



**Contra Costa Regional Medical Center  
& Health Centers**

**Medical Staff Bylaws**

**Rules & Regulations**

**2021 DRAFT**

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## Definitions

The following definitions apply to these Medical Staff Bylaws:

1. Administrator means the Chief Executive Officer of Contra Costa Regional Medical Center and Health Centers and her/his designee.
2. Chief Resident(s) means the fourth (4<sup>th</sup>) year resident(s) that is/are chosen by “Core Faculty” (as identified by the Residency Program Director).
3. Allied Health Practitioners (AHP) are those non-Medical Staff member practitioners described in Article 4 below.
4. Clinical Privileges or Privileges means permission, granted by this Medical Staff to members of the Medical Staff, to provide specific diagnostic, therapeutic, medical, dental, podiatric, surgical, psychiatric or psychology services.
5. AHP Clinical Privileges or Service Authorizations means permission granted by the Governing Body, upon the recommendation of the Interdisciplinary Practice Committee and the Medical Staff, to provide diagnostic and therapeutic services within the scope of the AHP’s training and expertise.
6. County means County of Contra Costa, California.
7. Department or Clinical Department means a clinical structure of the Medical Staff as further identified in these Bylaws.
8. Department Head means the practitioner elected or appointed, pursuant to these Bylaws to be responsible for the function of a Clinical Department.
9. Medical Director of Contra Costa Regional Medical Center, also referred to simply as the Medical Director, means the physician appointed by the Administrator to oversee clinical activities of the hospital.
10. Chief Medical Officer of the Health Services Department means the physician appointed by the Director of the Health Services Department to oversee the clinical activities of the Health Services Department.
11. Ex-officio means service as a member of a body by virtue of an office or positions held and, unless expressly provided, without voting rights.
12. Governing Body means the County Board of Supervisors.
13. Hospital or Medical Center means the Contra Costa Regional Medical Center and Health Centers.
14. Health Centers means the outpatient clinical facilities operated by the County where the Members of this Medical Staff provide patient care.
15. Medical Staff Year means the twelve (12)-month period commencing on the first of July of each year and ending on the thirtieth (30<sup>th</sup>) of June of the following year.
16. Member or Medical Staff Member means any Practitioner or Resident who has been appointed to the Medical Staff pursuant to these Bylaws.
17. Member in Good Standing means a Member of the Medical Staff who is not under a suspension.

18. Physician means an individual with a M.D. or D.O. degree who is currently licensed to practice medicine in the State of California.
19. Practitioner means a physician, dentist, clinical psychologist, or podiatrist who is currently licensed by the State of California to provide patient care services.
20. Residency Director means the physician who directs the postgraduate Family Medicine training program sponsored by Contra Costa Health Services.
21. Resident means a physician in training who is participating in a residency program approved by the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA).
22. Rules or Rules and Regulations mean the Medical Staff Rules and Regulations that are contained under separate cover and are adopted pursuant to the Bylaws.

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## **ARTICLE 1**

### **NAME AND PURPOSES**

- 1.1 The name of this organization is the Medical Staff of the Contra Costa Regional Medical Center and Health Centers.
- 1.2 The Medical Staff purposes are:
  - 1) To assure that all patients treated by any of its members receive the best possible care.
  - 2) To provide for professional performance that is consistent with the mission and goals of Contra Costa Health Services.
  - 3) To maintain Rules for the Medical Staff to carry out its responsibilities for the professional work performed in the Hospital and Health Centers.
  - 4) To provide a means for the Medical Staff, Governing Body and Hospital Administration to discuss issues of mutual concern.
  - 5) To provide for accountability of the Medical Staff to the Governing Body.

## **ARTICLE 2**

### **MEMBERSHIP**

#### **2.1 Nature of Membership**

Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been granted by the governing body in accordance with these bylaws. Only Members of the Medical Staff or Allied Health Professionals as defined in article 4 may care for patients in our Hospital and Health Centers.

#### **2.2 Eligibility and Qualifications for Membership**

##### **2.2.1 General Qualifications**

Privileges and membership on the Medical Staff shall be extended only to practitioners who are professionally and ethically competent and continuously meet the qualifications, standards, and requirements set forth in these Medical Staff Bylaws, Rules and Regulations and the Medical Staff policies.

Except for Honorary, Resident and Administrative membership, only physicians, dentists, podiatrists and clinical psychologists who:

- A. Document current, valid, unrestricted licensure; adequate experience, education and training; professional and ethical competence; good judgment; adequate physical and mental health status; and current eligibility to participate in Medicare, Medicaid or other federally-sponsored health care programs
- B. Abide by the ethics of their profession; work cooperatively with others; maintain confidentiality as required by law; and will participate in and discharge their

responsibilities as required by the Medical Staff shall be deemed to possess the basic qualifications and eligibility for membership on the Medical Staff.

#### 2.2.2 Specific Qualifications:

To be eligible and qualified for Medical Staff Membership and Privileges, the practitioner must meet the basic standards outlined above in Section 2.2.1, 'Eligibility and Qualifications for Membership,' and in these Specific Qualifications:

A. No record of criminal conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs. No record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any hospital for reasons related to professional competence or conduct.

B. Physicians seeking membership privileges or reappointment must meet the following criteria:

1) Successful completion of a postgraduate residency training program accredited by either the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA).

and

2) Current board certification or board eligibility leading to certification (with achievement of certification within the required time frame set forth by the respective boards). Board Certification shall be from an American Board of Medical Specialties (ABMS) or the American Osteopathic Association (AOA).

C. Resident Physicians seeking membership to the Medical Staff must meet all of the following criteria:

1) Have a valid M.D., D.O. or equivalent degree.

2) Be accepted for training by a residency program affiliated with Contra Costa Regional Medical Center and be a member in good standing in their program.

3) Obtain a Postgraduate Training License (PTL) from the Medical Board of California within 180 days of the commencement of residency training, which must be maintained throughout the resident physician's residency training.

4) Agree to be supervised by a licensed attending physician member of the Medical Staff for any patient care in which the resident physician is involved.

D. Controlled Substance Prescriber. Practitioner members on the Medical Staff must have a current, valid, unrestricted Federal DEA number/registration if prescribing controlled substances.



E. Dentists. An applicant for dental membership on the Medical Staff must have a DDS or equivalent degree. The Practitioner must have a current, valid, unrestricted license to practice dentistry issued by California Board of Dental Examiners.

F. Podiatrists. An application for Podiatric Membership in the Medical Staff must have a D.P.M. or equivalent degree. The Practitioner must have a current, valid, unrestricted license to practice podiatry issued by the California Board of Podiatric Medicine.

G. Clinical Psychologists. An applicant for Clinical Psychologist Membership on the Medical Staff must have a doctorate degree in psychology. The Practitioner must have a current, valid, unrestricted license to practice clinical psychology issued by the California Board of Psychology.

### **2.3 Waiver of Qualifications**

The Credentials Committee may recommend that certain eligibility criteria be waived by the Medical Executive Committee (MEC.) The Practitioner must demonstrate that he or she has the equivalent qualifications or that exceptional circumstances exist which warrant granting the waiver. The Practitioner has no right to have his or her waiver request considered or granted and denial of a waiver confers no right to a hearing or appellate review.

### **2.4 Membership Requirements**

An applicant for Membership appointment or reappointment on the Medical Staff must document his or her adequate experience, education, and training in the requested Privileges. The applicant must demonstrate current professional competence and good judgment in the use of such Privileges. The applicant must demonstrate his or her ability to exercise such Privileges for quality patient care at a level recognized as appropriate to a similar professional within the community. The MEC must determine that the applicant adheres to the lawful ethics of his or her profession; is able to work cooperatively with others in the Hospital so as not to adversely affect patient care or Hospital operations; and is willing and able to participate in and properly discharge Medical Staff responsibilities as describes in these Bylaws, the Rule and Regulations and applicable Medical Staff Policy.

### **2.5 Effect of Other Affiliations**

No Practitioner is entitled to Medical Staff Membership merely because he or she holds a certain degree, is licensed to practice medicine in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because he or she had, or presently has, Medical Staff Membership or Privileges at another health care facility.

### **2.6 Nondiscrimination**

No person in the Medical Staff or seeking admission thereto shall be appointed, promoted, disciplined, reduced, removed or in any way favored, disfavored, or discriminated on the basis of political, religious or union activities, age, sex, gender, gender identity, gender expression, sexual orientation, race, religion, color, national origin, physical or mental impairment, marital status or disability that does not pose a threat to the quality of patient care or substantially impair the ability to fulfill required staff obligations.

## **2.7 General Responsibilities of Medical Staff Membership**

Each Medical Staff Member or Allied Health Professional exercising Privileges in the Hospital and Health Centers shall continuously meet all of the following responsibilities:

- 2.7.1 Provide his or her patients with care meeting the professional standards of the Medical Staff of this Hospital.
- 2.7.2 Abide by the Medical Staff Bylaws and the Rules and all other lawful standards, policies, and rules of the Medical Staff and the Hospital.
- 2.7.3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of The Joint Commission (TJC).
- 2.7.4 Discharge such Medical Staff, department, division, committee, and service functions for which he or she is responsible by appointment, election, or otherwise.
- 2.7.5 Prepare and complete in a timely manner the Medical and the required records for all patients to whom the Practitioner in any way provides services to the Hospital.
- 2.7.6 Abide by the ethical principles of his or her profession.
- 2.7.7 Work cooperatively with other Medical Staff Members, nurses, administrators, and other members of the health care team so as not to adversely affect patient care.
- 2.7.8 Participate in educational programs approved by the Medical Staff and designed to improve the quality of patient care.
- 2.7.9 Refuse to engage in any improper inducements for patient care referrals.
- 2.7.10 Make appropriate arrangements for coverage for his or her patients when an absence is anticipated.
- 2.7.11 Complete continuing education programs that are required by the Medical Staff.
- 2.7.12 Participate in emergency service coverage and consultation (on-call) panels as may be required by the Medical Staff.
- 2.7.13 Accept responsibility for participating in Medical Staff Focused Professional Practice Evaluation (FPPE) in accordance with the Bylaws.
- 2.7.14 Pay Medical Staff dues and assessments within sixty (60) days of invoice receipt.
- 2.7.15 Participate in the resident training program as requested by the Residency Director.
- 2.7.16 Promptly notify the Medical Staff Office of any professional liability action the member is involved in as soon as the member becomes aware of his or her involvement.
- 2.7.17 Participate in quality assurance programs as determined by the Medical Staff.

2.7.18 Discharge such other duties and obligations as may be lawfully established from time to time by the Medical Staff, the Medical Executive Committee, the Member's Department, or the Administrator.

## **2.8 Professional Conduct**

### **2.8.1 Statement of Policy**

The Medical Staff is committed to providing a workplace free of sexual harassment or discrimination as well as unlawful harassment or discrimination based upon age, ancestry, color, marital status, medical condition, mental disability, physical disability, national origin, race, religion, gender, or sexual orientation. The Medical Staff does not tolerate harassment or discrimination by Medical Staff Members of resident physicians, support staff, County employees, patients, or other Medical Staff Members.

### **2.8.2 Harassment Defined**

- A. Harassment is unwelcome verbal, visual, or physical conduct that creates an intimidating, offensive or hostile working environment or that interferes with work performance. Such conduct constitutes harassment when:
- 1) Submission to the conduct is made either an implicit or explicit condition of employment;
  - 2) Submission to or rejection of the conduct is used as the basis for an employment decision; or
  - 3) The harassment unreasonably interferes with work performance or creates an intimidating, hostile or offensive work environment.

2.8.3 Harassing conduct can take many forms and includes, but is not limited to, slurs, jokes, statements, gestures, pictures, or cartoons regarding a person's age, ancestry, color, marital status, medical condition, mental disability, physical disability, national origin, race, religion, gender or sexual orientation. Sexually harassing conduct in particular includes all of these prohibited actions as well as requests for sexual favors, conversations containing sexual comments, and unwelcome sexual advances.

### **2.8.4 Investigation and Corrective Action**

- A. Every complaint of harassment, unlawful discrimination or retaliation made to the Medical Staff will be investigated thoroughly and promptly. The Medical Staff will attempt to protect the privacy of individuals involved in the investigation when appropriate. The Medical Staff will not tolerate retaliation against anyone who reports harassing conduct. Other entities, such as the County and legal authorities, may also separately investigate such complaints. When appropriate, the Medical Staff shall share investigatory information with such authorities.
- B. If the Medical Staff determines that harassment occurred, the Medical Staff will take corrective action up to and including termination of Medical Staff Privileges or

Membership. Corrective actions taken by the Medical Staff related to such harassing conduct are not grounds for a hearing unless those actions affect a Member's Privileges or Membership status on the Medical Staff. When appropriate, corrective action may include reporting the harassment to appropriate legal, administrative, and governing authorities.

## ARTICLE 3

### CATEGORIES OF THE MEDICAL STAFF

#### 3.1 Categories

The Medical Staff Members are divided into the following categories of membership: honorary, administrative, active, courtesy, provisional, resident, and temporary. Each Medical Staff Member shall be assigned to a Medical Staff category based upon the respective qualifications set forth in these Bylaws. Members of each Medical Staff category shall have the respective prerogatives and responsibilities as set forth in these Bylaws. Action may be initiated to change the Medical Staff category to terminate the membership of any Member who fails to meet the qualifications or fulfill the responsibilities as described in the Bylaws. Changes in Medical Staff category shall not be grounds for hearing unless it affects the Member's Clinical Privileges.

##### 3.1.1 The Honorary Medical Staff

The honorary Medical Staff consists of practitioners who are not active in the Hospital or who are honored by emeritus positions. These may be practitioners who have retired from active hospital practice or who are of outstanding reputation, not necessarily residing in the community. Honorary staff members are not eligible to admit, care for or consult on patients, to vote, to hold office, or to serve on standing Medical Staff.

##### 3.1.2 The Administrative Medical Staff

###### A. Qualifications

- 1) Administrative category membership shall be held by any physician, who is not otherwise eligible for another staff category and who solely performs ongoing medical administrative activities.
- 2) Document their (1) current licensure, (2) adequate experience, education and training, (3) good judgment, and (4) current physical and mental health status, so as to demonstrate to the satisfaction of the Medical Staff they are professionally and ethically competent to exercise their duties;

###### B. Prerogatives

The Administration Staff shall be entitled to attend meetings of the Medical Staff and various departments and education programs but shall have no right to vote at such

meetings. Administrative Staff members shall not be eligible to hold office in the Medical Staff Organization, admit patients, or exercise clinical privileges.

### 3.1.3 The Active Medical Staff

#### A. Qualifications

The active staff consists of physicians, dentists, podiatrists, and licensed clinical psychologists, each of whom;

- 1) Meets the qualifications for Medical Staff membership set forth in the Bylaws;
- 2) Has an office and residence that, in the opinion of the Medical Executive Committee, is located closely enough to the Hospital to provide appropriate continuity of quality care;
- 3) Regularly admits patients to the Hospital, is regularly involved in the care of patients at the Hospital, or regularly uses the Hospital and/or Health Centers in the care of patients;
- 4) Has satisfactorily completed his/her term in the provisional staff category.

#### B. Prerogatives

Each member of the active staff is entitled to:

- 1) Admit patients and/or exercise Clinical Privileges as are granted to him/her;
- 2) Attend and vote on all matters presented at general and special meetings of the Medical Staff, his/her department, and or committees to which he/she is a member;
- 3) Attend any staff or Hospital education programs;
- 4) Hold staff and/or departmental offices and service on committees to which he/she has been appointed.

#### C. Responsibilities

Each member of the active Medical Staff is responsible for the following:

- 1) Carrying out the basic responsibilities of Medical Staff membership set forth in the Bylaws;
- 2) Providing for the continuous care and supervision of each patient in the Hospital and Health Centers for whom he/she is providing services, including arranging for care and supervision in his/her absence and outside of his/her area of professional competence;
- 3) Providing consultation, supervision, and monitoring of patients, when requested; and
- 4) Attending meetings of the Medical Staff, his/her department, and committees of which he/she is a member in accordance with the Bylaws.

D. Demotion of Active Staff Member.

After one year in which a Member of the active staff fails to regularly care for patients in the Hospital or Health Centers or be regularly involved in Medical Staff functions as determined by the Medical Staff, that Member may be demoted to a lower staff category.

