional Staff members shall be entitled to:

a) exercise such clinical privileges as are granted pursuant to Article 7; and

b) attend meetings of the Medical Staff and the department of which he or she 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, but may serve upon committees.

4.4.3 Responsibilities

Each Provisional Staff member shall be required to discharge the responsibilities which are specified in Section 4.2.3 for Active Staff members. Failure to fulfill those responsibilities shall be grounds for denial of advancement to Active or Courtesy status and termination of Provisional Staff status.

4.4.4 Observations of Provisional Staff Members

Each Provisional Staff member shall undergo a period of observation by designated monitors as described in Article 6. Proctoring plans will be defined by department chairmen; individual proctoring plans will be specified within the letter of appointment to practitioners. The observations shall evaluate (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories.

Frequency and format of Provisional Staff observation shall be department-specific and appropriate to adequately evaluate the Provisional Staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate documentation shall be maintained; the results of the observation shall be reviewed and communicated to the Credentials Committee by the department chair.

4.4.5 Term of Provisional Staff Status

A practitioner shall remain in the Provisional Staff for a minimum period of twelve (12) months, unless that status is extended by the Executive Committee subject to approval of the Board for an additional period of up to twelve (12) months (maximum period of twenty-four (24) months total) upon a determination of good cause. Provisional medical staff are required to pay medical dues after 12 months of starting.

The Medical Staff membership and clinical privileges of practitioners who do not qualify for advancement to Active or Courtesy status within 24 months following their initial appointment shall be terminated and such members shall be entitled to the procedural rights set forth in Articles 8 and 9 as if they were initially denied membership and/or clinical privileges.

4.4.6 Action at Conclusion of Provisional Staff Status

a) At the end of the twelve (12) month Provisional term, the assigned department will review the practitioner observations. Provisional Staff members who have satisfactorily demonstrated, through documented proctoring/profiling, their ability to exercise the clinical privileges initially granted and otherwise appear qualified for continued Medical Staff membership, shall be recommended for Active or Courtesy Staff status as requested and/or appropriate, dependent upon recommendation of the Medical Executive Committee and approval by the Board of Directors.

b) For all other Provisional members, the appropriate department shall report its findings to the Credentials Committee which shall report to the Medical Executive Committee which, in turn, shall make recommendations to the Board of Directors regarding a modification, extension, or termination of membership status and/or clinical privileges.

4.5 TELEMEDICINE STAFF[18]

4.5.1 Qualifications

The Telemedicine Staff shall consist of members who

a) Meet the general qualifications for membership set forth in Article 3

b) are members in good standing of another Joint Commission accredited organization

c) satisfactorily completed appointment in the Provisional category.

4.5.2 Prerogatives

Except as otherwise provided, the Telemedicine Staff members shall be entitled to:

a) exercise such clinical privileges as are granted pursuant to Article 7; and

b) attend, in a non-voting capacity, meetings of the Medical Staff and the department of which he or she 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.

4.5.3 Responsibilities

Telemedicine Staff members shall meet the basic responsibilities, as applicable, set forth in Section 3.5 and provide diagnostic or treatment services from the distant site to hospital patients at San Mateo Medical Center via telemedicine devices. Telemedicine Staff members shall be required to pay medical staff dues.

4.5.4 Limitation

Telemedicine Staff members shall not be eligible to hold office in the Medical Staff.

[18] May 2008

4.6 HONORARY AND RETIRED STAFFS

4.6.1 Qualifications

a) Honorary Staff

The Honorary Staff also known as volunteer staff shall consist of practitioners 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 or special service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct and promote the ideals of the Hospital.

b) 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 ten (10) continuous years, and who continue to adhere to appropriate professional and ethical standards.

4.6.2 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 upon 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 program and will be exempt from paying Medical Staff dues

4.7 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, and by the Medical Staff Rules and Regulations, or by other policies of the Hospital. The prerogatives of dental, clinical psychology, or podiatric members of the Medical Staff shall be limited to those for **which they can demonstrate the possession of requisite licensure, education, training, and experience.**

4.8 GENERAL EXCEPTIONS TO THE PREROGATIVES

Regardless of the category of membership in the Medical Staff, unless otherwise required by law, non-physician 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

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

Section 7.4.

4.9 MODIFICATION OF MEMBERSHIP CATEGORY

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member under Section 6.6.1 b), or upon direction of the Board of Directors as set forth in Section 8.1.6, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws. Changes in Medical Staff category shall not be grounds for a hearing unless they affect the member's privileges.

ARTICLE 5 - AFFILIATES TO THE MEDICAL STAFF AND PHYSICIANS IN TRAINING

Privileges to perform certain functions under the supervision of a practitioner member of the Medical Staff may be granted to certain health professionals (i.e., including, but not limited to, residents, nurse practitioners and physician's assistants) based on their individual previous training, experience, demonstrated competence and applicable State law. Applications to perform such privileges must be processed, and specific privileges as recommended by the Medical Staff are granted by the Board of Directors as defined in Article 6.

5.1 QUALIFICATIONS OF AMS'S

Affiliates to the Medical Staff (AMS's) will be individuals holding a license, certificate, or such other legal credentials, if any, as required by California law and combined approval of the Hospital, which authorize the AMS's to provide certain professional or clinical service within the limit and scope of awarded delineated privileges. Such AMS's are eligible for privileges in this Hospital only if they:

a) hold a license, certificate, or other legal credentials, if any, as required by California law, which authorize the AMS's which the Board of Directors has identified as eligible to apply for practice privileges;

b) document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise practice privileges within the Hospital;

c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials;

d) hold professional liability insurance in the amount of one million dollars ($1,000,000) self-owned or owned by the practitioner from a carrier acceptable to the Hospital Governing Body to cover the AMS, and verify coverage annually; and

e) are prepared to disclose (upon request) a history of claims made against the AMS concerning their professional activities and provide documentation of all final judgments and/or settlements involving the AMS.

5.2 DELINEATION OF CATEGORIES OF AMS'S ELIGIBLE TO APPLY FOR PRACTICE PRIVILEGES

The Board of Directors shall, as often as necessary but at least every two (2) years, identify the categories of AMS's, based upon occupation or profession, and shall identify the mode of practice in the Hospital setting (i.e., independent or dependent) of each category. The categorical modes of AMS are:

a) Independent AMS - Those professionals who by State authority and Hospital approval may practice independently; those professionals not required to have designated Practitioners as supervisors.

b) Dependent AMS - Those professionals not permitted to practice independently, who will have an assigned Practitioner who can demonstrate their qualifications to be responsible and accountable for supervision.

The Board of Directors shall secure recommendations from the Medical Executive Committee as to the categories of AMS's which should be eligible to apply for privileges and as to the privileges, prerogatives, terms, and conditions which may be granted and applied to AMS's in each category. The delineation of categories of AMS's eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms, and conditions for each such AMS category, when approved by the Medical Executive Committee and the Board of Directors, shall be set forth in the Medical Staff Rules and Regulations.

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES TO AMS'S

An AMS must apply and qualify for practice privileges; and practitioners who desire to supervise or direct AMS's who provide dependent services must apply and qualify for privileges to supervise approved AMS's. Applications for initial granting of practice privileges, and every two years renewal thereof, shall be submitted and processed in a parallel manner to that provided in Article 7 - Clinical Privileges and further delineated in the Medical Staff Rules and Regulations.

Each AMS shall be assigned to the clinical department appropriate to his/her occupational or professional training and, unless otherwise specified in the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in Article 3, as they may logically be applied to AMS's and appropriately tailored to the particular AMS's profession.

An AMS who does not have licensure or certification in an AMS category identified as eligible for practice privileges in the manner required by Section 5.2 above may not apply for practice privileges, but may submit a written request to the Administrator, asking that the Board of Directors consider identifying the appropriate category of AMS's as eligible to apply for practice privileges. The Board of Directors must refer the request to the Executive Committee for recommendation; and the Board of Directors shall consider such request either before or at the time of its annual review of the categories of AMS's.

5.4 PREROGATIVES OF AMS'S

The prerogatives which may be extended to an AMS shall be defined in the Medical Staff Rules or Regulations or Hospital policies. Such prerogatives may include:

a) provision of specified patient care services consistent with the assigned categorical mode and delineated privileges granted to the AMS and within the scope of the AMS's licensure or certification;

b) service on Medical Staff, department, and Hospital committees;

c) attendance at the meetings of the department to which he/she is assigned, as permitted by the department Rules and Regulations, and attendance at Hospital education programs in his/her field of practice; and

d) each AMS is individually assigned to the Medical Staff Department appropriate to his professional training and/or in which the supervisor is a member, and is subject to a provisional period, observation, and formal periodic reviews as determined by the Department and defined in departmental Rules and Regulations.

5.5 RESPONSIBILITIES OF AMS'S

Each AMS shall:

a) Meet those responsibilities required by the Medical Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 3.5 as are generally applicable to the more limited practice of the AMS including meeting attendance.

b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services.

c) Participate, as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of AMS's in supervising initial appointees of his same occupation or profession, or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.

d) Attend required orientation, safety and infection control in-services, presented by the Hospital.

e) Acquire sufficient orientation from the supervising Active member of Medical Staff as directed by the Medical Staff.

f) AMS members of the Medical Staff shall pay dues, except as noted in Bylaws and those excepted by the Chief of Staff for good cause.

5.6 TERMINATION OF PRIVILEGES

The AMS's privileges shall be subject to automatic termination when:

a) the Medical Staff membership of the supervising physician is terminated, whether voluntary or involuntary, or when that member no longer is a member of the Active Medical Staff, or when the supervising physician is under review by the Medical Staff;

b) the supervising physician no longer agrees to act as the supervising physician, for any reason, or the relationship between the AMS and the supervising physician is otherwise terminated, regardless of the reason;

c) the contract between the Hospital and supervising physician in a medico-administrative position pursuant to Section 3.5 is terminated; or

d) the AMS certificate or license expires, is revoked, or suspended.

The AMS privileges may also be terminated by the Chair of the Department to which the AMS is assigned or by the Chief of Staff or by Hospital Administrator.

5.7 HEARING RIGHTS

Nothing in the Medical Staff Bylaws shall be interpreted to entitle an AMS to the fair hearing rights of Articles 8 and 9. However, an AMS shall have the right to challenge any action that would constitute grounds for a hearing under Section 9.2 of the Bylaws by filing a written grievance with the Medical Executive Committee within fifteen (15) days of this action. Upon receipt of the grievance, the Medical Executive Committee shall conduct an investigation that affords the AMS an opportunity for an interview concerning the grievance. The interview shall not constitute a "hearing" as established by Article 9 of these Bylaws, and need not be conducted according to the procedural rules applicable to these hearings. Before the interview, the AMS shall be informed of the general nature of the circumstances giving rise to the action and the AMS may present relevant information at the interview. A record of the interview shall be made and a decision on the action shall be made by the Medical Executive Committee. The Board of Directors may affirm this decision if it is supported by substantial evidence.

5.8 RESIDENTS - PHYSICIANS IN TRAINING

A Resident is a physician in training who works under the supervision of a Medical Staff member. A Resident may be a licensed physician and qualified to obtain privileges in a particular area of medicine but is training in another area of medicine. A Resident must seek appointment to the Medical Staff at such time as he/she intends to function as a member of the Medical Staff and is duly licensed and trained.

The respective department shall be responsible for the Residents. The Residents are not members of the Medical Staff but Medical Staff applications must be completed and processed as identified in Articles 6 and 7. Residents shall not have voting rights and are exempt from paying medical staff dues. Residents shall be supervised by a physician supervisor. During the internship year, Residents are unlicensed and, therefore, shall only be able to admit under the supervision of a physician supervisor. During clinical rotations, interns may make chart entries which must be cosigned by the physician supervisor. During the second year, when the California Medical License for the resident has been received, Residents shall have admitting privileges, however, under the supervision of a physician supervisor. All patient care will be under supervision.

Once licensed, when Residents staff Psychiatric Emergency Services and make chart entries, however, without the supervision of a physician supervisor, Residents shall apply for Medical Staff membership and clinical privileges.

Unlicensed Residents may write prescriptions and orders, to be honored in-house only, under the supervision of a physician supervisor. When writing orders for narcotics, licensed Residents must have a valid California Medical License, and must also have a DEA Certificate. In such case where the DEA Certificate has not yet been received, the Resident may write narcotic orders with the co-signature of physician supervisor.

ARTICLE 6 - APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL

Except as otherwise specified herein, only those members who have received appointment to the Medical Staff shall admit patients to or exercise clinical privileges in this Hospital. Temporary Members if granted temporary privileges to do so can admit patients to or exercise clinical privileges in this Medical Center.[19] Appointment to the Medical Staff shall confer on the appointee only such clinical privileges as have been requested by the practitioner and granted by the Board of Directors in accordance with these Bylaws.

The Medical Staff, through its designated departments, committees, and officers, shall consider each application for appointment or reappointment, and each request for modification of staff membership status utilizing the resources of the Administrative staff to investigate and validate the contents of the application, before adopting and transmitting a recommendation to the Board of Directors.

The Medical Staff shall also perform the same functions in connection with any practitioner applying for clinical privileges or temporary privileges, or with any individual who otherwise seeks to exercise privileges or to provide specific professional or clinical services in any Hospital department or service.

6.1.1 Burden of Producing Information

In connection with all applications for membership, membership renewal[20] advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical 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. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee.[21]

Any committee or individual charged under these bylaws with responsibility for reviewing the appointment or reappointment and/or request for clinical privileges may request further documentation or clarification. If the practitioner or member fails to respond within one month, the application or request shall be deemed withdrawn, and processing of the application or request will be discontinued. Unless the circumstances are such that a report to the Medical Board of California is required, such a withdrawal shall not give rise to hearing and appeal rights pursuant to Article 9, Hearing and Appellate Review.[22]

6.1.2 Appointment Authority

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19 05/15/2003

20 May 2011

21 May 2011

22 May 2011

Appointment, denials, and revocation of appointments to the medical staff shall be made as set forth in these bylaws, but only after there has been a recommendation from the Medical Staff, or as set forth in Section 8.1.6.

6.1.3 Duration of Appointment and Reappointment

Except as otherwise provided in these bylaws, initial appointments and reappointments to the Medical Staff shall be for a period of up to two years.

6.2 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

6.2.1 Application Form

An application form shall be developed by the Medical Executive Committee or their designee. The form shall require detailed information which shall include, but not be limited to, information concerning:

a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, required certifications (if any), 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; and

c) requests for membership category, department, and clinical privileges;

d) past or pending professional disciplinary action, previous or current membership rejections, previous or current privilege suspensions, licensure limitations, drug enforcement administration actions, final judgements or settlements made against the applicant in professional liability cases, and any filed and served cases pending, administrative or court cases involving non-compliance with laws or standards related to patient care, government or third-party payor sanctions and/or proceedings, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or privileges or any licensure or registration, and related matter;

e) current physical and mental health status;

f) professional liability coverage, if required;

g) an acknowledgment of the applicant's responsibility to maintain continuous compliance with the conditions of Medical Staff membership and/or clinical privileges, the Medical Staff Bylaws, Rules and Regulations and SMMC Service Commitment Guidelines, and that he or she agrees to be bound by the terms thereof, as they may be amended from time to time;

h) an acknowledgment of the applicant's duty/responsibility to inform the Medical Staff Office or approved designee of any changes in the information provided through the application form during the application period, or at any subsequent time.

Each application for initial appointment to the Medical Staff shall be in writing, submitted on the prescribed form with all provisions (completed or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form for initial appointment, he or she shall be given a copy of, and orientation to, these Bylaws and the Medical Staff Rules and Regulations; and summaries of other applicable policies or procedures relating to clinical practice in the Hospital, if any, as determined by the Medical Executive Committee and the Board of Directors.

6.2.2 Effect of Application

By applying for appointment to the Medical Staff, reappointment, advancement, or transfer, each applicant thereby:

a) signifies his or her willingness to appear for interviews in regard to the application;

b) authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her 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 his or her qualifications and ability to carry out clinical 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, and licensing boards, and to other similar organizations as required by law, any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and released 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 of 60 days;

h) pledges to provide for continuous quality care for his or her patients;

i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised or trained practitioners and Affiliates; and

j) pledges to be bound by the Bylaws and the Rules and Regulations, and policies.

6.3 PROCESSING THE APPLICATION

6.3.1. Verification of Information

The applicant shall deliver a completely, filled-in, signed, and dated application and supporting documents to the appropriate Medical Staff officer or approved designee, and an advance payment of Medical Staff dues or fees, if any is required. The administrator shall be notified of the application. The application and all supporting materials then available shall be transmitted to the chair of each department in which the applicant seeks privileges and to the credentials committee. The credentials committee, and the administrator when requested to assist by the credentials committee, shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The hospital's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the credentials committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. When collection and verification of information other than the National Practitioner Data Bank is accomplished, the application shall be considered complete, and all such information shall be transmitted to the credentials committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

6.3.2 Department Action

After receipt of the application, the chair or chief of each department and division to which the application is submitted shall review the application and supporting documentation, and may conduct a personal interview with the applicant at his or her discretion. The chair or chief and/or appropriate Department members shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, and shall transmit to the Credentials Committee a written report any recommendation as to appointment and, if appointment is recommended, as to membership category, department and division affiliation, clinical privileges to be granted, and any special conditions to be attached. The chair or chief may also request further documentation for application review and may request that action on the application be deferred by the Credentials Committee and/or the Medical Executive Committee.

6.3.3 Credentials Committee Action

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department chair's and division chief's reports 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 appointment and, if appointment is recommended, as to membership category, department and division affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may request additional documentation from the applicant or recommend that the Medical Executive Committee defer action on the application.

6.3.4 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 investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Administrator, for prompt transmittal to the Board of Directors, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department and division affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may defer action on the application. The reasons for each recommendation shall be stated.

6.3.5 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 promptly forwarded, together with supporting documentation, to the Board of Directors.

b) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall then be informed of the procedural rights as provided in Article 9. The Board of Directors will take no final action until all of the applicant's rights are waived or exhausted. If the Medical Executive Committee's recommendation to the practitioner is adverse, the Medical Executive shall also assess and determine whether the adverse recommendation is for a "medical disciplinary" cause or reason. A medical disciplinary action is one taken for cause or reason that involves that aspect of a practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care. All other actions are deemed administrative disciplinary actions, In some cases, the reason may involve both medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be medical disciplinary for Bylaws, Article 9 hearing purposes.[23]

c) Deferral, Additional Interviews, Further Documentation: Action by the Medical Executive Committee to interview the applicant, seek further documentation, or defer the application for further consideration must be followed up within sixty (60) days with a subsequent recommendation for appointment with specified clinical privileges, or for denial of the request for Medical Staff membership.

6.3.6 Action on the Application

The Board of Directors 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:

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a) If the Medical Executive Committee issues a favorable recommendation, and

1) the Board of Directors concurs in that recommendation, the decision of the Board shall be deemed final action, or

2) the tentative final action of the Board of Directors is unfavorable, the Administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article 9. If the applicant waives his or her procedural rights, the decision of the Board shall be deemed final action.

b) In the event the Medical Executive Committee recommendation, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article 9 shall apply.

1) If the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board 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 6.3.7(b) or an adverse Board of Directors tentative final action pursuant to 6.3.7(a)(2), the Board of Directors shall take final action only after the applicant has exhausted his or her procedural rights as established by Article 9. After exhaustion of the procedures set forth in Article 9, the Board shall make a final decision. The Board's decision shall be in writing and shall specify the reasons for the action taken.

6.3.7 Expedited Review

The Board of Directors may use an expedited process for appointment, reappointment or when granting Privileges when criteria for that process are met. This process, if used, will be further described in the Rules and Regulations.[24]

6.3.8 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 Administrator.

b) A decision and notice to appoint or reappoint shall include, if applicable:

1) the staff category to which the applicant is appointed;

2) the department and division to which he or she is assigned;

3) the clinical privileges granted; and

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4) any special conditions attached to the appointment.

6.3.9 Reapplication After Adverse Appointment Decision

The following individuals shall not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by the previous action for a period of at least two years from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable. 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.

a) An applicant who (1) has received a final adverse decision regarding appointment or (2) withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or Board of Directors.

b) A former Medical Staff member who has (1) received a final adverse decision resulting in termination of Medical Staff membership and clinical privileges or (2) resigned from the Medical Staff following the issuance of a Medical Staff or Board of Directors recommendation adverse to the member's Medical Staff membership or clinical privileges.

c) A Medical Staff member who has received a final adverse decision resulting in (1) termination or restriction of his or her clinical privileges or (2) denial of his or her request for additional clinical privileges.

A decision shall be considered to be adverse, for medical disciplinary reasons, only if it is based on the type of occurrences which might give rise to corrective action and not if it is based upon reasons that do not directly pertain to medical or ethical conduct. Actions which are not considered adverse include, but are not limited to, actions based on a failure to maintain a practice in the area, which can be cured by a move, or to pay dues, which can be cured by paying dues, or to maintain professional liability insurance, which can be cured by securing such insurance. Further, for the purpose of this Section, an adverse decision shall be considered final at the time of completion of: (a) all hearing, appellate review, and other quasi-judicial proceedings conducted by the Hospital bearing on the decision and (b) all judicial proceedings bearing upon the decision which are filed and served within thirty (30) days after the completion of the Hospital proceedings described in (a) above.

After the two (2) year period, the former applicant, former Medical Staff member, or Medical Staff member may submit an application for Medical Staff membership and/or clinical privileges, which shall be processed as an initial application. Ordinarily the waiting period shall be two (2) years. However, for practitioners whose adverse action included a specific period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specific conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Hospital Board, to waive the two (2) year period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.[25] The former applicant, former Medical Staff member, or Medical Staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which

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formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the Medical Executive Committee that he or she has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to further review by the Board of Directors within forty-five (45) days after the Medical Executive Committee decision was rendered.

6.3.10 Timely Processing of Applications

Applications for staff appointments 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 time periods provide a guideline for routine processing of applications:

a) Evaluation, review, and verification of application and all supporting documents: sixty (60) days from receipt of a completed application and all necessary documentation by the Medical Staff Office or approved designee. In the event the relevant materials are not received within sixty (60) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff Office or approved designee or the expiration of six months from the date the application was received. Applications which are not completed within six (6) months after receipt shall automatically be removed from consideration, as specified in Section 6.3.2.

b) Review and recommendation by the department chair and, where applicable, the division chief: thirty (30) days after receipt of all necessary documentation from the Medical Staff Office or approved designee by the respective chair/chief.

c) Review and recommendation by Credentials Committee: thirty (30) days after receipt of all necessary documentation from the department chair/division chief by the Credentials chair or designee.

d) Review and recommendation by Medical Executive Committee: thirty (30) days after receipt of all necessary documentation from the Credentials Committee by the Chief of Staff or designee.

e) Final action, by Board of Directors: disposition, as soon as possible but no longer than sixty (60) days after the Medical Executive Committee recommendation.

The time periods specified herein are to assist those named in accomplishing their tasks and shall not be deemed to create any right for the applicant to have his or her application processed within those periods.

6.4 APPOINTMENT AND REAPPOINTMENT DECISION AUTHORITY

Appointments, denials, and revocations of appointments to the Medical Staff shall be made as set forth in these Bylaws, but only after there has been a recommendation from the Medical Staff, or as set forth in Section 8.1.

6.5 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointment and reappointments to the Medical Staff shall be for a period of up to two (2) years.[26] Honorary and Retired Staff appointments shall be for life.

6.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS

6.6.1 Application

a) At least four (4) months prior to the expiration date of the current Staff appointment, reapplication, and privilege request forms developed by the Medical Executive Committee and Hospital shall be mailed or delivered to the member. At least ninety (90) days prior to the expiration date, each Medical Staff member shall submit to the Medical Staff Office or approved designee the completed application forms for granting reappointment to the Staff for the coming appointment period; and requests for re-granting or modifying clinical privileges. The reapplication forms shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 6.2.1, results of Medical Staff quality assurance activity, continuing education, as well as other relevant matters. Upon receipt of the application, the information shall be processed as generally set forth commencing at Section 6.3.2.

b) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee and Hospital, except that such application will not alter the regularly scheduled biennial review of the member. Requests for additional/increased privileges must be supported by evidence which would be necessary for such privileges to be granted on an initial application for the same.

6.6.2 Effect of Application

The effect of an application for reappointment or modification of staff status or privileges is the same that set forth in Section 6.2.2.

6.6.3 Standards and Procedures for Review

When a staff member submits an application for reappointment, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review following the procedure set forth in Section 6.3

6.6.4 Failure to File Reappointment Application

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges

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and prerogatives at the end of the current staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. If the member fails to submit a completed application for reappointment by the due date[27] [within 30 days past the date it was due], the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article 9 shall apply.

6.7 LEAVE OF ABSENCE

6.7.1 Leave Status

A Medical Staff member may obtain a voluntary leave of absence from the Medical Staff by submitting written notice to the Medical Executive Committee and the Administrator stating the reason for the leave and approximate period of time of the leave, which may not exceed two (2) years or the term of current membership. During the period of the leave, the member's clinical privileges, prerogatives, and responsibilities shall be inactive, but unless waived by the Medical Executive Committee, any obligation to pay dues shall continue.

6.7.2 Termination of Leave

At least thirty (30) days prior to the termination of the leave, or at any earlier time, the Medical Staff member may request reinstatement of privileges and prerogatives by submitting a written notice to that effect to the Administrator and to the Medical Executive Committee. The staff member shall submit a written summary of relevant activities during the leave and evidence of current compliance with Sections 3.2.1 and 3.2.2. Staff members returning from a medical or therapeutic leave must submit a final release or progress report from the treating physician or professional provider. The Medical Executive Committee shall recommend whether to approve the member's request for reinstatement of privileges and prerogatives. The procedures in Article 6.1-6.5 shall be followed.

6.7.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement prior to the end of the leave of absence period 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 9 for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, but only if the reinstatement request is within the previously granted appointment period. 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.

6.7.4 Medical Leave

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless

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accompanied by a reportable restriction of privileges, the leave shall be deemed a “medical leave” which is not granted for medical disciplinary cause or reason.

6.7.5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Article 6.7, but may be granted subject to monitoring and/or proctoring as determined by the Medical Executive Committee

ARTICLE 7 - CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, every practitioner, member, and/or AMS providing clinical services at this Hospital by virtue of staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically requested and granted. Except as otherwise provided in Section 7.6, 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, the Medical Staff, and the Board of Directors.

7.2 CRITERIA FOR PRIVILEGES[28]

Each department of the Medical Staff shall be responsible for developing criteria for granting setting (site) specific privileges (including but not limited to identifying and developing criteria for any privileges that may be appropriately performed via telemedicine). These criteria shall address the hospital's general competencies (as described below) and assure uniform quality of patient care, treatment, and services. Insofar as feasible, affected categories of AMS shall participate in developing the criteria for privileges to be exercised by AMS. Such criteria shall not be inconsistent with the Medical Staff bylaws, rules, policies, regulatory regulations or licensing boards.

7.3 GENERAL COMPETENCIES[29]

The Medical Staff shall assess all practitioners' current proficiency in the hospital's general competencies, which shall be established by the Medical Staff departments and shall include assessment of (1) patient care, (2) medical/clinical knowledge, (3) practice-based learning and improvement, (4) interpersonal and communication skills, (5) professionalism, and (6) systems-based practice. Each department will define how to measure these competencies as applicable to the privileges requested, and shall use them to regularly monitor and assess each practitioner's current proficiency. Will report back to MEC their criteria and how they are monitoring.

7.4 DELINEATION OF PRIVILEGES IN GENERAL

7.4.1 Requests

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific clinical privileges desired by the applicant.

Each AMS shall specifically request and apply for clinical practice privileges.

Requests for a modification of clinical privileges may be made at any time. All requests must be supported by documentation of training, experience, qualifications, and competency to exercise such

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privileges and in support of the request.

7.4.2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's, applicant's, or AMS's verified current licensing and/or certification, education, training, experience; demonstrated current professional competence and judgment, peer recommendations, observed clinical performance, and the documented results of patient care (including procedures performed) and other quality review/monitoring and evaluation activities; and coverage by appropriate professional liability insurance and disclosure of his or her malpractice history including any/all settlements made by or on behalf of the professional requesting the privileges. 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, applicant, or AMS exercises clinical privileges.

7.4.3 Telemedicine Privileges[30]

a) The initial appointment of telemedicine privileges may be based upon:

1) the practitioner's full compliance with this hospital's privileging standards;

2) by using this hospital's standards by relying on information provided by the hospital(s) at which the practitioner routinely practices; or

3) if the hospital where the practitioner routinely practices is accredited by The Joint Commission and agrees to provide a comprehensive report of the practitioner's qualifications, by relying entirely on the privileges of that other hospital.

b) Reappointment of a Telemedicine Staff member's privileges may be based upon the performance at this hospital, and if insufficient information is available, upon information from the hospital(s) where the practitioner routinely practices.

7.4.4 Procedure

All requests for clinical privileges shall be processed pursuant to the procedures outlined in Article 6, the only exceptions being those defined in Article 7.

7.5 PROCTORING

7.5.1 General Provisions

Except as otherwise determined by the Medical Executive Committee, and approved by the Board of Directors, all providers granted initial, increased, or additional clinical privileges shall be subject to a period of proctoring. Each recipient of new clinical 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

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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 the exercise of clinical privileges and to observe that the privileges practiced are within the scope granted. The exercise of clinical privileges in any other department shall also be subject to direct observation by that department's chair or his designee.

Such proctoring shall continue until the Medical Executive Committee has been furnished with:

a) a report signed by the Chair of the Department 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 qualifications 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, if applicable;

b) a report signed by the chairmen of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has clinical privileges initially granted in those departments.

Proctorship may be waived by rule of reciprocity with other accredited hospital or healthcare provider within the State of California if the member has completed his or her proctorship at a local hospital or healthcare facility. Written verification may be obtained from the Medical Staff (i.e., Department, QA, Credentials Committee, etc.) documenting completion of proctorship, identification of delineated clinical privileges, resultant award of full privileges, and current practice status at the local hospital.

The Medical Executive Committee shall also be provided a report signed by the AMS's supervising practitioner and the Chair of the Department(s) to which the AMS is assigned (or has privileges to practice in) describing the types and number of cases observed, the evaluation of the AMS performance, has not exceeded or abused the prerogatives of the AMS category or privileges, and has satisfactorily demonstrated the ability to exercise the clinical privileges as granted. Proctorship may not be waived by rule of reciprocity for Affiliates of the Medical Staff.

7.5.2 Failure to Obtain Certification

a) If an initial appointee fails within the time of Provisional membership to furnish the certification required for requisite privileges, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the Department, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article 9.

b) If appropriate certification is obtained for none of the clinical privileges requested by a member of the Provisional staff, that individual's Medical Staff membership shall terminate, and the member shall be entitled to a hearing upon request pursuant to Article 9.

c) If an AMS fails to obtain appropriate certification for any and/or all of the clinical privileges requested; (1) the specific privileges not certified shall be automatically terminated and/or (2) all of the clinical privileges not certified shall be automatically terminated and the category status of AMS shall be withdrawn; the AMS shall be entitled only to those hearing rights as

defined in Article 5.

7.5.3 Medical Staff Advancement

The failure to obtain certification for any specific clinical privilege 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 privilege shall continue for the specified time period.

7.6 CONDITIONS FOR PRIVILEGES OF NON-PHYSICIAN PRACTITIONERS

7.6.1 Admissions

Dentists, oral surgeons, podiatrists, and clinical psychologists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry, podiatry and psychology[31]) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the non-physician practitioner's lawful scope of practice.

7.6.2 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.

7.6.3 Medical Appraisal

All patients admitted for care in the Hospital by a dentist, psychologist, 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 non-physician practitioner based upon medical or surgical factors outside of the scope of licensure of the non-physician practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s). All members of the Medical Staff shall cooperate and assist in providing medical care to patients of limited license practitioners.