3.1.4 Courtesy Staff

A. Qualifications

The courtesy staff consists of practitioners, each of whom:

- 1) Meets the qualifications for Medical Staff membership set forth in the Bylaws;
- 2) Has an office and residence that, in the opinion of the Medical Executive Committee, is located closely enough to the Hospital to provide appropriate continuity of quality care;
- 3) Admits patients to the Hospital on an irregular basis, is occasionally involved in the care of Hospital patients, or occasionally uses the Hospital and/or Health Centers in the care of patients;
- 4) Is a member of the active staff of another licensed hospital unless the Medical Executive Committee, in writing, for good cause shown, waives this requirement. Dentists holding only General Dentistry, Endodontia, Periodontia, or Orthodontia privileges are exempt from this requirement.
- 5) Has satisfactorily completed his/her term in the provisional staff category.

B. Responsibilities

Each member of the courtesy staff is responsible for the following:

- 1) Carrying out the basic responsibilities of Medical Staff membership set forth in the Bylaws;
- 2) Providing for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, including arranging for care and supervision in his/her absence and outside of his/her area of professional competence;
- 3) Providing consultation, supervision, and monitoring of patients, when requested; and
- 4) Attending meetings of the Medical Staff, his/her department, and committees of which he/she is a member in accordance with the Bylaws.

C. Limitation

Courtesy staff members shall not be eligible to hold office in this Medical Staff organization nor shall they be eligible to vote on matters presented at general and

special meetings of the Medical Staff, departmental meetings, division meetings, or committee meetings except as specifically provided in the Bylaws.

### 3.1.5 Provisional Staff

#### A. Qualifications.

The provisional staff consists of practitioners, each of whom:

- 1) Meets the qualifications for Medical Staff membership set forth in the Bylaws;
- 2) Immediately prior to his/her application and appointment was not a member (or was no longer a member) in good standing of this Medical Staff;
- 3) Has an office and residence that, in the opinion of the Medical Executive Committee, is located closely enough to the Hospital to provide appropriate continuity of quality care.

#### B. Prerogatives.

Each member of the provisional staff is entitled to;

- 1) Admit patients and exercise such Clinical Privileges as are granted pursuant to the Bylaws;
- 2) Attend meetings of the staff and the department of which he/she is a member and any staff or hospital education programs;
- 3) Be appointed to any committee except the Medical Executive Committee. The provisional staff members shall not have the right to vote unless the Medical Staff President confers that right at the time of the committee appointment.

#### C. Responsibilities

Each member of the provisional Medical Staff is responsible for the following:

- 1) Carrying out the basic responsibilities of Medical Staff membership set forth in the Bylaws;
- 2) Providing for the continuous care and supervision of each patient in the hospital for whom he/she is providing services, including arranging for care and supervision in his/her absence and outside of his/her area of professional competence;
- 3) Providing consultation, supervision, and monitoring of patients, when requested;
- 4) Attending meetings of the Medical Staff, his/her department, and committees of which he/she is a member in accordance with the Bylaws.

#### D. Limitation

Provisional staff members are not eligible to vote on matters presented at general and special meetings of the Medical Staff, department meetings, division meetings, or committee meetings except as specifically provided in the Bylaws.

**E. Monitoring of Provisional Staff Member**

Each provisional staff member shall undergo a period of monitoring. The monitoring shall be to evaluate the member's (1) proficiency in the exercise of Clinical Privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Monitoring of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Results of the monitoring shall be communicated by the department chairperson to the Credentials Committee.

**F. Term of Provisional Staff Status**

A Member shall remain on the provisional staff for a period of six months unless the Medical Executive Committee or the Credentials Committee extends that status for an additional period of up to six months upon a determination of good cause, which determination shall not be subject to review. In special circumstances wherein the Member has had minimal activity at the Hospital and Health Centers, and current information is inadequate to allow a determination to conclude the provisional staff status, the Medical Executive Committee may extend the provisional staff status for an additional period of up to twelve (12) months, which determination shall not be subject to review. In no event shall the total provisional staff status of a member exceed twenty-four (24) months. At the conclusion of provisional staff status, further staff status is determined as stated below.

**G. Action at Conclusion of Provisional Staff Status**

- 1) If the Provisional Staff Member has satisfactorily demonstrated his or her ability to exercise the Clinical Privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the Member shall be eligible for placement in the Active or Courtesy Staff, as appropriate, upon recommendation of the Medical Executive Committee (MEC.) The Administrator and the Governing Body shall act upon this MEC recommendation. Should any disagreement occur between the MEC, the Administrator, and the Governing Body, resolution shall occur in compliance with the Bylaws.
- 2) In all cases, the appropriate department shall advise the Credentials Committee, which shall make its report to the Medical Executive Committee, which, in turn, shall make its recommendation to the Professional Affairs Committee regarding a



modification or termination of Clinical Privileges, or termination of Medical Staff membership.

### 3.1.6 Resident/Fellow Physician Staff

#### A. Qualifications

The resident staff consists of Members, each of whom;

- 1) Meets the qualifications for Medical Staff membership set forth in these Bylaws;
- 2) Exercises clinical privileges under appropriate supervision and direction of the Program Director, and the head of the department in which he/she is exercising privileges as described in section 6.3 and under Rules & Regulations section 1.1. of these Bylaws;
- 3) Attends meetings of the Medical Staff and, if invited, the departments to which he/she is currently assigned; and
- 4) May be appointed to any committee except the Medical Executive Committee. The resident/fellow physician staff member shall not have the right to vote as a committee member unless that right is conferred by the Medical Staff President.

#### B. Responsibilities

Each member of the resident/fellow staff is responsible for the following:

- 1) Carrying out the basic responsibilities of Medical Staff membership set forth in the Bylaws and Rules;
- 2) Contributing to the organization and administrative affairs of the Medical Staff by participating on staff, in the departments, and on committees as reasonably requested, and by participating in fulfilling such other staff functions as are reasonably requested.

#### C. Limitation

Resident/fellow physician staff members shall not be eligible to hold office in this Medical Staff organization nor shall they be eligible to vote on matters presented at general and special meetings of the Medical Staff, departmental meetings, division meetings, or committee meetings except as specifically provided in these Bylaws.

### 3.1.7 Temporary Staff

#### A. Qualifications

Temporary staff consists of Members, each of whom:

- 1) Meets the qualifications for Medical Staff membership set forth in the Bylaws;

- 2) Has been granted temporary privileges and is not currently on the active, courtesy, provisional, or resident staff.

**B. Prerogatives**

Each Member of the temporary staff is entitled to:

- 1) Admit patients and exercise Clinical Privileges as are granted to him/her;
- 2) Attend meetings of the staff in the department of which he/she is a Member and any staff and hospital educational programs.

**C. Responsibilities**

Each Member of the temporary staff is responsible for the following:

- 1) Carrying out the basic responsibilities of Medical Staff membership set for in the Bylaws;
- 2) Providing for the continuous care and supervision of each patient in the Hospital for whom he/she is providing services, including arranging for care and supervision in his/her absence and outside of his/her area of professional competence;
- 3) Providing consultation, supervision, and monitoring of patients, when requested; and
- 4) Attending meetings of the Medical Staff, his/her department, and committees of which he/she is a member.

**D. Limitations**

Temporary staff members are not eligible to hold office in this Medical Staff organization nor are they eligible to vote on matters presented at general and special meetings of the Medical Staff, departments, divisions, or committees. In the event that a practitioner's temporary clinical privileges are terminated, said practitioner's temporary staff status is also deemed terminated and the practitioner is thereafter entitled to the procedural rights afforded by the Bylaws.

**3.1.8 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 Rules.

**3.1.9 Modification of Membership**

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member, the Medical Executive Committee may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws.

## ARTICLE 4

### ALLIED HEALTH PRACTITIONERS

#### 4.1 Definitions

- 4.1.1 Allied Health Practitioner (AHP) means a health care professional, other than a physician, dentist, podiatrist or clinical psychologist, who holds a license, as required by California law, to provide certain professional services.
- 4.1.2 AHP Clinical Privileges or Service Authorization means the permission granted by the Governing Body, upon the recommendation of the Interdisciplinary Practice Committee and the Medical Staff, to provide diagnostic and therapeutic services with the scope of the AHP's training and expertise.

#### 4.2 Categories of AHPs Eligible to Apply for AHP Clinical Privileges or Services

##### Authorizations and Rules

- 4.2.1 The categories of AHPs, based upon occupation or profession that shall be eligible to apply for AHP Clinical Privileges shall be designated by the Governing Board, upon recommendation of the MEC. Currently, AHP includes the following categories;
- A. Nurse Practitioners who are registered nurses with additional training, expertise, certification and licensing that is recognized and authorized by the State of California to provide specific diagnostic and therapeutic services.
  - B. Optometrists who are licensed by the State of California to provide specific optometric services.
  - C. Midwives (Certified Nurse Midwives, Licensed Midwives, Certified Professional Midwives) who are health care providers with additional training, expertise, and certification that is recognized and authorized by the State of California, under the supervision of a licensed physician or surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum and postpartum care.
  - D. Physician Assistants who are healthcare professionals with specialized medical training from a program associated with a medical school and who are licensed by the California Physician Assistant Board to provide patient education, evaluation, and health care services under the supervision of a licensed physician.
  - E. Acupuncturists who are health care providers with training, expertise and knowledge in the practice of acupuncture who are licensed and regulated by the State of California under the Acupuncture Board.

#### 4.3 Eligibility and General Qualifications

An AHP is eligible for a Service Authorization in this Hospital/Health Centers if he or she:

- 1) Holds a current, valid, unrestricted license, certificate, or other legal credential in a category of AHP which the Governing Body has identified as eligible to apply for Service Authorization pursuant to the Bylaws; and
- 2) Documents his or her experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care at the generally recognized professional level of quality established by the Medical Staff; and
- 3) Is determined, on the basis of documented references to:
  - A. Adhere strictly to the lawful ethics of his or her profession;
  - B. Work cooperatively with others in the hospital setting so as not to adversely affect patient care;
  - C. Be willing to commit to and regularly assist the Medical Staff in fulfilling its obligations related to patient care; and
    - 1) Agrees to comply with all Medical Staff and Department and Division Bylaws, Rules and Regulations and protocols to the extent applicable to the AHP;
    - 2) Documents his or her current eligibility to participate in Medicare, Medicaid or other federally-sponsored health care program.

#### **4.4 Specific Qualifications**

In addition to meeting the basic standards as outlined in "Eligibility and General Qualifications," an AHP shall have the following specific qualifications to be eligible and qualified for AHP Clinical Privileges or Service Authorization in this hospital:

No record of conviction of Medicare, Medicaid, or insurance fraud and abuse, payment of civil money penalties for same, or exclusion from such programs.

No record of denial, revocation, relinquishment or termination of appointment or clinical privileges at any hospital for reasons related to professional competence or conduct.

- 1) Nurse Practitioners: A Nurse Practitioner shall have a current, valid, unrestricted license and furnishing number which authorizes ordering of drugs or devices if applicable to the Nurse Practitioner's practice
- 2) Midwives: A Midwife shall have a current, valid, unrestricted license and furnishing number which authorizes ordering of drugs or devices if applicable to the Midwife's practice.
- 3) Physician Assistants: A Physician's Assistant shall have a current, valid, unrestricted license and furnishing number which authorizes the Physician's Assistant to provide drug and medication orders, if applicable to the Physician's Assistant's practice.

- 4) Optometrists: An optometrist shall have a current, valid, unrestricted license and furnishing number which authorizes ordering of drugs or devices if applicable to the Optometrist's practice.
- 5) Acupuncturists: An Acupuncturist shall have a current, valid, unrestricted license authorizing the practitioner to provide acupuncture treatment and care within the State of California.

#### **4.5 Waiver of Qualifications.**

When exceptional circumstances exist certain eligibility criteria may be waived by the MEC upon recommendation by the Interdisciplinary Practice Committee or its designee the Credentials Committee. The AHP requesting the waiver bears the burden of demonstrating exceptional circumstances and/or that his or her qualifications are equivalent to or exceed the criterion/criteria in question.

#### **4.6 Prerogatives**

The prerogatives, which may be extended to an AHP, include:

- 1) Provision of specified patient care services consistent with the Service Authorization granted to the AHP and within the scope and licensure or certification of that AHP;
- 2) Service on Medical Staff and Hospital committees except as otherwise provided in the Bylaws. An AHP may not serve as chair of a Medical Staff committee;
- 3) Attendance at meetings of the department to which he or she is assigned. An AHP may not vote at department/division meetings.

#### **4.7 Responsibilities**

Each AHP shall:

- 1) Meet those responsibilities required by the Medical Staff Rules and Regulations.
- 2) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.
- 3) Participate, when requested, in patient care and audit and other quality review evaluation and monitoring activities required of AHPs and other functions as may be required by the Medical Staff from time to time.

#### **4.8 Procedure for Granting Initial and Renewal Services Authorizations**

- 1) An AHP who practices under Standardized Procedures must apply and qualify for a Service Authorization. An AHP must reapply for a renewed Service Authorization every two years.
- 2) AHP application for initial granting and renewal of service authorization shall be submitted to the Interdisciplinary Practice Committee (IPC), which may delegate the processing of such applications to the Credentials Committee. Credentialing and Privileging is processed in a parallel manner to that provided for the Medical Staff by the Bylaws. At the discretion of the Credential Committee an initial application of reappointment may be sent to the IPC for review.

- 3) The Credential Committee shall, as delegated by the IPC, make recommendations to the MEC and the Governing Body regarding the granting of individual Service Authorizations to AHP applicants.
- 4) Upon approval by the MEC and the Governing Body, an applicant AHP shall be granted Service Authorization and assigned to the clinical department appropriate to his or her occupation and training. The AHP is subject to the relevant rules and regulations of that department.

#### **4.9 Termination, Suspension, or Restriction of Service Authorizations**

- 1) The termination, suspension or restriction of Service Authorization shall be done as if the Service Authorization was a clinical privilege rendered to a Member of the Medical Staff. The AHP shall have the same procedural rights as a Medical Staff Member would have with the termination, suspension or restriction of privileges.

## **ARTICLE 5**

### **PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT**

#### **5.1 General**

The Medical Staff shall consider each application for appointment, reappointment, and privileges, and each request for modification of Medical Staff category using the procedures and the standards set forth in the Bylaws. The Medical Staff shall evaluate each applicant before recommending action by the Governing Body. The Governing Body is ultimately responsible for granting Medical Staff membership and Clinical Privileges. Temporary Privileges may be granted to a practitioner, pursuant to these Bylaws and the Rules, prior to final action by the Governing Body. By applying to the Medical Staff for appointment or reappointment, the applicant agrees that, whether or not he or she is appointed or granted Privileges, he or she will comply with the responsibilities of Medical Staff Membership and with the Medical Staff Bylaws and Rules as they exist and as they may be modified from time to time.

#### **5.2 Applicant's Burden**

An applicant for appointment, reappointment, advancement, transfer, and/or Privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status and Privileges, resolving any reasonable doubts about these matters and satisfying requests for information. 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 (MEC.) The applicant may select the examining physician from an outside panel of three physicians chosen by the MEC.

Misstatements and Omissions: Any misstatement in, or omission from, the application is grounds to suspend the application process. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response. The Chair of the Credentials Committee and/or the Medical Staff President will review the response and determine

whether the application should be processed further. The decision to suspend or cease processing an application due to a misstatement or omission does not entitle the applicant to a procedural hearing or appellate review rights.

### **5.3 Applicant for Initial Appointment and Reappointment for Medical Staff Membership**

Applicants for appointment or reappointment must complete, sign and date the prescribed application form provided by the Medical Staff. The application shall request detailed information about the applicant and shall document the applicant's agreement to abide by the Medical Staff Bylaws, Rules, and other terms. The applicant must provide all of the requested information, the agreements, and all supporting documentation to the Medical Staff office. An application which is incomplete will not be accepted for review. The applicant must pay the required fee, if any, at the time the application is submitted or it will not be accepted for review.

### **5.4 Basis for Appointment and Reappointment to the Medical Staff**

Recommendations for appointment and reappointment to the Medical Staff and for granting and renewal of Privileges shall be based upon:

- 1) The applicant's or Member's professional performance at this Hospital and in other settings;
- 2) Whether the applicant or Member meets the qualifications and is able to carry out all of the responsibilities specified in these Bylaws and the Rules; and
- 3) The Hospital's patient care needs and ability to provide adequate support services and facilities for the applicant or Member.