7.7 TEMPORARY CLINICAL PRIVILEGES

7.7.1 Circumstances

Upon written concurrence of the Administrator, or his or her designee, and the Chair of the Department where the privileges will be exercised and of the Chief of Staff, the Administrator may grant temporary privileges subject to the conditions of Article 7 in the following circumstances:

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a) Temporary clinical privileges may be granted to fulfill an important patient care need.[32]

b) Temporary privileges may be granted when an applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Governing Body.[33]

7.7.2 Application and Review

a) Upon receipt of a completed application and supporting documentation from a physician, dentist, podiatrist, or clinical psychologist authorized to practice in California, the Administrator or duly qualified Administrator designee may grant temporary privileges to a practitioner who appears to have qualifications, ability, and judgement, consistent with Section 3.2.1, but only after:

1) prerequisite verification of the application and supportive documentation has been accomplished according to Article 6 and statutory requirements, if any; and

2) the appropriate Department chair or Chief of Staff or a Medical Staff member designee who has contacted at least one person who has recently worked with the applicant, and directly observed the applicant's professional performance over a reasonable period of time, and provided reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.

b) The applicant's file, including the recommendation of the department chair, shall be forwarded to the Credentials Committee Chair or his designee, and the Chief of Staff or his designee; and, if there is mutual agreement, a recommendation to the Board of Directors to confirm the granted temporary privileges to the applicant shall be made.

c) In the event of a disagreement between the Board of Directors and the recommendations addressed in b) above, regarding the granting of temporary clinical privileges, the decision of the Board of Directors shall prevail.

d) If the applicant requests temporary privileges in more than one department, interviews shall be conducted and written concurrence shall first be obtained from the appropriate department chair and forwarded as described in Section 7.5.2.a) above.

e) If the available information is incomplete or casts any reasonable doubts on the applicant’s qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.[34]

7.7.3 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

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the Chair's designee, is kept informed as to his or her activities within the Hospital.

b) Temporary privileges shall automatically terminate at the end of the designated period (not to exceed 120 days)[35] or unless earlier terminated by the Medical Executive Committed upon recommendation of the Department or Credentials Committee, unless affirmatively renewed following the procedure as set forth in Section 7.7.2. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn.[36]

c) Requirements for proctoring and monitoring, including, but not limited to, those in Section 7.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Chief of Staff after consultation with the department chair or his designee.

d) At any time, for reasons raised about the practitioner's qualification as addressed in Section 7.2.2, temporary privileges may be terminated by 1) 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 and the Board of Directors or by 2) the Board of Directors, with a report to the Medical Executive Committee to follow giving the reasons for the action. 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 the Bylaws and Rules and Regulations of the Medical Staff including a pledge for continuous care.

f) A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff. There is no right to temporary privileges.[37]

7.7.4 Termination

On the discovery of any information or the occurrence of any event of a nature which raises a question about a practitioner's professional qualifications or ability to exercise any or all of the temporary privileges granted, or compliance with any Bylaws, Rules, Regulations, or special requirements, the Administrator or the Chief of Staff may, after consultation with the Department Chair responsible for supervision, terminate any or all of such practitioner's temporary privileges, provided that where the life or well-being of a patient is determined to be endangered by continued treatment by the practitioner, the termination may be effected by any person entitled to impose summary suspensions under Article 8.

In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned to another practitioner by the department chair responsible for supervision. The wishes of the patient

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35 05/15/2003; May 2015

36 May 2011

37 May 2008

shall be considered, where feasible, in choosing a substitute practitioner.

7.7.5 Rights of the Practitioner

Practitioners shall be entitled to the procedural rights afforded by Article 9 if their requests for temporary privileges are refused in accordance with Article 8 or because all or any portion of their temporary privileges are terminated or suspended in accordance with the conditions of Article 9.

7.8 DISASTER [38]AND EMERGENCY PRIVILEGES

Disaster privileges may be granted when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs. Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon the recommendations of the Chief of Staff (or designee). This process including a description of the two acceptable identifiers, verification process, and monitoring process is outlined in the Medical Staff Rules and Regulations, Section V, Medical Staff Policies, and the Medical Center's Disaster Policy and Procedure Manual. [39]

7.9 HISTORY AND PHYSICAL REQUIREMENTS (Refer to Rules and Regulations for more detail)[40]

7.9.1. Inpatient Admission
For all inpatients, a complete history and physical (H&P) examination shall be completed within 24 hours of admission. A physician or surgeon or other individual defined by the Medical Staff to possess the necessary scope of practice (e.g. nurse practitioner or physician assistant) can perform the H&P.

7.9.2 Operative or Invasive Procedures
An H&P exam shall be performed and recorded for every patient within 30 days prior to an operative or invasive procedure. If an H&P has been performed more than 24 hours but less than 30 days before the operative or invasive procedure, this H&P may be used as the current examination provided an updated H&P note is present in the progress notes section of the medical record. The updated note written by a physician or surgeon or other individual qualified to perform an H&P shall state that the findings on the existing H&P are still current or shall specify any changes since the last H&P.

7.10 TRANSPORT AND ORGAN HARVEST TEAMS[41]

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

7.11 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENTS

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38 May 2008, added Disaster Privileges, a-d.

39 May 2010, deleted b-d (#a part of 7.6), and added reference to Rules/Regs §V

40 May 2010

41 May 2008

On its own, upon recommendation of the Credentials Committee, or pursuant to a request under Section 6.6.1(b), the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s), of a member or Affiliate. The Executive Committee may also recommend that the granting of additional privileges to a current Medical Staff member or Affiliate be made subject to monitoring in accordance with procedures similar to those outlined in Section 7.3.1.

7.12 LAPSE OF APPLICATION

If a Medical Staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information necessary to evaluate the request, the application shall automatically lapse and the applicant shall not be entitled to a hearing as set forth in Article 9.

ARTICLE 8 - CORRECTIVE ACTION

8.1 GENERAL PROVISIONS

8.1.1 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 or constituting fraud and abuse; 3) contrary to the Medical Staff Bylaws, Rules and Regulations; 4) disruptive to Hospital operations; 5) below applicable professional standards; or 6) resulting in the imposition of sanctions by any governmental authority, an investigative action against such member may be requested by the Chief of Staff, a department chair, the Medical Executive Committee, or any member of the Governing Body.

8.1.2 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. The Medical Executive Committee shall make an appropriate record of the reasons and notify both the Administrator and the Governing Body.

8.1.3 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. 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 clinical privileges under Article 7.5 should circumstances warrant. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner 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 9, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension as defined in Section 8.2, termination of the investigative process, or other action, subject to approval by the Board.

8.1.4 Executive Committee Action

At the next regular meeting after the conclusion of the investigation, the Medical Executive Committee shall take action which may include, without limitation:

a) determining no corrective action be taken and, if the Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;

b) deferring action for no more than sixty (60) days 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 warning outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's quality assurance file;

d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;

e) recommending reduction, modification, suspension, or revocation of clinical 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.

8.1.5 Subsequent Action

a) If corrective action as set forth in Section 9.2(a) to (1) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors.

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 9. If the Board does not find the recommendation supported by substantial evidence, the Board may remand the matter to Medical Executive Committee for further action.

8.1.6 Initiation by the Board of Directors

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board 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 direction, the Board may initiate corrective action after written notice to the Medical Executive Committee, but this

corrective action must comply with Articles 8 and 9 of these Medical Staff Bylaws.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2.1 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, or any patient, prospective patient, or other person, the Chief of the Medical Staff, the Medical Executive Committee, the head of the department or designee in which the member holds privileges, the Administrator, or the Board of Directors may summarily restrict or suspend the Medical Staff membership or clinical 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 Board, the Medical Executive Committee, and the Administrator. The summary restriction or suspension shall be for no longer than fourteen (14) days while investigation into the need for further action is taken. 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.

8.2.2 Written Notice of Summary Suspension

Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was necessary because failure to suspend or restrict the member’s privileges summarily could reasonably result in an imminent danger to the health of an individual. The statement of facts provided in this initial notice shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice shall not substitute for, but is in addition to, the notice required under Article 9.3.1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Article 9.3.1 may supplement the initial notice provided under this section, but including any additional relevant facts supporting the need for summary suspension or other corrective action.

8.2.3 Medical Executive Committee Action

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article 9, 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.

8.2.4 Procedural Rights

Unless the Medical Executive Committee promptly terminates the summary restriction or suspension, subject to Board of Director's approval, the member shall be entitled to the procedural rights afforded by Article 9.

8.2.5 Initiation by the Board

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 clinical privileges, the Board (or designee) may immediately suspend a member's privileges if a failure to summarily 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 Board (or designee) make 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 (2) 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 Article 8.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC SUSPENSION OR LIMITATION[42]

In the following instances where patient safety and quality of care are not directly implicated such that corrective action is not undertaken for a medical cause or reason, the member's privileges or membership may be administratively suspended or limited as described without a right to hearing or further review. Administrative suspensions that remain in effect for a period in excess of fourteen (14) days shall be reported to the Medical Board of California or equivalent State licensing agency.

8.3.1 Licensure

When a member's license to practice in the State is revoked, restricted, suspended, surrendered or made subject to any probationary provisions by the State's medical board or licensing agency, the member's Medical Staff membership and clinical privileges shall be automatically suspended. Fair hearing and appeal rights shall not apply. A medical staff member shall promptly inform the Chief Executive Officer and Chief of Staff of any change in licensure status or entry into an order with any licensing board whether public, non-public, private or non-disciplinary. Upon petition of the physician, reinstatement of Medical Staff membership and clinical privileges shall be subject to the recommendations of the Medical Executive Committee taking into account any recommendations of the Credentialing Committee and additionally subject to the approval of the Governing Board.

8.3.2 Controlled Substances

Upon receipt by the hospital of notice that a member's right to prescribe or obtain controlled

[42] Amendments to 8.3, 8.3.1, 8.3.2, effective 05/15/2024

substances or medications has been suspended, revoked, or placed on probation, stayed, or otherwise restricted by the applicable governmental agency, such actions and terms shall automatically apply to the member's ability to prescribe controlled substances in the hospital. Whenever a member's DEA registration expires, the member's right to prescribe medications shall be automatically suspended until the DEA registration is renewed. Fair hearing and appeal rights shall not apply.

8.3.3 Professional Liability Insurance

Failure to maintain professional liability insurance, if any is required, shall be grounds for automatic suspension of a member's clinical privileges, and if within ninety (90) days after written warnings of the delinquency the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

8.3.4 Failure to Pay Medical Staff Dues

Failure to pay dues within sixty (60) days of a written warning, without good cause as determined by the Medical Executive Committee, shall result in automatic revocation of Medical Staff membership. If the member fails to pay required dues or fines within sixty (60) days after written warning of delinquency, a provider's Medical Staff membership and privileges shall be grounds for automatic suspension and shall remain so suspended until the provider pays the delinquent dues. A Medical Staff Member whose membership is suspended by reason of financial delinquency may be reinstated within sixty (60) days of such suspension by action of the Medical Executive Committee or Chief of Staff after payment of the delinquent amount. If after 60 consecutive days of suspension the medical staff member remains suspended, the medical staff member will be considered to have voluntarily resigned from the Medical Staff. Thereafter, such Member may apply as a new applicant for the membership.

8.3.5 Felony Conviction[43]

Conviction, or a plea of "guilty" or "no contest", to a felony in any jurisdiction shall result in automatic suspension upon conviction or entry of the plea. The Medical Executive Committee and the Governing Board may, but is not required, to consider action to reinstate the physician upon application following conviction or entry of the plea without right to any hearing or appeal.

8.3.6 Exclusion from Federal or State Health Care Programs

A physician who is excluded or debarred under the Medicare or Medicaid programs, by any governmental licensing agency, or convicted of any offense related to health care, or listed by a federal or state agency as being debarred, excluded, or otherwise ineligible for federal or state program participation shall be automatically suspended. The suspension shall be effective immediately upon debarment, exclusion, sanction, conviction or listing regardless of whether an appeal is filed and shall remain in effect. The Medical Executive Committee and the Governing Board may, but is not required, to consider action to reinstate the physician following debarment without right to any hearing or appeal.

8.3.7 Failure to Enter Legible Orders

Admitting privileges and surgical or procedure privileges may be suspended for illegible orders.

[43] New sections added 5/15/2024, 8.3.5, 8.3.6, 8.3.7, 8.3.8

Illegible orders occur when three other individuals cannot read the orders. Suspension will occur automatically after the member has been notified in writing on three separate occasions regarding legibility. Privileges shall be reinstated if the member demonstrates to the reasonable satisfaction of the Medical Executive Committee that sufficient remedial measures have been taken.

8.3.8 Behavioral Suspension

The Chief of Staff or designee, on behalf of the Medical Executive Committee and following consultation with the Chief Executive Officer, may summarily suspend a member **for up to** 7 days when information is discovered that shows the member has engaged in behavior that is contrary to the hospital's Code of Conduct or County policies concerning conduct in the workplace. The Chief of Staff may extend the suspension for an additional 7 days upon approval by Medical Executive Committee or a subset of MEC members or a similarly designated behavioral committee, which shall consider the facts and circumstances of the behavioral suspension in closed session without notice or hearing rights to the physician whose behavior is the subject of examination. A behavioral suspension under this section shall be for the purpose of investigating the need for further disciplinary action, sanctions, or requirements imposed by the Chief of Staff, subject to the advice and consent of the Medical Executive Committee, Medical Staff Office Manager (or equivalent behavioral committee), to correct the physician's behavior. Additional disciplinary action, sanctions, or requirements for correcting physician behavior may include but are not limited to requiring participation in anger management counseling, documentation of additional education or training concerning behavior in the workplace, referral to the hospital's well-being committee (if active and functioning), or similar orders that reasonably address the physician's behavior, which shall be recommended by the Medical Executive Committee and MSO (or equivalent behavioral committee) prior to imposition by the Chief of Staff. Any additional disciplinary actions, sanctions, or suspension based on the discovery of information that implicates or relates to the physician's medical competence or any medical cause or reason shall be administered in accordance with the notice, hearing, and appeal procedures set forth in Article 9, below.

8.3.9 Medical Records[44]

Suspension shall be imposed for failure to complete medical records within the time frames for completion specified in the Rules and Regulations. Clinical privileges shall be reinstated upon confirmation that the medical record(s) at issue have been completed. Failure to complete the medical records at issue within seven (7) weeks of suspension shall be deemed a voluntary resignation from the Medical Staff and the voluntary relinquishment of all clinical privileges. Accumulation of more than three (3) medical record suspensions in any consecutive twelve (12) month period shall also be deemed to constitute a voluntary resignation from the Medical Staff and voluntary relinquishment of all clinical privileges. Fair hearing and appeal rights shall not apply.

8.3.10 Executive Committee Deliberation

At the next regular meeting or no longer than sixty (60) days after action is taken or warranted as described in Section 8.3.1, or Sections 8.3.2., 8.3.3., 8.3.4, 8.3.5, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure set forth in Article 9. For actions of less than two years'

[44] Amendment made to 8.3.9 effective 05/15/2024

duration, the member's membership status and clinical privileges can automatically be reinstated subject to approval by the Hospital Board of Directors upon the recommendation of the Medical Executive Committee. For actions of greater than two years' duration, formal application for appointment in accordance with Article 6 must be made subject to approval by the Hospital Board of Directors upon the recommendation of the Medical Executive Committee.

8.3.11 Failure to Satisfy Special Appearance Requirement

A member who fails without good cause to appear and satisfy the requirements of Section 8 shall automatically be suspended from exercising all or such portion of clinical privileges as may be specified in accordance with the provisions of that section. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee.

ARTICLE 9 - HEARING AND APPELLATE REVIEW

9.1 DEFINITIONS

9.1.1 Exhaustion of Remedies

If adverse action described in Section 9.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

9.1.2 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.

9.1.3 Intra-organizational Remedies

The remedies and the hearing and appellate review bodies provided for in Article 9 of these Bylaws are strictly quasi-judicial in structure and function. Notwithstanding the foregoing, the Board may hear challenges to the substantive validity of intra-organizational decisions and in all proper cases shall hear and decide those questions. Where the substantive validity question is the sole issue, the petitioner shall be permitted a direct appeal and hearing, in the first instance, before the Board of Directors. The final determination by the body conducting such hearing shall be a condition precedent to petitioner's right to seek judicial review in a court of law.

9.1.4 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time.

9.1.5 Final Action

Recommended adverse action described in Article 9.2 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 actions by the Board of Directors.

9.2 GROUNDS FOR HEARING

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions shall be deemed actual or potentially adverse action and constitute grounds for a hearing:

a) Denial of Medical Staff membership.

b) Denial of requested advancement in staff membership status or category.

c) Denial of Medical Staff reappointment.

d) Demotion to lower Medical Staff category or membership status.

e) Suspension of staff membership.

f) Revocation of Medical Staff membership.

g) Denial of requested clinical privileges.

h) Involuntary reduction of current clinical privileges.

i) Suspension of clinical privileges.

j) Termination of all clinical privileges.

k) Involuntary imposition of significant consultation or monitoring requirement excluding monitoring incidental to Provisional status and Section 7.3 - Proctoring.

l) Any other action which requires a report to be made to the Medical Board of California under the provisions of Section 805 of the California Business and Professional Code.

9.3 REQUESTS FOR HEARING

9.3.1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Article 9.2, 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 to 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 Article 9.3.2, and that such hearing must be requested within thirty (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 to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

9.3.2 Request for Hearing

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Board. 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 of action involved.

9.3.3 Time and Place of Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty-five (35) days of the hearing give notice in writing to the member of the time, place, and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of

the request by the Chief of Staff 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 forty-five (45) days from the date of receipt of the request.

9.3.4 Notice of Charges

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, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Article 9.4.1.

9.3.5 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 have not have 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. All other members shall have M.D. or D.O. degrees. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable. All members of the judicial review committee shall disclose in writing to the parties to the hearing those current or impending personal, professional, or financial affiliations of which they are reasonably aware, including contractual, employment or other relationships with the hospital which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the judicial review committee. Potential conflicts so disclosed shall be resolved as set forth in these bylaws.[45]

9.3.6 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.

9.3.7 Continuances

Once a request for hearing is initiated, postponements and extensions of time beyond the times

[45] May 2011

permitted in these Bylaws may be permitted by the Judicial Review Committee, upon agreement of the parties, or by the presiding officer on a showing of good cause.

9.4 HEARING PROCEDURE

9.4.1 Pre-hearing Procedure

a) If either side of the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and hospital address of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy the documents or other evidence upon which the charges are based, and shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the Hospital or Medical Staff, and all evidence which will be made available to the Judicial Review Committee.

b) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

c) The Medical Executive Committee shall have the right to inspect and copy, at its expense, any documents or other evidence relevant to the charges which the Member has in his or her possession or control as soon as practicable after receiving the request.

d) The failure by either party to provide access to this information at least thirty (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.

e) 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.

f) 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.

9.4.2 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. The Member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. 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 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.

9.4.3 The Presiding and/or Hearing Officer(s)

a) Presiding Officers - The Presiding Officer at the hearing shall be a Hearing Officer as described in Section 9.4.3 or, if no such Hearing Officer has been appointed, the Chair of the Judicial Review Committee. The Presiding Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He or she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. He or she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.

b) The Hearing Officer - At the request of the petitioner, the Medical Executive Committee, the Judicial Review Committee, or the Board of Directors, the Administrator or his or her designee may appoint a Hearing Officer to preside at the hearing. The Hearing Officer may be an attorney at law qualified to preside over a quasi-judicial hearing and preferably with experience in Medical Staff matters, but an attorney regularly utilized by the Hospital for legal advice regarding its affairs and activities shall not be eligible to serve as Hearing Officer.

The Hearing Officer shall gain no direct financial benefit from the outcome of the hearing. He or she must not act as a prosecuting officer, as an advocate for the Hospital, Board of Directors, Medical Executive Committee, the body whose action prompted the hearing, or the petitioner. If requested by the Judicial Review Committee, he or she may participate in the deliberations of such body and be a legal advisor to it, but he or she shall not be entitled to vote.

Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all the duties assigned to the Hearing Officer

and to the Hearing Committee.[46]

9.4.4 Record of the Hearing

The pre-hearing proceedings as well as the hearing proceedings shall be recorded either by the services of a shorthand reporter or by a tape recorder if requested by either party or deemed appropriate by the Hearing Officer. The cost of the shorthand reporter, if used, and 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.

9.4.5 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 or other proponent may be called as a witness by the Judicial Review entity and examined as if under cross-examination. The member shall have the right to submit a written statement at the close of the hearing.

9.4.6 Miscellaneous Rules

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted hereunder. Any relevant evidence, including hearsay, shall be admitted by the Presiding Officer if it is the sort of evidence which responsible persons are accustomed to rely on in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement in support of his or her position, and the Judicial Review Committee may request such a statement to be filed following the conclusions of the presentation of oral testimony. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

9.4.7 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) When the hearing involves an applicant, the applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her 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, throughout the hearing, the Medical Executive

[46] May 2011

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.

9.4.8 Adjournment and Conclusion

After consultation with the chair of the Judicial Review Committee, 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. The Judicial Review Committee shall thereupon, outside of the presence of any other person, except the Hearing Officer, conduct its deliberations and render a decision and accompanying report.

9.4.9 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 Board of Directors as the final action if it is supported by substantial evidence, following a fair procedure.

9.4.10 Decision of the Judicial Review Committee

Within thirty (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 fifteen (15) days. A copy of said decision also shall be forwarded to the Administrator, the Board, 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 Board as the final action if it is supported by substantial evidence, following a fair procedure. If the final proposed action adversely affects the clinical privileges of a physician, dentist, podiatrist or clinical psychologist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Medical Board of California and shall state the text of the report as agreed by the committee.

9.5 APPEAL

9.5.1 Time for Appeal

Within ten (10) 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 Administrator, 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 Board as the final action if it is supported by substantial evidence, following a fair procedure.

9.5.2 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;

b) the decision was not supported by substantial evidence based upon the hearing record, if any, or such additional information as may be permitted pursuant to Section 9.5.5;

c) lack of substantive rationality of a Medical Staff Bylaw, Rule, or Regulation relied upon by the Judicial Review Committee in reaching its decision; and

d) action taken arbitrarily, unreasonably, or capriciously.

e) the test of the report(s) to be filed with the Medical Board of California and/or the National Practitioner Data Bank is not accurate.

9.5.3 Time, Place, and Date Notice

If an appellate review is to be conducted, the Appeal Board shall, within fifteen (15) 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 thirty (30) days nor more than sixty (60) days from the date of such notice; provided, however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed fifteen (15) days from the date of the notice. The time for appellate review may be extended by the Appeal Board for good cause.

9.5.4 Appeal Board

The Board of Directors may sit as the appeal board, or the Presiding Officer of the Board shall appoint an Appeal Board which shall be composed of the following:

a) not less than three (3) members of the Board of Directors; and

b) at least two (2) non-physicians.

Knowledge of the matter involved shall not preclude any person from serving as a member of the

Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

9.5.5 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 his or her position on appeal, and to personally appear and make oral argument. 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 Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

9.5.6 Decision

a) Except as provided in Section 9.5.6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors 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.

b) Should the Board of Directors 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 Board of Directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chair of the Board of Directors and the Judicial Review Committee.

c) The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the Chief of Staff, the Medical Executive and Credential Committees, the subject of the hearing, and the Administrator.

9.5.7 Right to One Hearing

Except in circumstances where a new hearing is ordered by the Board of Directors or a court because

of procedural irregularities or otherwise for reasons not the fault of the member, 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.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6.1 Medical Administrative Officers and Contract Physicians

Members who are directly under contract with the Hospital in a medical-administrative capacity or are employed by the Hospital, or members whose staff membership is contingent upon a faculty appointment, shall be subject to the procedural rights specified in Article 9:

a) to the extent that any contract modifications, termination, or restrictions of staff status or clinical privileges proposed by the Hospital, or loss of faculty status, deal with issues relating to professional character, performance or competence; or

b) to the extent that the Member's Medical Staff membership or clinical privileges which would otherwise exist independent of the contract are to be limited or terminated.

Stated in other words, contractual and employment issues or grievances are not covered by any provisions of the appeal process or mechanism.

9.6.2 Automatic Suspension or Limitation of Practice Privileges

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 8.3.1(a). In other cases described in Section 8.3.1 and 8.3.2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority of the DEA was unwarranted, but only whether the member may continue practice in the Hospital with those limitations imposed.

9.7 EXPUNCTION OF DISCIPLINARY ACTION

Upon petition, the Medical Staff Executive Committee may expunge previous disciplinary action upon showing of good cause or rehabilitation subject to approval of the Board of Directors.

9.8 NATIONAL PRACTITIONER DATA BANK REPORTING

9.8.1 Adverse Actions

The authorized representative shall report an adverse action to the National Practitioner Data Bank only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board of Directors upon the recommendation of the Medical Executive Committee. 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.

9.8.2 Dispute Process

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed 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.

If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE 10 - OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1.1 Identification

The general officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, Treasurer[47] and Immediate Past Chief of Staff.[48]

In addition, the Medical Staff department and section officers and committee chairs shall be deemed Medical Staff officers within the meaning of California Law. Whenever possible dual positions will be discouraged.[49]

10.1.2 Qualifications

Officers 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.

All Medical Staff officers shall:

a) be an active Medical Staff member (and remain in good standing as an active Medical Staff member while in office);

b) understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

c) understand and be willing to work towards attaining the mutual goals of the Medical Staff and Hospital's lawful and reasonable policies and requirements;

d) not have any significant conflict of interest.

10.1.3 Disclosure of Conflict of Interest

All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to 10.1.4-7) 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 that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

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47 November 2016

48 May 2003

49 May 2003

10.1.4 Nominations

a) The Medical Staff election year shall be every three (3) years[50]. A Nominating Committee shall be appointed by the Medical Executive Committee not later than ninety (90) days prior to the Annual Staff Meeting to be held during the election year or at least forty-five (45) days prior to any special election. The Nominating Committee shall consist of the current Chief of Staff, the Vice Chief of Staff, and two other members of the Medical Executive Committee, and one member chosen by agreement of the department chairmen from among the Active Medical Staff who are not then members of the Medical Executive Committee. The Nominating Committee shall nominate one or more nominees for each office. The nominations of the committee shall be reported to the Medical Executive Committee at least forty-five (45) days prior to the Annual Meeting and shall be delivered or mailed to the voting members of the Medical Staff at least thirty (30) days prior to the election.

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 twenty-five (25) percent of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the Chair of the Nominating Committee as soon as reasonably practicable, but at least twenty (20) days prior to the date of election. If any nominations are made in this manner, the voting members of the Medical Staff shall be advised by notice delivered or mailed at least ten (10) days prior to the meeting. Nominations from the floor will be recognized if the nominee is present and consents.

10.1.5 Elections

The Chief, Vice Chief, and Treasurer[51] shall be elected at or prior to the annual meeting of the Medical Staff which falls during the election year. Voting shall be by secret ballot, written or electronic.[52] Only authenticated ballots will be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. 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 runoff election shall be held promptly between the two (2) 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.

10.1.6 Term of Elected Office

a) Each officer shall serve a three (3)[53] year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he shall sooner resign or be removed from office.

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50 May 2003

51 Approved at Annual Meeting 05/10/05

52 May 2008

53 May 2003

b) At the end of his or her term, the Chief of Staff may automatically assume the office of Immediate Past Chief of Staff.

10.1.7 Recall of Officers

Any Medical Staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or malfeasance in office, or serious acts of moral turpitude. If an officer ceases to be a member in good standing of the Medical Staff, loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that Medical Staff officer may be removed by majority vote of a quorum of the Medical Executive Committee.

The recall of a Medical Staff officer may also be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officer. 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.

10.1.8 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the Medical Staff.

Vacancies, other than that of 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 Vice Chief of Staff shall serve out the remaining term and shall immediately appoint an ad hoc Nominating Committee to decide promptly upon nominees for the office of Vice Chief of Staff. Such nominees shall be reported to the Medical Executive Committee and to the Medical Staff. A special election to fill the position shall be conducted within three (3) months or at the next annual Staff meeting, whichever occurs first.

If there is a vacancy in the office of Vice Chief of Staff or the Treasurer[54], 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.

10.2 DUTIES OF OFFICERS

10.2.1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the Medical Staff. The Chief of Staff is eligible to receive a stipend from the Medical Staff Dues in the amount specified by the Medical Executive Committee. The Administration may choose to add to this stipend in recognition for the service the Chief of Staff provides the Medical Center.[55] The duties of the Chief of Staff shall include, but not be

[54] November 2016

[55] Approved at Annual Meeting 05/10/05

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;

d) serving as an ex-officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;

e) interacting with the Administrator and the Board of Directors in all matters of mutual concern within the Hospital;

f) appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, and multi-disciplinary committees, except where otherwise indicated, designating the chair of these committees;

g) representing the views, policies, and quality assurance activity of the Medical Staff to the Board of Directors and to the Administrator;

h) being a spokesman 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; and

j) serving on the Board of Directors as well as representing the Medical Staff in regard to outside licensing, accreditation, or official review agencies.

10.2.2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff is eligible to receive a stipend from the medical staff dues in the amount specified by the Medical Executive Committee. The Vice Chief of Staff shall be a member of the Medical Executive Committee of the Medical Staff and of the Governing Board. The duties shall include, but not be limited to:[56]

Serve as the Chair of the Quality Improvement Committee

a) Keeping or assigning a designee to keep accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings or overseeing that function carried out by administrative staff;

b) Calling meetings on the order of the Chief of Staff or Medical Executive Committee;

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[56] May 2003

c) Attending to all appropriate correspondence and notices on behalf of the Medical Staff;

d) Excusing absences from meetings on behalf of the Medical Executive Committee; and performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

10.2.3 Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Governing Board 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.

10.2.4 Treasurer[57]

The Treasurer shall assume all duties and authority of the Chief of Staff and / or Vice Chief of Staff in the absence of both or as delegated by either. The treasurer is eligible to receive a stipend from the medical staff dues in the amount specified by the Medical Executive Committee. The Treasurer shall be a member of the Medical Executive Committee and an alternate to the Governing Board. The treasurer shall perform other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the Medical Executive Committee. The duties shall include, but not be limited to:

a) Shall collect monies due to the Medical Staff, shall keep a record thereof, and shall deposit all such monies into the funds of the Medical Staff

b) Create, oversee and maintain the annual medical staff budget

c) In collaboration with the Medical Executive Committee, the Treasure shall determine the amount of the annual dues

d) Receive and safeguard all funds of the Medical Staff with regular review of banking statements and the adopted budget

e) Report budget and finances regularly to the Medical Staff Committee

f) Coordinate regularly with the CME committee leadership to review financial and collaborative agreements

g) Oversee an ad-hoc subcommittee as needed for more thorough financial affairs review, at the request of the Chief of Staff or Vice Chief of Staff

[57] November 2016

ARTICLE 11 - CLINICAL DEPARTMENTS AND DIVISIONS

11.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The Medical Staff shall 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 11.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties, and responsibilities specified in Section 11.7. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of departments or divisions.

11.1.1 Clinical Department/Division Formation or Elimination

A medical staff department/division can be formed or eliminated only following a determination by the Medical Staff of appropriateness of department/division elimination or formation. The Board of Directors' decision shall uphold the Medical Staff's determination unless the Board of Directors makes specific written findings that the Medical Staff's determination is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law.

a) The Medical Staff shall determine the formation or elimination of a department/division to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a department/division must be based upon the preponderance of the evidence, viewing the records as a whole, presented by any and all interested parties, following notice and opportunity for comment.

b) The Medical Staff member(s) whose privileges may be adversely affected by a Medical Staff's determination of appropriateness of department/division formation or elimination may request a hearing before the Judicial Review Committee. Such a hearing will be governed by the provisions of Article 9, except that:

   1) The hearing shall be limited to the following issues:

      (a) Whether the Medical Staff's determination of appropriateness is supported by the preponderance of the evidence;

      (b) Whether the Medical Staff followed its requirements for notice and comment on the issue of appropriateness.

   2) All requests for such a hearing will be consolidated.

   Should an affected Medical Staff member request a hearing under this subsection, the Medical Staff's recommendation regarding the department/division elimination or formation will be deferred, pending the outcome of the Judicial Review Committee hearing.

c) Except as specified in this Section, the termination of privileges pursuant to formation or

elimination of a department/division determined to be appropriate by the Medical Staff shall not be subject to the procedure rights otherwise set forth in Article 9.

11.2 DEPARTMENTS AND DIVISIONS

a) The current departments are:

1) Department of Medicine

2) Department of Surgery

3) Department of Psychiatry

4) Department of Primary Care and Community Medicine

5) Department of Emergency Medicine[58]

b) The Medical Staff Departments may establish divisions by a vote of the department.

11.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

a) Each member/practitioner (to include those with temporary privileges and any practitioner in training) shall be assigned to one department, and to a division, if any, within such departments. Member/practitioner may also be granted privileges in another department/division consistent with documented training.

b) Each Affiliate to the Medical Staff shall be assigned to one department, and to a division, if any, within such department as the practitioner supervisor is a member. Assignment to a department and/or division shall not infer any membership status or privileges to the AMS within that department and/or division except as defined in Article 5.

c) Residents shall be assigned to the department within which they are practicing their experiential training.

11.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

a) Conducting patient care reviews of members and Affiliates for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect information about important aspects of inpatient and outpatient care provided in or by the department, and periodically assess this information, develop objective criteria for use in evaluating patient care, and participate in coordinating and interpreting quality assurance activities with other departments and committees in consultation with the Medical Executive Committee. Patient care reviews shall

[58] Approved at Annual Meeting 05/10/05

include all clinical work performed under the jurisdiction of the department, regardless of whether the member or Affiliate whose work subject to such review is a member of that department, and include, but not be limited to, the specifics of drug utilization, blood utilization, surgical case review, mortality/morbidity, infection control, and medical record clinical pertinence when and as appropriate to the departments.

b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

c) Evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and clinical privileges within that department.

d) Conducting, participating, and making recommendations regarding continuing education programs pertinent to departmental clinical practice and based at least in part on the results of quality assurance activity including communication of this information to other Departments.

e) Reviewing and evaluating department adherence to: (1) Medical Staff policies and procedures; (2) sound principles of clinical practice.

f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services through regularly established communication channels and participation in the Hospital integrated Quality Management Program.

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; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital.

h) Meeting as often as necessary (which may be monthly) but at least quarterly to effectively: consider 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; and to receive other Medical Staff departmental or committee reports regarding patient care monitoring and evaluating, upon which consideration and conclusions shall occur and/or recommendations formulated; and to participate in interdepartmental Medical Staff review of patient care practices.

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

j) Upholding the Bylaws and discharging appropriate responsibilities within the quality management and peer review functions of the Medical Staff.

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 departmental Rules and Regulations reasonably necessary for the proper

discharge of its responsibilities subject to the approval by the Bylaws Committee, Medical Executive Committee, Medical Staff membership, and the Board of Directors.

n) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve are identified.

11.5 FUNCTIONS OF DIVISIONS

Subject to definition within the Departmental Rules and Regulations and approval of the Medical Executive Committee, each division shall perform the functions assigned to it by the department chair. Such functions may include, without limitation, patient care review, evaluation of patient care practices, credentials review and privileges delineation, formulating division Rules and Regulations as needed, and continuing education programs. The division shall transmit regular reports to the department chair on the conduct of its assigned functions. Divisions will meet quarterly either within the Department or independently.

11.6 DEPARTMENT CHAIR AND VICE CHAIR

11.6.1 Qualifications

Each department shall have a Chair and Vice Chair who shall be members of the Active Medical Staff, Board Certified or possess comparable competence, be qualified by training, experience, and demonstrated ability in at least one of the clinical areas covered by the department, and shall be willing and able to faithfully discharge the functions of the office. Specific qualifications, if any, shall be set forth in the Departmental Rules and Regulations.

11.6.2 Selection

Department Chairmen and Vice Chairmen shall be elected every three (3)[59] years 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 sixty (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 and Vice Chair positions shall be circulated to the voting members of each department at least twenty (20) days prior to the election. Nominations may also be made from the floor when the election meeting is held, as long as the nominee is present and consents to the nomination. Election of department Chairmen and Vice Chairmen shall be subject to ratification by the Medical Executive Committee and the Board. 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.

11.6.3 Term of Office

Each department Chair and Vice Chair shall serve a three (3)[60] year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed

[59] May 2003

[60] May 2003

from office, or lose their Medical Staff membership or clinical privileges in that department. Department officers shall be eligible for reelection.

11.6.4 Removal

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

11.6.5 Duties

Each Chair shall have the following authority, duties, and responsibilities as specified in these Bylaws and the Rules and Regulations of the Medical Staff, and the Vice Chair, in the absence of the Chair, shall assume all of them and shall otherwise perform such duties as may be assigned to him:

a) Act as presiding officer at departmental meetings;

b) Report to the Medical Executive Committee and to the Chief of Staff regarding all professional, administrative, and educational activities within the department;

c) monitor the quality of patient care and professional performance rendered by members and Affiliates with clinical privileges in the department through a planned and systematic process which includes the development of data that can be used in the reappointment process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee;

d) develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice to assure a single level of care, credentials review and privileges delineation, medical education, utilization review, and quality assurance;

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 his or her department;

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

g) Enforce the Medical Staff Bylaws, Rules and Regulations, and Policies within his or her 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 nursing and Hospital Administration in matters such as legal and accreditation requirements, personnel (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide

patient care services), 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 clinical privileges for each member and Affiliate of the department; and

l) 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.

11.7 DIVISION CHIEFS

11.7.1 Qualifications

Each division shall have a Chief 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 division.

11.7.2 Selection

Each Division Chief shall be jointly appointed by the Department Chair and the Division and must be affirmed by the Division and Administration. Vacancies due to any reason may be filled for the unexpired term by the Department Chair.

11.7.3 Term of Office

Each Division Chief shall serve a three (3) year term and shall be eligible for reappointment by the Department Chair and the Division, unless he or she shall sooner resign, be removed from office, lose Medical Staff membership, department membership or clinical privilege in that division. Division Chiefs shall be eligible for reappointment by the Department Chair and must be affirmed by the Division every three (3) years.

11.7.4 Removal

After appointment and ratification, a Division Chief may be removed by the Department Chair and the Medical Executive Committee.

11.7.5 Duties

Each Division Chief shall:

a) Act as presiding officer at division 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 division.

c) Evaluate the clinical work performed in the division;

d) conduct investigations and submit reports and recommendations to the Department Chair regarding the clinical privileges to be exercised within his division by members, Affiliates, 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 12 - COMMITTEES

12.1 DESIGNATION

The Committees described in this Article and 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 to perform specified tasks. 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. Changes in committee chair shall be reported to the Chief of Staff and Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee; shall regularly submit minutes and reports. Medical Staff committees shall annually notify the Medical Executive Committee of their composition. Findings and/or sources of information pertinent to quality review functions shall be reported directly to the Departments (i.e., Blood Utilization, Surgical Case, etc.). The Medical Executive Committee reserves the right to amend committee decisions or policies directly or by returning a decision to the committee for reconsideration.[61]

12.2 GENERAL PROVISIONS

Whenever these Bylaws require that a function be performed by, or that a report or recommendation be submitted to:

a) a named committee, but no such committee exists, the Medical Executive Committee shall perform such function or receive such report or recommendation or shall assign the functions of this Committee to a new or existing committee of the Medical Staff or to the staff as a whole; or

b) the Medical Executive Committee, but a standing or special committee has been formed to perform the functions, the committee(s) so formed shall act in accordance with the authority delegated to it, including, but not limited to, the transmitting of regular reports to the Medical Executive Committee and other pertinent Medical Staff departments, divisions, or committees.

12.2.1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a two (2) year term 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.

12.2.2 Removal

If a member of a Committee ceases to be a member in good standing of the Medical Staff loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

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[61] Addition of sentence 4, 6, & 8 approved at Annual Meeting 05/10/05

The removal of any Committee member who is automatically assigned to a Committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of those officers or officials.

12.2.3 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 who obtains membership by virtue of these Bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

12.3 MEDICAL EXECUTIVE COMMITTEE

12.3.1 Composition

The Medical Executive Committee shall be chaired by the Chief of Staff and shall consist of the following persons who may serve one or more of these functions:

a) Voting Members

1) the officers of the Medical Staff;

2) the Department Chairs;

3) up to six (6)* at-large physician members of the Active Medical Staff who shall represent insofar as feasible major services and who shall be nominated and elected for a three[62]-year term in the same manner and at the same time as provided in Sections 10.1.4 and 10.1.5 for the nomination and election of officers;

b) Non-Voting Members

1) two members of the Affiliate staff who shall represent in so far as feasible major services and who shall be nominated and elected for a three-year term in the same manor and at the same time as provided in Section 5.1 and 10.1.2 qualifications.

2) the Medical Staff Standing Committee Chairmen as identified in these Bylaws and the Rules and Regulations;

3) the Medical Director of Long Term Care;

4) the Administrator and the Director of Health Services as ex-officio members; CEO, and CMO and/or

5) other guests, as invited by the Chief of Staff such as the CNO, Chief of Quality and COO.

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62 * Change from 7 to 6 members-at-large and term from 2 to 3 years approved at Annual Mtg. 05/10/05

12.3.2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this broad delegation of authority, the duties performed in good faith by the Medical Executive Committee shall include, but not be limited to:[63]

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 or the law;

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, assigned activity groups, and Hospital communications;

d) recommending action to the Board on matters of a medical-administrative nature;

e) establishing, subject to Board approval, the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms used to conduct, evaluate, and review "such activities," termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff;

f) evaluating the quality and appropriateness of medical care rendered to inpatients and outpatients; documenting conclusions, actions, and results for reporting to the Board;

g) insuring that the clinical qualifications of all members, applicants, and Affiliates are relevant to their responsibilities and privileges in the organizational structure;

h) reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members and Affiliates, and making recommendations to the Board regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;

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

j) taking reasonable steps to ensure continuing education activities and programs for the Medical Staff and based at least in part on the results of quality assurance activity;

k) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff;

l) representing and acting on behalf of the Medical Staff between meetings of the Medical Staff,

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[63] May 2011: TJC Standard Ms 01.01.01, EP20

and reporting to the Medical Staff at each regular staff meeting;[64]

m) assisting in the obtaining and maintaining of accreditation;

n) developing and maintaining of 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) participating in the development and review of all medical staff and hospital policy, practice, and planning; providing a liaison between the medical staff, Chief Executive Officer, and the hospital Board of Directors; and

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

12.3.3 Meetings

This Committee shall meet as often as necessary at the call of its Chair, but at least ten (10) times a year. It shall maintain a record of its findings, proceedings, and actions, and shall make a report of its activities and recommendations to the Board each time it meets.

12.4 CREDENTIALS/MEDICAL STAFF AID COMMITTEE

(Generally referred to in these Bylaws as simply the "Credentials Committee.")

12.4.1 Composition

The Committee shall consist of not less than five (5) members of the Active Staff appointed by the Chief of Staff that will ensure, insofar as feasible, representation of major clinical specialties and each Medical Staff Department. The Chair shall be a physician appointed by the Chief of Staff.

12.4.2 Duties

The Committee shall:

a) maintain an individual credential file on each Medical Staff member and Affiliate;

b) review or monitor and evaluate the qualifications of each practitioner and Affiliate applying for initial appointment, reappointment, granting or re-granting or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;

c) submit required reports and information on the qualifications of each practitioner and Affiliate

[64] May 2011: TJC Standard Ms 01.01.01, EP23

applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;

d) investigate, review, and report on matters referred by the Chief of Staff, Department Chairmen, or the Medical Executive Committee regarding the qualifications, conduct, professional character, or competence of any applicant or Medical Staff member or Affiliate;

e) submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications; and

f) with respect to matters involving individual Medical Staff members or Affiliates, the Committee shall provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential and not become part of the credentials file; however, in the event information received by the Committee clearly demonstrates that the health or known impairment of a Medical Staff member or Affiliate poses risk or harm to patients, that information shall be referred for corrective action. The Committee shall also consider general matters related to the health and well-being of the Medical Staff and Affiliates and, with the approval of the Executive Committee, develop educational programs or related activities.

12.4.3 Meetings

The Committee shall meet as often as necessary at the call of its Chair to conduct expeditious and timely review of credentials, but at least quarterly. It shall maintain a record of its proceedings including conclusions, recommendations, actions, and results, and shall report its activities and recommendations to the Medical Executive Committee.

12.5 OTHER COMMITTEES

a) The Medical Staff shall develop and/or participate in other standing or ad hoc committees and review and evaluate functions as are deemed necessary to the proper provision of patient care, Hospital operations, and/or Medical Staff organization and governance. All committees are delineated in the Rules and Regulations and shall be defined for composition, duties, and reporting responsibilities by the formulating body which shall submit the Committee Charter to the Medical Executive Committee for approval and maintain it with the standing or ad hoc committee.

b) The Medical Staff shall participate in other Hospital committees which shall address, at a minimum, internal and external disaster plans, Hospital safety, and Interdisciplinary Practice.

c) Such other committees shall meet as often as necessary to perform their function and shall maintain a written record of their proceedings.

ARTICLE 13 - MEETINGS

13.1 ANNUAL MEETING

There shall be an Annual Meeting of the Medical Staff.[65] The Chief of Staff or such other officers, department or division heads, or committee chairmen as the Chief of Staff or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the membership. Notice of this meeting shall be given to all members at least twenty (20) days prior to the meeting.

13.2 AGENDA

The order of business at a meeting of the Medical Staff shall be determined by the Chief of Staff and Medical Executive Committee. The agenda shall include, insofar as feasible:

a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

b) administrative or informational reports from the Chief of Staff, departments, committees, the Administrator, the County Manager, the Director of Health Services, and a member of the Board of Supervisors;

c) election of officers when required by these Bylaws;

d) reports including recommendations by responsible officers, committees, and departments on the overall results of patient care, audits, and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions as addressed in these Bylaws and by the Rules and Regulations;

e) old business;

f) new business; and

g) appointment or privilege recommendations, if any.

13.3 SPECIAL MEETING

Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of ten (10) percent of the members of the Active Medical Staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical Executive Committee within thirty (30) days after receipt of such request. No later than ten (10) days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

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[65] Deletion of holding annual meeting in May deleted per approval at Annual Mtg. 05/10/05.

13.4 COMMITTEE AND DEPARTMENT MEETINGS

13.4.1 Regular Meetings

Except as otherwise specified in these Bylaws, the chairmen of committees, departments, and divisions may establish the times for the holding of regular meetings. The chairmen shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

13.4.2 Special Meetings

A special meeting of any Medical Staff committee, department, or division may be called by the Chair thereof, the Medical Executive Committee, or the Chief of Staff, and shall be called by written request of one-third of the current members eligible to vote, but not less than three (3) members.

13.5 QUORUM

13.5.1 Staff Meetings

The presence of thirty-five (35) percent of the total members of the Active Medical Staff at any regular or special meeting in person or through written ballot 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 twenty-five (25) percent of such members shall constitute a quorum for all other actions.

13.5.2 Department and Committee Meetings

A quorum of thirty (30) percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of twenty-five (25) percent of the voting members of a committee but in no event less than three (3) voting members. For department and division meetings, the quorum shall consist of twenty-five (25) percent of the voting members of a committee but in no event less than three (3) voting members. Attendee's that are not active members of the department do not carry voting privileges.

13.6 VOTING AND 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 determine the action of the group. Double votes will be disallowed. Votes cast by those serving in dual voting positions will be the vote of the higher position.[66] 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. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the matters discussed in that telephone conference. Valid action may be taken without a meeting by a

[66] May 2003

committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

13.7 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and Affiliates, the discussion, the vote taken on significant matters, and the resultant conclusions, recommendations, and actions. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the Medical Executive Committee.

13.8 ATTENDANCE REQUIREMENTS

13.8.1 Regular Attendance

Except as stated below, each member of the Active and Provisional staff and all practitioners with temporary privileges during the term of appointment whose prerogatives/responsibilities are to attend meetings under Article 4 shall be required to attend the following:

a) the Annual Medical Staff meeting;

b) at least fifty (50) percent of all special staff meetings duly convened pursuant to these Bylaws;

c) at least fifty (50) percent of all meetings of either department or division, of which he or she is a member, as per Section 11.5; and this can be in person, by phone, video conferencing, or with permission of the chair by reviewing the department meeting minutes.

d) at least fifty (50) percent of committee meetings of which he or she is a member.

Each member of the Courtesy staff, all members of the Provisional Staff who qualify under criteria applicable to Courtesy members, and each Affiliate to the Medical Staff shall be required to attend such other meetings as may be determined by the Medical Executive Committee, assigned Department, and/or Quality Review Committees.

13.8.2 Absence from Meetings

Any member who shall be absent from Medical Staff, department, division, or committee meetings, by virtue of an LOA, shall notify the respective presiding officers. Failure to meet the attendance requirements may be grounds for removal from such committee or corrective action and/or insertion of adverse information into the member's file.

13.8.3 Special Attendance

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a

general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

13.9 CONDUCT OF MEETINGS

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

13.10 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.

ARTICLE 14 - CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical 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 provision 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 the exercise of clinical privileges at this Hospital.

14.2 CONFIDENTIALITY OF INFORMATION

14.2.1 General

Medical Staff, Department, Division, and Committee minutes, files, and records, including information regarding any members or applicants to this Medical Staff or to any AMS and/or Physician in Training collected or prepared for the purpose of achieving and maintaining quality patient care, reducing morbidity and mortality or contributing to clinical research, shall be confidential to the fullest extent permitted by law. Dissemination of such information and these records shall only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, if no officially adopted policy exists, only with the express approval of the Medical Executive Committee, or its designee. This confidentiality shall also extend to information of like kind that may be provided by third parties. The information shall be part of the Medical Staff Committee files and shall not become part of any particular patient's file or of the general Hospital records.

14.2.2 Breach of Confidentiality

Inasmuch 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, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

14.3 IMMUNITY FROM LIABILITY

14.3.1 For Action Taken

Each representative of the Medical Staff and Hospital shall be exempt, 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 his or her duties as a representative of the Medical Staff or Hospital.

14.3.2 For Providing Information

Each representative of the Medical Staff and Hospital and all third parties shall be exempt, 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 clinical privileges or provide services at this Hospital.

14.4 ACTIVITIES AND INFORMATION COVERED

14.4.1 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 clinical privileges;

b) corrective action;

c) hearings and appellate reviews;

d) utilization review;

e) other department, or division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and

f) peer review, quality review, and credentialing organizations (Medical Board of California, National Practitioner Data Bank, and similar reports).

14.4.2 Releases

Each applicant, member, or AMS shall, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

ARTICLE 15 - GENERAL PROVISIONS

15.1 RULES AND REGULATIONS[67]

15.1.1 Medical Staff Rules and Regulations[68]

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 at least be reviewed biennially and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff.[69] Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility. Proposed rules shall be submitted to the Medical Executive Committee for review and action as follows:

a. Except as provided in Section 15.1.1d, below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. [This review and comment opportunity may be accomplished by posting proposed Rules on the San Mateo Medical Center website at least fifteen (15) days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.]

b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least twenty-five percent (25%) of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1.4.

    1) If conflict management is not invoked within 30 days, it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1.1b.3, the proposed rule shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed Rule.

    2) If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Governing Body.

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67 May 2011

68 May 2011

69 May 2011: TJC Standard 01.01.01

3) With respect to the proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least 51 percent votes have been cast.

c. Following approval by the Medical Executive Committee or the favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body. If there is a conflict between the bylaws and the rules, the bylaws shall prevail.

d. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Governing Body for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described in Section 15.1.2a), the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided however, the approved Rule shall remain effective until such time as superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1.1.

15.1.2 Department Rules

Subject to the approval of the Medical Executive Committee and Governing Body, each department may formulate its own rules for conducting its affairs and discharging its responsibilities. Such rules shall not be inconsistent with the Medical Staff or hospital bylaws, rules or other policies.

15.1.3 Medical Staff Policies

Policies shall be developed as necessary to implement more specifically the general principles found within these bylaws and the Medical Staff Rules. Processes described in 15.1.1 apply to development of Medical Staff policies.

15.1.4 Conflict Management[70]

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least 25% of the voting members of the Medical Staff regarding a proposed or adopted Rule or policy, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that

[70] May 2011: TJC Standard MS 01.01.01

respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences shall be submitted to the Governing Body for final resolution.

15.2 MEDICAL STAFF POLICIES[71]

Policies shall be developed as necessary to implement more specifically the general principles found within these Bylaws and the Medical Staff Rules and Regulations. The policies may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval by the Governing Board. Such policies shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules and Regulations or other policies, and upon adoption shall have the force and effect of Medical Staff Bylaws.

15.3 INFORMED CONSENT[72]

a) Based on input from the Medical Staff and Hospital Departments, the Medical Staff shall develop a list of procedures requiring informed consent of the patients. This list may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval by the Governing Board and upon adoption shall have the force and effect of Medical Staff Bylaws. Informed consent will be required with respect to all procedures.

b) The informed consent policy shall assure that the patient (or his/her representative) receives information necessary to make informed decisions about his/her care.

c) Informed consents will be documented in the medical record.

15.4 MEDICAL STAFF 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, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff and shall not jeopardize the nonprofit tax exempt status of the hospital. [73] Failure to pay the recommended amount of annual dues in a timely manner shall result in automatic revocation of membership from the Medical Staff. Reinstatement to the Medical Staff requires reapplication as a new member in accordance with Section 8.3.4 of these Bylaws.[74]

15.5 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or

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71 May 2008

72 May 2008

73 May 2011: Business & Professions Code Section 228.5

74 November 2016

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. The use of the term "days" in these Bylaws refers to calendar days, as opposed to workdays or weekends, except where specifically defined.

15.6 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.

15.7 DIVISION OF FEES

Any division of fees 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.

15.8 NOTICES

Except where specific notice provisions are otherwise provided in these Bylaws, any and all notices, demands, requests required or permitted to be mailed in writing, properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid or sent electronically. An alternative delivery mechanism may be used if it is reliable, is expeditious, and if evidence of its use is obtained. Notice to the Medical Staff or officers or committees thereof shall be addressed as follows:

Medical Staff Office
San Mateo Medical Center
222 West 39th Avenue
San Mateo, CA 94403
Office Phone: 650-573-2198

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

15.9 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairmanships, the Medical Executive Committee, or Judicial Review Committees shall, at least twenty (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.

15.10 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.

15.11 CONFIDENTIALITY

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

a) The records of the Medical Staff and its departments and 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 credential file of any members 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 shall require the authorization of the Chief of Staff and the concerned department chair and notice to member.

e) A Medical Staff member shall be granted access to the individual's credentials file, subject to the following provisions:

    1) Timely notice of such shall be made by the member to the Chief of Staff or the Chief of Staff's designee;

    2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the designated officer of the Medical Staff (at the time the member reviews the credentials file/within a reasonable period of time, as determined by the Medical Staff). Such summary shall disclose the substance, but not the source, of the information summarized;

    3) The review by the member shall take place in the Medical Staff Office, during normal work hours, with an officer or designee of the Medical Staff present.

f) In the event a notice of action or proposed action is filed against a member, access to that member's credentials file shall be governed by Section 9.4.1.

15.12 LEGAL COUNSEL[75]

The Medical Staff may, at its expense, retain and be represented by independent legal counsel through the Medical Staff Association of San Mateo County[1].

15.13 DISPUTES WITH THE GOVERNING BOARD[76]

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

a. Invoking the Dispute Resolution Process

1) The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.

2) In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.

b. Dispute Resolution Forum

1) Ordinarily, the initial forum for dispute resolution shall be the regular joint meetings between the Chief of Staff, Vice Chief of Staff, Hospital CEO, and CMO.

2) However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of (a) at least a majority of the Medical Executive Committee plus two members of the Governing Body; or (b) at least a majority of the Governing Body plus two members of the Medical Executive Committee.

c. The parties' representatives shall convene as early as possible, shall gather and share relevant information, and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute the Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.[77]

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75 May 2011

76 May 2011

77 May 2011: Business & Professions Code Section 2282.5 and TJC Standard MS 01.01.01

ARTICLE 16 - ADOPTION AND AMENDMENT OF BYLAWS

16.1 PROCEDURE

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff bylaws and amendments which shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the general recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body.[78]

a) INITIATED BY MEDICAL STAFF - On the request of the Chief of Staff, the Medical Executive Committee, the Bylaws Committee, or on timely written petition signed by at least twenty-five (25%) percent of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.

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

2) Proposed amendments submitted upon petition of the voting Medical Staff members shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Governing Body for review and comment. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Governing Body when the proposed amendments are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for vote.[79]

This action shall be taken at an annual or special meeting provided (1) written notice of the proposed change was sent to all members on or before the last annual or special meeting of the Medical Staff and these changes were offered at such prior meeting and (2) notice of the next annual or special meeting at which action is to be taken including notice that a Bylaw change would be considered.

b) INITIATED BY GOVERNING BODY AND/OR HOSPITAL ADMINISTRATION[80]- If these Bylaws are not in compliance with the requirements imposed by law, regulations, order of court of law, for accreditation, for tax purposes, or otherwise reasonably necessary, the Governing Body may request appropriate amendment. Additionally, hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the

78 May 2011

79 May 2011

80 May 2011

impact of any proposed Bylaws on hospital operations and feasibility.[81] The Medical Staff shall take action on that amendment at its next annual meeting, following requisite notice as outlined in 16.1.a.[82]

16.2 ACTION ON BYLAW CHANGE

If a quorum is present for the purpose of enacting a Bylaw change, the change shall require an affirmative vote of fifty-one (51) percent of the members voting in person or by written ballot.

16.3 APPROVAL

Bylaws changes, revisions, and/or amendments adopted by the Medical Staff shall become effective following approval by the Governing Body, which approval shall not be withheld unreasonably. Medical Staff members are provided with copies of the revisions in the Bylaws, Rules and Regulations and Medical Staff policies. If approval is withheld, the reasons for doing so shall be specified by the Board of Directors in writing, and shall be forwarded to the Chief of Staff, the Medical Executive and Bylaws Committees.

16.4 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Bylaws.

16.5 BIENNIAL REVIEW

These Bylaws shall be reviewed by the Medical Staff biennially for the purpose of insuring they are meeting current needs and/or reflecting current function of the Medical Staff. A report of the review and findings to include recommendations as appropriate will be delivered to the Medical Executive Committee and Medical Staff at its annual meeting.

16.6 TECHNICAL AND EDITORIAL AMENDMENTS[83]

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other error or grammar or expression or inaccurate cross-references. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and to the Governing Board. Such amendments would be effective upon adoption by the Medical Executive Committee, provided however, they may be rescinded by vote of the Medical Staff or the Governing Board within 120 days of the date of adoption by the Medical Executive Committee. [For purposes of

81 May 2011

82 05/15/2003

83 May 2008

this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least 25 percent of the voting members of the Medical Staff cast ballots.]

16.7 EFFECT OF THE BYLAWS

Upon adoption and approval as provided in Article 16, in consideration of the mutual promises and agreements contained in these bylaws, the hospital and the Medical Staff, intending to be legally bound, agree that these bylaws shall constitute part of the contractual relationship existing between the hospital and the Medical Staff members, both individually and collectively.

Affiliations between the hospital and other hospitals, healthcare system or other entities shall not, in and of themselves, affect these bylaws.

- ORIGINALLY ADOPTED April 9, 1986
- REVISED AND ADOPTED by the Medical Staff on May 9, 2017
- REVISED AND ADOPTED by the Medical Staff on May 15, 2019
- REVISED AND ADOPTED by the Medical Staff on May 24, 2023
- REVISED AND ADOPTED by the Medical Staff on May 15, 2024

_____
Chief of Staff

_____
Vice Chief of Staff

- APPROVED as revised by the Board of Directors on June 1, 2017
- APPROVED as revised by the Board of Directors on June 3, 2019
- APPROVED as revised by the Board of Directors on August 7, 2023
- APPROVED as revised by the Board of Directors on May 6, 2024

_____
Presiding Officer

_____
Secretary

MEDICAL STAFF GENERAL RULES AND REGULATIONS

2024 PROPOSED REVISIONS

Current Language	**2024 Proposed Changes**
Section II.H.3.c (Sanctions), third paragraph: Physicians with one or more deficiencies assigned to them for more than 21 days shall be sent a "Notice of Pending Suspension" on a Monday by the Chief of Staff informing the physician that, should his or her record deficiencies remain incomplete one week from the date of notice, the physician shall be sanctioned until his or her record deficiencies are cleared and shall not be able to perform the following: • Admit non-emergency patients to the medical center. • Perform consultations. • Schedule new procedures or operations. • Treat Patients in clinic. • Attend in clinics.	**Section II.H.3.c** Physicians with one or more deficiencies assigned to them for more than 5 days shall receive a "First Notification Letter" from the Health Information Management (HIM) department within the electronic medical record advising them of outstanding deficiencies. Physicians with one or more deficiencies assigned to them for more than 10 days will receive a "Second Notification Letter" from the HIM department within the electronic medical record advising them the need to complete their deficiencies within the next four days or they will be suspended. Physicians with one or more deficiencies assigned to them for more than 14 days shall receive a "Suspension Letter" advising the physician their admitting privileges have been suspended and shall not be able to perform the following: • Admit non-emergency patients to the medical center. • Perform consultations. • Schedule new procedures or operations. • Treat Patients in clinic. • Attend in clinics.
Section 7. Focused Professional Practice Evaluation [FPPE] 3) Criteria for existing privileges Quality Management Department and other services will collect OPPE data on an ongoing basis; analyze and aggregate data by practitioner every six months for each medical staff member (including affiliate staff) and report the results to the medical staff department chairs.	**Section 7. Focused Professional Practice Evaluation [FPPE]** 3) Criteria for existing privileges Quality Management Department and other services will collect OPPE data on an ongoing basis; analyze and aggregate data by medical staff member (including affiliate staff) and report the results to the medical staff department chairs. The organized medical staff defines the frequency for data collection. However, the timeframe for review of the data cannot exceed every 12 months.
G. CONFIDENTIALITY AND CONSENT **3. Records Access, Including Research**	**G. CONFIDENTIALITY AND CONSENT** **3. Records Access, Including Research**

Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients, and consistent with policies and procedures of the Medical Records Committee as it applies to HIPPA regulations.	Should say “HIPAA regulations”

SAN MATEO MEDICAL CENTER

MEDICAL STAFF

GENERAL
RULES AND REGULATIONS

Revised 06/10/98; reviewed 1999; reviewed 2000; revised 06/20/2001, revised 06/27/2002, revised 05/25/2004
Revised 05/10/2005, revised 01/05/2006, revised 02/01/2007, revised 05/03/2007, revised 05/26/2009, revised 05/25/2010; Revised 05/24/2011; reviewed 05/12/2012; revised 06/04/2013; revised 06/05/2014; revised 07/02/2015; revised 12/08/2015; revised 4/26/2017: revised 08/08/2017, reviewed 2/13/19, revised 4/09/2019; reviewed 09/28/2020; reviewed 5/24/2023; REVISED 5/15/2024

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SECTION I - ADMISSION AND DISCHARGE OF PATIENTS

A. ADMISSION OF PATIENTS

Admission policies and procedures developed by Administration and approved by the Medical Staff define methodology and priority for hospitalization of medical, surgical, and psychiatric patients at San Mateo Medical Center. Triage of patients to accommodate differing care setting needs is also defined in administrative policy and procedure. Interfacility transfer of all patients shall be managed within the constraints of both State and Federal laws to assure patients are not transferred for economic or non-medical reasons before emergency services and care are provided. Medical Staff members shall complete all communication and documentation requirements of the transfer protocols before sending or receiving patients.

1. Scope of Service

The Medical Center shall accept patients for care and treatment subject to the provisions of these Rules and Regulations. Inpatient Obstetrical Services and Pediatrics are available only on an emergency basis.

Regional treatment centers shall be utilized for the care of major burns, acute spinal cord injuries, surgical procedures requiring cardiac bypass, and specialty/intensive neonate and general pediatric services.

2. Limitations to Members

A patient may be admitted to the Medical Center only by a physician or Advanced Provider (AP's) of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Medical Center.

3. Responsibility for Care and Treatment

A physician or Advanced Provider (AP's) of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Medical Center, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another service or level of care, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

4. Provisional Diagnosis

No patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.

5. Bed Allocation

In any emergency case in which it appears the patient will have to be admitted to the Medical Center, the practitioner shall first contact the Admitting Office to ascertain whether there is an available bed.

6. Emergency Admissions

a. Practitioners admitting emergency cases shall be prepared to justify through the Medical Records Committee, to the Medical Executive Committee, and the Medical Center Administration that the Medical Center admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

b. A patient to be admitted on an emergency basis who does not have a private practitioner will be assigned any practitioner in the applicable department or service to attend to him. The chairman of each department shall provide a schedule for such assignments, to include only current Medical Staff members.

7. Timely Professional Care

Each practitioner must assure timely, adequate, professional care for his patients in the Medical Center by being available or having available, through his office, an eligible alternate practitioner with whom prior arrangements have been made, who has at least equivalent clinical privileges at the Medical Center, and who will be available to respond to a request for patient care; at a minimum each patient shall have a daily visit by the physician or Advanced Provider at a frequency required by state licensing.

Failure of an attending practitioner to meet these requirements may result in loss of clinical privileges.

8. Admission to and Discharge from Specialty Units

a. Intensive Care Unit (ICU)[1]

Medical and surgical patient with significant physiologic instability requiring specialized nursing care, specific infusions, physiologic monitoring, and rapid skilled intervention as needed, are suitable for admission to the ICU. Admission, triage, and discharge criteria as well as practitioner roles and responsibilities and related policies and procedures as approved by the Critical Care Committee are available for reference in the Intensive Care Unit.

b. ECG Telemetry

Monitoring of cardiac rhythm for patients at risk for adverse consequences from either an existing or potential arrhythmia, who may benefit from the treatment of such an arrhythmia, and who may not meet the ICU admission criteria may be admitted to a monitored alarm bed. Monitoring is generally limited to 48 hours, but may be extended situationally. Policies and procedures related to the use of alarm telemetry as approved by the Critical Care Committee are available for reference.

c. Short Stay Unit (SSU)

[1] *M.E.C. revision 04/10/2007*

Adult and pediatric patients scheduled for elective surgical, diagnostic, or therapeutic procedures may be admitted to the Short Stay Unit Monday through Friday. "Surgery in an outpatient bed" patients enter the Medical Center on the morning of surgery and are subsequently admitted to regular floor care postoperatively. The scope of service for the "come-and-go" patients are limited to those who are anticipated to be fully recovered and ready for discharge home no later than 1600 hours. Policies and procedures related to the use of Short Stay Unit as approved by the Department of Surgery are available for reference in SSU.

B. DISCHARGE OF PATIENTS

1. Written Orders

Patients shall be discharged only on an order of the attending practitioner or a physician whom he/she designates as an alternate. Whenever these responsibilities are transferred to another service or level of care, a note covering the transfer of responsibility shall be entered in the medical record on the progress note and entered in the EHR.

2. AMA/AWOL

Should a patient leave the Medical Center against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the physician.

3. Timeliness of Discharge

It shall be the responsibility of the attending practitioner to discharge his/her patients when the patient no longer meets acute care Medical Center criteria as identified in the Utilization Management Plan and approved by the Medical Staff.

4. Management of Patient Death

a. In the event of a Medical Center death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. If the attending physician for that Medical Center admission is not in the Medical Center and is not available to come to the Medical Center, a licensed physician of the Medical Staff may pronounce the patient. The attending physician's name would still be on the death certificate. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to release of dead bodies shall conform to the Coroner's policies.

In all cases in which any doubt exists regarding legal status of death, the Coroner shall be notified by the physician.

b. It shall be the duty of all staff members to utilize the Medical Staff autopsy criteria, which are as follows:

Unexplained death or unexpected death, in which meaningful information would be expected to be obtained by autopsy.[2]

[2] M.E.C. 02/05/2002

Request for autopsy and/or denial shall be documented in the patient's medical record. The benefit derived from the autopsy should outweigh the considerable risk and biohazard exposure to the staff, the autopsy physician and assistant performing the necropsy.