#### **A) Term of Appointment, Extensions, and Failure to File Reappointment Application**

Except as otherwise provided in these Bylaws, initial appointments to the Medical Staff shall be until the applicants' second birthday after the initial provisional appointment. Reappointments shall be for a maximum period of two years. The Credentials Committee may recommend the granting of reappointments for less than two years.

Failure to file a complete and timely application for reappointment shall result in the automatic termination of the Members' membership Privileges and prerogatives at the end of that term.

### **5.5 Application Procedure.**

5.5.1 Application for Medical Staff membership must be submitted directly to the Credentials Committee by the applicant in writing and on such form as approved by the MEC. Prior to the application being submitted, the applicant will be provided access to a copy of the Medical Staff Bylaws, the Rules and Regulations of the Staff and its Departments and Divisions, and summaries of the policies and resolutions relating to clinical practice in the Hospital and Health Centers. An applicant who does not meet the basic qualifications or requirements as outlined in these Bylaws, related rules or policies, is not eligible or qualified to apply for Medical Staff membership and the application shall not be accepted for review.

If, during any stage of the application process, it is discovered that the applicant does not meet the basic qualifications or requirements as outlined in these Bylaws, related rules or policies, review of the application shall be discontinued.

An applicant who does not meet the basic qualifications or requirements is not entitled to procedural hearing and appellate review rights.

#### 5.5.2 Application Content

Every applicant, except Resident staff applicants, must furnish a complete application providing all supporting documentation and an accurate and complete response to each query including but not limited to the following:

- 1) The applicant's undergraduate, medical school, and postgraduate training, including the name of each institution, degrees granted program completed, and dates attended;
- 2) All currently valid medical, dental, podiatric and other professional licensures or certifications, and Drug Enforcement Administration registration (with exceptions determined by Credentials Committee action when the applicant will not be prescribing medication) and any other controlled substances registration, with the date and number of each;
- 3) Specialty or sub-specialty board certifications and/or recertification;
- 4) Health impairments (including alcohol and drug dependencies), hospitalizations, and institutionalizations, if any, which may affect the applicant's ability in terms of skill, attitude and judgment to perform professional and Medical Staff duties;
- 5) Applicant's statement that his or her health status is such that he or she has the ability to perform the privileges requested;
- 6) Applicant's statement that he or she will consent to and cooperate with any required physical or mental health evaluations and provide the results from the evaluations to enable a full assessment of the applicant's fitness, as described in Section 5.2, 'Applicant's Burden';
- 7) Evidence of applicant's current Professional Liability Insurance coverage, or if not currently insured, evidence of past Professional Liability Coverage;
- 8) Whether there are any pending or completed actions involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of the applicant's license or certificate to practice any profession in any state or country; Drug Enforcement Administration or other controlled substances registration; membership or fellowship in local, state or national professional organizations; or faculty membership at any medical or other professional school;
- 9) The location of offices, names and addresses of other practitioners with whom the applicant is associated and inclusive dates of such association; names and locations of any other hospital, clinic or health care institution where the applicant provides or



- provided clinical services with the inclusive dates of each affiliation, status held, and general scope of clinical privileges, for the last five years;
- 10) Requests for department assignment(s), staff category after conclusion of provisional status, and specific Clinical Privileges;
  - 11) Whether the applicant has ever been charged with or convicted of a crime, other than minor traffic violations, or whether a criminal action is now pending;
  - 12) Whether there are any pending or completed actions involving denial, revocation, suspension, reduction, limitation, probation, non-renewal or voluntary relinquishment (by resignation or expiration) of Medical Staff membership, or privileges at another hospital, clinic or health care facility of institution;
  - 13) References as required below;
  - 14) An acknowledgement that the applicant has read the Medical Staff Bylaws of the Contra Costa Regional Medical Center and Health Centers, that he/she understands said Bylaws, and that he/she agrees to be bound by the terms thereof, as they may be amended from time to time, if he/she is granted membership or Clinical Privileges, and to be bound by the terms thereof, without regard to whether or not he/she is granted membership and/or clinical privileges in all matters relating to consideration of this application;
  - 15) Any and all continuing medical education classes attended by applicant in the last twenty-four (24) months;
  - 16) Whether the applicant has had any notification of, or involvement in, a professional liability action, the applicant's complete malpractice claims history, including all information regarding lawsuits, or settlements made, concluded and pending;
  - 17) Whether the applicant has been excluded from federal health care program in the past, or is subject to a pending or current exclusion from a federal health care program;
  - 18) The applicant's consent to the release and inspection of all records and documents as may be necessary for a thorough evaluation of the applicant's professional qualifications, background and health status;
  - 19) The applicant's consent to provide release and a release from liability for all individuals requesting and all individuals providing information related to the applicant's professional qualifications, background, or health, or evaluating and making judgments regarding the applicant's professionalism qualifications, background, or health;
  - 20) A valid photo identification issued by a state federal agency;

Applicants to the Resident Staff must furnish the information and/or documentation listed in (1), (2), (5), (6), (8), (11), (12), (14), (18), (19) and (20) above, and may do so by submitting their residency application form, updated as necessary to include these required items, in lieu of submitting the standard application form described herein.

Furthermore, each applicant will be assessed an application fee as determined by policies set forth by the Medical Executive Committee. The application will not be processed without receipt of this fee.

### 5.5.3 References

The applicant must include the names of at least three (3) professionals currently licensed and practicing in the same discipline as the applicant, not currently or about to become corporate or business partners with the applicant in professional practice or personally related to him, who have personal knowledge of the applicant's current clinical ability, competence, ethical character, health status and ability to work cooperatively with others and who will provide specific written comments on these matters, and letters of recommendation for staff membership.

The named individuals must have acquired the requisite knowledge through recent observation of the applicant's professional performance over a reasonable period of time and at least one must have had organizational responsibility for supervision of his/her performance (e.g., Department Chairperson, Service Chief, Training Program Director). The applicant is responsible for submitting three (3) letters of recommendation from the named professional references to the Credentials Committee Chairperson.

At the discretion of the Credentials Committee, the requirement of receipt of all three letters of reference may be reduced to two (2).

### 5.5.4 Effect of Application

The applicant must sign the application and in so doing:

- 1) Attests to the correctness and completeness of all information furnished and acknowledges that any significant misstatement in or omission from the application constitutes grounds for denial of appointment or revocation of Medical Staff membership;
- 2) Signifies his/her willingness to appear for interviews in connection with his/her application;
- 3) Agrees to abide by the terms of the Bylaws, Rules, and policies and procedures manuals of the Medical Staff if granted membership and/or Clinical Privileges, and to abide by the terms thereof in all matters relating to consideration of the application without regard to whether membership and/or privileges are granted;
- 4) Agrees to maintain an ethical practice and to provide continuous care to his or her patients;
- 5) Agrees to keep Medical Staff representatives up to date on any change made or proposed in the status of his/her professional license to practice, DEA or other controlled substances registration, malpractice insurance coverage, and membership or clinical privileges at other institutions;
- 6) Authorizes and consents to Medical Staff representative consulting with prior associates or others who may have information bearing on professional or ethical qualifications and competence and consents to Medical Staff representatives inspecting all records

and documents that may be material to evaluation of said qualifications and competence;

- 7) Releases from any liability all those who, in good faith and without malice, review, act upon or provide information regarding the applicant's competence, professional ethics, utilization practice patterns, character, health status, and other qualifications for staff appointment and clinical privileges.

#### 5.5.5 Processing the Application

##### 1) Verification of Information

After the application is submitted to the Credentials Committee Coordinator, the Credentials Committee Coordinator shall seek to verify the references, licensure status, and other qualification evidence submitted in support of the application, and to obtain the supporting information relevant to the application. The Coordinator shall verify in writing and from the primary source whenever feasible. The Credentials Committee Coordinator shall also query the National Practitioner Databank, and shall promptly notify the applicant of any problems in obtaining any of the information required. Upon such notification, it shall be the applicant's obligation to obtain the required information.

Verification shall include sending a copy of the list of Clinical Privileges requested by the applicant to at least his/her most recent affiliations and a request for specific information regarding his/her competence in exercising those privileges.

When the application is complete as defined in subsection (b), the Credentials Committee Coordinator transmits the application and all supporting materials to the Head of each Department in which the applicant seeks Privileges.

##### 2) Definition of Completed Application

A completed application shall consist of all pertinent material including receipt in the Medical Staff office of all correspondence from references and other medical staffs as required.

##### 3) Incomplete Applications

Incomplete applications will not be accepted for review. In addition to applications which are incomplete as described by Section 5.3, 'Application for Initial Appointment and Reappointment for Medical Staff Membership', applications may be deemed incomplete as follows.

If the MEC, the Medical Staff office, or Credentials Committee, Administrator or Governing Body review the application requests additional information, documentation, or clarification from the applicant, and/or an interview with the applicant, the applicant

will be promptly notified and the application process will be suspended, and the application shall be deemed incomplete, until the requested information, documentation, or clarification has been provided and/or the requested interview has been conducted. No application shall be considered complete until it has been reviewed by the Department Head or designee for each department for which the applicant seeks privileges, the Credentials Committee or designee and the Medical Executive Committee, and all have determined that no further documentation or information is required to permit consideration of the application.

The Medical Staff shall promptly inform the applicant of the specific request(s) made, the time period within which the applicant must satisfy the request and the effect on the application process if the request is not satisfied within that time period.

#### 4) Department Evaluations

The Head of each Department in which the applicant seeks privileges reviews the application and its supporting documentation and forwards to the Credentials Committee a written report as required evaluating the evidence of the applicant's training, experience and demonstrated ability and stating how the applicant's skills are expected to contribute to the activities of the Department.

The Department Head or his/her designee shall conduct an interview with the applicant. If a Department Head requires further information, he/she may defer transmitting his/her report, but overall the combined deferral time generally should not exceed thirty (30) days. In case of a deferral, the Department Head must notify the Chairperson of the Credentials Committee in writing of the deferral and the grounds. If the applicant is to provide additional information or a specific release/authorization to allow Medical Staff's representative to obtain information, the notice to him/her must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed a voluntary withdrawal of the application.

#### 5) Credentials Committee Evaluation

The Chairperson of the Credentials Committee or a designated committee member may conduct an interview with the applicant. Following the interview, the Credentials Committee reviews the application, the supporting documentation, the reports from the Department Heads, and any other relevant information available to it. The Credentials Committee then transmits to the Medical Executive Committee (MEC) its written report and recommendations as required. If the Credentials Committee requires further information, it may defer transmitting its report, but generally for not more than thirty (30) days. If the applicant is to provide the additional information or specific release/authorization to allow Medical Staff representatives to obtain information, the

notice to him/her must so state, must be a special notice, and must include a request for the specific data/explanation or release/authorization required and the time frame for response. Failure to respond in a satisfactory manner, i.e. provide the requested information by the date specified is deemed a voluntary withdrawal of the application.

The Credential Committee's written report, as required, is transmitted with all supporting documentation to the MEC.

- 6) The MEC, at its next regular meeting after receiving the Credentials Committee recommendation, reviews the application, the supporting documentation, the reports and recommendations from the Department Heads and Credentials Committee, and any other relevant information available to it. The MEC is responsible for determining staff status. The MEC defers action on the application, or prepares a written report with recommendations as required.
- 7) Effect of Medical Executive Committee Action
  - A. Deferral. Action by the MEC to defer the application for further consideration must, except for good cause, be followed up within forty-five (45) days with its report and recommendations. The Medical Staff President promptly sends the applicant a special notice of an action to defer, including a request for the specific data/explanation or release/authorization, if any, required from the applicant and the time frame for response. Failure, without good cause, to respond in a satisfactory manner by that date is deemed voluntary withdrawal of the application.
  - B. Favorable Recommendation. When the MEC's recommendation is favorable to the applicant in all respects, the Medical Staff President promptly forwards it, together with all supporting documentation, to the Administrator. All supporting documentation means the application form and its accompanying information, the reports and recommendations of the Division and Department Heads, Credentials Committee and MEC, and dissenting views.
  - C. Adverse Recommendation. When the MEC's recommendation is adverse to the applicant, the Medical Staff President promptly forwards it, together with all supporting documentation, to the Administrator, and the Administrator immediately informs the applicant by special notice, and the applicant is entitled to the procedural rights provided in the Bylaws.
- 8) Administrator Action
  - A. On MEC recommendation the Administrator may adopt or reject, in whole or in part, a favorable recommendation or refer the recommendation back to the MEC for further consideration stating the reasons for such referral and setting a time limit within which a subsequent recommendation must be made to the Administrator.
  - B. If the Administrator's action is favorable to the applicant, this action is forwarded to the Governing Body for final approval. If the Administrator's action, after complying with the applicable requirements, is adverse to the applicant in any respect, the

Administrator promptly informs the applicant by special notice, and the applicant is then entitled to the procedural rights provided in the Bylaws.

- C. If the Governing Body, upon receiving a report from the Administrator for favorable action, disagrees with the Administrator, it must comply with the requirements below concerning Conflict Resolution. If, after such compliance, the decision is adverse to the applicant in any respect, the Administrator shall promptly inform the applicant by mailing a special notice to the applicant. The applicant is then entitled to the procedural rights provided in the Bylaws and the applicant shall be so informed by the special notice.
- 9) Content of Reports and Bases for Recommendations and Actions. The report of each individual or group, including the Administrator, required to act on an application must include recommendations as to approval or denial of, and any special limitations on, staff appointment, category of staff membership and prerogatives, Department affiliation(s) and scope of Clinical Privileges.
  - 10) Conflict Resolution. Whenever the Administrator or Governing Body disagrees with the recommendation of the MEC, the matter will be submitted for review and recommendation to a joint conference composed of two members each from the Medical Staff and the Governing Body, appointed by the President of the Medical Staff and the Chairperson of the Governing Body, respectively, before the Governing Body makes its decision.
  - 11) Notice of Final Decision
    - A. The Administrator shall mail notice of the Governing Body's final decision to the applicant, with copies to the Medical Staff President and the applicable Department Head(s).
    - B. A decision and notice to appoint included:
      - 1) The Staff category to which the applicant is appointed;
      - 2) The Department(s) to which he/she is assigned;
      - 3) The Clinical Privileges he/she may exercise; and
      - 4) Any special conditions attached to the appointment.
  - 12) Time Periods for Processing
    - Individual/Group
      - A. Applicant. One hundred and twenty (120) days.
        - 1) If the fully completed application is not received by the Medical Staff Office as defined, within One hundred and twenty(120) days, the application will be returned and reapplication will not be allowed for a period of ninety (90) days and any temporary privileges granted are immediately terminated.
      - B. Credentials Committee Coordinator. Thirty (30) days.
      - C. Department Heads. Thirty (30) days after receiving material from Credentials Committee Coordinator.

- D. Credentials Committee. Thirty (30) days after receiving reports from the Credentials Committee Coordinator and Department Head.
- E. Medical Executive Committee. At the next regular meeting after receiving report from the Credentials Committee.
- F. Administrator. Fifteen (15) days after receiving report from the Medical Executive Committee.
- G. Governing Board. At the next regular meeting after receiving report from the Administrator.
- H. The time periods set forth are guidelines, not directives, and do not create any rights in any application to have his or her application processed within a specific time frame.

If an applicant is not offered or does not accept an offer for employment (permanent, temporary or contract) at CCRMC and Health Centers, the application will be deemed withdrawn.

When a Medical Staff member's employment (permanent, temporary, or contract) at CCRMC and Health Centers ends, clinical privileges will automatically expire, except when (1) the member requests an exception and (2) the exception is approved by both the Credentialing Committee and the Medical Staff President. The expiration of clinical privileges is an administrative action and does not entitle the individual to procedural hearing and appellate review rights.

#### 5.5.6 Staff Category upon Appointment

Except for applicants to the Resident Staff, all appointments to the Staff shall be to the Provisional Staff. After successful completion of the provisional term, as defined, the Medical Executive Committee, after recommendation from the Credentials Committee, shall assign the appropriate staff category.

### 5.6 Reappointment and Requests for Modifications of Staff Status or Privileges

Applications for reappointment are due one hundred and fifty (150) days prior to the expiration of a Member's term. Applications that are not complete at ninety (90) days prior to the expiration of a term are not processed and the membership automatically expires at the end of the term. Applications completed between one hundred and fifty (150) and ninety (90) days from the end of a term are charged a late fee as noted in the Rules.