Other than Coroner's cases, an autopsy may be performed only with a written consent signed in accordance with state law. All non-Coroner case autopsies shall be performed by the Medical Center pathologist, or by a practitioner delegated this responsibility by the Medical Center pathologist. Provisional anatomic diagnosis shall be recorded on the medical record within seventy-two (72) hours and the complete protocol should be made a part of the record within 30 days, unless the case is complex and requires an outside consultation, for example, complex brain examination.

c. Universal Donors

In accordance with the uniform Anatomical Gift Act, the attending practitioner or designee shall follow the established Medical Staff and administrative protocol to discuss with appropriate patients or their legal next-of-kin, their desire to donate organs and/or tissues for transplantation. Documentation of the patient/family acceptance or refusal or the patient's not meeting donor criteria shall be reflected in the progress notes.

SECTION II - MEDICAL RECORDS

A. RESPONSIBILITY

The attending physician shall be responsible for (or delegate to appropriate practitioners) the preparation of a complete and legible medical record for each patient. In cases where the physician is no longer available to complete the record, the Department Chair in consultation with the Medical Director and department members, will assign the responsibility of chart completion to an appropriate Medical Staff member.[3] Its contents shall be clinically pertinent and current. This record shall include: presenting complaint; personal, family, and social history; history of present illness; physical examination; procedure and therapeutic consent forms; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed. Dentists, clinical psychologists, and podiatrists shall be responsible for those portions of the history and physical examination and progress notes relative to the specialty.

B. HISTORY AND PHYSICAL [4][5]

A medical history and physical examination must be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. There must be a complete H&P and an update, if applicable, in the medical record of each patient prior to surgery or procedure requiring anesthesia services, except in emergencies. In the case of emergencies, the H&P must be recorded immediately following the procedure and the practitioner must sign, date, and time a statement of the emergency circumstances in the patient's medical record.[6]

The medical history and physical examination must be completed and documented by a physician, nurse practitioner or physician assistant who is credentialed and privileged to perform an H&P. Dentists, clinical psychologists, and podiatrists shall be responsible for those portions of the history and physical examination and progress notes relative to the specialty.

At a minimum, the H&P must contain the following elements for both inpatients and outpatient procedures requiring an H&P: (1) chief complaint, (2) history of present problem, (3) past medical history, (4) relevant social and family history, (5) current medications and allergies, (6) review of systems, (7) physical examination, and (8) impression/ plan.

When a medical history and physical examination has been completed within 30 days of admission (or registration), a patient examination and updated medical record entry must be completed and documented in the patient's medical record within 24 hours after admission or registration. The examination must be conducted by a licensed practitioner who is credentialed and privileged to perform an H&P. In all cases, the update must take place prior to surgery or a procedure requiring anesthesia services. The update note must document an examination for any changes in the patient's condition that might be significant for the planned course of treatment.

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[3] M.E.C. revision 01/09/2007

[4] M.E.C. revision 03/09/2004

[5] M.E.C. revision 07/12/2005 (deleting "limited H&P"); December 2015 updated revision

[6] May 2008, per Title 22/CMS Medical Conditions of Participation; December 2015 updated revision

If, upon examination, the licensed practitioner finds no significant changes in the patient's medical condition since the H&P was completed, he/she may indicate in the patient's medical record that the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. [6]

C. PROGRESS NOTES [7]

Inpatient Admission

All inpatients shall have a daily progress note by a medical physician or advanced provider that includes assessment of symptoms related to the reason for admission, assessment of new symptoms arising during the hospitalization, a physical exam specific to reason for admission and relevant to any new symptoms developing during the hospitalization, review of pertinent laboratory results, current impression, and treatment plan. All progress notes are to be entered into the electronic medical record (EMR).

Operative and Invasive Procedures

Brief Pre-procedure note
A pre-procedure note or H&P shall be recorded in the progress notes section of the medical record for every patient within 7 days prior to an operative or invasive procedure. The physician or surgeon, co-surgeon, or designee who will perform the operative or invasive procedure shall write this note. The pre-procedure note shall include the diagnosis/indication for the procedure; the planned procedure; the risks, complications, or side effects associated with the procedure; the available alternatives or that no reasonable alternative exist; and that consent was given by the patient.

Brief Post-procedure note
A brief post-procedure note shall be recorded in the progress notes section of the medical record for every patient immediately after performance of an operative or invasive procedure. This note should contain the name of the physician or surgeon and assistants, operative findings, the procedure performed, the presence/disposition of the specimen, estimated blood loss, occurrence of complications, and where patient will receive post-operative monitoring. This note will act as a record of events until the dictated operative/procedure note appears in the medical record.

D. OPERATIVE REPORTS

Operative reports shall be dictated immediately after surgery. The report shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. The completed operative reports shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately after completion of the procedure, identifying the planned and actual surgical procedures, post-op diagnosis, and any unusual occurrence/complications. This progress note shall assure continuity of care until the report is available in the chart.

When a progress note is entered immediately after completion of the procedure, the full operative report shall be dictated within 24 hours of the procedure.[8]

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[7] M.E.C. revision 03/09/2004

[8] M.E.C. 05/12/2009 (added language)

E. CONSULTATIONS

The ordering practitioner shall define the reason for and the responsibilities of the consultant (i.e., opinion only, orders, degree of patient management, etc.). Response to request for consult shall be within twenty-four (24) hours unless identified differently within the order (i.e., consultation in clinic post-discharge).

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

F. ENTRIES

1. Dating, Timing

All clinical entries in the patient's medical record shall be accurately dated and timed.

2. Authentication [9]

Authentication means to establish authorship. All clinical entries in the medical record shall be authenticated including authentication through the EHR. ***At a minimum, entries of histories and physical examinations, consults, operative procedures, and discharge summaries shall be authenticated.***

3. Final Diagnosis

Final diagnosis shall be recorded using approved Medical Staff abbreviations, and dated, and signed by the responsible physician at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.

4. Discharge Summary [10]

Every patient discharged from a Medical Center stay should have a dictated discharge summary. The dictation must include information as outlined in the Discharge Summary Sheet where applicable.

It is strongly encouraged that the discharge summary be dictated within 72 hours of the time of discharge but in no case later than 7 days.

If dictating at time of discharge, the physician may briefly indicate so on the Discharge Summary Sheet in lieu of filling it out completely.

In cases where the discharge summary is not dictated at time of discharge and outpatient follow-up is to occur in less than 72 hours, it is required that the Discharge Summary Sheet be filled

[9] M.E.C. revision 09/11/2001

[10] M.E.C. revision 04/20/2000, 11/28/2000

out in its entirety at time of discharge. In such cases the patient is asked to bring their copy of the Discharge Summary to the outpatient visit.

The content of the summary shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible physician. (Refer to Section II.H.3 for consequences of incompleteness.) If patient is discharged AMA or AWOL, the summary shall reflect this process.

5. Interval History and Physical on Readmissions

Readmission within thirty (30) days for the same or related diagnosis will require only an interval history and physical examination, reflecting any subsequent changes, provided the original history and physical is readily available in the old medical record.

G. CONFIDENTIALITY AND CONSENT

1. Written Consent

Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

2. Records Management

Records may be removed from the Medical Center's jurisdiction and safe keeping only in accordance with a court order, subpoena, or statute, and for storage purposes, and, as stated in policies, for transfer of patients to and from other facilities. All records are the property of the Medical Center. In case of readmission of a patient, all previous records shall be available for the use of all practitioners. Unauthorized removal of charts from the Medical Center grounds is reason for suspension of the practitioner and/or affiliates for a period to be determined by the Medical Records Committee of the Medical Staff.

3. Records Access, Including Research

Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients, and consistent with policies and procedures of the Medical Records Committee as it applies to HIPAA regulations.

H. COMPLETENESS OF THE RECORD

1. Permanent Filing

A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Department Chair or by the Chief of Staff.[11]

2. Use of Order Sets[12]

[11] May 2015

[12] May 2015

Order sets that include medications shall be reviewed, approved, and revised if needed on an a biennial basis. Other order sets shall be reviewed, approved, and revised as needed.[13]

3. Post-discharge Timely Completion and Suspension for Unmet Standard [14]

a. Expectations[15]

The medical record shall be complete within 14 days following the discharge of the patient. (CA Code Title 22 Sect. 70751)

Physicians are expected to complete their record deficiencies weekly. Physicians should have continuous on-line access to all assigned electronic medical record (EMR) deficiencies. It is the responsibility of each physician to establish remote access to SMMC's electronic health record (EHR).

b. Definitions

Incomplete records - The total number of medical records with one or more deficiencies that need to be completed by a physician.

Delinquent records - The subset of incomplete records that are 14 or more days past discharge at the time of the weekly mailing of notices.

c. Sanctions[16]

The Medical Staff through the Medical Executive Committee, the Chief of Staff and the department chairs will sanction physicians who do not complete their medical records in a timely fashion.

Physicians have continuous on-line access to all assigned electronic medical record (EMR) deficiencies. It is the responsibility of each physician to establish remote access to the EMR. Physicians with one or more delinquent records shall be sent a weekly notice of their record deficiencies.

Physicians with one or more deficiencies assigned to them for more than 5 days shall receive a "First Notification Letter" from the Health Information Management (HIM) department within the electronic medical record advising them of outstanding deficiencies. Physicians with one or more deficiencies assigned to them for more than 10 days will receive a "Second Notification Letter" from the HIM department within the electronic medical record advising them the need to complete their deficiencies within the next four days or they will be suspended. Physicians with one or more deficiencies assigned to them for more than 14 days shall receive a "Suspension Letter" advising the physician their admitting privileges have been suspended and shall not be able to perform the following:

- Admit non-emergency patients to the medical center.

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13 May 2015

14 M.E.C. revision 05/12/2009

15 May 2015

16 May 2015

- Perform consultations.
- Schedule new procedures or operations.
- Treat patients in clinic.
- Attend in clinics.

Patient Access, O.R. Scheduling, and Clinic Management shall be notified of physicians whose medical staff privileges have been suspended.

The medical staff privileges of a sanctioned physician may be restored upon the completion of the physician's delinquent records. Patient Access, O.R. Scheduling, Clinic Management, and the Medical Staff Office shall be informed immediately of the lifting of sanctions.

The Medical Staff Office shall place a medical records sanction notice in the credentialing file for OPPE/professionalism. The sanction notice shall document the start and end dates of each sanction occurrence.

Suspensions cumulatively totaling thirty (30) days or more for any twelve (12) month period shall be reported to the Medical Board of California. (CA Business & Professions Code Sect. 805)

Procedural Considerations[17]

All communications to physicians will include a phone number to call to resolve discrepancies regarding their notices and to request assistance with the record completion process.

Physicians who report vacations and illnesses to the Medical Record Department will not be sent delinquent notices during the period of their absence. Physicians are expected to complete record deficiencies prior to the start of a planned absence.

Informal contacts to physicians may include departmental reminders and administrative contacts advising them of their delinquency status and any pending sanction.

[17] May 2015: This revision combines Section II, Subsection H. and Section V, Subsection B. of the SMMC Medical Staff Rules & Regulations.

SECTION III - GENERAL CONDUCT OF CARE

A. CONSENTS FOR TREATMENT

1. Admission Consent

A general consent form, signed by or on behalf of every patient admitted to the Medical Center, must be obtained before or at the time of admission. In the event a patient's condition meets the criteria for medical necessity and delay in treatment would be detrimental, the admission consent can be deferred and emergency care initiated.

2. Procedural and Therapeutic Consents

All procedures require informed consent. Any procedures performed in the operating room and in radiology involving intravenous contrast material requires informed consent.[18] Informing the patient of the nature and risks inherent in treatments and procedures shall be the responsibility of the appropriate physician, practitioner, or affiliate.

Patients unable to provide their own consent (i.e., minors, forensic custody, conserved, incompetent, etc.) shall not undergo special treatments or surgical procedures requiring specific consent without family or durable power of attorney authorization unless in emergencies. Family or durable power of attorney authorization can consent for central lines, dialysis, transfusion, etc. for patients who are with intubated with AMS. If family or durable power of attorney is not available or unable or unwilling to provide authorization for whatever reason, then a court or public guardian/conservator authorization is required, unless an emergency exists. The process of informed consent remains the responsibility of the appropriate physician, practitioner, or affiliate to obtain and coordinate with the Department of Nursing and the Court, public guardian, or conservator.

B. ORDERS FOR TREATMENT [19]

Refer to ***Patient Care Function Manual Volume 1, Care of Patient, Policy #3.21, "Physician's Orders – Policy/Procedure."***

1. Written and Verbal Orders

All orders for treatment shall be in writing or placed in EHR. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his/her sphere of licensure, or scope of practice, and signed by the responsible practitioner or affiliate. Verbal orders for medications must be signed by the responsible provider within 48 hours. All other verbal orders shall be signed by the ***attending*** practitioner as soon as possible, unless more stringent standards apply for specific types of orders (i.e., restraints).[20],[21]

2. Illegible or Improperly Written Orders

Practitioners' and affiliates' orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the

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[18] May 2015

[19] M.E.C. revision 11/28/2000

[20] M.E.C. revision 09/11/2001

[21] M.E.C. revision 11/18/2003

nurse or applicable ancillary department staff. The use of "Renew," "Repeat," and "Continue orders" are not acceptable when transferring a patient in or out of the Intensive[22] Care Unit, or as the initial orders written after surgery. All providers are strongly discouraged from writing orders. The preferred method is the electronic entry of the order into the EMR.

3. Automatic Cancellation

All previous orders are canceled and need to be fully rewritten when patients go to surgery and when transferred in or out of the Intensive[23] Care Unit (refer to separate DNR policy).

4. Medications - Standard and Research

All medications that are to be given immediately require a "stat" or "first dose now" order. Medication orders not designated "stat" or "give now" will be considered routine and given at the next appropriate routine medication time. "Stat"/" Give Now" admission orders on patients being admitted from the medical and psychiatric emergency departments will be given in the emergency department prior to transfer to the inpatient unit.[24]

a. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Medical Center Formulary Service, or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Medical Centers and current drug usage policies and procedures as approved by the Pharmacy and Therapeutics Committee.

b. Inpatient Automatic Stop Medication Orders

Antibiotic orders shall automatically stop at twenty-four (24) hours for prophylactic use, five (5) days for empiric use, and seven (7) days for therapeutic use. Antiretrovirals (ARVs) used for HIV care and anti-Tuberculosis drugs are exceptions to the antibiotic 7 day stop rule. Antiretrovirals and anti TB medications will not be stopped on inpatients unless a specific order is written. All ordered scheduled drugs (narcotics, sedatives, etc.) and Coumadin shall automatically stop at seven (7) days.

5. Restraints Orders

Refer to "***Restraints and Seclusion Policy"*** on SharePoint for more information and details.

[22] M.E.C. revision 04/10/2007

[23] M.E.C. revision 04/10/2007

[24] M.E.C. revision 11/13/2001

C. CONSULTATIONS

1. General

a. A consultant can be any qualified practitioner, affiliate, or resident with clinical privileges in this Medical Center and can be called for consultation within his area of expertise.

b. Consults beyond those required as listed below can be initiated or requested on any patient by the Department Chair, Medical Director of the Service, Division Chief, or the Chief of Staff.

2. Required Consultation

Except in an emergency, consultation is required in the following situations for patients of all ages:

a. When the patient is not a good risk for operation or treatment;

b. Where the diagnosis is obscure after usual/customary diagnostic procedures have been completed;

c. Where there is doubt as to the choice of therapeutic measures to be utilized;

d. In unusually complicated situations where specific skills of other practitioners may be needed;

e. In instances in which the patient exhibits severe psychiatric symptoms;

f. When reasonably requested by the patient or his family.

3. Pediatric and Maternal Child Care

Pediatric admissions should be reserved only for emergency situations, however pediatric consultation shall be available at all times.

An Ob/Gyn consultation shall be required at the discretion of the admitting physician for pregnant patients admitted to the Medical Center with non-Ob/Gyn diagnosis(es).

4. Consideration for Suicidal Patients

For the protection of patients, the medical and nursing staff, and the Medical Center, certain principles will be met in the care of the potentially suicidal patient. Any patient known or suspected to be suicidal in intent shall be cared for according to established suicide precautions. All attempted suicides must have a consultation by a psychiatrist or psychiatric resident.

D. REGULATORY COMPLIANCE [25]

1. Emergency Medical Treatment and Labor Act (EMTALA)

a. Designation of "Qualified Staff"

The on-campus Emergency Room and satellite clinics shall provide a screening exam for all emergency patients by "qualified staff." Designated qualified staff shall include:

1) Physicians who routinely provide medical screening exams, and

2) Nurse Practitioners and Physician Assistants who have met their licensure requirements, are certified by their practice board, and have received privileges to provide such screening exams according to the Medical Staff Bylaws. ***[A list of qualified staff will be kept current and available at each service site and reported to the Medical Executive Committee.]***

b. On-Call Staff Responsibility

Medical Staff who agree to provide on-call coverage for specialty services or for back-up are responsible for responding, examining, and treating patients with routine and emergency conditions. Each service area that uses on-call coverage shall adhere to policies that establish response times and mechanisms to assure such coverage is provided. Where lapses in on-call coverage do occur, they shall be documented and reported to the appropriate Administrative and Medical Staff leaders for investigation and corrective action. The Medical Executive Committee shall ensure the effectiveness of the on-call schedule including the using of disciplinary action when deemed necessary**.**
Generally pages to consultants should be returned within 30 minutes. In instances where the provider is unable to answer within 30 minutes, that provider shall designate a person (such as a nurse) to return to the page, informing the caller that the consultant is aware of the request and will answer when available.

2. Organized Health Care arrangement (OHCA)

a. Description

Under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPPA), the Medical Staff and the Medical Center are in an Organized Health Care Arrangement (OHCA). The OHCA is a clinically integrated care setting in which individuals receive health care from more than one provider and the providers hold themselves out to the public as participating in a joint arrangement. The Medical Staff is in an OHCA with the Medical Center for care provided at Medical Center locations. The joint arrangement is disclosed to the patients in the Notice of Privacy Practices given to patients when they access care at any Medical Center facility. Members of the Medical Staff shall use patient medical and demographic information only as describe in the Notice of Privacy Practices.

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[25] M.E.C. revision 01/23/2001

b. Authorization and Conditions

Providers acknowledge Medical Staff participation with the Medical Center in an OHCA under the privacy regulations of the Health Insurance Portability and Accountability Act (HIPPA), and agree to be bound by the provisions of the Notice of Privacy Practices given to Medical Center patients when they access care at any of the Medical Center's facilities.

SECTION IV - COMMITTEES

The Committees described in this Section are considered Medical Staff Committees. Description of assignments, terms, removal, and vacancies is in Article 12 of the Medical Staff Bylaws. Committee members as defined in the composition of each committee are allowed to vote on committee business. Committee members designated as non-voting may not vote. This applies to physician and non-physician committee members. Any active member of the Medical Staff may join a committee by appointment of the Chief of Staff with approval of the Medical Executive Committee or by attending two meetings and petitioning the committee chair for appointment. Admission to a committee may be put up to a vote of the members of that committee at the discretion of the committee chair. If membership changes are made at the committee level, a report shall be submitted to the Medical Executive Committee for approval. A roster of committee members indicating the Chair, who attends, and who may vote shall be submitted to the Medical Executive Committee annually[26].

A. BYLAWS COMMITTEE

1. Composition

The Bylaws Committee shall consist of at least three (3) members of the Medical Staff, including the Chief of Staff. The Chair shall be appointed by the Chief of Staff.

2. Duties

The duties of the Bylaws Committee shall include:

a. conducting a biennial review of the Medical Staff Bylaws, as well as the Rules and Regulations and forms promulgated by the Medical Staff, its departments and divisions, and reporting to the Governing Body;

b. submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and

c. receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a).

3. Meetings

The Bylaws Committee shall meet as often as necessary at the call of its Chair, but at least bi-annually for the specific purpose of determining if a revision is in order to reflect changes in Medical Staff needs or functions. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

[26] Sentences 2-7 approved at Annual Meeting 05/10/05

B. CONTINUING MEDICAL EDUCATION COMMITTEE [27]

1. Composition

The Committee shall consist of physician members and other health professionals of the Medical Staff whose number shall be appropriate to the size of the Medical Center and amount of program activities produced annually. It shall consist of a sufficient number of members to afford, insofar as feasible, representation from the major departments and specialties. The Chair of the Committee shall be a practitioner appointed by the Chief of Staff.

2. Duties

The duties of the Committee shall include:

a. planning, implementing, coordinating, and promoting ongoing special clinical and scientific programs for the Medical Staff. This includes:
   - identifying the educational needs of the Medical Staff;
   - formulating clear statement of objectives for each program;
   - assessing the effectiveness of each program;
   - choosing appropriate teaching methods and knowledgeable faculty for each program; and
   - documenting staff attendance at each program.

b. assisting in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.

c. establishing liaison with the quality improvement program of the medical center in order to be apprised of problem areas in patient care which may be addressed by a specific continuing medical education activity.

d. maintaining close liaison with other Medical Center Medical Staff and department committees concerned with patient care.

e. making recommendations to the Medical Executive Committee regarding library needs of the Medical Staff.

f. advising administration of the financial needs of the continuing medical education program.

3. Meetings

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings including conclusions, recommendation, actions, and results, and shall report its activities and recommendations to the Medical Executive Committee.

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[27] M.E.C. addition 10/14/2003

C. CRITICAL CARE COMMITTEE

1. Composition

The Critical Care Committee shall consist of at least the physician director of the Special Care Unit; a representative of the Department of Surgery; a representative of Anesthesia Services; the Nurse Manager of the Special Care Unit, or designee; and the Director of Nursing. Additional representatives from other services (e.g., Respiratory Therapy, Emergency Department) as recommended by the Chair or Chief of Staff. The Chair shall be appointed by the Chief of Staff.

2. Duties

The duties of the Critical Care Committee shall be to:

a. review and evaluate activities, policies, practices, and procedures with respect to the quality, safety, and appropriateness of patient care services provided by the Special Care Units;

b. review and evaluate all Code Blue events within the Division of Medical Centers and Clinics and recommend changes;

c. make recommendations or propose actions to resolve problems identified in the review process;

d. evaluate the effectiveness of such recommendations and proposed actions; and

e. review and evaluate the CPR and Advanced Cardiac Life Support(ACLS) training programs required of the Medical Staff Department and/or Medical Staff Division Rules and Regulations.

3. Meetings

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings including conclusions, recommendations, actions, and results, and shall report its activities and recommendations to the Medical Executive Committee.

D. ETHICS COMMITTEE[28]

1. Composition

The Committee shall consist of physicians and other staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorney, administrators, and representatives from the Medical Center's Board of Directors. The chair shall be appointed mutually by the Chief of Staff and Chief Executive Officer[29].

[28] M.E.C. addition 09/09/2003

[29] M.E.C. revision 12/13/2005

2. Duties

The Committee may participate in development of guidelines for consideration of cases having ethical or bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment of such cases; retrospective review of cases for the evaluation of ethical and bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the Medical Center's staff on ethical and bioethical matters. The Committee shall make an opinion/ recommendation however, the staff is not bound by this advisement in any case.

3. Meetings

The Committee shall meet as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the Medical Executive Committee.

E. INFECTION CONTROL COMMITTEE

1. Composition

The Committee shall consist of at least five (5) members, including the county Public Health Officer or his/her designate, representatives from the Departments, specialty of Infectious Diseases, Nursing Service Administration, and an individual employed in a surveillance or epidemiological capacity. It may include non-voting consultants in microbiology and non-voting representatives from relevant Medical Center services. The Committee Chair shall be a practitioner appointed by the Chief of Staff.

2. Duties

The two-fold purpose of this working group is to provide an overview and direction to infection prevention and control activities, and to ensure the dissemination of the results of these activities to the Medical Staff and other pertinent committees. Towards that end, the group has been given the authority and responsibility for:

a. development of a Medical Center-wide infection control program;

b. evaluation and approval of the applicability and appropriateness of all surveillance activities and action taken to prevent and control infections;

c. delegation of responsibility to a qualified individual, task force, or department to carry out actions on any recommendations from the group, the Chief of Staff, the Medical Executive Committee, or other departments and committees as appropriate;

d. approval of the use of infection control resources;

e. annual SMMC Infection Control plan based on the risk assessment and previous year evaluation, a review minimally every 3 years of Medical Center-wide infection control policies and procedures; and

f. assistance in the formulation of professional practices and policies regarding antibiotic usage.

3. Meetings

This Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings including conclusions, recommendations, action and results, and shall report its activities and recommendations to the Medical Executive Committee.

F. ANTIBIOTIC STEWARDSHIP COMMITTEES (Both SMMC and Skilled Nursing Facilities)

1. Composition

The Committee shall be organized and presided over by the Chief of Infectious Diseases and the Head of Pharmacy. Other voting committee members will include physicians, nurses and lab colleagues.

2. Duties

The duties of the antibiotic stewardship committees include:

a. Monitor antibiotic use consistent with empiric institutional guidelines and best practices;

b. Oversee inpatient and outpatient antibiotic review by Pharmacists;

c. Promote educational activities related to annual antibiogram, annual SMMC empiric antibiotic guidelines and other stewardship related topics;

d. Report antibiotic stewardship measures, including days of therapy to Quality committee and National Healthcare Safety Network as indicated.

3. Meetings

Meetings of both committees will be quarterly.

G. INTERDISCIPLINARY PRACTICE COMMITTEE

1. Composition

The Committee shall be organized and presided over jointly by the Chief Executive Officer and a member of the Medical Staff as appointed by the Chief of Staff and approved by the Medical Executive Committee, and:

a. Director of Nursing.

b. Equal number of physicians and nurses, appointed respectively by the Chief of Staff and Director of Nursing.

c. Allied health professionals as deemed appropriate.

2. Duties

The duties of the Interdisciplinary Practice Committee shall include:

a. The Committee shall oversee the establishment and administration of standardized procedures for registered nurses at the Medical Center. Specifically, the Committee shall:

1) Identify nursing functions that require the adoption of standardized procedures;

2) Establish written policies and procedures setting forth the required form of each standardized procedure, including the subjects to be covered;

3) Review and approve (as to both form and content) all proposed standardized procedures covering the extended role of registered nurses at the Medical Center, with approval to be given by the Chief Executive Officer (or designee), a majority of physician members of the Committee, and a majority of registered nurse members of the Committee, after consultation with appropriate persons in the medical and nursing specialties under review;

4) Recommend to the Executive Committee written policies and procedures for the designation of registered nurses who are authorized to perform functions under each standardized procedure;

5) Assume responsibility for identifying and designating registered nurses who are qualified to practice according to standardized procedures, both on an initial and on a continuing basis;

6) Insure that the names of registered nurses approved to perform functions according to each standardized procedure are on file in the appropriate nursing unit.

b. The Committee shall oversee the practice of allied health professionals at the Medical Center. Specifically, the Committee shall:

1) Make recommendations to the Executive Committee concerning any protocols that should be developed to govern the practice of allied health professionals at the Medical Center, and supervise the development of such protocols;

2) Review applications for appointment or reappointment to allied health professional status and clinical privileges, in accordance with governing protocols;

3) Initiate corrective action against allied health professionals at the Medical Center, in accordance with governing protocols;

4) Monitor the role of allied health professional categories permitted to practice at the Medical Center and make recommendations to the Executive Committee concerning that role; and

5) Serve as liaison between the allied health professionals at the Medical Center and the Medical Staff.

c. The Committee shall assist in defining the responsibilities of physicians and of registered nurses in areas of ambiguity or overlap.

d. The Committee shall establish a means of securing recommendations from health care professionals and personnel at the Medical Center who practice in the clinical field or specialty under review concerning matters within the Committee's jurisdiction.

e. The Committee shall establish policies and procedures governing the discharge of the above responsibilities and setting forth the procedure for the approval of any Committee recommendations.

3. Meetings

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of the proceedings including conclusions, recommendations, actions, and results, and shall report its activities and recommendations to the Medical Executive Committee.

H. OPERATING ROOM COMMITTEE [30]

1. Composition

The Operating Room Committee shall consist of at least the Chair of the Department of Surgery, a representative from the General Surgery Service, a representative of Anesthesia Services, and the Clinical Services Manager for Surgical Services or designee. Additional representatives from other services (e.g., Clinic Manager, Emergency Department) as recommended by the Chair or Chief of Staff. The Chair of this committee shall be appointed by the Chief of Staff.

2. Duties

The duties of the Operating Room Committee shall be to:

a. Have a forum for discussion of topics in a working session prior to the monthly Department of Surgery meeting. Topics for discussion include but are not limited to:

Block Utilization
Policy Development
Review of standing reports

[30] M.E.C. addition 04/13/2004.

Input for Capital equipment
Review of new products and technology
Review of Process Improvements and Risk Management issues

b. Facilitate communication and dissemination of O.R. policies and procedures.

3. Meetings

The Committee shall meet as often as necessary at the call of its chair, but at least monthly. It shall maintain a record of its proceedings including conclusions, recommendations, actions, and results, and shall report its activities and recommendations to the Medical Executive Committee.

I. PHARMACY/THERAPEUTICS COMMITTEE

1. Composition

This Committee shall consist of at least five (5) members, including representatives from the Departments, Nursing Service, Pharmacy, and Administration. It may include non-voting representatives from relevant Medical Center services. The Committee Chair shall be a practitioner appointed by the Chief of Staff.

2. Duties

The duties of this Committee shall include:

a. assisting in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Medical Center, Clinics, and affiliated skilled nursing facilities, including antibiotic usage and diagnostic testing materials;

b. advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

c. making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

d. periodically developing and reviewing a formulary or drug list for use in the Medical Center;

e. evaluating clinical data concerning new drugs or preparations requested for use in the Medical Center;

f. shall be informed/notified about the use and control of investigational drugs and research in the use of recognized drugs;[31]

g. maintaining a record of all activities relating to drug utilization evaluation functions, including the appropriateness of the use of antibiotics and other

[31] M.E.C. revision 09/09/2003.

drugs and diagnostics through the analysis of patterns of drug practice; and submitting periodic reports and recommendations to the Medical Executive Committee, Quality Assurance Committee, and/or appropriate Medical Staff Department concerning those activities including findings, recommendations, actions, and results, Medical Center-wide, department, and practitioner-specific;

h. reviewing adverse drug reactions;

3. Meetings

This Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings including conclusions, recommendations, action and results, and shall report its activities and recommendations to the Medical Executive Committee.

J. QUALITY IMPROVEMENT COMMITTEE [32]

1. Composition[33]

The Vice Chief of Staff shall serve as Chair of the Quality Improvement Committee. The Quality Improvement Committee shall consist of:

Voting Members[34]

a. the Chairs of the respective Medical Staff Departments, or their designee(s), Medical Director of Skilled Nursing Facility; and Chair of the Utilization Management Committee.

b. the CEO to represent Medical Center Administration, and liaison with Governing Body;

c. Administrative Vice Presidents for Ambulatory Services, Ancillary/Support Services, Skilled Nursing Facility Services, Patient Care Services, and Quality Department, or their designee(s).

Nonvoting Members
Others including Nursing Executives, Administration, Quality Management, and as may be recommended by the Quality Improvement Committee itself, the Chief of Staff or the Medical Executive Committee.

2. Duties

The Quality Improvement Committee shall perform the following duties:

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[32] M.E.C. revision 01/23/2001. M.E.C. revision of name only 09/10/2002.

[33] M.E.C. revision 09/09/2003.

[34] M.E.C. revision re: voting designation 12/13/2005

a. receive reports of all Medical Staff and departmental quality assessment and improvement activities;

b. monitor and evaluate the effectiveness and adequacy of quality review activities conducted throughout the Division of Medical Centers and Clinics, including Medical Staff responsibilities;

c. refer to the appropriate Medical Staff or other committee the responsibility for assessing concerns and monitoring resolutions;

d. identify trends and priorities for improvement;

e. submit quarterly reports to the Medical Executive Committee on quality review activities;

f. annually review the Division of Medical Centers and Clinics' Quality Improvement Plan for comprehensiveness.

g. recommend approval of action plans for root cause analyses and focus reviews.[35]

3. Meetings

The Committee shall meet as often as necessary at the call of its Chair, but at least quarterly. It shall maintain a record of its proceedings and report its activities and recommendations to the Medical Executive Committee and the Board.

K. WELL-BEING COMMITTEE

1. Composition

a. The Well-Being Committee shall be composed of no fewer than three active medical staff members, a majority of whom, including the chair, shall be physicians and one of whom shall be a psychiatrist whenever possible.

b. Except for initial appointments, each member shall serve a term of three years, and the terms shall be staggered to achieve continuity. Insofar as possible, members of this committee shall not actively participate on other peer review or quality improvement committees while serving on this committee.

2. Duties

a. The Well-Being Committee is charged to develop a process that provides education about physician health, addresses prevention of physical, psychiatric or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. These processes should include mechanisms for the following:

- Educating medical staff and medical center staff about illness and

[35] M.E.C. addition 12/13/2005

impairment recognition issues specific to practitioners
- Self-referral by a practitioner, and referral by other medical staff and medical center staff
- Upon its own initiative, upon request of the involved practitioner, or upon request of a medical staff or department committee or officer, providing such advice, counseling or referrals to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern
- Evaluating the credibility of a complaint, allegation or concern, including such investigation as reasonably deemed necessary
- Monitoring the affected practitioner and the safety of patients until the rehabilitation or any corrective action process is complete
- Confidentiality; however, if the committee receives information that demonstrates that the health or impairment of a medical staff member may pose a risk of harm to medical center patients (or prospective patients), that information shall be referred to the Chief of Staff, who will determine whether corrective action is necessary to protect patients.

b. The Well-Being Committee shall review the responses from applicants concerning physical or mental disabilities and recommend what, if any, reasonable accommodations may be indicated in order to assure that the practitioner will provide care in accordance with the medical center and medical staff's standard of care.