At least one hundred and eighty (180) days prior to the expiration date of the current staff appointment (except for temporary appointments), a reappointment form developed by the Medical Executive Committee shall be mailed or delivered to the Member. The completed application form and Medical Staff dues are due one hundred and fifty (150) days prior to the expiration date. The department Chair will be notified if the member is delinquent. Each Medical Staff Member shall submit to the Credentials Committee the completed application form for renewal of appointment to the staff and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the

qualifications of the applicant including, but not limited to, the matters set forth in these Bylaws as well as other relevant matters.

The results of performance monitoring, evaluation, and identified opportunities to improve care and service are printed and included in the reappointment file. Ongoing Professional Practice Evaluation (OPPE) data are collected and provided as evidence of the practitioner's current competence. A reappointment may be deferred if more information is needed.

Upon receipt of the application, the information shall be processed as set forth commencing at Section 5.4. In addition, the Department Head will review the applicants' QA profile if there is one.

A Medical Staff Member who seeks a modification of Clinical Privileges may submit such a request at any time upon a form developed by the Medical Executive Committee, except that such application may not be filed within one year of the time similar request has been denied.

#### 5.6.1 Effect of Application

The effect of an application for reappointment or modification of staff status or privileges is the same as that set forth in Section 5.5.

#### 5.6.2 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 generally following the procedures set forth in Section 5.5.

### 5.7 Leave of Absence from the Medical Staff

A Member may request a leave of absence not to exceed two (2) years. No leave is effective unless and until approved by the Medical Executive Committee. At the end of the leave the Member must apply for reinstatement. The Member must provide information regarding his or her relevant activities during the leave of absence if the MEC so requests. During the period of leave, the Member shall not exercise Privileges at the Hospital, and membership rights and responsibilities shall be inactive. The obligation to pay dues, if any, shall continue during the leave unless waived by the Medical Executive Committee.

#### 5.7.1 Reinstatement after a Leave

Failure, without good cause, to request reinstatement of Membership at least thirty (30) days prior to the end of an approved leave shall be deemed voluntary resignation from the Medical Staff. The MEC shall make recommendations concerning reinstatement of the Member's Membership and Privileges to the Governing Body for final action.



## **5.8 Waiting Period after Adverse Action**

An applicant, Member, or prior Member is not eligible for Membership in the Medical Staff and /or granting of Privileges for twenty-four (24) months after an adverse action regarding his or her Membership or Privileges.

5.8.1 An Adverse Action occurs when any of the following occur:

- A. A final adverse decision regarding appointment or privileges is made by the Governing Body, or an applicant withdraws his or her application or request for Privileges following an adverse recommendation by the Medical Executive Committee to the Governing Body.
- B. A final adverse decision resulting in termination of a Member's membership or Privileges is made by the Governing Body, or if the Member resigns Membership or relinquishes Privileges while an investigation and resolution is pending concerning her/his membership and/or relevant Privileges.,
- C. A final adverse decision resulting in termination or restriction of Privileges or denial of a request for additional Privileges is made by the Governing Body

5.8.2 The Medical Staff may, as part of an adverse action, waive the twenty-four (24) month ineligibility period or limit it in some way including but not limited to require proctoring or supervision.

5.8.3 An action is considered final on the date the application was withdrawn, a Member's resignation became effective, or upon completion of all hearings and appellate reviews described in the Bylaws pertinent to the action. After an ineligibility period, the individual may reapply for Membership or re-request Privileges. The application will be treated as an initial application or request, except that the individual must document to the satisfaction of the Medical Staff that the basis for the adverse action no longer exists and that sufficient measures have been taken to assure that it will not occur again. With regard to the subject of the adverse action, the Medical Staff may impose more stringent conditions and requirements for evaluation, documentation, and monitoring than it might in an application de novo or it may deny the request outright.

## **5.9 Confidentiality and Impartiality**

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

## ARTICLE 6

### PRIVILEGES

#### 6.1 Exercise of Privileges

Except as otherwise provided in these Bylaws, every Member providing direct clinical services at this Hospital shall be entitled to exercise only those Privileges specifically granted to him or her. Clinical privileges may be granted, continued, modified, or terminated by the Governing Body only upon the recommendation of the Medical Staff as outlined in these Bylaws.

#### 6.2 Delineation of Privileges in General

##### 6.2.1 Requests

- A. Each applicant for appointment and reappointment to the Medical Staff must contain a request for the specific Privileges desired by the applicant. A request for modification of Privileges must be supported by documentation of training and/or experience supportive of the request. A Member may make requests for modifications of Privileges at any time.
- B. Each department is responsible for developing written criteria for granting Privileges. These criteria take effect only after approval by the Medical Executive Committee (MEC.)

##### 6.2.2 Basis for Privilege Determinations

Requests for Privileges shall be evaluated upon the basis of the Member's education, training, experience, demonstrated professional competence and judgment, clinical performances, and the documented results of patient care. Privilege determinations shall also be based upon pertinent information concerning clinic performance obtained from other sources, especially other institutions and health care setting where an individual exercises Privileges.

##### 6.2.3 Privileges for Department Heads

Privileges for Department Heads will be acted upon by the Medical Staff President. If a Department Head is also the Medical Staff President, privileges will be acted upon by the Past President. In no event will a Department Head approve his/her own privileges.

##### 6.2.4 Admissions

Dentists, oral surgeons, podiatrists and clinical psychologist Members are non-Physician members. They may admit patients only if a Physician Member assumes responsibility for the care of the Patient's medical problems during the hospitalization. These non-physician members may participate in the patient's care to the extent allowed by the responsible Physician Member and the Medical Staff Bylaws and Rules.

### 6.2.5 Medical Appraisal

A Physician Practitioner shall provide ongoing medical evaluation of all patients receiving some care from a non-physician Member. The Physician shall also provide appropriate supervision and control of the patient care provided by the non-physician Member.

## 6.3 Resident Physicians

By virtue of their enrollment in an accredited training program, resident physicians hold privileges to admit patients, perform procedures and provide services as assigned under the supervision of licensed physician members of the Medical Staff who have privileges for the patient care being rendered and the Residency Director. All resident physicians must meet qualifications for licensing and membership as outlined above in section 2.2.2 subsection C. Second year residents with 18 months of training and in good standing with the residency program may apply for privileges

## 6.4 Temporary Privileges

### 6.4.1 Circumstances

The Administrator (or his/her designee), with the written concurrence of the Medical Staff President and the Chairperson of the Department where the Privileges will be exercised, may grant temporary Privileges to a practitioner subject to the following conditions:

#### A. Pendency of Application:

After receipt of a completed application for appointment or reappointment (see Section 5.5- including a request for specific Privileges for an initial period of sixty (60) days while the application is being processed. If the processing of the completed application by the Medical Staff requires more than sixty (60) days, the temporary Privilege may be extended for up to an additional sixty (60) days at the discretion of the Medical Staff President or his/her designee. Temporary Privileges shall automatically terminate at the end of a maximum of one hundred and twenty (120) days, unless earlier terminated in accordance with the Bylaws.

#### B. Important Patient Care, Treatment and Service Need.

After receipt of an application for appointment or reappointment, including a request for specific Privileges, an applicant may be granted temporary privileges for the purposes of important patient care, treatment or service need, for an initial period of sixty (60) days while the application is being processed. The Medical Staff must be able to verify the applicant's current licensure and competence, or temporary Privileges are denied. The National Provider Data Bank will be queried. If the processing of the application by the Medical staff requires more than sixty (60) days, the temporary Privileges may be extended for up to an additional one hundred and twenty (120) days at the discretion of the Medical Staff President or his/her designee. Temporary

Privileges shall automatically terminate at the end of a maximum of one hundred and eighty (180) days, unless earlier terminated in accordance with the Medical Staff Bylaws.

#### 6.4.2 Conditions

Temporary Privileges may be granted only after the practitioner has submitted a written application for appointment and a request for temporary Privileges and the information available reasonably supports a favorable determination regarding the requesting practitioner's licensure, qualifications, ability, and judgment to exercise the Privileges requested, and only after the practitioner has satisfied the requirement regarding professional liability insurance. The chairperson of the department to which the practitioner is assigned shall be responsible for supervising the performance of the practitioner granted temporary Privileges, or for designating a department member who shall assume this responsibility. That Chairperson may impose special requirements of consultation and reporting. Before temporary Privileges are granted, the practitioner must acknowledge in writing that he/she has received a copy of the Bylaws and Rules and that he/she agrees to be bound by the terms thereof in all matters relating to his/her temporary Privileges.

#### 6.4.3 Termination

The Administrator or the President of the Medical Staff may terminate any or all of a practitioner's temporary Privileges:

- A. Upon discovery of any information or the occurrence of any event of a nature which raises question about a practitioner's professional qualifications or ability to exercise any or all of the temporary Privileges granted by the Administrator or President of the Medical Staff;
- B. If the life or well-being of a patient is endangered in the opinion of the grantor of the temporary Privilege;
- C. In addition, any person entitled under these Bylaws to impose summary suspensions may terminate temporary Privileges if the well-being of a patient is endangered or thought to be endangered by the person termination the temporary Privilege. Any such termination shall be reviewed at the next scheduled meeting of the Medical Executive Committee. In the event of any such termination, the Department will assign the practitioner's patients then in the Hospital to another practitioner(s) or Division Head responsible for supervision. The wishes of the patient will be considered, where feasible, in choosing a substitute practitioner.

#### 6.4.4 Rights of the Practitioner

A practitioner shall not be entitled to the procedural rights afforded by these Bylaws merely because his/her request for temporary Privileges is denied. However, if all or any portion of

his/her temporary Privileges are terminated or suspended, the practitioner shall be entitled to those procedural rights.

## **6.5 Emergency Privileges**

In the event of an emergency, any Member of the Medical Staff is permitted to do everything reasonably possible to save the life of a patient or to save a patient from serious harm. The Member shall promptly enlist assistance from and yield patient care to a qualified Member as soon as one becomes available.

## **6.6 Focused Professional Practice Evaluation (FPPE)**

### **A. General Requirements**

All initial appointments to the Medical Staff and all Members granted new Privileges shall be subject to Focused Professional Practice Evaluation (FPPE). Information used for evaluation may be obtained through, but is not limited to the following:

- 1) Concurrent or targeted medical record review.
- 2) Direct observation.
- 3) Monitoring/proctoring of diagnostic, procedural, and/or treatment techniques.
- 4) Discussion with other practitioners involved in the care of specific patients.
- 5) Interviews with the physician involved in the patient's care.
- 6) Sentinel event data.
- 7) Any applicable peer review data.
- 8) Review of data from other institutions with applicant/member's permission.

B. Each appointee or recipient of new Clinical Privileges shall be assigned to a department (or departments) where performance on an appropriate number of cases as established by the Medical Executive Committee shall be observed by the chair of the department or the chair's designee, to determine suitability to continue to exercise the Clinical Privileges granted in that department.

C. The Member shall remain subject to FPPE until the Credentials Committee has been furnished with a report signed by the chair of the department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department.

D. FPPE may be implemented whenever the Medical Executive Committee or its designee determines that additional information is needed to assess a Member's performance.

E. FPPE is not an adverse action or a disciplinary measure. It is a means of gathering information regarding a Members' skills. Therefore, the requirements of proctoring does not itself give rise to the hearing rights triggered by an adverse action.

F. During FPPE, the Member must demonstrate the requisite competence required to exercise the Clinical Privileges.

#### 6.6.1 Completion of FPPE

FPPE shall be deemed successfully completed when the Credentials Committee has received sufficient information about the applicant's competency.

#### 6.6.2 Requirements to Provide FPPE

Members of the Medical Staff shall serve in a manner consistent with FPPE requirements. Refusal to serve in this capacity, without good cause, as determined by the Medical Executive Committee, is grounds for corrective action.

#### 6.6.3 Failure to Complete FPPE

A Member who fails to complete the required initial FPPE within one year shall be deemed to have voluntarily withdrawn his or her request for those Privileges. The Credentials Committee or the Medical Executive Committee may extend the time for completion of FPPE in appropriate cases. If a Member completes the necessary FPPE but fails to perform competently he or she may have the relevant Privileges revoked or involuntarily modified in order to assure quality patient care. Failure to successfully complete proctoring may, in certain situations, be adequate grounds for revocation, suspension, or other involuntary modification of membership and/or privileges. Such actions regarding Privileges and Membership qualify as adverse actions entitling the practitioner to appropriate procedural hearings.

### 6.7 Disaster Privileges

In the event of a disaster of sufficient magnitude to require use of resources beyond those available to the Hospital and Medical Staff, privileges may be granted to volunteers on an emergent basis to handle immediate patient care needs ("Disaster Privileges").

#### 6.7.1 Declaration of Disaster

The Hospital disaster plan must be implemented prior to consideration of granting Disaster Privileges.

#### 6.7.2 Individuals Responsible for Granting Disaster Privileges

The Medical Staff President or his/her designee, or the Administrator or his/her designee(s) are responsible for granting Disaster Privileges. Under the disaster plan, and in the absence of the above persons or designees, the incident commander, or his/her designee(s), is the individual responsible for granting Disaster Privileges until the above person or designees are present to carry out the function of granting Disaster Privileges.

##### A. Responsibilities of Individuals Granting Disaster Privileges.

Disaster Privileges may be granted on a case-by-case basis, and the responsible individual, at his or her discretion, is not required to grant Privileges to any individual.

### 6.7.3 Identification Requirements for Disaster Privileges

Disaster Privileges may be granted upon the presentation of a valid photo identification issued by a state or federal agency, and at least one of the following items;

- A. A current hospital ID card that clearly identifies professional designation.
- B. A current license to practice and a valid photo ID issued by a state or primary source verification of the license.
- C. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR-VHP, or other recognized state or federal organization or group.
- D. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity.)
- E. Verification of identity and qualifications by current Hospital or Medical Staff Member(s) with personal knowledge of the practitioner's identity and qualifications.

### 6.7.4 Disaster Identification

Practitioners granted disaster Privileges shall be identifiable to other staff by the wearing of a Disaster Identification Badge.

### 6.7.5 Management of Persons Granted Disaster Privileges

Persons granted disaster Privileges will be assigned duties either by the granting authorities as defined in Section 6.7.2, 'Individuals Responsible for Granting Disaster Privileges,' or assigned to a specific department, by the Department Chair or his/her designee. In the absence of these persons, the incident commander may assign duties or delegate this responsibility to person(s), identified in the disaster plan, who are responsible for designation of duties.

The Medical Staff oversees the professional practice of volunteer licensed independent practitioners by direct observation and clinical record review.

Disaster Privileges are automatically terminated when the disaster plan is deactivated. Disaster Privileges may be revoked at any time or for any reason by the Medical Staff President, Administrator, Department Chair, or their designee(s).

The Hospital must make a decision (based on information obtained regarding the professional practice of the volunteer) within seventy-two (72) hours related to the continuation of Disaster Privileges initially granted.

### 6.7.6 Verification Process

Verification:

Primary source verification of licensure begins as soon as the immediate situation is under control and is usually completed within seventy-two (72) hours from the time the volunteer practitioner presents to the organization. In extraordinary circumstances, when primary source verification cannot be completed in seventy-two (72) hours, there must be documentation of the following:

- Why the Primary source verification could not be performed;
- Evidence of demonstrated ability to continue to provide adequate care, treatment and services.

Primary source verification must still be done as soon as possible.

## ARTICLE 7

### GENERAL MEDICAL STAFF OFFICERS

#### 7.1 Identification

The general officers of the Medical Staff are the President, the President -Elect, and the Past President.

#### 7.2 Qualifications

Each general officer must:

- 7.2.1 Be a member of the Active Staff at the time of nomination and election and remain a Member in good standing during his/her term of office;
- 7.2.2 Be licensed as a physician and surgeon;
- 7.2.3 Willingly and faithfully discharge the duties of the office; and
- 7.2.4 Exercise the authority of the office held, working with the other general and Department officers of the Medical Staff.

#### 7.3 Attainment of Office

7.3.1 The election for the office of President-Elect shall take place in January of odd-numbered years. The person who receives the majority of the votes cast is the President-Elect and shall immediately assume the office. On July 1 of that same year, the President-elect shall assume the office of the President.

#### 7.3.2 Term of Office

The President shall serve a two-year term, and may serve a maximum of four consecutive terms. If nonconsecutive, the number of terms a President may serve is not subject to limit. At the conclusion of the President's term(s) of office, the President shall assume the office of Past-President.



7.3.3 Should the incumbent President be reelected, the office of President-Elect shall remain vacant until the next January election for President.

#### 7.3.4 Nomination

The MEC shall nominate qualified candidates for the office of President-Elect. Each nominee must be an M.D. or a D.O. Nominations may also be made from the floor at the October quarterly meeting by a Member of the Active Staff in good standing. Any such floor nomination must be seconded by a Member of the Active Staff in good standing and accompanied by evidence of the nominee's willingness to be nominated.

#### 7.3.5 Election

The President-Elect is chosen from among the nominated candidates by election as defined in these Bylaws. Candidates for Medical Staff President-Elect may submit a written statement not to exceed two pages to the Medical Staff Office no later than close of business on December 3rd. On or before December 7th, the Medical Staff Office shall mail to all active Members of the Medical Staff a list of the candidates for Medical Staff President-Elect, accompanied by the candidates' statements, if any. Approximately thirty (30) days, but no less than twenty-five (25) days, before the January meeting of the Medical Executive Committee, the Medical Staff Office shall mail ballots to all active Members of the Medical Staff.

7.3.6 In order for a ballot to be counted, it must be returned to the Medical Staff Office no later than close of business on the 11th day before the January meeting of the Medical Executive Committee. The Medical Staff President and at least one other member of the MEC shall count the ballots, unless the Medical Staff President is a candidate. In that event, the MEC shall designate a second member of the MEC to count ballots. As soon thereafter as possible, the MEC shall notify all candidates of the election results. Thereafter, but at least seven (7) calendar days before the January meeting of the MEC, the MEC shall post, or otherwise disclose the election results to the Medical Staff.

### 7.4 Vacancies

7.4.1 If the office of the President becomes vacant after an election but before the end of the current President's term, the President-Elect will assume office to fill that vacancy and will serve the remainder of the current President's term and his/her own full term as President. If the office of the President becomes vacant while the election is underway, the Past President will serve as Acting President until the results of that election are determined. Once those results are determined, the President-Elect will assume office and will serve the remainder of the current President's term and his/her own full term as President. At any other times, if the office of the President becomes vacant, the Past President will serve as Acting President pending the outcome of a special election for the office of President to be conducted as expeditiously as possible and generally in the same manner as provided in this Article. The MEC may determine, however, not to call a special election if a regular election

for the office is to be held within ninety (90) days. The winner of a special election will serve only the remainder of the current President's term.

7.4.2 In the event of a vacancy in the office of Past President, the MEC shall appoint a Member of the MEC to serve out the remainder of the vacated term.

## **7.5 Resignation and Removal from Office**

### **7.5.1 Resignation**

Any general Medical Staff officer may resign at any time by giving written notice to the Medical Executive Committee. Such resignation, which may or may not be made contingent upon formal acceptance, takes effect on the date specified in the resignation or, if no date is specified, on the date of receipt.

### **7.5.2 Removal**

**A. Authority and Mechanism:**

- 1) Removal of a general staff officer may be effected by two-thirds majority vote by secret ballot of the members of the Active Staff in good standing.

**B. Grounds:**

- 1) Permissible grounds for removal of a general staff officer include, without limitation;

**C. Failure to perform the duties of the position held in a timely and appropriate manner;**

**D. Failure to continuously meet the qualifications for the position;**

**E. Physical or mental infirmity that renders the officer incapable of fulfilling the duties of his/her office.**

## **7.6 Duties of General Staff Officers**

### **7.6.1 Medical Staff President**

The Medical Staff President shall serve as the Chief Office of the Medical Staff. The duties of the Medical Staff President shall include, but are not limited to:

- A. Enforcing the Bylaws and Rules, implementing sanctions where indicated, and enforcing 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 the chair of the Medical Executive Committee;**
- D. Serving as an ex-officio member of all other Medical Staff Committees;**
- E. Interacting with the Administrator and the Governing Body in all matters concerning 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 provided by these Bylaws and, except where otherwise indicated, designating the chairpersons of these committees;

- G. Representing the views and policies of the Medical Staff to the Governing Body and to the Administrator;
- H. Being a spokesperson for the Medical Staff in external professional and public relations;
- I. Performing such other duties as may be required by the Bylaws, the Medical Staff, or by the Medical Executive Committee;
- J. Serving as an ex-officio member on liaison committees with the Governing Body and Administration and with outside licensing and accreditation agencies.

#### 7.6.2 President-Elect

The President-Elect shall assume all duties and authority of the Medical Staff President in the absence of the Medical Staff President. The President-Elect shall also be a member of the Medical Executive Committee and an ex-officio member of the Joint Conference Committee. The President-Elect shall perform such other duties as the Medical Staff President may assign or delegate to the President-Elect.

#### 7.6.3 Past President

The Past President shall have the same duties and responsibilities as the President-Elect in the absence of the President-Elect.

## ARTICLE 8

### DEPARTMENT AND DIVISIONS

#### 8.1 Organization of Departments

Each Department shall be organized as an integral unit of the Medical Staff and shall have a chair. The authority, duties, method of selection and responsibilities of these Department officers is set forth below. Each Department may appoint such standing or ad-hoc committees as it deems appropriate to perform its required functions. A Department may be further divided, as appropriate, into divisions. The division shall be directly responsible to the Department within which it functions. Each division shall have a division head appointed by the department head or elected by the division members, entrusted with the authority, duties and responsibilities specified in Section 8.7. When appropriate, the Medical Executive Committee may recommend to the Medical Staff the creation, elimination, modification, or combination of Departments or divisions.

##### 8.1.1 Current Clinical Departments and Divisions:

The current Clinical Departments and Divisions are:

1. Family and Adult Medicine
  - i. West County
  - ii. Martinez
  - iii. Concord
  - iv. East
  - v. Far East
2. Internal and Specialty Medicine
3. Hospital Medicine
4. Emergency Medicine
5. Psychiatry/Psychology
6. Pediatrics
7. Obstetrics and Gynecology
8. Surgery
9. Anesthesia
10. Critical Care Medicine
11. Dental
12. Diagnostic Imaging
13. Pathology

## **8.2 Assignment to Departments**

Each Member shall be assigned membership in at least one Department, but may also be granted membership and/or Privileges in other Departments.

## **8.3 Functions of Departments**

The functions of each Department shall include:

- 1) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the Department. The Department shall routinely collect information about important aspects of patient care provided in the Department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the Department;
- 2) Recommending to the Medical Executive Committee guidelines for the granting of Clinical Privileges and the performance of specified services within the Department;
- 3) Evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and Clinical Privileges within that Department;
- 4) Conducting, participating in, and making recommendations regarding continuing education programs pertinent to departmental clinical practice;
- 5) Reviewing and evaluating departmental adherence to: (1) Medical Staff policies and procedures; and (2) sound principles of clinical practice;
- 6) Coordinating patient care provided by the Department's Members with nursing and ancillary patient care services;

- 7) 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 Hospital;
- 8) Meeting regularly for the purpose of considering patient care review findings and the results of the Department's review and evaluation activities, as well as reports on other Department and staff functions;
- 9) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols;
- 10) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified;
- 11) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the Department;
- 12) Appointing such committees as may be necessary or appropriate to conduct Department functions;
- 13) Formulating recommendations for departmental rules and regulation reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the Medical Staff;

When the department or any of its committees meet to carry out the duties described above, the meeting body shall constitute a peer review body, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review bodies and/or committees. Each department and/or its committees, if any, must meet regularly to carry out its/their duties.

#### **8.4 Department Heads**

Each Department shall have a Department Head who shall be a Member of the active Medical Staff and shall be certified by an appropriate specialty board, or affirmatively establish, through the Privilege delineation process, that the person possesses comparable competence in at least one of the clinical areas covered by the Department.

Each Department Head shall have the following authority, duties and responsibilities:

- 1) Act as presiding Officer (Chairperson) at departmental meetings;
- 2) Report to the Medical Executive Committee and the Medical Staff President regarding all professional and administrative activities within the Department;
- 3) Generally monitor the quality of patient care and professional performance rendered by Members with Clinical Privileges in the Department through a planned and systematic process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee;
- 4) Prepare and transmit to the appropriate authorities, as required by these Bylaws, recommendations concerning appointment, reappointment, delineation of Clinical

- Privileges, and corrective action with respect to practitioners holding membership or exercising privileges or services in the Department;
- 5) Annually review, and amend as necessary, Department policies and procedures;
  - 6) Participate in managing the Department through cooperation and coordination with nursing and other patient care services and with Administration on all matters affecting patient care, including personnel, equipment, facilities, services, and budget;
  - 7) Endeavor to enforce the Bylaws, Rules and policies and regulations with the Department;
  - 8) Appoint an acting Department Head (Vice-Chairperson) during any absence;
  - 9) Assure all Department functions are performed;
  - 10) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Medical Staff President or the Medical Executive Committee;
  - 11) Plan and conduct, as requested by and in cooperation with the Residency Director, a program of instruction, supervision, and evaluation of Residents'
  - 12) Assess and recommend to the relevant hospital authority off-site sources for needed patient care services not provided by the department or organization;
  - 13) Recommend a sufficient number of qualified and competent persons to provide care, treatment and services;
  - 14) Determine the qualifications and competence of Department or service personnel who are not licensed independent practitioners and who provide patient care, treatment and service;
  - 15) Continually assess and improve the quality of care, treatment and services;
  - 16) Maintain quality control programs, as appropriate;
  - 17) Oversee the orientation and continuing education of all persons in the Department or service;
  - 18) Recommend space and other resources needed by the Department or service;
  - 19) Recommend to the Medical Staff the criteria for Clinical Privileges that are relevant to the care provided in the Department;
  - 20) Integrate the Department or service into the primary functions of the organization and coordinate and integrate interdepartmental and intradepartmental services;
  - 21) Develop and implement policies and procedures that guide and support the provision of care, treatment and services.

## **8.5 Election of Department Heads**

8.5.1 In April of each election year, the active Medical Staff of the applicable Department shall elect a Department Head.

8.5.2 The following Departments shall elect a Department Head in odd-numbered years: Family and Adult Medicine, Anesthesia, Pediatrics, Internal and Specialty Medicine, Hospital Medicine, Pathology and Dentistry.

The following Departments shall elect a Department Head in even-numbered years: Emergency Medicine, Surgery, Psychiatry/Psychology, Diagnostic Imaging, Obstetrics & Gynecology and Critical Care.

- 8.5.3 The Medical Staff President shall request nominations for Department Head at the January Quarterly Medical Staff meeting and at the applicable Department meeting. Nominations may be submitted by any department member within the nominating department regardless of status (e.g. active; courtesy, etc.). Nominations may be made only to the current Department Head or to the Medical Staff President.

The last day to nominate a candidate for Department Head is March first. Candidates may submit a written statement not to exceed two pages to the Medical Staff office no later than close of business on March 3<sup>rd</sup>. The Medical Staff Office shall mail a list of candidates to all active Members of the Medical Staff in the affected Department no later than March 7<sup>th</sup>. The candidates' statements, if any, shall accompany the list.

- 8.5.4 Approximately thirty (30) days, but no less than twenty-five (25) days, before the April meeting of the Medical Executive Committee, the Medical Staff office shall mail ballots to all the active Medical Staff Members within the affected Department.

In order for a ballot to be counted, it must be returned to the Medical Staff Office no later than close of business on the 11<sup>th</sup> day before the April meeting of the Medical Executive Committee. The Medical Staff President and at least one other member of the Medical Executive Committee shall count the ballots, unless the Medical Staff President is a candidate. In that event, the Medical Executive Committee shall designate a second member of the Medical Executive Committee to count ballots. As soon thereafter as possible, the Medical Executive Committee shall notify all candidates of the election results. Thereafter, but at least seven (7) calendar days before the April meeting of the medical Executive Committee, the Medical Executive Committee shall post, or otherwise disclose to the Medical Staff, the election results.

- 8.5.5 The Medical Executive Committee shall review the newly elected Department Heads for approval at its April meeting. The elected Department Head is thereafter subject to the approval of the Chief Medical Officer. In the event that the elected Department Head is not approved by either the Medical Executive Committee or the Chief Medical Officer, a new election shall be conducted as soon as possible. If the Chief Medical Officer does not approve a Department Head, she/he will discuss the reasons for disapproval at the next Medical Executive Committee meeting.

- 8.5.6 The Medical Staff President can appoint an acting Department Head, subject to MEC approval, to carry out the duties of Department Head until an election is possible.

- 8.5.7 Term of Office

The term of office of Department Heads is two Medical Staff years. Each assumes office on the first day of the Medical Staff year, except that a Department Head appointed to fill a vacancy assumes office immediately upon appointment. Each Department Head serves

until the end of his or her term until a successor is elected, unless he /she resigns sooner or is removed from office. A Department Head is eligible to succeed himself/herself.

#### 8.5.8 Removal

After election and ratification, removal of a Department Head from office may occur for cause by two-thirds vote of the Medical Executive Committee or a two-thirds vote of the Department Members on active staff.

### 8.6 Functions of Divisions

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

### 8.7 Division Heads

Each division shall have a Division Head who shall be a Member of the active or provisional Staff and a Member of the division which he/she heads, and shall be certified by an appropriate specialty board, or affirmatively establish through the privilege delineation process that he/she possesses comparable competence in at least one of the clinical areas covered by the division.

Each Division Head shall:

- 1) Act as presiding officer at division meetings;
- 2) Assist in the development and implementation, in cooperation with the Department Head, of programs to carry out the quality review and monitoring functions assigned to the division;
- 3) Continually review the patient care and the professional performance of Division members, and report to the Department Head patterns or situations affecting patient care within the Division;
- 4) As requested by and in cooperation with the Department Head, conduct investigations and submit reports and recommendations to the Department Head regarding the Clinical Privileges to be exercised within his/her division by Members of or applicants to the Medical Staff;
- 5) Manage the Division through cooperation and coordination with nursing and other patient care services and with Administration on all matters affecting patient care, including personnel, equipment, facilities, services, and budget;
- 6) Assure all Division functions are performed;
- 7) Perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Head, the Medical Staff President, or the Medical Executive Committee.



## **8.8 Election of Division Heads**

8.8.1 In April of each election year, the active Medical Staff of the applicable division shall elect a Division Head as set forth below.

8.8.2 Family and Adult Medicine West County and Family and Adult Medicine Far East County shall elect Division heads in even-numbered years; Family and Adult Medicine Martinez, Family and Adult Medicine Concord and Family and Adult Medicine East County shall elect Division Heads in odd-numbered years.

8.8.3 The Medical Staff President shall request nominations for Division Heads at the January Quarterly Medical Staff meeting and at the applicable division meeting. Nominations may be made only to the current Department Head or to the Medical Staff President.

The last day to nominate a candidate for Division Head is March 1st. Candidates may submit a written statement not to exceed two pages to the Medical Staff Office no later than close of business on March 3rd. The Medical Staff Office shall mail ballots to all the active Medical Staff Members within the affected division no later than March 7th. The candidates' statements shall accompany the list, if any.

8.8.4 Approximately thirty (30) days, but no less than twenty-five (25) days, before April meeting of the Medical Executive Committee, the Medical Staff Office shall mail ballots to all the active Medical Staff Members within the affected division.

For a ballot to be counted, it must be returned to the Medical Staff Office no later than the close of business on the 11th day before the April meeting of the Medical Executive Committee. The Medical Staff President and at least one other member of the Medical Executive Committee shall count the ballots, unless the Medical Staff President is a candidate. In that event, the Medical Executive Committee shall designate a second member of the Medical Executive Committee to count ballots. As soon thereafter as possible, the Medical Executive Committee shall notify all candidates of the election results. Thereafter, but at least seven calendar days before the April meeting of the Medical Executive Committee, the Medical Executive Committee shall post, or otherwise disclose to the Medical Staff, the election results.

8.8.5 The newly elected Division Heads shall be reviewed for approval by the appropriate Department Head prior to the April meeting of the Medical Executive Committee and by the Medical Executive Committee at its April meeting. The elected Division Head is thereafter subject to approval of the Chief Medical Officer. In the event that the elected Division Head is not approved by the Department Head, the Medical Executive Committee or the Chief Medical officer, a new election shall be conducted as soon as possible. If the Department Head or the Chief Medical Officer does not approve a Division head, she/he will discuss the reasons for disapproval at the next Medical Executive Committee meeting.

8.8.6 Division members shall fill vacancies due to any reason for the unexpired term by election as soon as possible. The Department Head can appoint an acting Division head, subject to MEC approval, to carry out the duties of Division Head until this election is possible.