3. Meetings

The committee shall meet as often as necessary. It shall maintain only such records of its proceedings as it deems advisable and shall routinely report on its activities to the Medical Executive Committee.

L. MORBIDITY AND MORTALITY COMMITTEE[36]

1. Composition

The Morbidity and Mortality Committee shall consist of clinicians from nursing, medical staff, and allied health. All appropriate members of staff are invited to attend M & M conferences, in so far as they potentially play a role in improving systems surrounding the case. Any members of the medical staff whose case has been chosen is expected to present the case at M & M unless otherwise approved by the Vice Chief of Staff. Alternatively, the medical staff member may appoint an appropriate delegate to present the case. The Chair of the Committee shall be the Vice Chief of Staff or his/her designee.

2. Duties

The duties and purpose of the Committee shall include:

a. Organizing the morbidity and mortality conference (M&M), which is a traditional forum that provides clinicians with an opportunity to discuss, with impunity, medical error and adverse events.

[36] M.E.C. addition 08/2017

b. The focus of these meetings should be on overall institutional systems and processes of care, not on individual performance.

c. The Committee will encourage the essential elements of openness, honesty and thoughtful criticism. The Vice Chief of Staff is to chair these meetings. In doing so, he/she will select appropriate cases, guide discussion, invite comments from appropriate individuals, involve and encourage staff in debate and prevent undue or unfair criticism.

d. Meetings should be used to critically analyze the circumstances surrounding outcomes of care. These outcomes may include selected deaths, serious morbidity, or significant aspects of regular clinical practice.

e. The goal of these meetings is to make recommendations that will prevent similar outcomes or adverse events, and thus improve patient safety. The meeting should not apportion blame to individuals.

f. Participants shall keep in mind the information within this conference is privileged and confidential. Please see terms of Confidentiality in the Rules and Regulations.

3. Meetings

Morbidity and Mortality review should meet as often as necessary at the call of its Chair, but at least quarterly. There shall be due notice to make sure the maximum number of participants can attend. This may change due to the caseload at any time. Minutes of meetings should be written from the assumption that they could potentially become public documents. This means writing the minutes in a style which avoids statements of blame and concentrates on the actions arising from the deliberations. A sign in sheet will be mandatory.

M. GRADUATE MEDICAL EDUCATION COMMITTEE [GMEC]

1. Composition

The Committee shall consist of physicians and other staff members as the Medical Executive Committee may deem appropriate. Providers who routinely support participants in clinical training programs, supervising physicians, clinic managers, Infection Control manager, Medical Staff Services manager, and others as deemed appropriate.

2. Duties and Purpose

The purposes and duties of GMEC shall be:

Purposes:

a. To provide communication with the medical staff and governing board about the safety and quality of patient care, treatment, and services provided by participants of graduate medical education (GME) programs, and the related educational and supervisory needs of GME participants.

b. To support and oversee activities of the individual clinical training programs.

c. To monitor, including establishing and maintaining appropriate oversight of, and advising on clinical education, compliance with the Accreditation Council for Graduate Medical Education (ACGME) Residency Review Committees (RRC), and Health System requirements.

Duties:

a. Develop and review policies and procedures that affect both ACGME-accredited and other clinical training programs and their trainees, including but not limited to:
i. defining a process for supervision and appropriate autonomy of GME participants involved in patient care responsibilities by a licensed independent practitioner with appropriate clinical privileges,
ii. ensuring written descriptions of the roles, responsibilities, and patient care activities of GME participants are appropriately communicated to medical staff and hospital staff.

b. Coordinate and monitor regular reviews of all residency and clinical training programs with regards to compliance with institutional policies.

c. Maintain oversight of and liaison with clinical program directors

d. Review and approve changes to training programs which could affect educational quality or require ACGME approval

e. Request that programs provide information on GME participants for quality assurance/improvement programs

f. Provide a mechanism for SMC Health System to communicate information to the program(s) about the quality of prevention and treatment services performed by GME participants, and educational needs of GME participants.

g. Provide a forum for exchange of information among all parties involved in graduate medical education

h. Review letters or reports concerning all clinical training programs and monitor action plans for correction in areas of non-compliance, and demonstrate compliance with any residency review committee citations.

i. Provide a mechanism for SMC Health System to communicate information to the program(s) about applicable compliance and regulatory requirements related to hospital reimbursement of GME participant activities.

Meetings:

The GMEC will meet as often as necessary but at least quarterly each year. Minutes of meetings, as appropriate will be maintained.

Original June 2016
M.E.C. addition 09/2020

SECTION V- MEDICAL STAFF POLICIES

A. MEDICAL STAFF MEMBERS CODE OF CONDUCT POLICY[37]

1. Policy

San Mateo Medical Center (SMMC) Medical Staff members have a responsibility for the welfare, well-being, and betterment of their patients, along with a responsibility to maintain their own professional and personal well-being. Each Medical Staff member is expected to treat all fellow medical staff members, medical center staff, residents, students, and patients with courtesy and respect and with regard for their dignity.

When a member is not able to meet these expectations, the Medical Staff supports intervention strategies focused on restoring trust and supporting the Medical Staff member to engage in professional and productive behaviors. However, the safeguarding of patient care and safety is paramount, and the Medical Staff will enforce this policy with disciplinary measures whenever necessary.

2. Purpose

A high standard of professional behavior, ethics and integrity is expected of each individual member of the Medical Staff at SMMC. This Code of Conduct is a statement of the ideals and guidelines for professional behavior of the Medical Staff in all dealings with patients, their families, other health professionals, employees, students, vendors, government agencies, and others, aiming for the highest levels of patient care, trust, integrity and honesty.

The SMMC Medical Staff has adopted this Code of Conduct as part of our Medical Staff Bylaws in order to facilitate the highest standard of safety and quality. This document will also serve to describe the primary means for the review and discipline of members for inappropriate or disruptive behavior.

3. Definitions

Acceptable behavior is defined as behavior that enables others to perform their duties and responsibilities effectively, promotes the orderly conduct of the organization, and results in respectful and constructive communication. Examples of acceptable behavior include, but are not necessarily limited to:

- Demonstration of dignity, respect, courtesy, cooperation and presentation of a positive and professional image when dealing with all patients and coworkers.
- Respectful communication in a calm and professional manner.
- Addressing disagreements professionally, factually and timely.
- Communication with department and intradepartmental team members that is accurate and timely.

Disruptive or inappropriate behavior is defined as behavior that disrupts the operation of the Medical Center, affects the ability of others to do their jobs or to practice competently, or

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creates a hostile work environment for Medical Center employees, physicians, patients or other individuals. The Medical Staff will not tolerate disruptive behavior, which may include but is not limited to:

- Rude, vulgar or abusive conduct toward, or in the presence of, patients, nurses, medical center employees, other practitioners or visitors.
- Non-constructive criticism addressed to a recipient in a way as to intimidate, belittle or to infer stupidity or incompetence.
- Deliberate destruction or stealing of medical center property, including medical records.
- Disrupting medical center case management, committee or peer review functions.
- Disrupting medical center personnel's ability to perform their assigned functions.
- Harassment by a medical staff or Affiliate Staff member against any individual (other medical staff member, Affiliate Staff member, medical center employee, patient or visitor) on the basis of race, color, national origin, ancestry, physical disability, mental disability, Medical disability, marital status, sex, age, religion, or sexual orientation.

Sexual Harassment
Sexual harassment is not only unprofessional but may also have legal implications that transcend the authority of the Medical Staff. Sexual harassment is defined as verbal, visual or physical conduct of a sexual nature that is unwelcome and reasonably perceived by those individuals who are subjected to it or who witness it as offensive. Examples of sexual harassment include, but are not limited to:

- Verbal conduct such as the use of innuendos, epithets, derogatory slurs, off-color jokes, propositions, graphic comments, threats and/or suggestive or insulting sounds;
- Visual conduct such as the use or display of derogatory images suggestive objects or pictures; leering; and/or obscene gestures;
- Physical conduct such as making unwanted physical contact, including touching, interference with an individual's normal work and/or movement, and/or assault;
- Conduct which implies that employment, advancement, work assignments and/or employment benefits are conditional upon acquiescence in sexual activities;
- This conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.
- Retaliation for having reported or threatened to report sexual harassment.

This policy applies to behavior directed toward any individual who is associated with SMMC, including employees, colleagues, patients, families, visitors, vendors, contractors and other associates. The policy may also apply to behavior which occurs outside of SMMC physical boundaries, if it is directed toward any of the above persons, even if in a non-SMMC or non-Medical Staff sponsored setting.

Any member of the Medical Staff who engages in disruptive, inappropriate behavior or sexual harassment will be considered to be in violation of this policy. In addition, this policy may apply to a Medical Staff Member who has been deemed AWOL (not showing up to work without prior communication).

4. Procedures

a. Procedures for Reporting and Reviewing Behaviors that Undermine a Culture of Safety or Other Inappropriate Behaviors

1) The Medical Staff Leadership and SMMC Administration encourage prompt reporting of all concerns regarding unprofessional conduct. Nurses or other SMMC staff who observe or are subjected to inappropriate behavior on the part of a member of the Medical Staff will notify their supervisor or the Chief of Staff (or his/her designee). Any member of the Medical Staff who is the target of inappropriate behavior on the part of another member shall notify the Chief of Staff (or his/her designee) directly. Upon learning of a complaint of inappropriate conduct, the Chief of Staff will request, but not require, that the individual who reported the incident document it in writing. The documentation should include:

   - The date, time and location of the behavior
   - The names of all parties involved, including the name of the patient, if the behavior affected or involved a patient in any way, and or the name of any patient's family member who may have been involved, including any patient or family member who may have witnessed the incident;
   - The circumstances surrounding the incident;
   - A factual, objective description of the questionable behavior;
   - Perceived consequences, if any, of the behavior with respect to patient care, personnel, or medical center operations;
   - Any action taken to intervene or to remedy the situation;
   - The name and signature of the individual reporting the complaint of inappropriate conduct.

2) The Chief of Staff (or his/her designee) will review the report and other pertinent documentation. The Department Chair and or-Section Chief may be involved in the review, if appropriate. The Chief of Staff (or his/her designee) may contact the accused Medical Staff member, the individual who prepared the document, and/or any witnesses to the incident, to ascertain the details, and all perspectives relating to this complaint. A representative from the Quality may assist in the review. Other physicians or medical center staff may be requested to assist at the discretion of the Chief of Staff.

   At all times the Chief of Staff (or his/ her designee) will protect any person who raises a concern honestly. Honest reporting does not mean that you have to be right when you raise a concern, one just has to believe the information provided is accurate. It is a violation of the Code for either party to knowingly make a false accusation, lie to investigators, or interfere or refuse to cooperate with a Code investigation. The accused medical staff member will be presumed innocent until all the above information has been obtained.

   If an aggrieved individual or witness is an SMMC employee, the Chief of Staff and other Medical Staff representatives will work cooperatively with the SMMC administration to *facilitate the support of SMMC's legal responsibilities as an employer*. The individual who has made the complaint will be informed that confidentiality will be respected, generally, but that the substance of the complaint, and possibly the identity of the complainant and witnesses, will be shared with the Medical Staff member involved. It will also be stated that there

will be no tolerance for retaliation, and that any such conduct is to be reported immediately to Employee Relations in HR, the appropriate manager, and/or the Chief of Staff or his/her designee, so that appropriate action can be taken.

The initial review done by the Chief of Staff or his/ her designee shall be completed as soon as is reasonably possible or within at least ten (10) business days. After this initial review has been completed, the Chief of Staff and/or his/her designee, such as the Vice Chief of Staff, the Department Chair or Specialty Chief, and/or the Department Vice Chair, will speak with the Medical Staff Member in accordance with the Stepwise Process outline below. To the extent that the initial review does not yield enough reliable information to support reasonable conclusions, further review, including additional witness interviews, will be conducted as warranted.

3) The member of the Medical Staff who is alleged to have engaged in behavior that undermines a culture of safety or other inappropriate behaviors will be informed that neither the Medical Staff nor SMMC will tolerate any retaliation towards or intimidation of any individual who has registered a complaint or who has cooperated in the review process. The individual registering the complaint will be informed that he/she should immediately contact Risk management, the appropriate manager, and/or the Chief of Staff if he/she believes that any further violation of the Policy has occurred or if retaliation occurs.

4) Stepwise Process for discussion with Medical Staff member and Developing an Action Plan

Note: Every effort will be made to accommodate the Medical Staff member with respect to scheduling meetings. At most, however, three attempts at scheduling a meeting will be made. Thereafter, the meeting will be scheduled by the Chief of Staff, and attendance will be mandatory.

a) **Step 1: First Occurrence:** (if the complaint or allegation involves serious misconduct, as determined by the Chief of Staff and/or the Department Chair or Section Chief, proceed immediately to Step 2):

The Department Chair and/or Section Chief or designee will converse, in person or by telephone, with the Medical Staff member to discuss the incident(s) in question in a collegial manner. If a meeting is held, a summary of the complaint and a copy of this Policy will be available at the meeting. The perspective of the Medical Staff member will be taken into consideration. The Medical Staff member will be counseled by the Department Chair and/or Section Chief or designee at the time of discussion, if warranted. At the conclusion of the discussion, the Department and/or designee may:

- Determine that no further action is warranted;
- Plan to obtain further information about the incident;
- Based on the nature of the issue, refer the Medical Staff member to
- MEC or the Wellness Committee; or
- Immediately proceed to Step 2, 3, or 4, depending upon the seriousness

- of the situation.

The Chief of Staff or his/her designee will submit a memo regarding the discussion and action taken, if any, including any counseling of the Medical Staff member, to the confidential peer review section of the member's credentialing file. A Medical Staff Counseling Form will be attached to the memo. At the discretion of the Chief of Staff or his/her designee, a follow-up letter outlining the outcome of the meeting may be sent to the Medical Staff member.

b) **Step 2: Second Occurrence** (or first occurrence, depending on the seriousness of the complaint):

The Chief of Staff, the Vice Chief of Staff, Department Chair and/or Section Chief and appropriate medical center personnel shall be apprised of the incident.

The Chief of Staff, the Vice Chief of Staff, Department Chair and/or Section Chief, and other members of the Medical Staff and SMMC staff at the discretion of the Chief of Staff shall meet with the practitioner to discuss the incident. The perspective of the Medical Staff member will be taken into consideration. The Medical Staff member will be counseled by the Chief of Staff, Vice Chief of Staff and/or Department Chair and/or Section Chief at the time of the meeting, if warranted.

The Chief of Staff or his/her designee may then:

- Determine that no further action is required;
- Issue a letter of warning or reprimand;
- Require a written apology to the target of the inappropriate behavior;
- Based on the nature of the issue, refer the Medical Staff member to the Medical Staff Assistance Committee; and/or
- Depending on the seriousness of the situation proceed to Step 3 or 4.
- The Chief of Staff or his/her designee will submit a memo regarding the meeting and action taken, if any, including any counseling of the Medical Staff member, to the practitioner's credentials file.

c) **Step 3: Third Occurrence** (or first or second occurrence, depending on severity of complaint):

The Chief of Staff, the Vice Chief of Staff, Department Chair and/or Section Chief, and appropriate medical center personnel, including the Chief Medical Officer, the CEO/and/or the COO, shall be apprised of the incident. A thorough review will be completed. The Chief of Staff, Vice Chief of Staff, Department Chair and/or Section Chief, and other members of the Medical Staff and SMMC staff at the discretion of the Chief of Staff shall meet with the Medical Staff member to discuss the incident and any related issues, such as a history of similar complaints or prior remedial efforts.

The findings will be presented to the MEC and the Medical Staff member will be invited to meet with the MEC to discuss the complaint. Previous complaints and the Medical Staff member's entire confidential peer review section of the member's credentialing file may be considered. Deliberation by the MEC will then result in one of the following:

- Any or all of possibilities 1 through 4 outlined in Step 2, above; or
- Proceed to Step 4 (below).

d) **Step 4: Fourth Occurrence** (or first, second, or third depending on severity of complaint)

All parties as listed in Step 3 will be apprised of the incident. A thorough review of the incident will be completed. The findings will be presented to the MEC, and the Medical Staff member will be invited to meet with the MEC to discuss the complaint and any related issues, such as a history of similar complaints or prior remedial efforts. If, after careful review, the complaint appears to be valid, corrective action may be taken or recommended, as the MEC determines to be reasonable and warranted, pursuant to the Medical Staff Bylaws. This may include suspension, revocation or restriction of the practitioner's privileges. The practitioner will be afforded all notices, information and rights under the Medical Staff Bylaws to the extent provided therein.

Once a report has been generated and inappropriate and/or disruptive behavior was felt to have occurred, the CMO or Chief of Subspecialty Services/ Ambulatory Care and the Medical Director, Department Chair or COS (and his / her designee) should all meet with the member of the medical staff in question. This assures involvement of both administration and Medical Staff in these significant events. The identified individuals will communicate:

- The inappropriate behavior
- The expected behavior going forward
- The consequences of any repeat conduct
- Any necessary monitoring or follow-up

The substance of the meeting shall be documented in written form and placed in the provider's credentialing file. The medical staff member will be given a written summary of the meeting and a copy of this Policy in a timely fashion, in no case more than 30 days from receipt of the concern. The subject shall be offered an opportunity to provide a written response to the concern, and any such response will be kept along with the original concern in all relevant files.

The Medical Staff member will be notified that attempts to confront, intimidate, or otherwise retaliate against the person who brought for the concern is a violation of this Code of Conduct and may result in corrective action for the Medical Staff member.

Department Chairs and or Chiefs of Service will be kept informed regarding concerns brought forth naming their member s. This should always occur at the

time of final disposition (for routine complaints), but the Chair or Chief will also be informed earlier in the process when indicated by the seriousness or repetitive nature of the incident.

5) Consequences

a) The COS (or his / her designee) jointly with the CMO (or his / her designee) may mandate interventions to support behavioral change, such as anger management training, psychiatric evaluation, drug testing, privilege probation, or any other intervention that ensures patient safety and/or provider rehabilitation. If the ability to practice medicine is restricted, the County Counsel shall be contacted about the need to report under the California Business and Professional Code Section 805.

b) If interventions to support behavioral change are mandated, an informational report shall be made by the COS to the MEC in closed session. On a case-by-case basis, involvement of the CMO or administration is allowed.

c) If this is the first incident of inappropriate behavior, administration or the COS or designee shall discuss the matter with the offending Medical Staff member, emphasizing that the behavior is inappropriate and must cease. The offending Medical Staff member may be asked to apologize to the complainant. The approach during this initial intervention should be collegial and helpful.

d) Further isolated incidents that do not constitute persistent, repeated inappropriate behavior will be handled by providing the named Medical Staff member with notification of each incident, utilizing the process outline above, and a reminder of the expectation the individual will comply with this Code of Behavior.

e) If anyone determines the Medical Staff member has demonstrated persistent, repeated inappropriate behavior, constituting harassment (a form of disruptive behavior), or has engaged in disruptive behavior on the first offense, and following the process outlined above, the COS or designee will advise the Staff Member that such behavior must immediately cease, or corrective action will be initiated. This "final warning" shall be sent to the named Medical Staff member in writing.

f) If after the "final warning" the disruptive behavior recurs, corrective action (including possible suspension or termination of privileges) shall be initiated pursuant to the Medical Staff bylaws of which this Code of Conduct is a part, and the Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws. Upon the discretion of the COS, this can involve a required appearance of the subject of the concern before a closed session of the MEC.

g) If a single incident of disruptive behavior or repeated incidents of disruptive behavior constitute an imminent danger to the health of an individual or individuals, the named Medical Staff member may be summarily suspended as provided in the Medical Staff Bylaws. The Medical Staff member shall have all of the due process rights set forth in the Medical Staff Bylaws.

h) A confidential file summarizing the disposition of the concern, along with copies of any written warnings, letters of apology, and written responses from the offending Medical Staff member, shall be retained in the MSO for up to five years. This will be part of the provider's credentialing file. Upon written request, the provider is permitted access to this credentialing file with proctoring.

b. Awareness of the Code of Conduct:

The Medical Staff shall, in cooperation with the medical center, promote continuing awareness of this Code of Conduct among the Medical Staff and the medical center community, by:

1) Sponsoring or supporting educational programs on disruptive behavior to be offered to Medical Staff members and medical center/ contracted employees;

2) Disseminating this Code of Conduct Policy to all current Medical Staff members upon its adoption and to all new applicants for membership to the Medical Staff.

3) Encouraging both Administration, Contracted Services, Medical Directors, Service Chiefs, Department Chairs and Medical Staff leadership to assist members of the Medical Staff exhibiting inappropriate or disruptive behavior to obtain education, behavior modification, or other treatment to prevent further incidents.

4) Educating the members and the medical center staff regarding the procedures the Medical Staff and the medical center have put into place for effective communication to the medical center administration of any Medical Staff member's concerns, complaints and suggestions regarding medical center personnel, equipment, and systems.

References for Code of Conduct Policy:

1. Sequoia Hospital Medical Staff Code of Conduct, Policy, Approved 2018
2. Sutter Health-Mills-Peninsula Medical Center Behaviors Policy Statement, Approved May 2018
3. Stanford Hospital Code of Conduct, Policy, Approved: October 2007, 12115
4. California Legislative Information, Business and Professions Code 805
5. California Hospital Association, New Law and Updates for Physician Reporting Webinar, February 13, 2018 (California Business and Professions Code 805.1 & SB 798

B. COMPLETION OF THE MEDICAL RECORD[38]

Refer to Section II-Medical Records, Subsection H-Completeness of the Record.

C. DISASTER PRIVILEGES[39]

1. General:

It is the policy of San Mateo Medical Center to permit the Chief Executive Officer (or designee) to grant disaster privileges on a case-by-case basis based upon the recommendations of the Chief of Staff (or designee) when the medical center's disaster plan has been activated and the organization is unable to handle the immediate patient care needs. This policy outlines San Mateo Medical Center's plan to grant disaster privileges to individuals who do not currently possess medical staff privileges at San Mateo Medical Center but are deemed qualified and competent, for the duration of the disaster situation. Granting of these privileges will be handled on a case-by-case basis and are not a "right" of the requesting provider.

2. Procedure:

When the medical center's emergency management plan has been activated, and it has been determined that disaster privileging will be required, the following process for any licensed independent practitioner (LIP) who is not on the medical staff of San Mateo Medical Center and who presents his/herself as a volunteer to render services will be utilized:

a. The LIP who wants to request Disaster Privileges must present a valid government-issued identification issued by a state, federal, or regulatory agency (i.e., a driver's license or passport), and at least one of the following:

- Current medical center photo ID card that clearly identifies professional designation
- Current California medical license
- Primary source verification of the license
- An ID that certified the LIP is a member of a state or federal disaster medical assistance team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
- An ID that certifies that LIP has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies
- Identification by a current medical center or medical staff member who possesses personal knowledge regarding the volunteer's identity and ability to act as a licensed independent provider during a disaster

b. The Medical Staff oversees the performance and professional practice, care, and treatment and services provided by the volunteer LIP through direct observation, mentoring, and clinical record review. The Chief of Staff or designee shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster

[38] May 2015: Section V, Subsection B combined with Section II, Subsection H

[39] M.E.C. approved 05/11/2010

privileges. Based on the oversight of each volunteer LIP, the medical staff will determine how long the granted disaster privileges shall continue.

c. Volunteer Licensed Independent Practitioners granted disaster privileges will wear identification badges denoting their status as part of the Disaster Medical Assistance Team. LIP's who are already on the medical staff and who have been identified as a member of the medical staff will be provided a name badge in the event that their Medical Center's identification is not available.

d. Primary source verification of licensure and the verification process of the credentials and privileges of practitioners who receive disaster privileges occurs as soon as the immediate situation is under control. The verification process is identical to that described in Medical Staff Bylaws, Section 7.5 (Temporary Privileges) for granting temporary privileges to meet an important patient care need.

e. All disaster privileges immediately terminate once the emergency management plan is no longer activated. However, the Medical Center may choose to terminate disaster privileges prior to that time.

f. A list of all volunteer practitioners who received disaster privileges during the emergency management/disaster event will be maintained.

g. When emergency management plan has been activated, providers who receive temporary privileges pursuant to this policy will be covered for professional and general liability for acts undertaken in this capacity on behalf of San Mateo Medical Center.

D. MEDICAL STAFF PEER MONITORING[40]

1. Purpose

Implementation of a Continuous Quality Program for the Medical Staff including Affiliates to the Medical staff that through the activities of the Medical Staff, the Ongoing Professional Practice Evaluation (OPPE) of individuals granted clinical privileges are assessed, Focused Professional Practice Evaluation (FPPE) of individuals with clinical privileges is conducted; and the results of such assessments and evaluations is used to improve professional competency, practice, and care.

2. Policy

San Mateo Medical Center Medical Staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance. Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. Relevant information resulting from the focused professional practice evaluation (FPPE) process is integrated into performance improvement activities, consistent with policies and

[40] M.E.C. 07/13/2010

procedures that are intended to preserve confidentiality and privilege of information.

3. Definitions

    a. Ongoing Professional Practice Evaluation (OPPE) is the routine monitoring and evaluation of competency for current medical staff. Ongoing professional practice evaluation includes a documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke existing privileges prior to or at the end of the two-year reappointment cycle.

    b. Focused Professional Practice Evaluation (FPPE) is the time-limited evaluation of a practitioner's competence in performing any specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care.

    c. Peer Review is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care.

4. Procedure

    a. All peer review information is privileged and confidential in accordance with medical staff and medical center bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

    b. Peer review will be conducted in a timely manner. The goal is for review of routine cases to be initiated and the initial review completed within 14 days from the date the Peer Review Form is generated. When the case is sent for referral, review of the case should be completed within 60 days. Exception may occur based on case complexity or reviewer availability.

    c. The involved practitioner will receive practitioner-specific feedback as needed.

    d. The Medical Staff will use the practitioner-specific peer review results in making its recommendations to the governing board regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.

    e. The medical center will keep practitioner-specific peer review and other quality information concerning a practitioner in a secure, locked file.

    f. Only the final determinations of the medical staff departmental quality review committees and the Credentials Committee, and any subsequent actions are considered part of an individual practitioner's quality file.

    g. Peer review information in the individual practitioner quality file is available only to

authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or medical center employee to the extent necessary to carry out their assigned responsibilities.

h. No copies of peer review documents will be created and distributed unless authorized by medical staff or medical center policy.

5. Conflict of Interest

a. It is the obligation of the individual reviewer or committee member to disclose to the committee a potential conflict of interest. For example, it is a conflict of interest if the reviewer may not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the practitioner involved as a direct competitor or partner.

b. It is the responsibility of the medical staff departmental quality review committee to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participation. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decision other than to provide specific information requested.

6. Ongoing Professional Practice Evaluation [OPPE]

a. Medical Staff approved clinical indicators: The medical staff has approved indicators for the departments/services (see Appendix A). Cases are identified by the Quality Management Department and other sources, and are forwarded to the Medical Staff Office for peer review (see Appendix B).

b. Adverse events including a sentinel event as defined in policy, or a near miss with potential for major or permanent injury.

c. Events required by regulatory agencies to be reported

d. Cases identified by external third party quality reviews

e. Unusual Occurrence Reports of clinically significant events

f. Significant patient/family or staff complaints

g. Autopsy findings

h. Results of blood utilization review

i. Results of pre-op and post-op diagnosis review

j. Medical records completion data

k. Process measures for evidence-based practices including core measures

l. Continuing medical education

m. An unusual, adverse, egregious individual case or clinical pattern of care as defined by the medical staff department chairs, specialty chiefs, QIC Committee Chair, or Chief Medical Officer

n. Correspondence regarding commendations and patient complaints.

o. And other metrics decided by medical staff leaders in the Departments given the data is readily available by the Quality Management Department and collected at the level of the individual provider.

7. Focused Professional Practice Evaluation [FPPE]

FPPE is initiated for all initially requested privileges and when the results of ongoing professional practice evaluation trigger additional review. FPPE includes each of the following elements:

a. Criteria for conducting performance monitoring

1) Criteria for new providers
- New members of the Medical Staff shall remain on the provisional staff for a period of one year
- During the term of provisional appointment, the person receiving the provisional privileges shall be monitored by the Chief of Service/Department Chair in which he has clinical privileges, and by the medical staff departmental peer review committees as to his clinic competence, general behavior, and conduct in the medical center. Monitoring shall include all aspect of medical care.
- Surgeries will be directly and concurrently proctored by a member of the active medical staff as assigned by the chief of the appropriate service.
- The chief of service/department chair shall design a proctoring program that reflects the education and experience of the applicant. When needed the proctoring program will be reviewed by the Credentials Committee and will become part of the recommendation for provisional appointment. Monitoring of other aspects of medical care will be performed by the medical staff departmental quality review committee that is conducting the peer review. The Credentials Committee shall review the performance of the provisional staff member.

2) Criteria for new privileges

Criteria are established by the medical staff for monitoring all initially requested privileges. These criteria include proctoring, chart review and discussion with others involved in the care of patients.

3) Criteria for existing privileges

Quality Management Department and other services will collect OPPE data on an ongoing basis; analyze and aggregate data by medical staff member (including affiliate staff) and report the results to the medical staff department chairs. The organized medical staff defines the frequency for data collection. However, the timeframe for review of the data cannot exceed every 12 months.

If the results of OPPE indicate a potential issue with practitioner performance, medical staff departmental quality review committee(s) may initiate a FPPE to determine whether there is a problem with current competency of the practitioner for either specific privileges or for more global dimensions of performance.

If the results of individual case reviews for a practitioner exceed thresholds established by the medical staff as described below, the department will review to determine whether further focused review is needed.

The triggers for further review include:

- For rate-based indicators, practitioners whose rate is greater than two standard deviations above the aggregate rate will be identified for review by the peer review committee. The denominator is the total number of procedures or visits for a practitioner over a twelve month period. The numerator is the total number of cases identified for review. The rate will be compared to the aggregate rate for all selected practitioners for the same period.
- Practitioners that have had at least one case referred for review based on the current rating system outlined on the Case Review Form within the review period will be identified for the peer review committee to determine whether further focused review is needed.
- Single incidents will also be triggers for medical staff departmental peer review. These include sentinel events, wrong side-site procedures, and significant departures from established standards of professional behavior.

b. Method for establishing the specific monitoring plan

The service chief is responsible for establishing a monitoring plan specific to the requested privilege or specific to a given practitioner when the results of OPPE require focused review. The monitoring plan is reviewed and approved by the service/department quality review committee.

c. Method for establishing the duration of performance monitoring

The service chief is responsible for establishing a monitoring timeframe or duration specific to the requested privilege or specific to a given practitioner when the results of OPPE require focused review. The duration is part of the monitoring plan reviewed and approved by the service/department peer review committee.

d. Circumstances requiring external peer review

The Medical Executive Committee (MEC), Credentials Committee, or any peer review committee can make determinations on the need for external peer review. These determinations will be forwarded to the Quality Management Department and Chief Medical Officer for review and recommendation. No practitioner can require the medical center to obtain external peer review if it is not deemed appropriate by the MEC. Circumstances requiring external peer review may include the following:

1) Litigation – cases involving litigation or the potential for a claim as determined by risk management

2) Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner's membership or privileges

3) Lack of internal expertise – when no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above.

4) New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the medical center and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.

5) Miscellaneous issues – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

E. EXPEDITED CREDENTIALING PROCESS

1. Purpose

To ensure the timely processing of applications for appointment/reappointment and granting of privileges to the Medical Staff and Affiliate Licensed Independent Practitioners at San Mateo Medical Center.

2. Scope

This policy applies to physician, dentist and Affiliate members of San Mateo Medical Center who fulfill the criteria for expedited credentialing and privileging.

3. Procedure

Appointment to the Medical/Affiliate Staff and Requests for Clinical Privileges:
Applications for appointment and requests for clinical privileges shall be processed as expedited when the following criteria are met:

- A complete application is received;

- All primary source verifications are received;
- There is no current challenge or previously successful challenge to
- licensure or registration;
- The applicant has not received an involuntary termination of
- medical/allied staff membership at another organization;
- The applicant has not received involuntary limitation, reduction, denial, or loss of clinical privileges; or
- The medical center determines that there has not been either an unusual pattern of, or an excessive number of professional liability actions resulting in a final judgment against the applicant. The Credentials Committee will be made aware of any malpractice claims that a new applicant has had regardless of number.

4. Quality Management

Quality Department supports the Practitioner Evaluation Process by:

- Providing aggregate data for rate-based indicators
- Providing referral cases for review
- Providing the Medical Staff Office data for practitioner files

APPENDIX A

Service Indicators

Department of Emergency Medicine
Department of Medicine
Department of Primary Care/Community Medicine
Department of Psychiatry
Department of Surgery

Specialty of Pediatrics
Specialty of Adolescent Medicine
Specialty of Family Practice
Specialty of Primary Care/ Internal Medicine
Specialty of Public Health/ Preventative Medicine
Specialty of Cardiology
Specialty of Critical Care
Specialty of Dermatology
Specialty of Endocrinology
Specialty of Gastroenterology
Specialty of Infectious Diseases
Specialty of Internal Medicine
Specialty of Geriatrics/ Long Term Care
Specialty of Nephrology
Specialty of Neurology
Specialty of Oncology
Specialty of Pulmonary Diseases
Specialty of Radiology
Specialty of Rheumatology
Specialty of Emergency Psychiatry Services
Specialty of Inpatient Psychiatry Services
Specialty of Psychology
Specialty of Obstetrics/Gynecology
Specialty of Anesthesia
Specialty of Dentistry
Specialty of General Surgery
Specialty of Vascular Surgery
Specialty of Neurosurgery
Specialty of Ophthalmology
Specialty of Oral Surgery
Specialty of Orthopedics
Specialty of Otolaryngology
Specialty of Pathology
Specialty of Plastic Surgery
Specialty of Podiatry
Specialty of Urology

APPENDIX B

Peer Review Process for Individual Case Review

1. **Case Identification** -Referrals from Quality Management (unusual occurrence reports), case management, patient relations, Credentials Committee, and specific informal requests for review are preliminarily screened to determine if they qualify for case review based on medical staff review indicators.

2. Quality Management Department reviews referrals to determine need for practitioner review. If practitioner review is required, a Peer Review Form is generated and is routed to the Medical Staff Office for assignment of case review.

3. **Practitioner Reviewer Assignment** – Cases will be initially assigned for review based on a list maintained by Medical Staff Services. Reviewers may be assigned by the MEC, Department Chair, or Specialty Chief. If the initial reviewer determines the case has issues outside of the reviewer's expertise, the reviewer will request the MEC, Department Chair or Specialty Chief to assign an appropriate second reviewer.

4. Practitioner reviewer performs case review and completes the Peer Review Form with appropriate recommendations.

5. Reviews indicating potential controversial or inappropriate care or questions regarding practitioner care are presented to the medical staff departmental quality review committee* for discussion. If the medical staff departmental quality review committee feels that care may be controversial, or questions are raised, it will communicate with the involved practitioner(s). The involved practitioner(s) is informed of the key questions regarding the case.

6. After the initial response from the practitioner(s), if the medical staff departmental quality review committee determines it needs further clarification, it may allow the practitioner to provide a second response to specific, predetermined questions within a specified timeframe.

7. The medical staff departmental quality review committee will make the final determination of the overall practitioner care issues.

8. The rating system for determining results of individual case reviews is outlined on the Case Review Form.

9. **Communicating Findings to Practitioners** – For cases determined to be inappropriate or controversial care, practitioners are informed of the decision in a meeting with the service chief or designee. Decisions ***can be*** relayed in a letter if extenuating circumstances warrant, and this type of communication is deemed appropriate. Copies will be sent to the confidential peer review file.

10. Medical Staff Services department will enter the results of all final review findings into the database used for tracking and reappointment reports.

*The medical staff departmental quality review committees are formed by the respective departments to conduct peer review. These may be standing departmental committees or ad hoc committees convened to conduct the review. Departmental members are selected by the department chair and those who serve on these committees shall have no conflict of interest.

ADMINISTRATION REPORTS

BOARD OF DIRECTORS
SAN MATEO MEDICAL CENTER

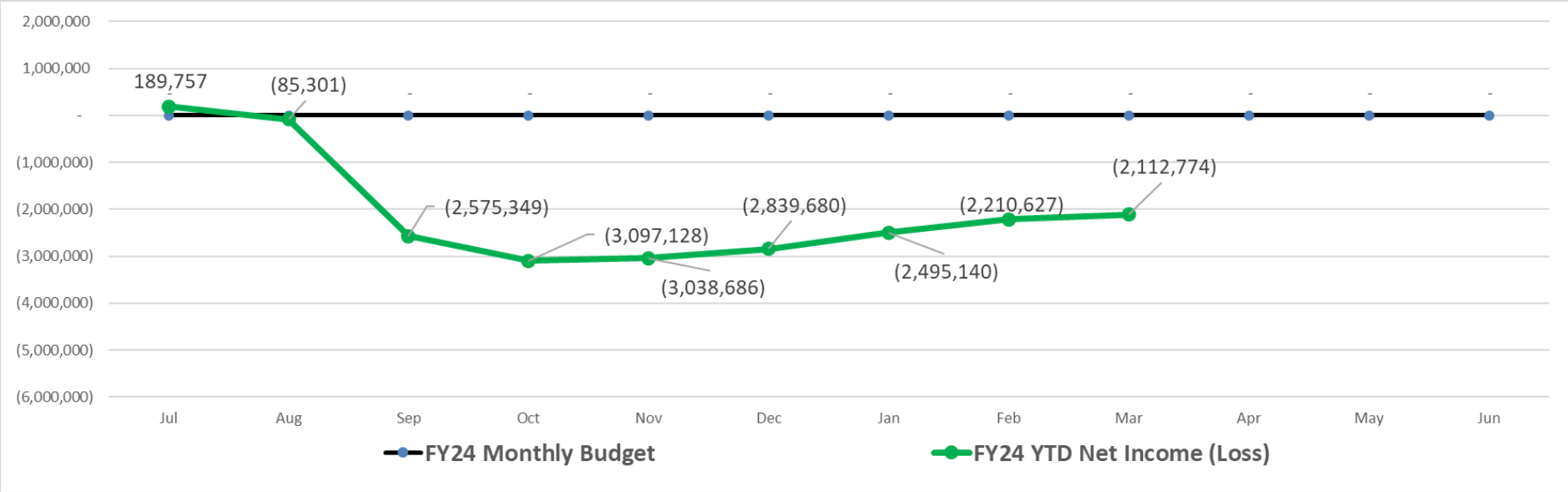
Financial Report: March FY23-24

May 6, 2024

Presenter: David McGrew, CFO

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

FY23-24 Cumulative YTD Financial Results



Net Income(loss) – Mar $97.9K, YTD ($2.1M)

- **FTEs 7% favorable**
- **Labor costs favorable by $14.6M**
- **FY2015 DSH**

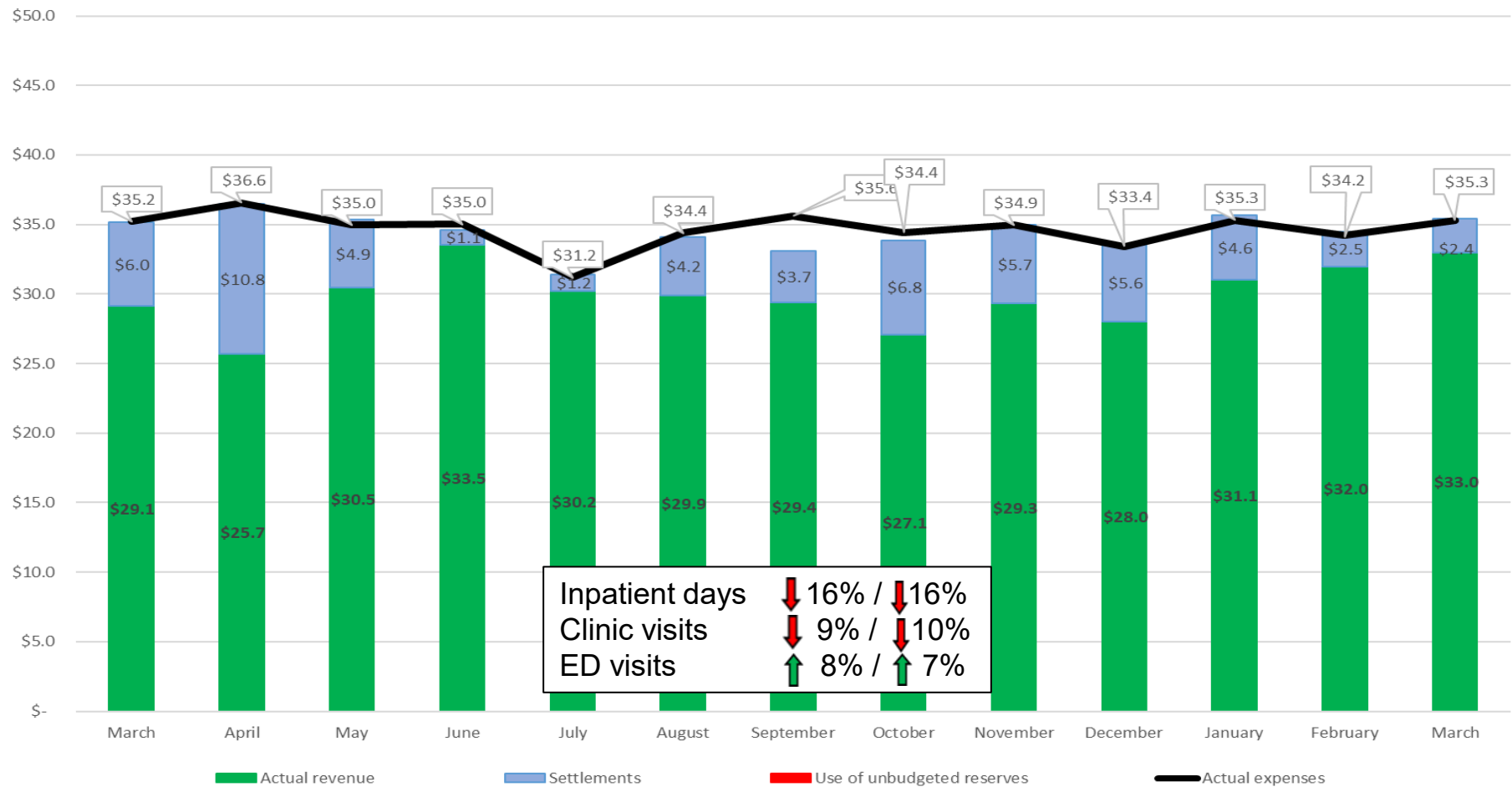
- **Drugs**
- **Supplies**
- **Debt Svc 2018 Bond**

Mar FY24 Snapshot – March is favorable to budget by $98K. SMMC still projects to be near breakeven for the full year. Nursing registry costs remain unfavorable due to the difficulties with hiring permanent nurses. Inpatient acute volume decreased as placements improved and Medical ED visits continue to be higher than budget. Managed care membership remains favorable to budget.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

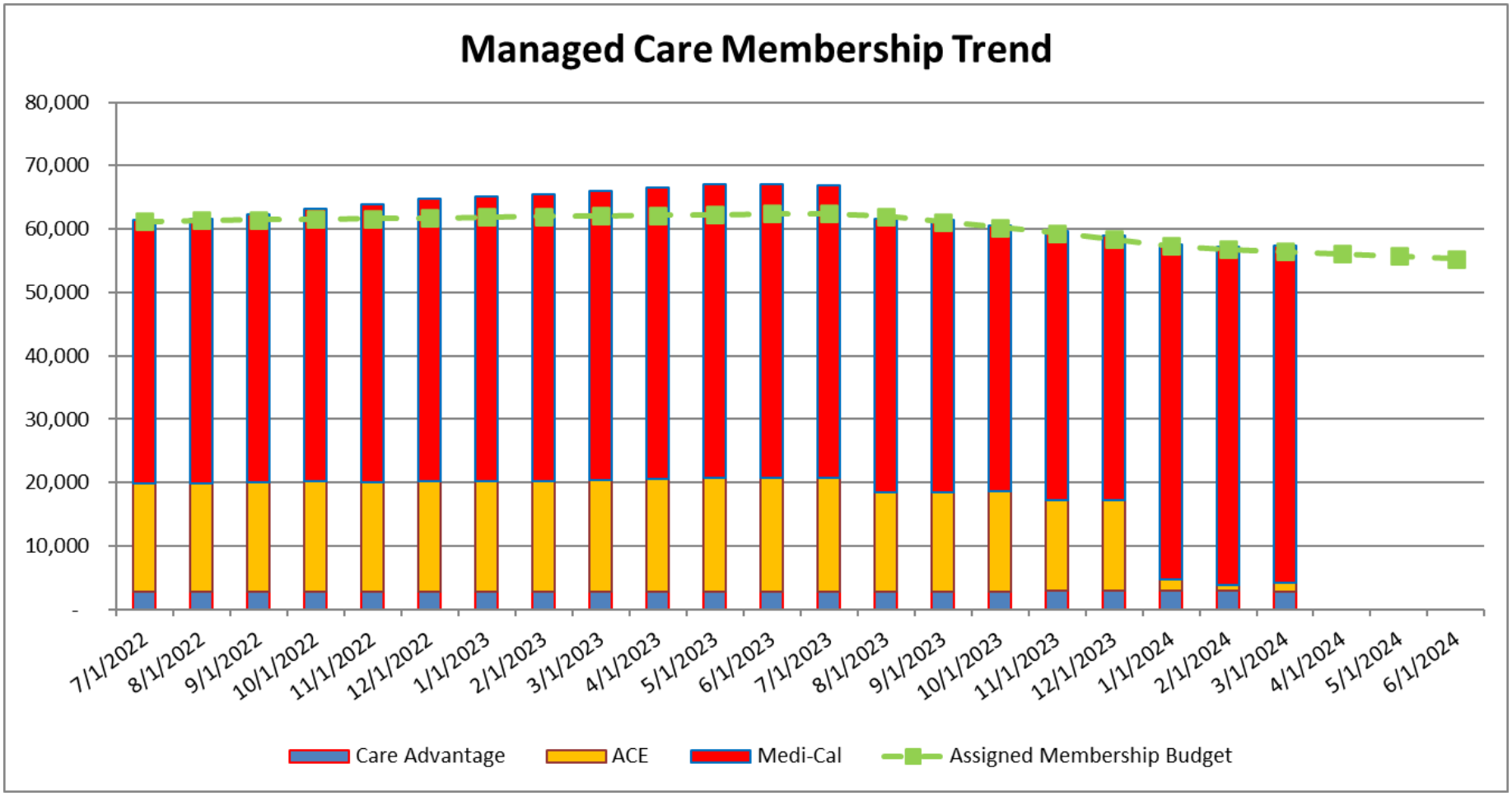
FY 23-24 Revenue & Expense Trend

SMMC's current operating revenue fluctuates around an average of $29 million (green bar). Operating expenses (black line) in FY24 are averaging $34 million per month and trending right at budget.



Note: Volume %s are Current Month/YTD actuals vs budget

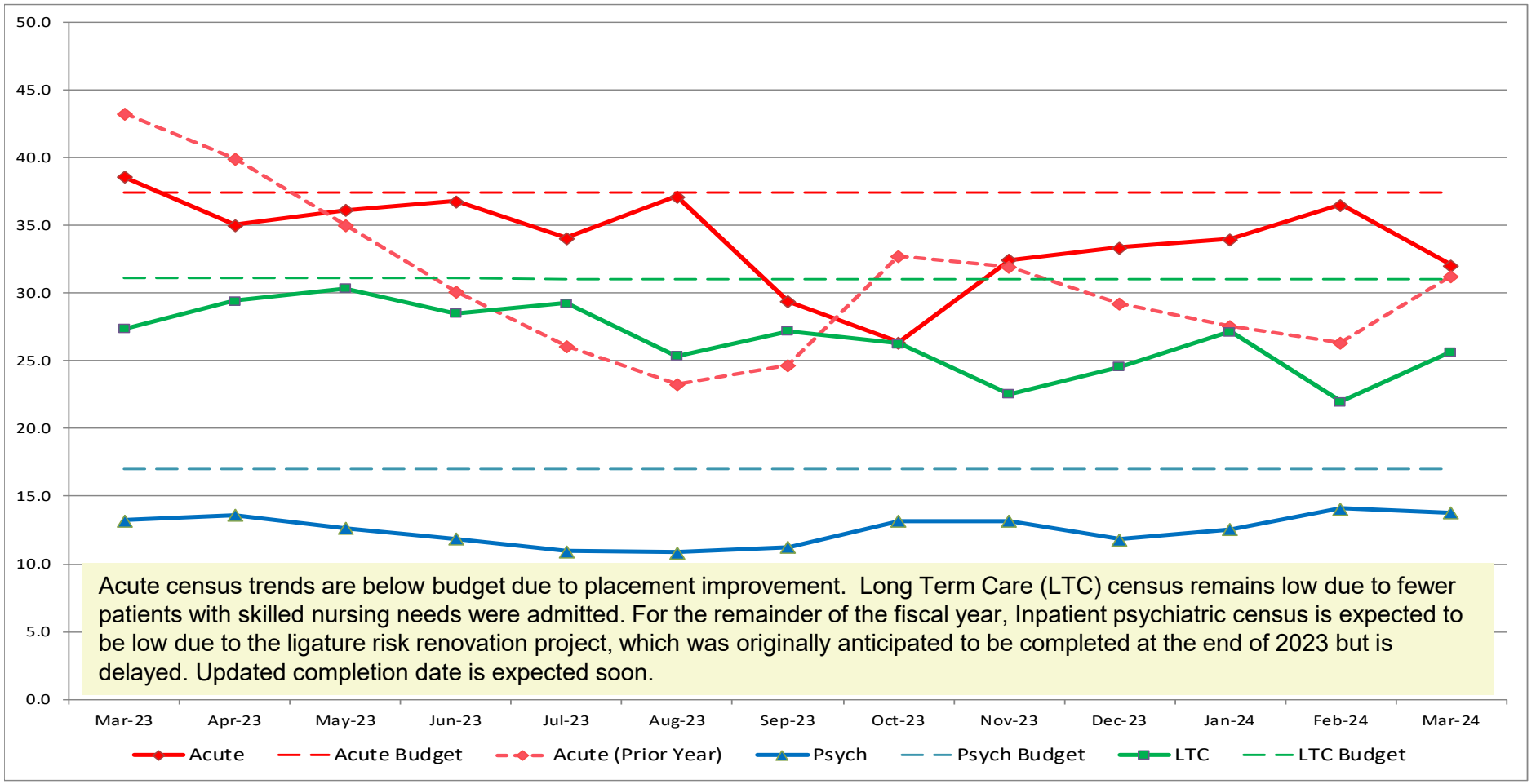
SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER



The membership in managed care programs peaked in July 2023 and started trending down since. This is a result of the State beginning the process of redetermining eligibility for Medicaid enrollees and the end of continuous enrollment that was in place during the public health emergency. In January 2024, approximately 10,000 ACE 26-49 population shifted from ACE to Medi-Cal, partially off-setting Medi-Cal assignment losses. By June 2024, total assignments losses of 7,000 are projected across all lines of business.

San Mateo Medical Center
Inpatient Days
March 31, 2024

	MONTH				YEAR TO DATE			
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
Patient Days	2,217	2,649	(432)	-16%	19,654	23,500	(3,846)	-16%

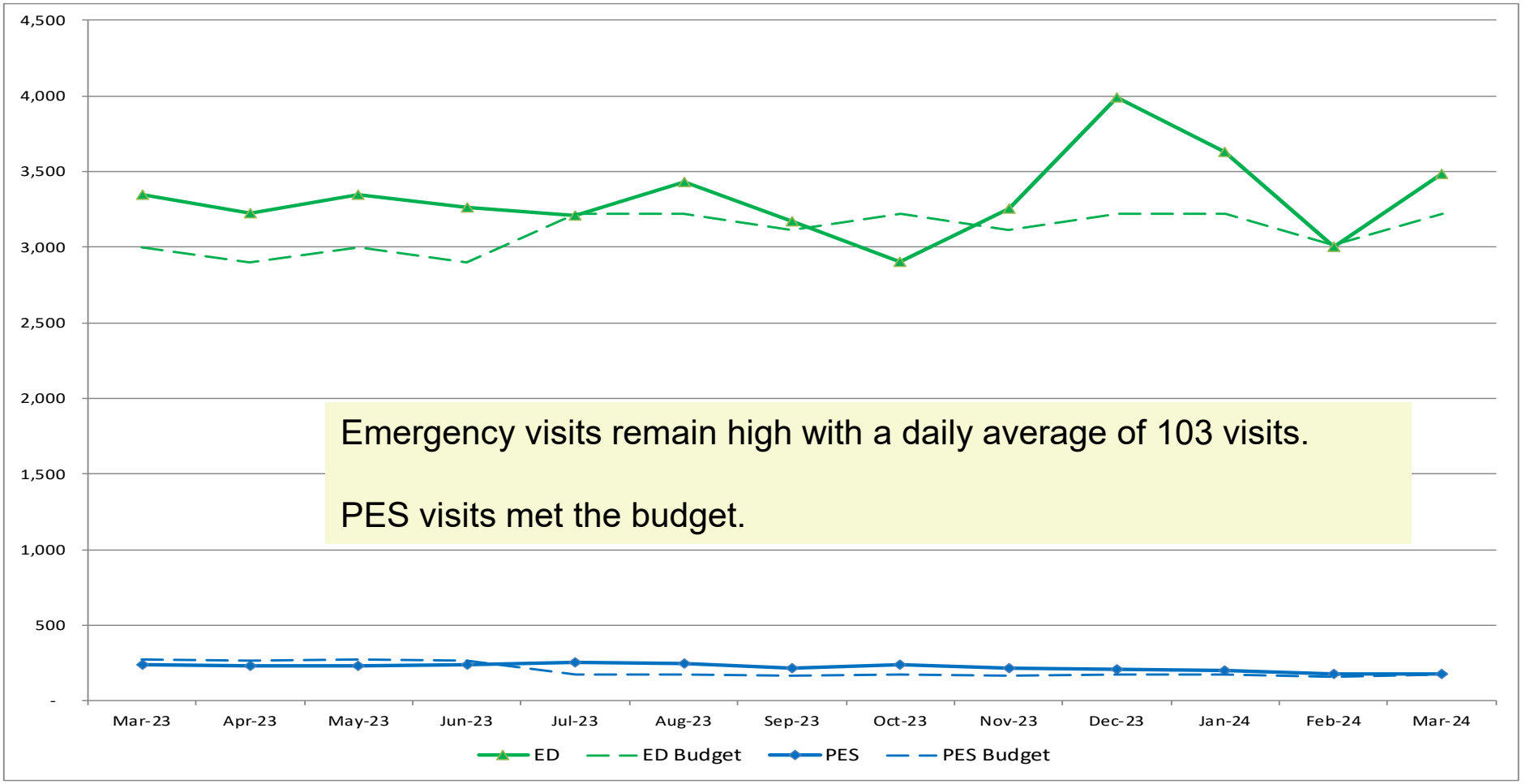


Acute census trends are below budget due to placement improvement. Long Term Care (LTC) census remains low due to fewer patients with skilled nursing needs were admitted. For the remainder of the fiscal year, Inpatient psychiatric census is expected to be low due to the ligature risk renovation project, which was originally anticipated to be completed at the end of 2023 but is delayed. Updated completion date is expected soon.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

San Mateo Medical Center
Emergency Visits
March 31, 2024

	MONTH				YEAR TO DATE			
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
ED Visits	3,657	3,389	268	8%	32,260	30,065	2,195	7%

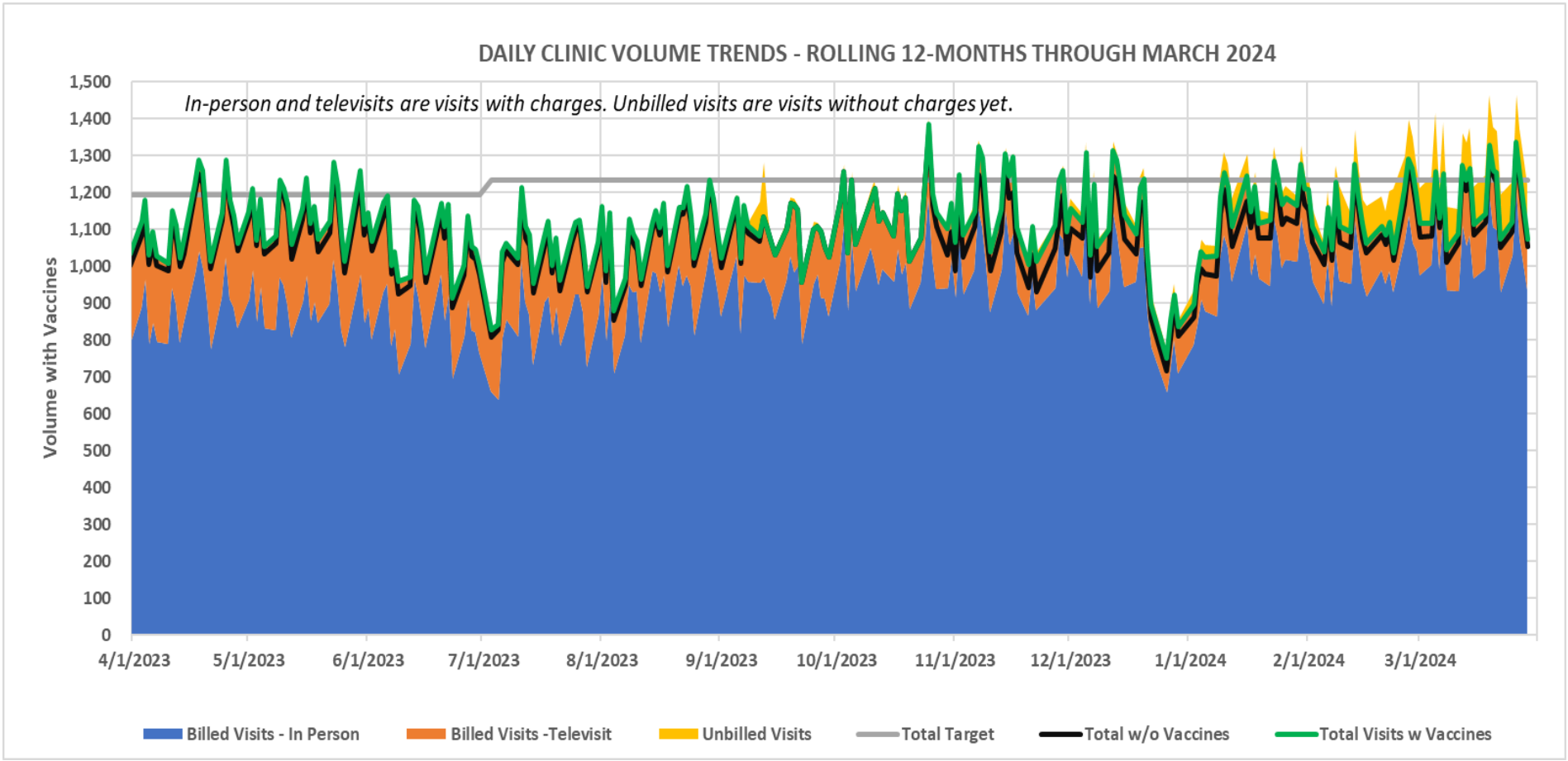


Emergency visits remain high with a daily average of 103 visits.

PES visits met the budget.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

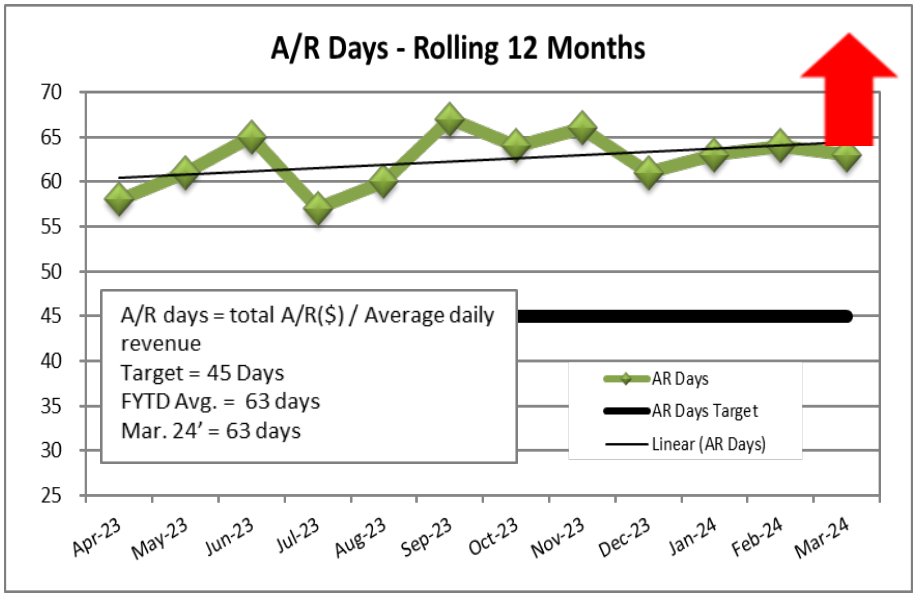
San Mateo Medical Center
Clinic Visits
March 31, 2024

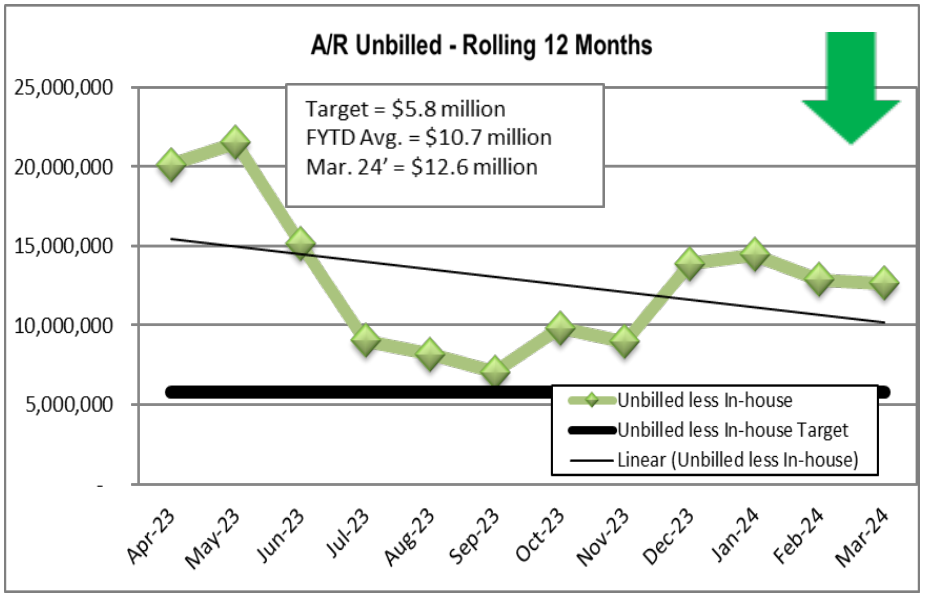


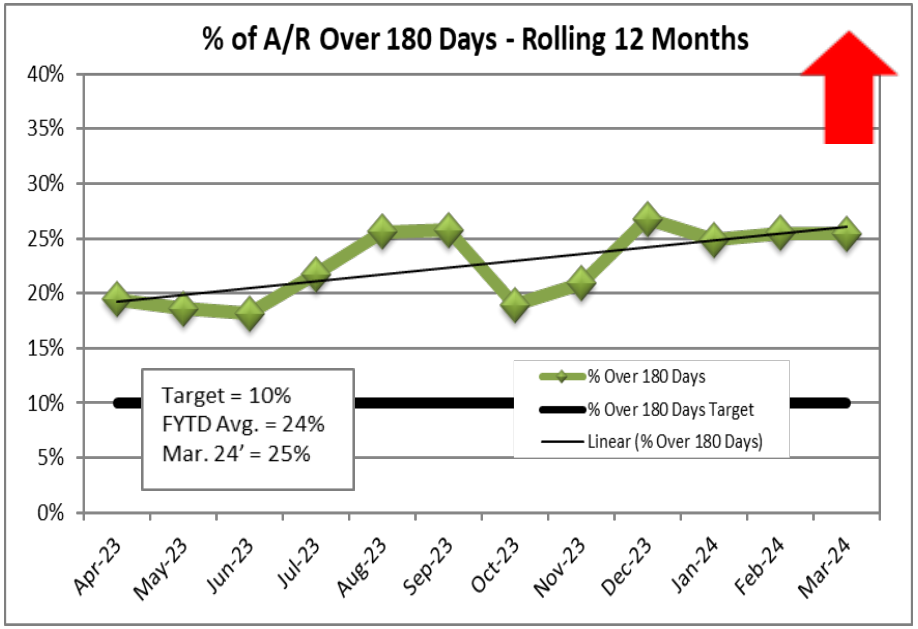
Clinic visits are 10% below budget fiscal year to date. The drop in volume in the latter half of December is due to low utilization and staff time-offs typical in holiday season. Televisits are running at 14% of total visits in FY24. Clinic televisits were 22% of total visits in FY23. Early in the pandemic the ratio was as high as 78%.