#### 8.8.7 Term of Office

The term of office of Division heads is two Medical Staff years. Each assumes office on the first day of the Medical Staff year, except that a Division head elected to fill a vacancy assumes office immediately upon election. Each Division head serves until the end of his/her term and until a successor is elected, unless he/she sooner resigns or is removed from office. A Division Head is eligible to succeed himself/herself.

#### 8.8.8 Removal

After selection and ratification, a Division head may be removed for cause by the Department Head, a two-thirds vote of the Division Members on active Staff, or by a two-thirds vote of the MEC.

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## ARTICLE 9

### COMMITTEES

#### 9.1 General Provisions

##### 9.1.1 Designation

- A. The Medical Executive Committee and the other committees described in these Bylaws shall be standing committees of the Medical Staff unless otherwise indicated.
- B. The Chairperson of the Medical Executive Committee, a standing committee, or a Department may create subcommittees, or Ad-Hoc committees, in order to carry out specified tasks. These specified tasks must be within the scope of authority of the committee whose chairperson created the committee. Such committees terminate once the specified task is completed and are not standing committees.

##### 9.1.2 Appointment of Members to Committees

- A. The Medical Staff President, with the approval of the MEC, shall appoint chairpersons and members of standing committees unless otherwise specified in the Bylaws. Committee members are appointed for a term of one Medical Staff year unless otherwise specified by the Bylaws, and shall serve either until the end of this period, until the member's successor is appointed, or until the member resigns or is removed from the committee.
- B. Only Medical Staff in good standing may be voting members of any Medical Staff Committee. Other individuals may be appointed to committee positions as either Ex-officio or non-medical Staff members.
- C. For committees that are not standing committees, the person creating the committee shall appoint Chairpersons and Members.

##### 9.1.3 Removal of Committees

Unless otherwise specified in the Bylaws, committee members may be removed by the appointing authority without cause.

##### 9.1.4 Vacancies

Vacancies on any committees shall be filled in the same manner as an original appointment is made.

##### 9.1.5 Conduct of Meeting of Committees

Committee meetings shall be conducted and documented in the manner specified in these Bylaws.

### 9.1.6 Attendance of Non-Members

Members in good standing of the Medical Staff who are not committee members may attend committee meetings only with the permission of the Chair of the committee.

### 9.1.7 Accountability

All committees of the Medical Staff are accountable to the Medical Executive Committee.

## 9.2 Medical Executive Committee

### 9.2.1 Composition

The Medical Executive Committee (MEC) consists of the following Members of the Medical Staff as voting members:

- 1) President of the Medical Staff;
- 2) President-Elect;
- 3) Past President;
- 4) Clinical Department Heads;
- 5) Division heads;
- 6) The Chairpersons of the following committees shall be voting members of the MEC:
  - A. Administrative Affairs
  - B. Ambulatory Policy
  - C. Credentials
  - D. Patient Safety and Performance Improvement
  - E. Patient Care Policy and Evaluation
- 7) Chief administrators are official members of MEC with regular reporting duties without voting rights. These include the Director of Health Services, the Chief Financial Officer, the Chief Executive Officer of Hospital and Clinics, the Chief Medical Officer, the Chief Nursing Officer, the Chief Operations Officer for CCRMC/HC, the Ambulatory Care Medical Director, the Hospital Medical Director, Medical Director of Patient Safety and Performance Improvement, the Chief Medical Informatics Officer, the Residency Program Director and the Medical Director of Contra Costa Health Plan. The Chairperson of the MEC may invite other individuals to participate in the MEC meetings as non-voting guests.

### 9.2.2 Duties

The Medical Executive Committee shall:

- A. Perform and/or delegate performance of all Medical Staff functions in a manner consistent with the Bylaws and the Rules;
- B. Coordinate and implement the Activities of the committees and the Departments;
- C. Make recommendations regarding Medical Staff membership and privileges;
- D. Initiate and pursue disciplinary or corrective actions when indicated;

- E. Supervise the Medical Staff's compliance with the Medical Staff Bylaws, Rules and policies;
- F. Supervise the Medical Staff's compliance with County laws, rules, policies and procedures;
- G. Supervise the Medical Staff's compliance with state and federal laws and regulations;
- H. Supervise the Medical Staff's compliance with TJC and other applicable accreditation and certification rules;
- I. Regularly report to the Governing Body regarding the status of Medical Staff issues;
- J. Meet monthly to conduct Medical Staff business;
- K. Represent and act on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject only to such specific limitations as may be imposed by those Bylaws.

### **9.3 Committees**

In order to remain in good standing on a committee, a member must attend at least 50 percent of the meetings.

#### **9.3.1 Administrative Affairs Committee**

##### **A. Purpose and Meetings**

The Administrative Affairs Committee (AAC) fulfills staff responsibilities relating to review and revision of Medical Staff Bylaws and related manuals and forms and assumes the responsibilities for investigating and providing recommendations on such other administrative policy-making and planning matters and activities of concern to the Staff as are referred by the MEC. The AAC oversees the Institutional Review Committee (IRC) which reviews, approves or denies, monitors and evaluates research projects, protocols, and clinical investigations to be conducted within the Medical Services, in compliance with the regulations of the Food and Drug Administration and observing all requirements of any other applicable regulatory authorities for any given study. The AAC may overrule a positive recommendation of the IRC, but the AAC may not approve a study or the use of an investigational agent if disapproved/denied by the IRC. The AAC meets as needed, and reports to the MEC. When appropriate, it shares its monitoring and evaluation findings from research projects with the Patient Safety and Performance Improvement Committee and vice versa.

##### **B. Composition**

The Administrative Affairs Committee includes;

- 1) A Physician Chairperson, appointed by the Medical Staff President, subject to MEC approval;
- 2) At least 4-6 additional Staff Members;
- 3) Administrator, with vote; and
- 4) Their members with special expertise as necessary on an ad-hoc basis, without vote.

### 9.3.2 Ambulatory Policy Committee

#### A. Purpose and Meetings

The Ambulatory Policy Committee (APC) sets Medical Staff policy in the health centers and acts as a liaison with Nursing and Administration for coordination of policies and procedures under joint Medical Staff-Administration or Medical Staff-Nursing purview.

APC develops policies to resolve issues that affect more than one Medical Staff Department and focuses on policies and projects that relate to quality of care, the efficiency of the health centers and patients that relate to quality care, the regulatory compliance. APC coordinates its activities with PSPIC and receives quality assurance reports suggestive of or requiring changes in policies and procedures from individual Medical Staff Departments and from the Ambulatory Subcommittee of PSPIC.

#### I. Composition

The Ambulatory Policy Committee includes:

- 1) A Physician Chairperson; appointed by the Medical Staff President, subject to MEC approval
- 2) One Staff Member from each Region;
- 3) The Department Head of Family Medicine or his/her designee;
- 4) Representative of the Departments of Obstetrics & Gynecology, Surgery, Pediatrics and Medicine, with vote;
- 5) Other members with special expertise as needed on an ad-hoc basis without vote;
- 6) Director of Health Information Management as needed on an ad-hoc basis without vote;
- 7) A representative of the Allied Health Professionals, without vote;
- 8) Ambulatory Care Medical Director without vote;
- 9) Chief Nursing Officer without vote.

### 9.3.3 Bioethics Committee

#### A. Purpose and Meetings

The Bioethics Committee provides a multi-disciplinary forum for the development of guidelines for consideration of cases and issues having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment in cases or issues having bioethical implications; consultation with concerned parties to facilitate and education of the hospital staff regarding bioethical matters. The committee will meet regularly (at least six (6) times yearly) and will also provide a mechanism for other meetings as necessary to perform the case consultation functions. The committee chair will report to the Medical Executive Committee.

## B. Composition

The Bioethics Committee includes;

- 1) A physician chairperson appointed by the Medical Staff President subject to Medical Executive Committee approval;
- 2) Multi-disciplinary representation selected to represent the various clinical services of the medical and nursing staff, ancillary support services (such as social workers, chaplains, etc.) and lay members. At least a third of the committee membership will be physicians;
- 3) A member representing hospital administration; and
- 4) The committee may invite other professional or community lay members to be utilized when discussing issues involving their particular clinical, ethnic, religious or other background.

### 9.3.4 Cancer Committee

#### A. Purpose and Meetings

The Cancer Committee is a multi-disciplinary committee that organizes, conducts and evaluates hospital-wide oncology services and the cancer registry. The committee assures that full oncology services including surgery, chemotherapy, radiation therapy, as well as rehabilitation and hospice care are available to all patients. The committee will develop and monitor annual goals and objectives for clinical care, community outreach, quality improvement and programmatic endeavors related to cancer care. The committee is responsible for establishing and monitoring the Cancer Conference format, frequency and multi-disciplinary attendance. The committee will ascertain if there is a need for specific educational programs both professional and public based on survival and comparison data. The committee will also supervise the Cancer Registry for quality control of case-funding, abstracting, staging, reporting and follow-up. The committee will conduct a minimum of two patient care evaluation studies annually, one to include survival data. The committee will meet at least quarterly or more often as needed and communicate as necessary with the Patient Safety and Performance Improvement Committee. The committee will designate one coordinator for each of the four areas of Cancer Committee activity: Cancer Conference, quality control of the cancer registry, quality improvement and community outreach.

#### B. Composition

The Cancer Committee includes:

- 1) A Physician chairperson appointed by the Medical Staff President, subject to Medical Executive Committee approval;

- 2) At least five (5) additional Medical Staff Members including representation from Surgery, Pathology, Hematology/Oncology, Family Practice, and Diagnostic Imaging;
- 3) Cancer Liaison Physician;
- 4) Representation for Administration, Social Services, Nursing, and the American Cancer Society all with vote; and
- 5) The Cancer Registrar, who will act as staff to the Cancer Committee, with vote.

### 9.3.5 Continuing Medical Education Committee

#### A. Purpose and Meetings

The Continuing Medical Education Committee (CMEC) directs the development of CME programs for the Staff responsive to quality assurance findings and to developments pertinent at the Hospital and apprises the Staff of outside education opportunities. It coordinates the educational activities of the Departments and of the Staff and Hospital Department. The CMEC also analyzes the status and needs of, and makes recommendations regarding, the medical library services. It meets at least quarterly and more frequently if needed and reports on its activities to the MEC.

#### B. Composition

The CMEC includes:

- 1) A Chairperson appointed by the Medical Staff President, subject to MEC approval;
- 2) At least two additional Staff Members; and
- 3) Medical Librarian, without vote.

### 9.3.6 Credentials Committee

#### A. Purpose and Meetings

The Credentials Committee coordinates the staff credentials function by receiving and analyzing applications and recommendations for appointment, provisional period conclusion or extension, reappointment, clinical privileges, and changes therein, and recommending action therein, and by integrating quality assurance and utilization review and monitoring, membership, and other relevant information into the individual credentials files. It also assists in designing and participates in implementing the credentialing procedures for Allied Health Practitioners. It meets monthly or as necessary and reports to the MEC regarding the credentialing of Staff Members.

#### B. Composition

The Credentials Committee includes:



- 1) A physician chairperson, appointed by the Medical Staff President, subject to MEC approval; and
- 2) At least 4-6 additional Staff Members, selected to be representative of the Departments and major clinical specialties.

### 9.3.7 Informatics Advisory Committee

#### A. Purpose and Meetings

The Informatics Advisory Committee provides governance in informatics and Information Technology (IT)-related clinical systems. It prioritizes issues, reports and optimization and acts as a liaison between medical staff departments and IT/clinical informatics.

#### I. Composition

- 1) Chief Medical Informatics Officer (CMIO) who serves as Chair
- 2) Director of Nursing Informatics
- 3) Director of Medical Outpatient Informatics
- 4) Director of Medical Inpatient Informatics
- 5) A representative of each department.

### 9.3.8 Institutional Review Committee

#### A. Purpose and Meetings

The Institutional Review Committee shall review and have authority to: approve, require modification in (to secure approval), or disapprove all research activities within the Hospital and Health Centers; approve, require modification in, or disapprove the use of investigation drugs or devices in individuals (i.e. “compassionate use” cases); receive prompt notification of the emergency use of investigational drugs or devices and approve, require modification in or, disapprove their continued use; continue, require modifications in or terminate any ongoing studies at intervals of not greater than twelve (12) months; immediately terminate or suspend any research not conducted in accordance with the IRC’s requirements or that has been associated with unexpected serious harm to subjects; ensure all compliance with federal informed consent regulations regarding investigational use of drugs and devices; and assure the protection of the rights and welfare of all human subjects. The Institutional Review Committee shall meet semi-annually or more often as necessary to fulfill its obligations. If the Institutional Review Committee disapproves of any activity within its purview, that decision is final. The Institutional Review Committee chairperson reports to the Administrative Affairs Committee.

#### B. Composition

The Institutional Review Committee includes:

- 1) A Chairperson appointed by the Chairperson of the Administrative Affairs Committee, subject to Medical Executive Committee approval;
- 2) At least one member of each gender;
- 3) At least one member from outside the medical profession;
- 4) At least one non-scientist;
- 5) At least one member not affiliated with the Hospital and Health Centers; and
- 6) A total of at least five (5) members, including representative ethnic and cultural backgrounds, of the community.

#### 9.3.9 Inter-Disciplinary Practice Committee

##### A. Purpose and Meetings

The Inter-Disciplinary Practice Committee (IPC) shall perform functions consistent with the requirements of law and regulations (Title 22 of the California Code of Regulations, Section 70706). Method for the approval of standardized procedures in accordance with sections 2725 of the Business and Professions Code in which affirmative approval of the administrator or designee and a majority of the physicians and a majority of registered nurse members would be required. The IPC shall routinely report to the MEC; and, in addition, shall submit an annual report to the MEC. The IPC shall meet at least annually, or more often as necessary.

##### B. Composition

The IPC shall consist of:

- 1) A Physician Chairperson, appointed by the Medical Staff President, subject to MEC approval;
- 2) A Director of Nursing, or Designee: such as the clinical services director of Public Health who has oversight over NP/AHP function;
- 3) An Administrator, or designee: such as the Ambulatory Care Medical Director;
- 4) Chair of the Credentials Committee;
- 5) Nurse Practitioner Division Head
- 6) Two (2) additional allied health professionals, appointed by the IPC Chairperson, in consultation with the NP Division Head
- 7) A medical staff representative from the clinical psychology department.
- 8) Additional Allied Health Professionals who are performing or will perform functions requiring standardized procedures will be appointed by the IPC Chair on a temporary basis when issues pertaining to their functions are discussed.
- 9) Additional physician members of the medical staff physicians and/or registered nurses may be appointed by the physician chairperson or the director of nursing,

respectively, to maintain equal numbers of each on the committee in accordance with Title 22 of the California Code of Regulations, Section 70706.

#### 9.3.10 Joint Conference Committee

##### A. Purpose and Meetings

The Joint Conference Committee constitutes a forum between the Medical Staff, the Administration and the Governing Body. Two members of the Medical Executive Committee who serve at the will of the Medical Executive Committee represent the Medical Staff. These members shall act as directed by the MEC in their capacity as members of the Joint Conference Committee.

The Governing Body and the Administration shall have representation pursuant to authority separate from these Bylaws.

#### 9.3.11 Medical Staff Assistance Committee

##### A. Purpose and Meetings

In order to improve the quality of care and promote the well-being of the Medical Staff, the Medical Staff Assistance Committee (MSAC) receives reports related to health concerns, well-being, or impairment of Medical Staff Members, and other Licensed Independent Practitioners (LIPs) and, as it deems appropriate, investigates such reports. With respect to matters involving individual Medical Staff Members and other LIPs, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical Staff Member or LIP poses an unreasonable risk of harm to patients, that information may be referred for corrective action.

The process that the MSAC uses to accomplish these goals includes:

- 1) Education of the Medical Staff and other organization staff about illness and impairment recognition issues specific to the Medical Staff Member or licensed independent practitioners;
- 2) Self-referral by a physician or Licensed Independent Practitioner (LIP) and referral by other organization staff;
- 3) Referral of the Physician, or the affected LIP to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern;
- 4) Maintenance of the confidentiality of the Physician, or LIP seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;
- 5) Evaluation of the credibility of a complaint, allegation, or concern;

- 6) Monitoring of the Physician, or affected LIP and the safety of patients until the rehabilitation or any disciplinary process is complete;
- 7) Reporting to the Medical Staff leadership instances in which a Physician or LIP is providing unsafe treatment; and
- 8) Initiating appropriate action when a Physician or LIP fails to complete the required rehabilitation program.