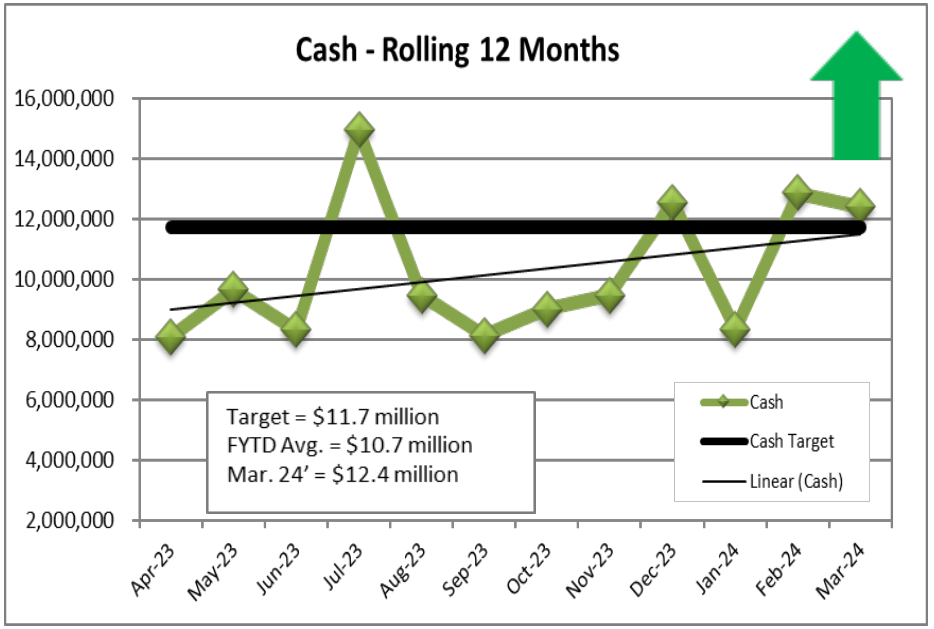
SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Fee-For-Service Revenue - KPIs

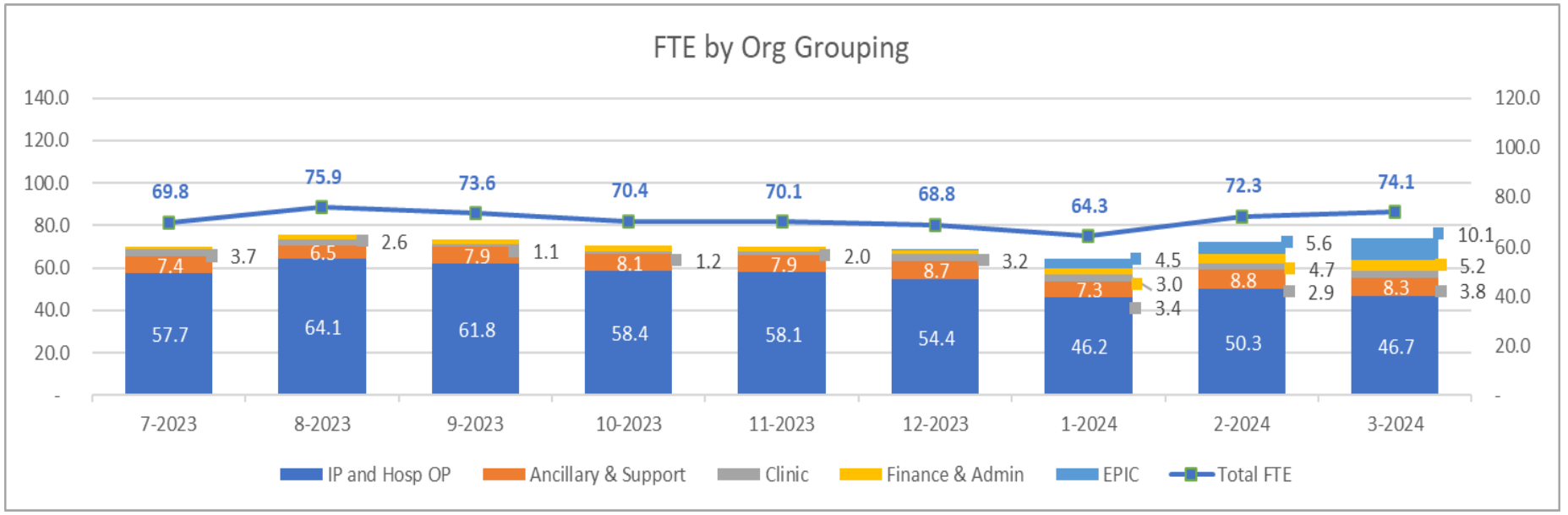


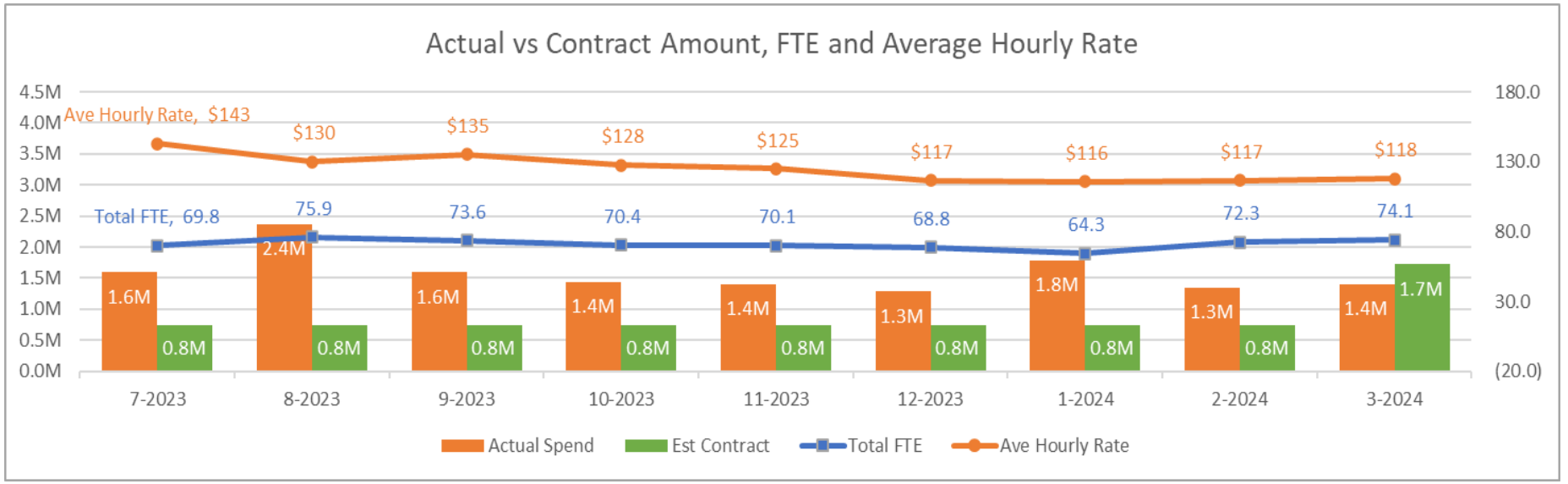






Registry Analysis





SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

APPENDIX

SAN MATEO COUNTY HEALTH
SAN MATEO
MEDICAL CENTER

San Mateo Medical Center
Income Statement
March 31, 2024

		MONTH				YEAR TO DATE			
		Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
		A	B	C	D	E	F	G	H
1	**Income/Loss (GAAP)**	97,853	0	97,853		(2,112,774)	0	(2,112,774)	
2	**HPSM Medi-Cal Members Assigned to SMMC**	53,177	51,101	2,076	4%	414,885	408,851	6,034	1%
3	**Unduplicated Patient Count**	69,696	67,727	1,969	3%	69,696	67,727	1,969	3%
4	**Patient Days**	2,216	2,649	(433)	-16%	19,653	23,500	(3,847)	-16%
5	**ED Visits**	3,658	3,389	269	8%	32,262	30,065	2,197	7%
7	**Surgery Cases**	228	283	(55)	-19%	2,002	2,505	(503)	-20%
8	**Clinic Visits**	23,533	25,939	(2,406)	-9%	207,416	229,745	(22,329)	-10%
9	**Ancillary Procedures**	74,227	67,006	7,221	11%	614,010	593,515	20,495	3%
10	**Acute Administrative Days as % of Patient Days**	17.0%	20.0%	3.0%	15%	21.0%	20.0%	-1.0%	-5%
11	**Psych Administrative Days as % of Patient Days** (Days that do not qualify for inpatient status)	91.0%	80.0%	-11.0%	-14%	88.0%	80.0%	-8.0%	-10%
	Pillar Goals								
12	**Revenue PMPM**	144	151	(8)	-5%	138	162	(25)	-15%
13	**Operating Expenses PMPM**	402	400	(2)	0%	394	387	(6)	-2%
14	**Full Time Equivalents (FTE) including Registry**	1,129	1,213	84	7%	1,134	1,213	79	7%

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

San Mateo Medical Center
Income Statement
March 31, 2024

		MONTH				YEAR TO DATE			
		Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
		A	B	C	D	E	F	G	H
21	**Inpatient Gross Revenue**	12,776,624	14,335,992	(1,559,368)	-11%	115,861,660	129,023,930	(13,162,270)	-10%
22	**Outpatient Gross Revenue**	34,946,053	30,680,132	4,265,921	14%	283,416,831	276,121,187	7,295,644	3%
23	**Total Gross Revenue**	47,722,677	45,016,124	2,706,553	6%	399,278,491	405,145,117	(5,866,626)	-1%
24	**Patient Net Revenue**	12,595,871	14,288,817	(1,692,946)	-12%	101,645,563	128,599,349	(26,953,786)	-21%
25	Net Patient Revenue as % of Gross Revenue	26.4%	31.7%	-5.3%	-17%	25.5%	31.7%	-6.3%	-20%
26	**Capitation Revenue**	590,831	510,911	79,920	16%	4,547,405	4,598,203	(50,797)	-1%
27	**Supplemental Patient Program Revenue**	14,899,408	13,312,505	1,586,903	12%	130,528,750	119,812,543	10,716,207	9%
	Volume Based (GPP, EPP, VRR, AB915)	6,914,377	6,889,343	25,034	0%	73,030,487	62,004,084	11,026,403	18%
	Value Based (QIP, HPSM P4P)	3,474,237	3,100,472	373,765	12%	32,401,424	27,904,250	4,497,173	16%
	Other	4,510,794	3,322,690	1,188,104	36%	25,096,839	29,904,208	(4,807,370)	-16%
28	**Total Patient Net and Program Revenue**	28,086,110	28,112,233	(26,123)	0%	236,721,719	253,010,095	(16,288,376)	-6%
29	**Other Operating Revenue**	1,585,074	1,182,353	402,721	34%	12,279,944	10,641,178	1,638,765	15%
30	**Total Operating Revenue**	29,671,184	29,294,586	376,598	1%	249,001,662	263,651,273	(14,649,611)	-6%

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

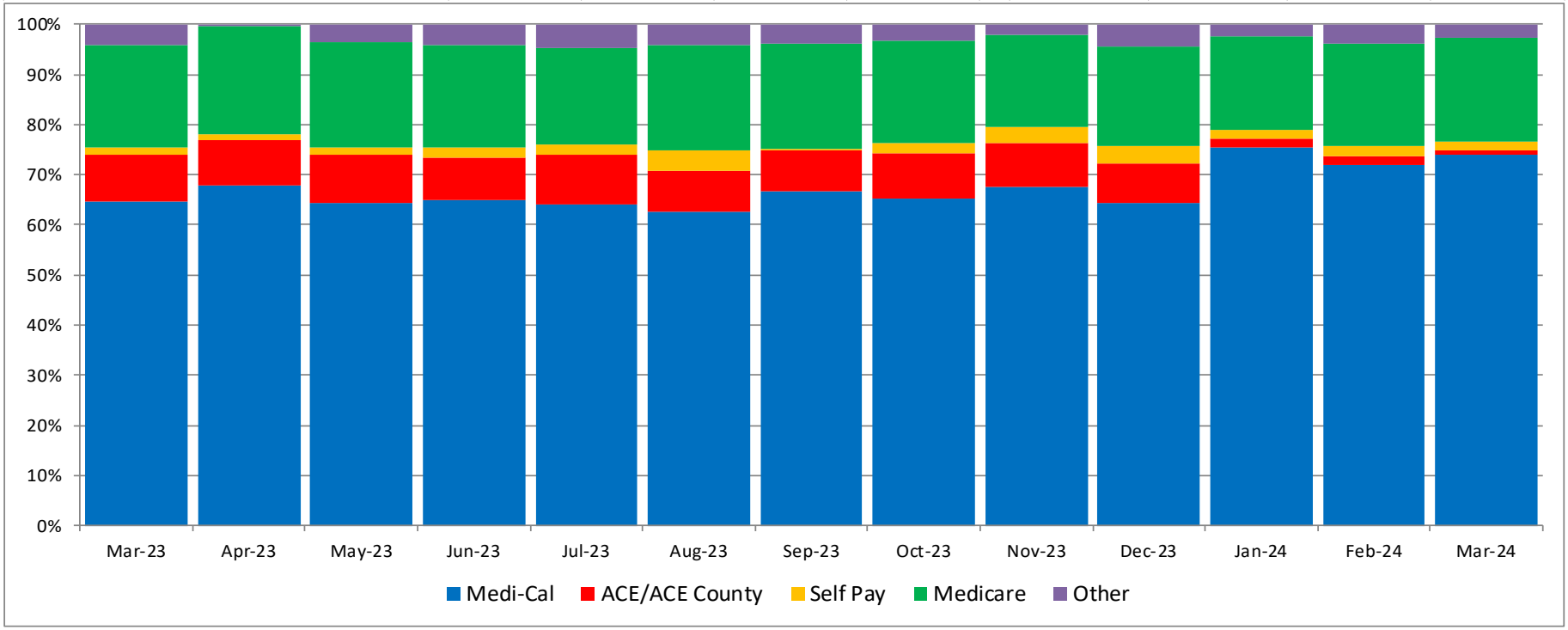
San Mateo Medical Center
Income Statement
March 31, 2024

		MONTH				YEAR TO DATE			
		Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
		A	B	C	D	E	F	G	H
	Operating Expenses								
31	Salaries & Benefits	18,726,887	19,747,380	1,020,493	5%	159,489,751	177,726,416	18,236,665	10%
32	Drugs	1,793,892	1,246,836	(547,056)	-44%	13,446,540	11,221,528	(2,225,013)	-20%
33	Supplies	1,575,338	1,142,708	(432,629)	-38%	11,124,843	10,284,376	(840,467)	-8%
34	Contract Provider Services	3,674,241	4,127,930	453,689	11%	40,675,886	37,151,369	(3,524,517)	-9%
	Registry	*968,406*	*699,888*	*(268,518)*	*-38%*	*13,455,318*	*6,298,995*	*(7,156,323)*	*-114%*
	Contract Provider	*2,598,785*	*3,021,524*	*422,739*	*14%*	*23,696,760*	*27,193,716*	*3,496,956*	*13%*
	ACE Out of Network	*56,793*	*351,675*	*294,882*	*84%*	*3,103,292*	*3,165,075*	*61,783*	*2%*
	Other	*36,810*	*54,843*	*18,032*	*33%*	*433,055*	*493,583*	*60,528*	*12%*
35	Other fees and purchased services	6,952,916	6,549,964	(402,951)	-6%	60,745,471	58,949,680	(1,795,791)	-3%
36	Other general expenses	689,234	784,425	95,191	12%	6,695,058	7,059,824	364,766	5%
37	Rental Expense	237,845	173,397	(64,448)	-37%	1,701,193	1,560,575	(140,618)	-9%
38	Lease Expense	1,374,465	729,484	(644,980)	-88%	12,370,181	6,565,360	(5,804,821)	-88%
39	Depreciation	302,880	330,567	27,688	8%	2,713,371	2,975,105	261,735	9%
40	**Total Operating Expenses**	35,327,697	34,832,693	(495,004)	-1%	308,962,295	313,494,235	4,531,939	1%
41	**Operating Income/Loss**	(5,656,513)	(5,538,107)	(118,406)	-2%	(59,960,633)	(49,842,961)	(10,117,672)	-20%
42	**Non-Operating Revenue/Expense**	452,564	236,305	216,259	92%	10,581,643	2,126,746	8,454,897	398%
43	**Contribution from County General Fund**	5,301,802	5,301,802	-	0%	47,266,216	47,716,216	(450,000)	-1%
44	**Total Income/Loss (GAAP)**	97,853	0	97,853		(2,112,774)	0	(2,112,774)	
	(Change in Net Assets)								

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

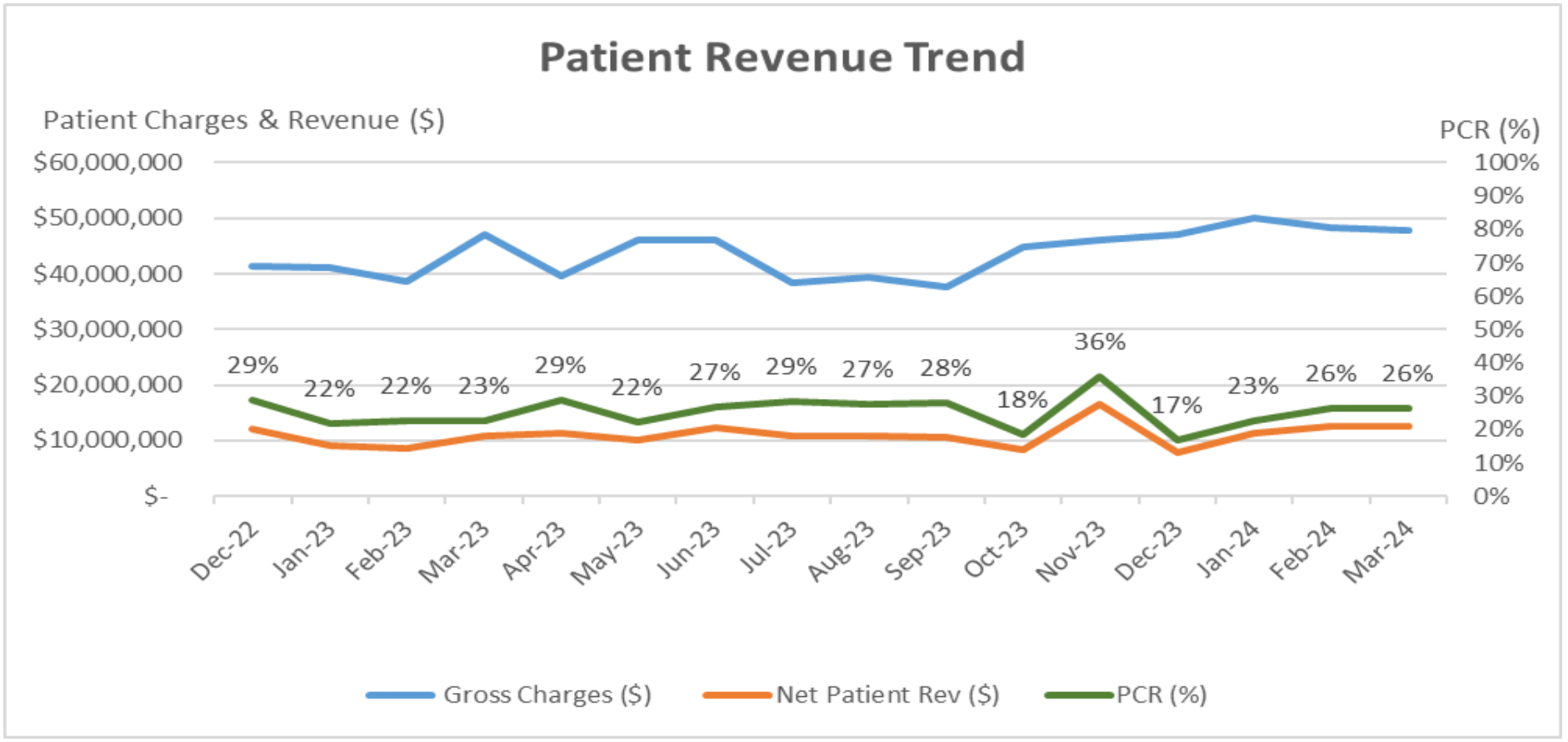
San Mateo Medical Center
Payer Mix
March 31, 2024

	MONTH				YEAR TO DATE			
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
Payer Type by Gross Revenue	A	B	C	D	E	F	G	H
Medicare	20.7%	21.1%	-0.5%		19.9%	21.1%	-1.3%	
Medi-Cal	74.0%	64.7%	9.4%		68.3%	64.7%	3.6%	
Self Pay	1.7%	1.4%	0.3%		2.3%	1.4%	0.9%	
Other	2.7%	3.7%	-1.0%		3.5%	3.7%	-0.2%	
ACE/ACE County	0.9%	9.1%	-8.2%		6.1%	9.1%	-3.0%	
Total	100.0%	100.0%			100.0%	100.0%		



SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Fee-For-Service Patient Revenue Trend

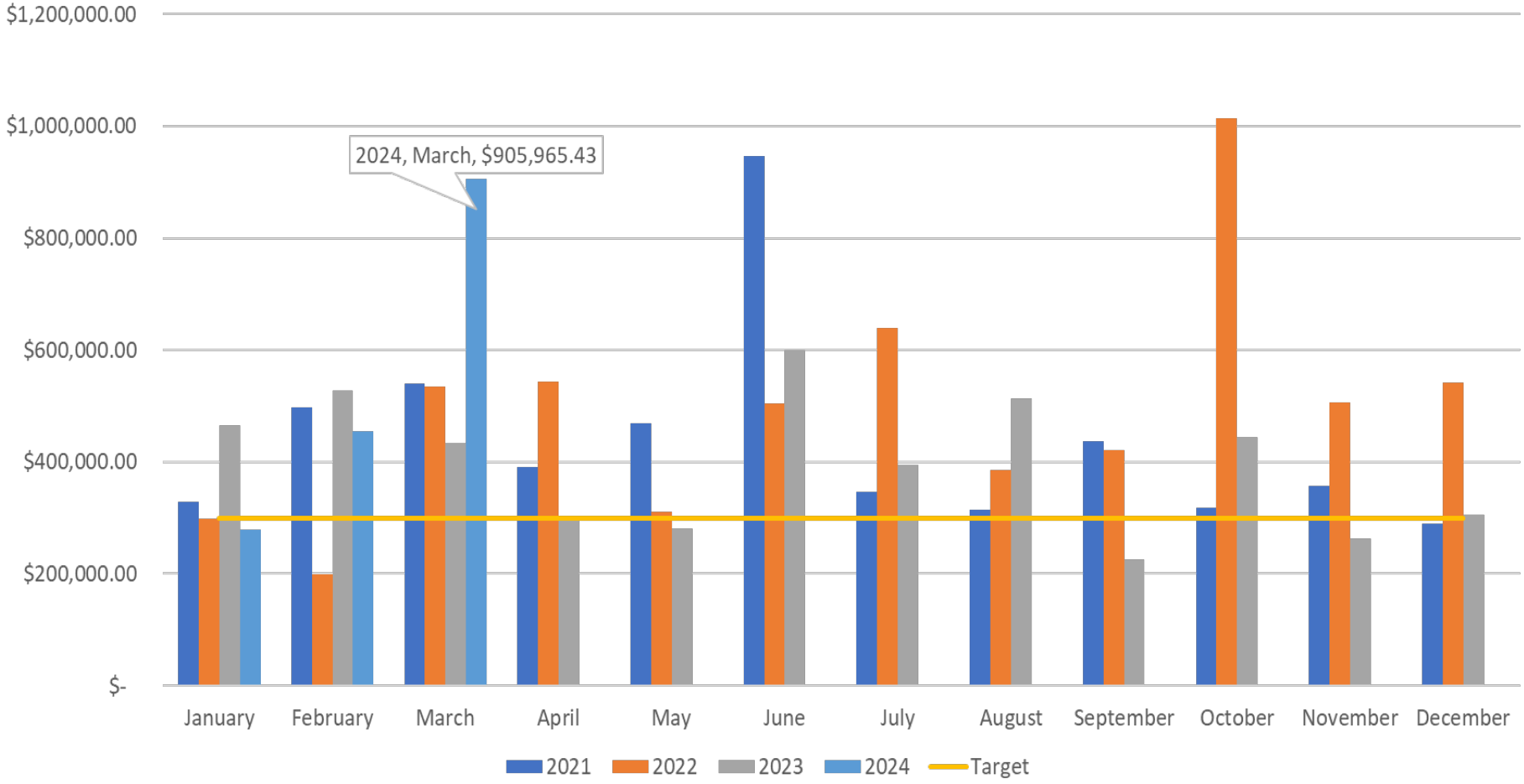


Budgeted PCR 33.9% (FY22), 31.2% (FY23), 31.7% (FY24)

Gross patient revenue increased in recent months due to CDM price increase effective Nov 2023. The collection rate (PCR) in FY24 YTD is trending at average 25%. Low PCR in Oct 23 is due to delay in patient revenue recognition in part due to CorroHealth. PCR surge in Nov 23 and drop in Dec 23 was due to one-time adjustments. PCR is expected to remain in mid/high 20s for the rest of this fiscal year.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

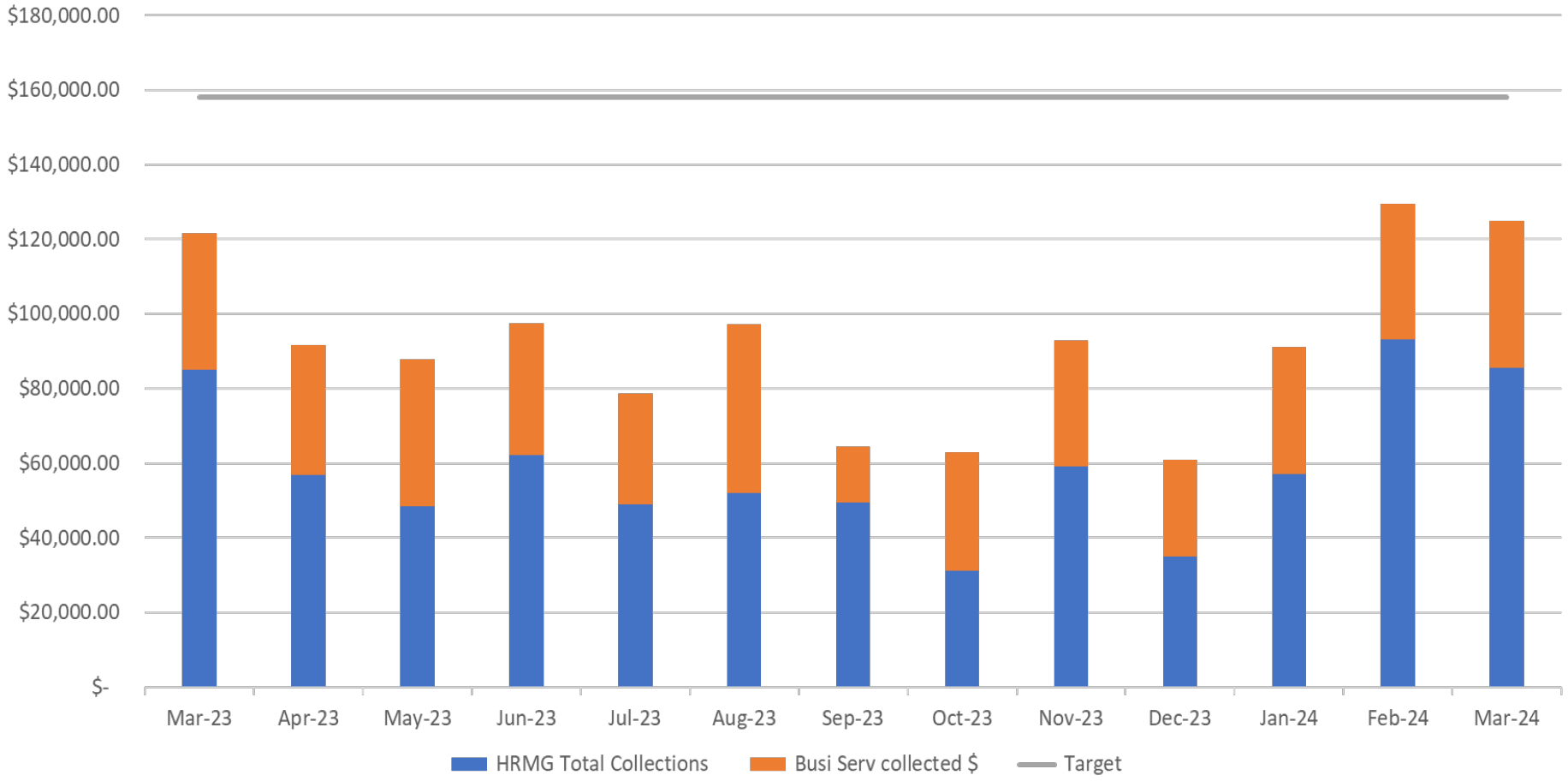
Fee-For-Service Commercial Collections



July 2020 MMX began supporting PFS with Commercial Collections

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

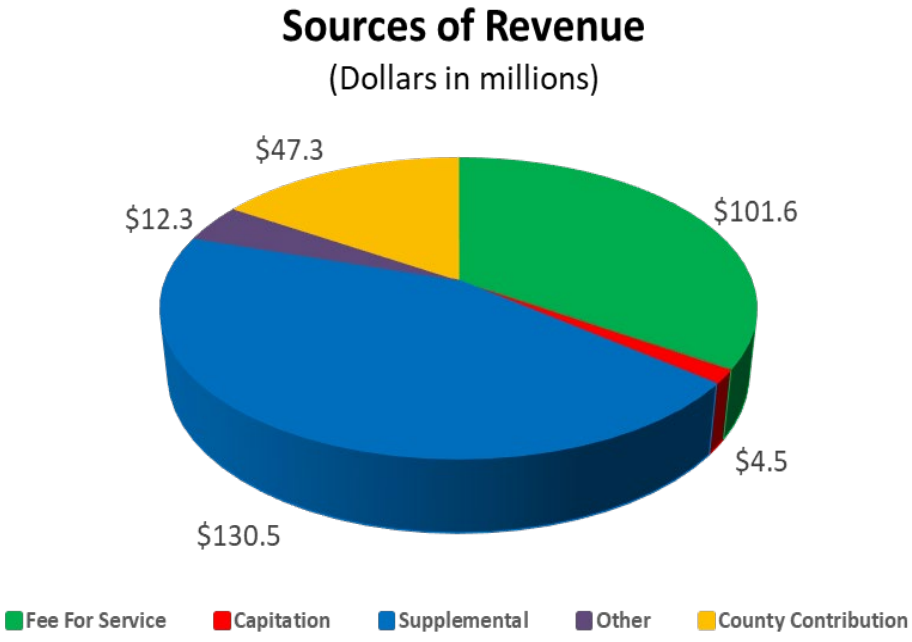
Fee-For-Service Self Pay Collections

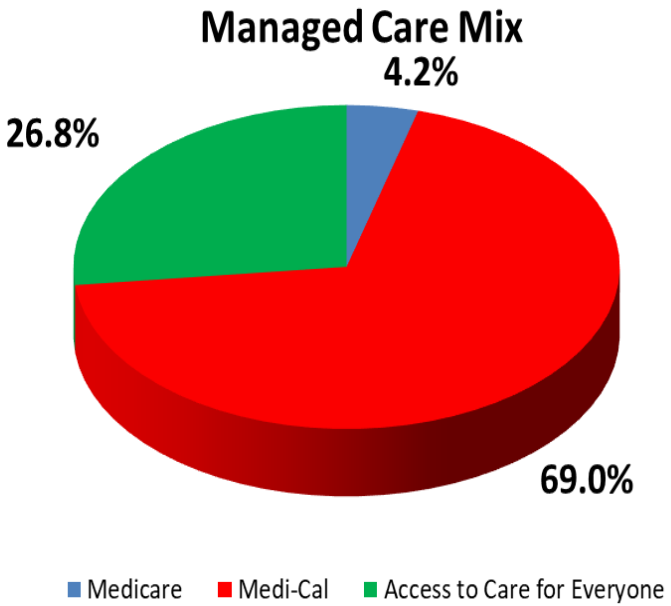


SMMC contracted with Healthcare Revenue Management Group to support SMMC's Business Services unit with collections of self-pay balances

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Revenue Mix





Total YTD Revenue of $296 million consists of 44% in Supplemental Programs and 34% in Fee For Service

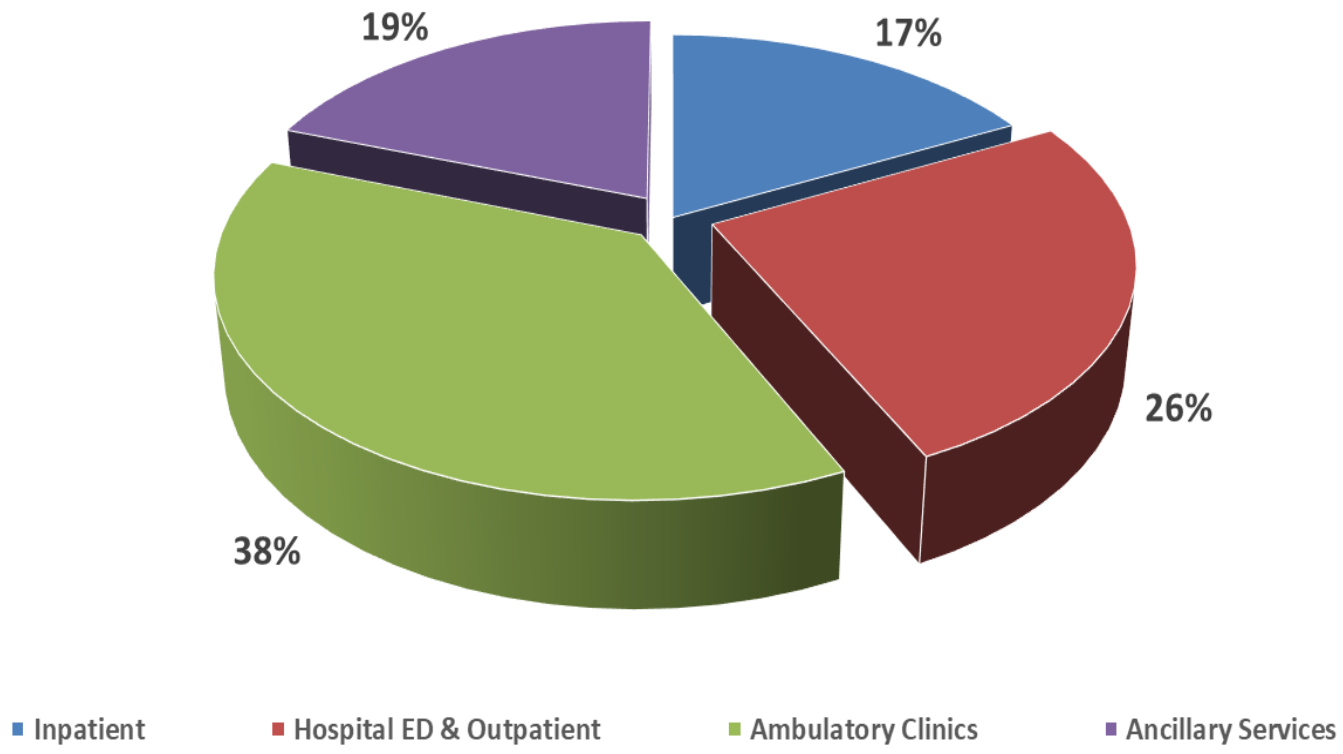
Health Plan of San Mateo (HPSM) represents 44% of our Operating Revenue