The committee shall also consider general matters related to the health and well-being of the Medical Staff, and, with the approval of the Medical Executive Committee, develop educational programs or related activities. The Medical Staff Assistance Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record of its proceedings as it deems advisable but shall report on its activities on a routine basis to the Medical Executive Committee.

#### B. Composition

The Medical Staff Assistance Committee includes;

- 1) A Physician Chairperson, appointed by the Medical Staff President, subject to Medical Executive Committee approval;
- 2) At least two (2) additional practitioners; and
- 3) A Member of the Resident staff.

Except for the resident, who shall serve on the committee for one (1) year, each member shall serve for a term of three (3) years, and the term shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. In so far as possible, members of this committee shall not serve as active participants on other peer review or quality assurance committees while serving on this committee.

The Chairperson may appoint additional individuals who are not members of the Medical Staff, including non-physicians, when such appointment may materially increase the effectiveness of the work of the committee. These individuals shall serve for a term that shall be determined by the Chairperson.

### 9.3.12 Informatics Clinical Communication Committee (ICCC)

#### A. Purpose and Meetings

The Informatics Clinical Communication Committee addresses clinical workflows to enhance patient safety and maximize efficient care. The InBasket is the hub of communication and information flow in the electronic health record. The committee brings together provider, nursing, ancillary and technical representative to design, build, and troubleshoot processes to allow providers, nurses, and ancillary staff to care for patients safely and efficiently.

The committee will meet at least monthly and more frequently as needed.

**B. Composition**

- 1) A Chairperson appointed jointly by the Chief Medical Informatics Officer and the Medical Staff President
- 2) Family and Adult Medicine Department Representative
- 3) Pediatrics Department Representative
- 4) Internal and Specialty Medicine Representative
- 5) At least one (1) representative from Nursing Administration
- 6) At least one (1) representative from Nursing Informatics
- 7) A representative from the Public Health Division
- 8) A representative from the Information Technology Department
- 9) A representative from the Residency Program

In addition, the committee will seek representation from departments whose workflows appear on the meeting agenda, including the various ancillary services departments.

This ICCC Chair or his/her designee shall report to the Medical Executive Committee on an annual basis. The ICCC will make recommendations to IAC and operations leadership as appropriate.

**9.3.13 Patient Care Policy and Evaluation Committee**

**A. Purpose and Meetings**

The Patient Care Policy and Evaluation (PCP&E) Committee monitors, assesses and recommends improvements to the MEC for:

- 1) The clinical and medical records policies and rules of the Medical Staff and of its inpatient clinical units and diagnostic and therapeutic support services (including OR/PAR, ER, CCU's, etc.);
- 2) Medical-related aspects of infection control policies;
- 3) Pharmacy and therapeutics policies and practices; and
- 4) Blood and blood products usage policies and practices.

It also acts as liaison with Nursing and Administration for review and coordination of policies, procedures, rules or regulations under joint Medical Staff-Administration or Medical Staff-Nursing purview and coordinates its activities with those of the Ambulatory Policy Committee. The PCP&EC receives quality assurance findings suggestive of or requiring changes. It serves as a forum for identifying and discussing problems in the delivery of patient care services and in the observance of patients' rights. The PCP&EC meets monthly and reports to the MEC.

**B. Composition**

The Patient Care Policy and Evaluation Committee includes:

- 1) A Physician Chairperson appointed by the Medical Staff President, subject to MEC approval;
- 2) At least 6-8 staff members selected to be representative of major clinical areas;
- 3) A representative of Nursing Service;
- 4) Director of Pharmacy ad-hoc for Pharmacy and Therapeutic function;
- 5) A representative from Pathology Department ad-hoc for blood and blood product review function;
- 6) Manager of Infection Control and Prevention Committee of the Hospital;
- 7) A representative of Administration responsible for policy committee support without vote;
- 8) A Nursing Supervisor/Coordinators for specialty units invited on an ad-hoc basis without vote;
- 9) A representative of other clinical services and professional, technical, administrative support staff participate as consultants in relevant areas of expertise ad-hoc without vote; and
- 10) Director of Health Information management quarterly and as needed without vote.

#### 9.3.14 Patient Safety and Performance Improvement Committee

##### A. Purpose and Meetings

The Patient Safety and Performance Improvement Committee (PSPIC) has the authority and responsibility for implementing and directing the Quality Management Program for the Hospital. It is responsible for setting the quality management standards, determining criteria by which care will be measured, setting priorities for which aspects of care will be monitored, and analyzing the quality of care studies, indicators, utilization reports, grievances, survey data, and risk management information. A systematic, multi-disciplinary improvement process is followed. It develops an annual plan for performance improvement activities (Quality Management Plan).

##### B. Composition

The Patient Safety and Performance Improvement Committee includes the following Members:

- 1) A Physician Chairperson, appointed by the Medical Staff President, subject to MEC Approval.
- 3) The Medical Staff President;
- 4) The CCRMC Chief Executive Officer;
- 5) The Director of Pharmacy;
- 6) The Chief Medical Officer;
- 7) The Chief Nursing Officer;

- 8) The Ambulatory Care Medical Director;
- 9) The Chief Operating Officer;
- 10) The Chief Quality officer;
- 12) The past Medical Staff President;
- 13) The Chair of the Patient Care Policy and Evaluation Committee; and
- 14) Two (2) Medical Staff Physician representatives, appointed by the Medical Staff President, subject to MEC approval;
- 15) Patient Safety Officer;
- 16) Director of Safety and Performance Improvement;
- 17) Medical Director of Quality and Safety;
- 18) Hospital Medical Director;
- 19) Specialty Medical Director;
- 20) Hospital Regulatory Compliance Officer;
- 21) Quality Manager Program Coordinator;
- 22) One (1) Medical Staff Member representative from the Behavioral Health Division, appointed by the Medical Staff President, subject to MEC approval.

#### 9.3.15 Peer Review Oversight Committee

##### A. Purpose and Meetings

The Peer Review Oversight Committee will oversee the peer review that is carried out by the departments. It will supervise the processes, help address systems issues and review cases that involve more than one department.

##### B. Composition

- 1) The Medical Staff President shall serve as Chair of the Committee;
- 2) Each department will have at least one (1) representative. Large departments will have two (2) representatives one from inpatient and the other from outpatient. Large departments are: Family and Adult Medicine, Internal and Specialty Medicine, Surgery, and Psychiatry/Psychology.

#### 9.3.16 Perinatal Morbidity and Mortality (PM&M) Committee.

##### A. Function

The Perinatal Morbidity and Mortality Committee (PM&M Committee) is an interdisciplinary committee which monitors perinatal outcomes. It is intended to complement the quality assurance activities of the Departments of Pediatrics and Obstetrics and Gynecology by focusing on those cases whose management involves both obstetrical and pediatric issues. The PM&M Committee reports to the Departments of OB/GYN and Pediatrics.

##### B. Composition.

The Perinatal Morbidity and Mortality Committee consist of:

- 1) All Members in good standing of the Departments of OB/GYN, Pediatrics and Anesthesia. The individual departments established attendance obligations;
- 2) Nurse Program manager for the Perinatal Unit, Clinical Nurse Specialists for maternity and nursery and the RN Case Coordinator are members, all with voting privileges; and
- 3) Regularly invited members, all without vote, including:
  - (a) Consultant Perinatologist;
  - (b) Consultant Neonatologist;
  - (c) Any Member of the Department of Ambulatory Medicine having obstetrical privilege;
  - (d) Any Member of the Resident Staff presently assigned to the Pediatrics or OB/GYN services or with a particular interest in a case being discussed; and
  - (e) Any member of the nursing staff with a particular interest in a case being discussed. The Nurse Program Manager or his/her designee will maintain a file of confidentiality agreements signed by non-physician attendees.

#### 9.3.17 Professional Affairs Committee

##### A. Purpose of Meetings

The Professional Affairs Committee consists of the two members of the Governing Body who sit on the Joint Conference Committee. The members of the Professional Affairs Committee shall invite representatives from the Medical Staff and Administration, as appropriate, to its meetings.

##### B. Composition

The Professional Affairs Committee consists of the two (2) members of the Governing Body who sit on the Joint Conference Committee. The members of the Professional Affairs Committee shall invite representatives from the Medical Staff and Administration, as appropriate, to its meetings.

#### 9.3.18 Utilization Management Committee

##### A. Purpose and Meetings

The Utilization Management Committee develops and oversees implementation and operation of the utilization management plan relating to inpatient, ambulatory and clinical support services, makes utilization decisions as required under the plan, analyzes utilization profiles and evaluates the effectiveness of the UR program.

Physician members of the committee act as the physician advisors required by the UR plan. The URC meets at least quarterly and reports to the Performance Improvement Committee.

##### B. Composition



The Utilization Management Committee includes:

- 1) A Chairperson appointed by the Chairperson of the PSPIC, subject to MEC approval;
- 2) At least 6-8 additional Medical Staff members, selected to provide broad representation from the Medical Staff;
- 3) At least one (1) representative from Administration, without vote;
- 4) Director of Social Services, without vote;
- 5) Representative from Nursing, without vote;
- 6) Representative from Finance, without vote;
- 7) Representative from Quality Assurance Department, without vote; and
- 8) Director of Health Information Management, without vote.

## ARTICLE 10

### MEETINGS

#### 10.1 Medical Staff Meetings

##### 10.1.1 Regular Meetings

General Staff meetings will be held quarterly. The Medical Executive Committee may authorize additional regular general Staff meetings by resolution. The resolution authorizing any such additional meeting shall require notice specifying the place, date, and time for the meeting, and that the meeting can transact any business as may come before it.

##### 10.1.2 Special Meetings

A special meeting of the Medical Staff may be held by the Medical Executive Staff President. A special meeting must be held by the President at the written request of the Governing Body, the Chief Medical Officer, the Administrator, the Medical Executive Committee, or 25% of the active staff in good standing.

#### 10.2 Clinical Department and Committee Meetings

##### 10.2.1 Regular Meetings

Clinical Departments, Division, and Committees may establish by resolution the time for regular meetings. No additional notice is required.

##### 10.2.2 Special Meetings

A special meeting of any Department, Division, or Committee may be held by the Head or Chairperson thereof. A special meeting must be held by the Head or Chairperson at the written request of the Administrator, the Medical Executive Committee, the Medical Staff

President, the Chief Medical Officer, or 25% of the group's current members in good standing.

#### 10.2.3 Executive (Closed) Session

Any Committee, Department or Division may call itself into executive session at any time during a regular or special meeting. All ex-officio members shall leave during the executive session unless requested to remain by the Chairperson. Accurate and complete minutes must be made and kept of any executive session.

### 10.3 Quorum

#### 10.3.1 Medical Staff Meetings

The presence of one-third (1/3) of the active Medical Staff at a General or Special Medical Staff meeting shall constitute a quorum for all appropriate actions except the removal of a Medical Staff Officer. For a meeting considering the removal of a Medical Staff Officer, the quorum shall be one-half (1/2) of the active Medical Staff. Ex-officio members do not count for quorum purposes.

#### 10.3.2 Department and Committee Meetings

For committees, a quorum shall consist of 25% of the members of a committee by no fewer than two (2) members. For Department and division meetings, a quorum shall consist of 25% of the members. Ex-officio members do not count for quorum purposes.

### 10.4 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by a least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws.

### 10.5 Notice of Meetings

Written notice of any regular general medical Staff meeting, or any regular committee or Department meeting, not held pursuant to resolution, will be delivered personally or via mail to each person entitled to attend at not less the five (5) days or more than fifteen (15) days before the date of such meeting. Notice of any special meeting of the Medical Staff, a Department, or a committee will be given orally or in writing at least seventy-two (72) hours prior to the meeting. Personal attendance at a meeting constitutes a waiver of notice of such meeting, except when a person attends a meeting for the express purpose of objecting, at the beginning of the meeting, to the transaction of any business because of lack of notice. No business shall be transacted at any special meeting except that listed in the meeting notice.

## **10.6 Minutes**

Except as otherwise specified herein, minutes of all meetings will be prepared and retained. They shall include, at a minimum, the date and time of the meeting, a record of the attendance or members and the vote taken on all matters. A copy of the minutes shall be signed by the presiding officer of the meeting and forwarded to the medical Executive Committee.

## **10.7 Agenda**

The Medical Staff president and Medical Executive Committee shall determine the order of business at a meeting of the Medical Staff. The agenda shall include, insofar as feasible:

- 1) Reading and acceptance of the minutes of the last regular meeting and of all special meetings held since the last regular meeting;
- 2) Administrative reports from the Medical Staff president, Departments, Committees, and the Administrator;
- 3) Election of officers when required by these Bylaws;
- 4) Reports by responsible Officers, Committees and Department 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;
- 5) Old business; and
- 6) New business.

## **10.8 Attendance Requirements**

### **10.8.1 Medical Staff Meetings**

The Medical Executive Committee may adopt attendance requirements for the Medical Staff and Department meetings.

### **10.8.2 Special Attendance**

At the discretion of the Chairpersons 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 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/she was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, is grounds for corrective action.

## **10.9 Conduct of Meetings**

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

## ARTICLE 11

### CORRECTIVE ACTION

#### 11.1 Corrective Action

##### 11.1.1 Initiation

Any person may provide information to the Medical Executive Committee about the conduct, performance, or competence of its Members. When reliable information indicate a Member may have exhibited acts, demeanor, or conduct reasonably likely to be (a) detrimental to patient safety, (b) unethical or illegal, (c) contrary to the Medical Staff Bylaws and/or rules and regulations, or (d) below applicable professional standards, a request for an investigative and/or corrective action against such Member may be initiated. The President of the Medical Staff, a Department Chair, the Chair of any standing Committee, or the Governing Body may initiate such a request. All requests for corrective action and/or formal investigation shall be in writing, shall be made to the Medical Executive Committee, and shall be supported by reference to the specific activities or conduct which constitutes the grounds for the request. If the Medical Executive Committee initiates the request, it shall make an appropriate written record of the reasons for the request.

##### 11.1.2 Formal Investigation

If the Medical Executive Committee concludes a formal investigation is warranted, it may conduct the investigation itself, or assign the task to an appropriate medical Staff Officer, Department, or standing or ad-hoc committee of the Medical Staff. If the investigation is delegated, the designee shall proceed with the investigation in a prompt manner and shall provide a written report of the investigation to the Medical Executive Committee as soon as practical. The report may include recommendation for appropriate corrective action. The Member 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, 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 the imposition of summary suspension, termination of the investigative process, or other action. Any reports that are made to the Medical Executive Committee must be shared promptly with the Member under investigation.

The MEC may also require a medical or psychological exam. The examining physician shall be chosen in the manner described in Section 5.2, however, the Member is not required to pay for the exam.

### 11.1.3 Medical Executive Committee Action

As soon as practical after the conclusion of the formal investigation (or without a formal investigation if deemed unwarranted), the Medical Executive Committee shall take action that may include, without limitation:

- A. Determining no corrective action is warranted 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 a reasonable time where circumstances warrant;
- C. Issuing letters of admonition, censure, reprimand, or warning. Nothing herein shall preclude Department Heads from issuing written or oral warnings or counseling. In the event the MEC issues such letters, the affected Member may make a written response which shall be placed in the Member's file;
- D. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of 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;
- H. Taking other actions that are appropriate under the circumstances.

### 11.1.4 Subsequent Action

- A. If corrective action as set forth above is recommended by the Medical Executive Committee, the MEC shall notify the Administrator, the Governing Body, and the affected member of the Medical Staff of the recommended action.
- B. The recommendations of the Medical Executive Committee shall be final, unless the affected member or the Governing Body requests a hearing to challenge the recommendations.

## 11.2 Summary Restriction of Suspension

### 11.2.1 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, or safety of any patient, prospective patient, or other person, the Governing body, the Administrator, the Medical Staff President, the Medical Executive Committee, or the head of the Department in which the Member holds privileges may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such member. Unless otherwise stated, the summary

restriction or suspension shall become effective immediately, and the person or body responsible shall promptly give written notice to the Member as described below, the Governing Body, the Medical Executive Committee, and the Administrator. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the Member's patients shall be promptly assigned to another member(s) by the Department Chair or by the Medical Staff President, considering, where feasible, the wishes of the patient in the choice of a substitute Member.

#### 11.2.2 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 practitioner's privileges summarily could reasonably result in an imminent danger to the health of an individual. The statements 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 by these Bylaws for further action of the MEC regarding issues related to such a summary suspension.