- Medi-Cal Managed Care and Medicare Managed Care FFS
- Medi-Cal PCP Capitation

Capitation is a pre-payment reimbursement model that pays providers a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

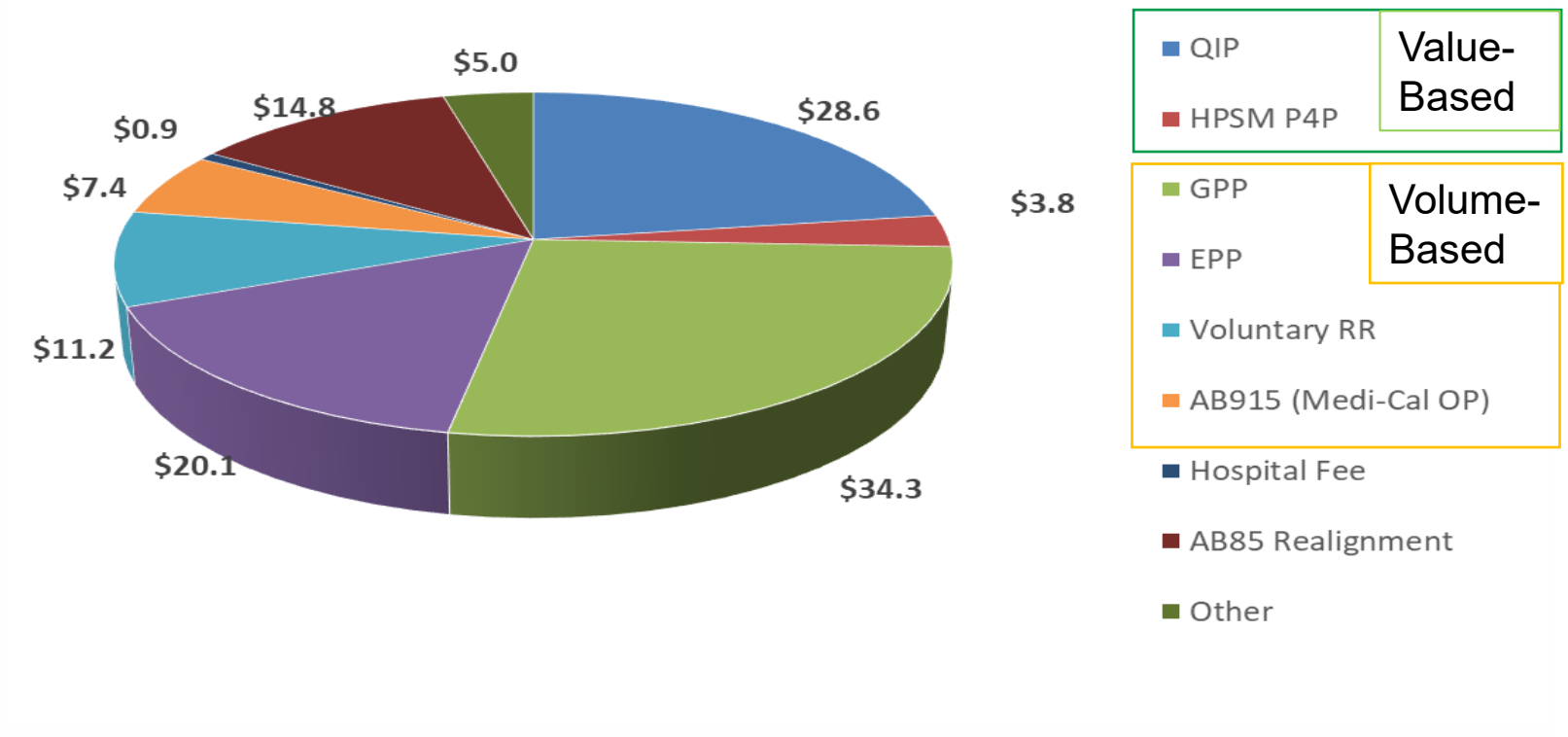
Revenue Mix by Service Line



SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Supplemental Revenue Mix

(Dollars in millions)

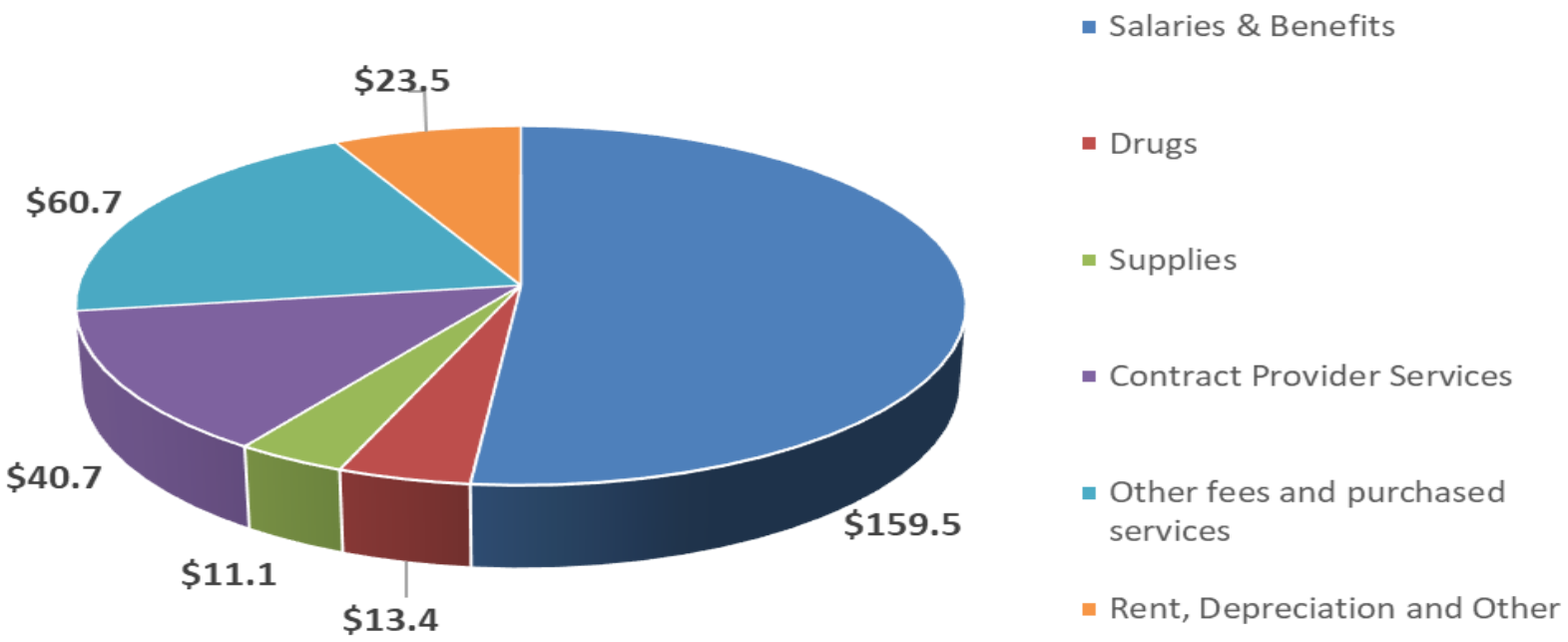


- **Value-Based** programs, including Capitation revenue, represents 26% of total revenue
- **Volume-Based** supplemental programs, plus FFS revenue, represent 58% of total revenue

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Total Operating Expenses

(Dollars in millions)



Salaries & Benefits represent 52% of total expenses

Personnel costs* represent 65% of total expenses

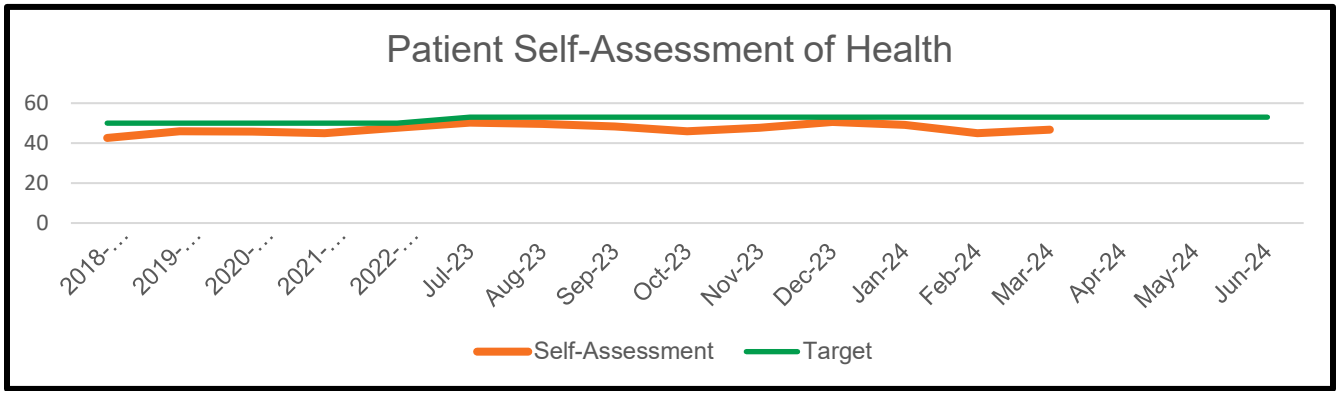
* Personnel costs includes S&B plus Registry/Contract Providers

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

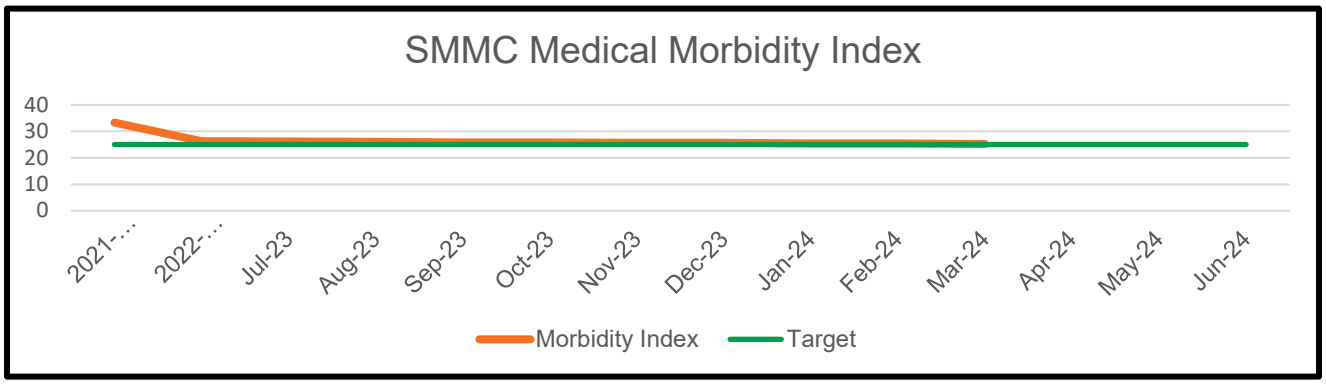
CEO Report
May 2024

SAN MATEO COUNTY HEALTH
SAN MATEO MEDICAL CENTER

Excellent Care

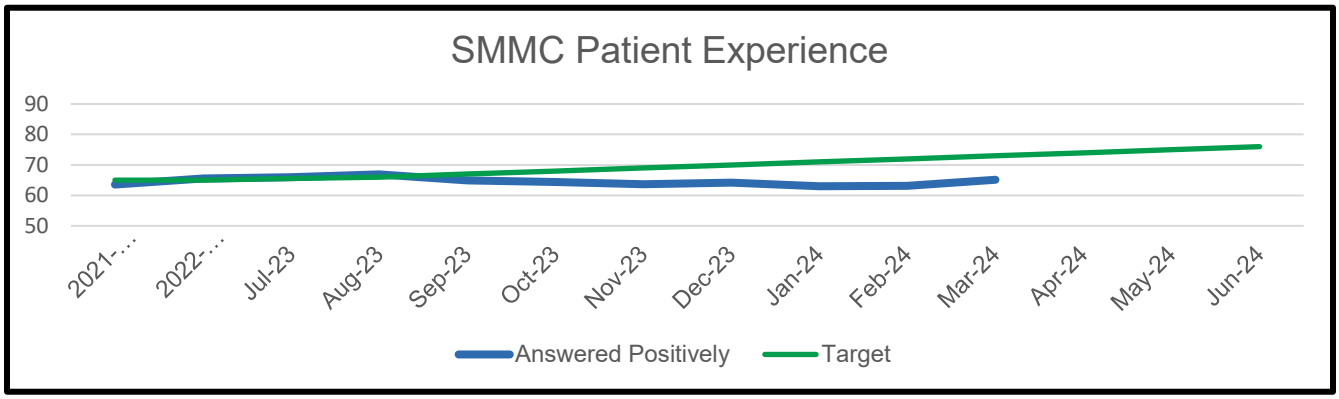


Patient Self-Assessment of Health: All Primary Care patients receive an experience survey. One question asks them to rate their health from poor to excellent. This is the percentage that rate their health as very good or excellent. **Higher is better.**



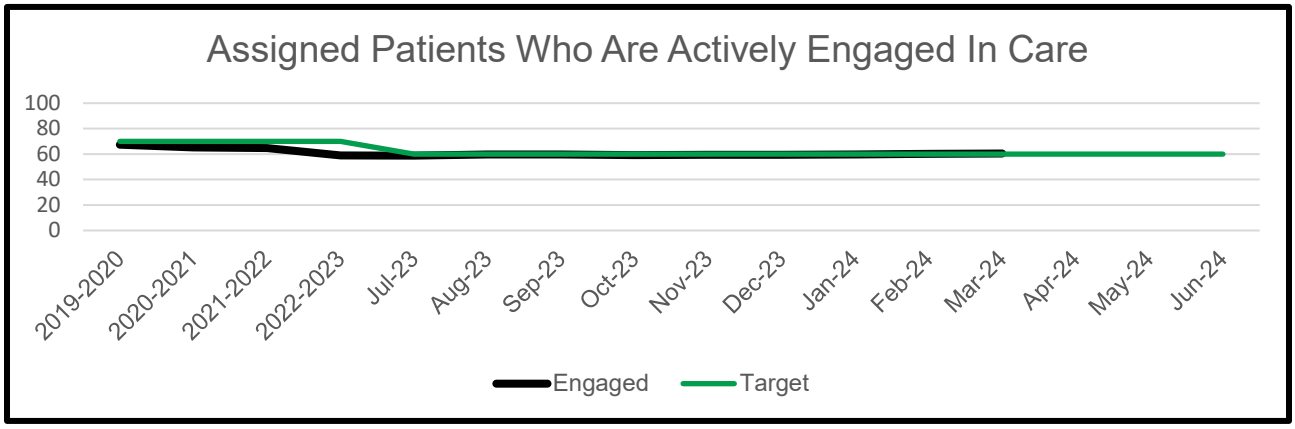
Medical Morbidity Index: This represents the percentage of SMMC patients who meet one or more of the following criteria: Inadequately Controlled Diabetes, Inadequately Controlled Hypertension, Obesity, or a Positive Depression Screen. **Lower is better.**

Patient Experience



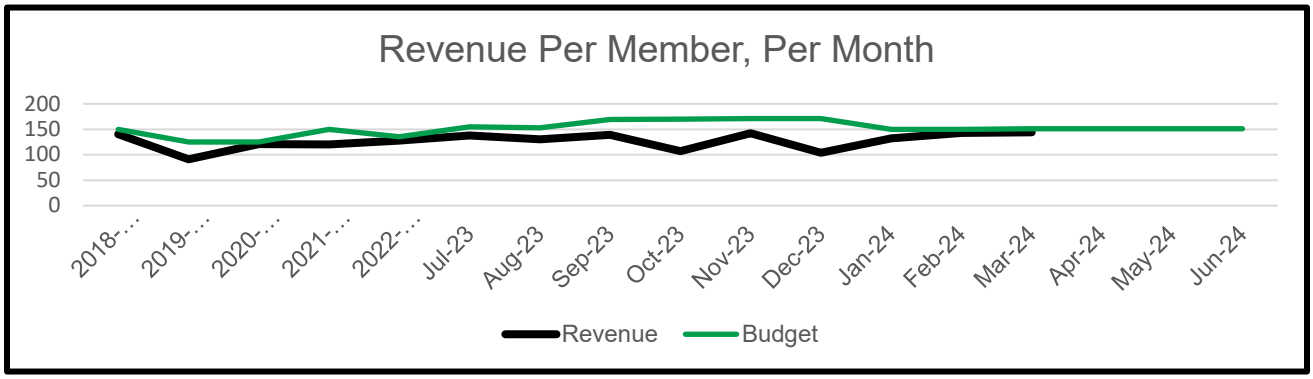
Patient Experience: Percentage of patients who answered affirmatively to the patient experience survey question: “Did the staff work together to meet your needs?” **Higher is better.**

Access to Care

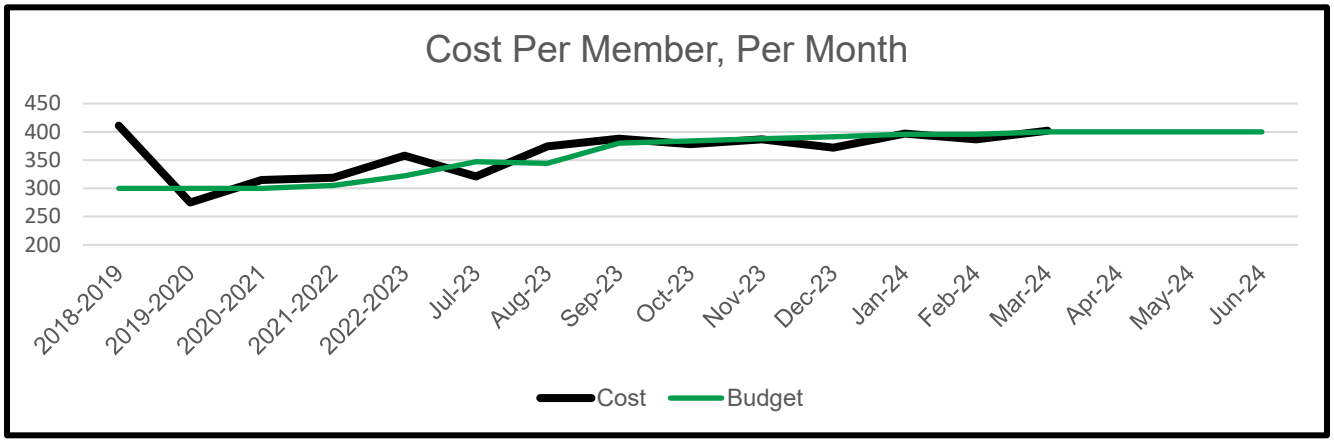


Assigned and Engaged: Percentage of patients assigned to SMMC by the Health Plan of San Mateo who are actively engaged in Care. **Higher is better.**

Financial Stewardship

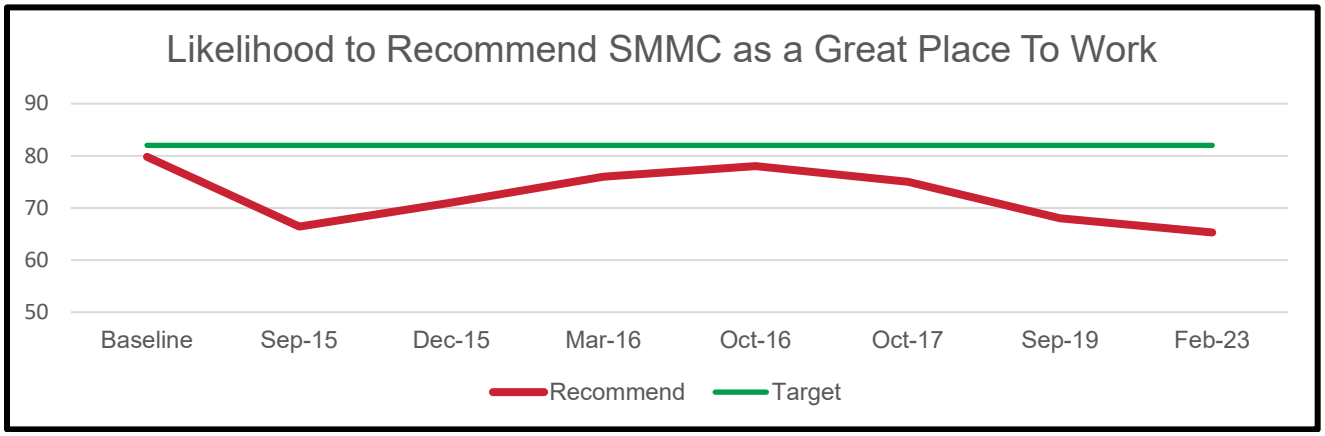


Revenue Per Member, Per Month: Total patient revenue divided by total number of assigned members. **Higher is better.**

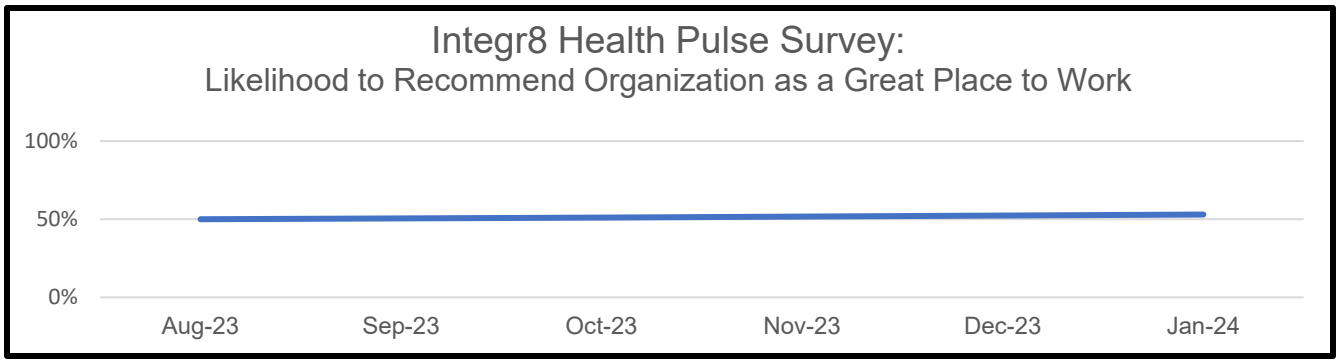


Cost Per Member, Per Month: Total cost divided by total number of assigned members. **Lower is better.**

Staff Engagement



Likelihood to Recommend SMMC: Percentage of staff who agree or strongly agree that they would recommend SMMC as a great place to work. Measured using the annual Blessing White staff engagement survey. *-Awaiting next County survey.* **Higher is better.**



SMMC Integr8 Health Pulse Survey: As part of Integr8 Health (SMC Health's Epic implementation), we are performing quarterly pulse surveys to evaluate staff engagement during the effort. This graph represents the percentage of staff who agree or strongly agree that they would recommend the organization as a great place to work. **Higher is better.**

Strategic Updates, Recognitions & Awards

Pictured above left: *(left to right): Speech Language Pathologists Olive Kobayashi-Lang and Donna Gray*
Pictured above right*: Kara Ramos, NP, Daly City Clinic*

Gender-Affirming Speech Therapy Now Available at SMMC

At times, patients may want to change the way they talk and sound, especially if they feel their voice doesn't represent who they are and want their communication style to be more aligned with their gender.

SMMC is proud to now offer this gender-affirming speech therapy for patients. SMMC's Speech Language Pathologists will work with patients to address pitch, intonation, resonance, rhythm, volume and more. They can also help patients adjust their nonverbal communications.

May is Speech, Language, and Hearing Month and I would like to celebrate SMMC's Speech Language Pathologists Olive Kobayashi-Lang and Donna Gray, and the Rehabilitation Services team led by Heather Rudolph, Clinical Services Manager, for launching this critical service for our patients.

Preceptor of the Month: Kara Ramos

Kara Ramos, NP, was named University of California, San Francisco School of Nursing's March 2024 Preceptor of the Month. A graduate of the University of Pennsylvania School of Nursing, Kara has practiced pediatric primary care at the Daly City Clinic for four years.

"I started precepting in 2022, and love giving back to the NP community," Ramos said. "It's wonderful to watch students grow, and I'm grateful for the opportunity to really immerse students in primary care!"

Kara's colleagues and students at UCSF are highly complementary of her and her "excellent clinical teaching" skills. She has been recognized by the students for the high-quality

compassionate care she provides her patients. We are so grateful to have Kara as part of the Daly City Clinic care team.

Rally for Rounding!

As part of this year's strategic initiative to amplify the voice of staff, our Executive Management Team (EMT) launched a new rounding program to develop and strengthen relationships between EMT and frontline staff and better support our improvement work.

A few weeks ago, members of EMT partnered up to begin visiting our ambulatory clinics across the County. The executives worked with clinic leaders to find a time that works best for staff. During their visit, executives are hoping to interact with as many staff as possible and get to know your areas better. They are eager to celebrate successes and partner in problem solving to remove the barriers staff may experience.

Thank you to the "Voice of Staff" workgroup who helped develop and shape the new SMMC Executive Rounding program: Adelaida Ruiz, Alexa Tiletile, Asmi Mehta, Emily Weaver, Jack Nasser, Katalina Ahoia, Kyaw Myint, Marie Sheppy, Michele Cantrell, Michele Medrano, Phuong Hathaway, Robert Blake, Rob Larcina, Steven Needels, and Margarita Harrington.

Integr8 Health Update

Ensuring User and System Readiness

We have entered the User & System Readiness phase of Integr8 Health. During this phase, our HIT analyst team will complete the build of our instance of Epic, prepare for third-party integration, and conduct system testing, including interface, conversion, application, and integrated testing.

Meanwhile, our operational teams will focus on making sure our workforce is ready for go-live. Readiness efforts include design teams reviewing decisions they made during the build phase so they can identify gaps between our adoption of the Epic foundation system and how we operate today. Those gaps or changes – especially ones that have a high impact on our operational workflows – require detailed plans for an effective roll-out.

Our Leader Development strategic workgroup developed and hosted a virtual kick-off for more than 100 design team, improvement council, and executive leaders to prepare them to lead through this next phase.

Legacy Data Validation

Our Integr8 Health Legacy Systems Design Team assembled a Legacy Data Conversion Team, led by Dr. Katalin Szabo, to begin the process of verifying all the data we are transferring from our legacy systems to Epic.

Epic has a robust process for transferring data, which includes working with current vendors to electronically transfer data, manual data transfer, and a four-round validation process to ensure data is transferred accurately. The first round commenced on April 15th and is scheduled to conclude on May 10th. The subsequent two rounds are slated for June 17th

through July 12th and August 19th to September 13th. The final production validation is earmarked for October 14th to October 28th.

Ensuring the integrity of our operations, data validation holds pivotal importance and demands dedicated attention from our Legacy Data Conversion Team. The success of this initiative hinges on the commitment of nearly 70 staff. I am grateful to all who are contributing to this substantial endeavor to ensure access to critical patient and client data at go-live.

Breakthrough Initiative Continues Focus on Improvement System

The 2023-2024 Breakthrough Strategic Initiative focuses on continuing our work to evolve our Improvement System and ensure everyone knows how to use it. As we move into the next phase of the strategies, the work is focused on three major areas.

The ***Leader Development*** strategic initiative is focused on how executives support various leaders in the improvement system including Improvement Council chairs and Design Team liaisons. The goal is to ensure people have all the support they need to be successful in fulfilling the responsibilities of their roles.

As outlined above, the ***Voice of Staff*** strategic initiative has launched efforts to support a new approach to Executive Rounding. All members of the Executive Management Team are utilizing new standard work to drive their rounding which is starting with twice monthly rounding in Ambulatory Services.

Our strategies focused on ***Standardize and Stabilize Local Improvement Systems*** and ***Continuous Improvement of the Improvement System*** have now merged to form the ***Prepare Local Teams for Spread and Continuous Improvement*** strategy focused on the effective spread of local improvement huddles. This includes a focus on how executives can support that spread.

In addition to the three focus areas outlined above, our strategy focused on **What Patients Want Us to Improve** is in the process of transitioning/operationalizing their strategic work directly to the improvement system. This will include the Social Determinants of Health Improvement Council continuing work to improve our system to respond to patient grievances and revamping our Patient and Family Advisory Council(s) to better represent all our patients.

We will continue to update the board as all these efforts advance.

SAN MATEO COUNTY HEALTH
All together better.

April 2024

SNAPSHOT: **San Mateo County Health**

TO: SMMC Board Members | FROM: Louise F. Rogers, Chief

INDICATOR	NUMBER	CHANGE FROM PREVIOUS MONTH	CHANGE FROM PREVIOUS YEAR
ACE Enrollees	1,404 (March)	-22.7%	-92%
SMMC Emergency Department Visits	3,482 (March)	1.8%	4%

Aging & Adult Services Hosts Technology Summit

Aging & Adult Services (AAS) hosted a Power Platform Summit for staff about the challenges, learnings and innovations around improvements to the technologies that support their work. Undersheriff Chris Hsiung kicked off the event to a crowd of over 90 participants by sharing his passion for public service and his encouragement for adaptive leadership. The day was filled with staff-led presentations on how AAS has adopted technologies such as Docusign, PowerBI and PowerApps to improve workflows and streamline processes for client services over the last several years. Will Sanson-Mosier, CIO of San Francisco Police Department, shared similar innovations from his organization. Gale Stafford from County Health's LEAP Institute presented research on how County Health can embrace technology while supporting staff going through change. The summit recap video is here. A 360-degrees group photo is here.

State Grants County $14 Million to Expand Homeless Services, Remove Encampments

The state has awarded the County $14.1 million to jump-start a plan to provide housing and services for people now living in small encampments scattered from South San Francisco to Menlo Park. The grant, coupled with local and other funds, will help move individuals into permanent, supportive housing and

temporary housing. Behavioral health and substance abuse treatment, mental health counseling, medical care and case-management services will be among the assistance available.

The funds will support a full-time clinician from Behavioral Health and Recovery Services to be part of its Homeless Engagement and Linkage (HEAL) team.

Public Health, Policy and Planning's street and shelter medicine programs will also receive funds to support a psychiatrist embedded with the outreach teams, a public health nurse for medical case management and ongoing coordination with the HEAL team.

Key to success will be "sustained engagement" – that is substantial efforts by outreach workers to demonstrate the positive outcomes of moving into housing or a shelter. This will involve "light-touch and intensive services" while "accepting (shelter) will be a choice," according to the County's grant application. The County's grant was among $192 million in homelessness assistance for cities and counties announced by the Governor's Office. The $14.1 million is the full amount the County sought.

Training Session Coordinates Response to Foodborne Illness

Staff from Communicable Disease Control (CD) presented a five-session training series on foodborne illness outbreaks, which included representatives from Environmental Health Services, the Office of Epidemiology and Evaluation and the Public Health Lab. The multi-day training course utilized a team-based approach to teach professionals how to respond to a foodborne illness outbreak efficiently and effectively. The training modules were designed by the Integrated Food Center of Excellence to help staff understand the roles and responsibilities of the disciplines involved. It also provided a space for the teams to meet and interact in a collaborative environment.

The CD team has recently responded to outbreaks linked to single events, which has helped identify gaps and allowed staff to implement some of what they have learned. As a result, the team was asked to make a presentation to the Washington Integrated Food Center of Excellence about their recent successful response efforts.

Staff Join Stanford's Inaugural Health Equity Ambassadors Program

Deandra Lee, senior community health planner for Public Health, Policy and Planning (PHPP), participated in Stanford's inaugural Health Equity Ambassadors Program in April. The program has three goals: to increase and strengthen community partnerships, to drive research that is responsive to community needs and to build research capacity in the community, particularly in the Bay Area and Central Valley.

With Scarleth Contreras (*left*), public policy coordinator for local non-profit El Concilio of San Mateo, Lee

(*right*) presented a poster at the Stanford Community Health Symposium on April 17th. The poster highlighted the work of the community collaborative model, which is a formal structure for cooperation between the community and PHPP. It also proposed next steps for community-led research, evaluating the current structure for trust-building and power-sharing. The opportunities to bridge community, government, and academia will help PHPP better address the health needs of the community.

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