#### 11.2.3 Medical Executive Committee Action

As soon as practicable after a summary restriction or suspension has been imposed, but no more than ten (10) calendar days thereafter, a meeting of the Medical Executive Committee shall be convened to review and consider the summary suspension or restriction. The Member may attend the meeting and make a statement concerning the issues under investigation on such terms and conditions as the Medical Executive Committee may impose. In no event shall any meeting of the Medical Executive Committee, with or without the Member in attendance, constitute a hearing, nor shall any procedural rules apply. A Member's failure, without good cause, to attend a meeting of the Medical Executive Committee after a written request to attend was mailed to the Member by the Medical Executive Committee, shall constitute a waiver of the Member's right to appear and be heard. The request of the Medical Executive Committee for the Member to attend the meeting shall be made in writing, mailed to Member's last known address by first class mail of the United States Postal Service at least five (5) calendar days before the meeting, and shall inform the Member that his or her failure to attend said meeting shall constitute a waiver of his or her rights to appear and be heard. The Medical Executive Committee may postpone or reschedule the meeting on the written request of the Member. The Medical Executive Committee may modify, continue, vacate, or terminate the summary restriction or suspension. The Medical Executive Committee shall

mail the Member written notice of its decision that shall be effective upon deposit in the United States Mail.

#### 11.2.4 Procedural Rights

Unless the Medical Executive Committee terminated or vacates the summary restriction or suspension, the Member is entitled to the procedural rights afforded by these Bylaws.

### **11.3 Grounds for Automatic Suspensions and/or Restrictions**

In certain instances, the Member's Privileges or membership may be suspended or limited as a result of certain occurrences that disqualify the member from membership or the exercise of certain Privileges. These grounds for automatic suspension do not require any action of the MEC or the Governing Body prior to the suspension and/or restriction. If a Member requests a hearing to challenge these automatic suspensions and/or restrictions, the scope of such a hearing is limited. The only question before the Judicial Review Committee in these situations is whether the grounds for automatic suspension have occurred.

#### 11.3.2 Licensure

##### A. Revocation and Suspension

Whenever a Member's license or other legal credential authorizing practice in the state is revoked or suspended by the applicable licensing or certifying authority, 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 are automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

##### C. Probation

Whenever a Member is placed on probation by the applicable licensing or certifying authority, his or her membership status and Clinical Privileges are automatically subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

##### D. Suspension of Membership when a License is Not Renewed

Expiration:

Whenever a Member's license or other credential authorizing practice in the state expires, Medical Staff Membership and Clinical Privileges shall automatically be suspended. If the member renews his or her license and is effective retroactive, the suspension will be vacated. If it is not renewed within six (6) months, Medical Staff Membership and Privileges shall be automatically revoked.

#### 11.3.3 Controlled Substances

Whenever a Member's DEA certificate is revoked, limited or suspended, the Member 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.

##### A. 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.

#### 11.3.4 Failure to Satisfy Appearance Requirement

Failure of a Member, without good cause, to appear at a Special Appearance is cause for automatic suspension of membership and restriction of Privileges.

#### 11.3.5 Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. Failure to comply with the Medical Executive Committee policies regarding completion of medical records is criteria for suspension or other corrective action. If a Member is automatically suspended for incomplete records, his/her membership is automatically reinstated once the medical records are completed. A prolonged period of automatic suspension or a repeated pattern of automatic suspensions for incomplete medical records may be grounds for further corrective action by the Medical Staff and may result in adverse reports to governmental and licensing authorities.

#### 11.3.6 Professional Liability Insurance

Failure to maintain professional liability insurance shall result in the immediate suspension of the Member's Clinical Privileges. Written notice of the suspension shall be mailed to the member at his or her last known address. Said notice shall also state that the member has ninety (90) days to provide proof of professional liability insurance, that the suspension will continue until proof of insurance is provided, and that failure to provide proof of insurance within ninety (90) days shall result in termination of Medical Staff membership. If proof of professional liability insurance is not provided to the Medical



Executive Committee within ninety (90) days, the Medical Executive Committee shall mail written notice of termination of Medical Staff membership to the Member at his or her last known address, including the information that he or she is entitled to the procedural rights set forth in these Bylaws.

## ARTICLE 12

### HEARING AND APPELLATE REVIEWS

#### 12.1 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 potential adverse action and constitute grounds for a hearing:

- 12.1.1 Denial of Medical Staff Membership;
- 12.1.2 Denial of requested advancement in Staff Membership category;
- 12.1.3 Denial of Medical Staff reappointment;
- 12.1.4 Demotion to lower Medical Staff category;
- 12.1.5 Suspension of Staff Membership;
- 12.1.6 Revocation of Medical Staff Membership;
- 12.1.7 Denial of any requested Clinical Privilege(s) except temporary Privileges;
- 12.1.8 Involuntary reduction of current Clinical Privileges, including temporary Privileges;
- 12.1.9 Suspension of any Clinical Privileges, including temporary Privileges;
- 12.1.10 Termination of any or all Clinical Privileges, including temporary Privileges;
- 12.1.11 Involuntary imposition of significant consultation or monitoring requirements, excluding monitoring incidental to provisional status;
- 12.1.12 Any other restriction(s) on Medical Staff membership or Clinical Privileges which is reportable pursuant to Section 805 of the Business and Professions Code.

#### 12.2 Exhaustion of Remedies

If adverse action described above is taken or recommended, the applicant of Member must exhaust the remedies afforded by these Bylaws before resorting to legal action.

#### 12.3 Requests for Hearing

- 12.3.1 Notice of Action or Proposed Action.

In the event of a proposed or actual action against a Member of the Medical Staff or an applicant, the Medical Staff President shall give the Member or applicant:

- 12.3.2 Prompt notice of the recommendation or action, including a brief description of the reasons for the recommendation or action;
- 12.3.3 Notice of the right to request a hearing;
- 12.3.4 Notice that failure to request a hearing within the prescribed time period and in the proper manner constitutes a waiver of rights to a hearing and to an appellate review on the matter that is the subject of the notice;
- 12.3.5 Notice regarding whether the proposed action, if adopted, is reportable pursuant to Business & Professions Code Section 805 and following;
- 12.3.6 A summary of the rights the Member or applicant will have at the hearing.
- 12.3.7 Requesting a Hearing

The affected Member or applicant must request a hearing within thirty (30) calendar days after the date of the notice of action or proposed action. The request for hearing shall be in writing and address to the Medical Staff President. Failure to make a timely request and in the manner described may result in the denial of a hearing at the discretion of the Medical Executive Committee.

#### 12.3.8 Time and Place for Hearing

Upon receipt of a request for hearing, the Medical Staff President shall schedule a hearing and provide notice to the Member or applicant of the time, place and date of the hearing. The hearing shall commence not less than thirty (30) days or more than ninety (90) days from the date of the Notice of Hearing. When the Member is under summary suspension, the hearing shall commence not more than forty-five (45) days from the date of the Notice of the Hearing is mailed or otherwise delivered to the Member under summary suspension. The Member may waive these time limits if he/she wishes.

#### 12.3.9 Notice of Charges

In the Notice of Hearing, the Medical Staff President shall state the reason(s) for the adverse action taken or recommended, including the acts or omissions with which the Member or applicant is charged and a list of the charges in question, where applicable. In addition, the Medical Staff President shall furnish a list of witnesses the Medical Executive Committee expects will testify on its behalf at the hearing. This list may be amended at a later time should new names emerge.

#### 12.3.10 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 have not actively participated in the consideration of the matter leading up to the recommendation or action and who are not in direct economic competition with the member charged. The Medical Executive Committee shall designate one of the five as Chair. 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 Medical Staff, the Medical Executive Committee may appoint practitioners who are not Members of the Medical Staff. The Judicial Review Committee shall include at least one member with the same healing arts licensures as the affected Member. All other members shall have M.D. or D.O. degrees.

#### 12.3.11 Failure to Appear or Proceed

Failure, without good cause, of the Member or applicant to personally attend and proceed at such a hearing shall constitute voluntary acceptance of the recommendations or action at issue.

#### 12.3.12 Postponements and Extensions

Once a hearing is requested, postponements and extension of time beyond the times permitted in these Bylaws may be permitted by the Medical Staff President, the Judicial Review Committee, or its Chairperson on a showing of good cause.

### **12.4 Hearing Procedure**

#### 12.4.1 Pre-hearing Procedure

- A. The Medical Executive Committee or its designee may request, in writing, a list of names and addresses of all persons the Member or applicant anticipates calling to testify at the hearing on the Member's or applicant's behalf. The Member or applicant shall furnish the witness list within seven (7) days of the date of the request. Upon written request, the Medical Executive Committee or its designee shall provide the Member or applicant with copies of all documents upon which the adverse action is based. Upon written request, the Member or applicant shall provide the Medical Executive Committee or its designee with copies of all documents the Member or applicant expects to present at his/her hearing.
- B. It is the duty of the Member or applicant and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the Chairperson 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 decision concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decision may be again made at the hearing.

#### 12.4.2 Representation

The hearings provided for in these Bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, and/or character. The Member or applicant shall be entitled to representation by legal counsel in any phase of the hearing and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the Member or applicant shall be entitled to be accompanied by and represented at the hearing by a practitioner licensed to practice in the State of California who is not also an attorney at law. If the Member or applicant is not represented by an attorney, the Medical Executive Committee shall appoint a representative who is not an attorney to represent its position, present the supporting witnesses and material, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall only be represented by an attorney at law if the Member or applicant is also represented by an attorney.

#### 12.4.3 The Hearing Officer

The Medical Executive Committee shall appoint a Hearing Officer (who may also be the Chair of the Judicial Review Committee) to preside at the hearing. The Hearing Officer will not act as a prosecuting officer or as an advocate. The Hearing Officer shall endeavor to ensure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The Hearing Officer shall determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions that pertain to matters of law, procedure and/or the admissibility of evidence. If the Hearing Officer determines that any participant is not proceeding in an efficient and expeditious manner, the Hearing Officer may take actions as seems warranted by the circumstances.

#### 12.4.4 Hearing Record

A record of the hearing shall be made that is of sufficient accuracy to permit review by any appellate group that may later be called upon to review the matter. The Judicial Review Committee may determine to make the record by use of (a) a court reporter or (b) by a tape recording and minutes of the proceedings. The Member or applicant may request, in writing, a copy of the hearing record. The copy will be provided to the Member or applicant upon payment of the cost of preparing and copying the record.

#### 12.4.5 Rights of the Parties

Both parties at the hearing may call and examine witnesses for relevant testimony, introduce relevant documents, cross-examine and/or impeach witnesses who have testified 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

applicant may be called by the Medical Executive Committee or its designee and examined as if under cross-examination. The Member or applicant may, at the beginning of the hearing, challenge the membership of the Judicial Review Committee because of alleged conflict of interest on the part of any committee member. Should such a challenge occur, the Medical Staff President may choose to remove and replace the challenged member (requiring a postponement if necessary) or proceed without removal. If the Medical Staff President chooses to proceed without removal, any challenge by the Member or applicant shall be made succinctly in writing and shall be made part of the hearing record.

#### 12.4.6 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence, do not apply to a hearing conducted under this Article. Any relevant evidence, including Quality Assurance profiles, credentials files, and hearsay shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. However, no finding of fact may be based solely on hearsay. The Judicial Review Committee may interrogate the witnesses and/or call additional witnesses if it deems such action appropriate. At its discretion, the Judicial Review Committee may request or permit both sides to file written arguments. A Medical Staff Member does not have the right to view or use peer review information of other practitioners as part of the fair hearing process.

#### 12.4.7 Burden of Proof

When a hearing related to denial of initial appointment, denial of requested Department or division membership, denial or restriction of Clinical Privileges, mandatory consultation or supervision requirements as it pertains to an initial application for membership or Privileges, or denial of a request to advance from courtesy to active Staff, or termination due to inactivity, the practitioner has the burden of proving that the adverse action or recommendation lacks a substantial factual basis or that the action is arbitrary, unreasonable, or capricious. Otherwise, the Medical Executive Committee has the burden of proving that the adverse action is warranted and has a substantial factual basis.

#### 12.4.8 Adjournment and Conclusion

After the presentation of the oral and written evidence, oral closing arguments, or written closing arguments, if requested by the Judicial Review Committee, the hearing shall be closed.

#### 12.4.9 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, and shall be within the constraints of these Bylaws. The decision of the Judicial Review Committee shall be final, subject to the Appeal provision of these Bylaws.

#### 12.4.10 Presence of Judicial Review Committee members and Vote

A majority of the Judicial Review Committee must be present throughout the hearing and deliberations. If the committee member is absent from any part of the proceedings, he/she may not participate in the deliberations or the decision.

#### 12.4.11 Decision of the Judicial Review Committee

- A. The Judicial Review Committee shall make findings of fact.
- B. The Judicial Review Committee may make one of the following decisions based upon the findings of fact:
  - 1) The action of the Medical Executive Committee is sustained;
  - 2) The action of the Medical Executive Committee is overturned; or
  - 3) The action of the Medical Executive Committee is modified. (The modification may be less or more adverse to the Member or applicant than the action of the Medical Executive Committee.)
- C. The Judicial Review Committee shall make its decision by simple majority vote. The numerated results of the vote are not reported in the final report of the Judicial Review Committee.
- D. Within thirty (30) workdays after adjournment of the hearing, the Judicial Review Committee shall render a decision, which shall be in writing. If the Member is currently under suspension, however, the time for the decision and report shall be fifteen (15) workdays. The original report and decision shall be forwarded to the Medical Staff President, the Professional Affairs Committee and the Member or applicant at his or her last known address. The report shall contain the findings of fact, a statement of the reasons in support of the decision, and the decision. The decision of the Judicial Review Committee shall be final, subject to such rights or appeal as set forth in these Bylaws.

## 12.5 Appeals

### 12.5.1 Time for Appeal

Within ten (10) calendar days of the date that the report/decision of the Judicial Review Committee is mailed to the Member of applicant, either the Member or applicant or the Medical Executive Committee may request an appellate review of the decision. The written request for such review shall be delivered to the Medical Staff President and mailed or delivered to the other party to the hearing. If a request for appellate review is not made within the specified time period, the decision of the Judicial Review Committee shall be final.

### 12.5.2 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 fact 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 or such additional information as may be permitted.

#### 12.5.3 Time, Place and Notice

If an appellate review is to be conducted, the appeal board shall, within thirty (30) 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) 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.

#### 12.5.4 Appeal Board

The Governing Body, or an authorized committee of the Governing Body, shall sit as the Appeal Board. 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.

#### 12.5.5 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 in connection with the appeal, to present a written statement in support of his or her position on appeal and, in its sole discretion, the Appeal Board shall present its written recommendations as to whether the Governing Body should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

#### 12.5.6 Decision

- A. Except as otherwise provided herein, within thirty (30) days after the conclusion of the appellate review proceeding, the Governing Body shall render a decision in writing and shall forward copies thereof to each side involved in the hearing.
- B. The Governing Body may affirm, modify, or reverse the decision of the Judicial Review Committee or remand the matter to the Judicial Review Committee for reconsideration. If the matter is remanded to the Judicial Review Committee for further review and recommendation, said committee shall promptly conduct its review and make its recommendations to the Governing Body. 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 Chairpersons of the Governing Body and the Judicial Review Committee.
- C. In the event the decision of the Governing Body is unfavorable to the applicant or Member, that action shall become final. In the event the decision is favorable, that action also shall become final unless the Medical Executive Committee elects within fifteen (15) days to submit the matter to an ad-hoc committee. This ad-hoc committee shall be composed of two (2) members of the Governing Body (appointed by the Chair of the Governing Body) and two (2) Members of the Medical Staff (as appointed by the Medical Staff President) and shall have access to the records from the hearing and appeal. The decision of this committee shall be in writing within thirty (30) days of receipt of the matter unless extended for good cause. The decision of this committee shall specify the reasons for the action taken and shall be forwarded to the Governing Body who shall reconsider its action, and then render a final decision.

#### 12.5.7 Right to One Hearing

No Member or applicant shall be entitled to more than one evidentiary hearing and one appellate review on any matter that has been the subject of adverse action or recommendation.

### **12.6 Exceptions to Hearing Rights**

#### 12.6.1 Automatic Suspension or Limitations of Practice Privileges.

In the circumstances set forth in these Bylaws causing Automatic Suspension, 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 was unwarranted, but only (1) whether the revocation, suspension, restriction, or probation occurred, (2) the terms of any restrictions, or probation, and (3) whether the Member may continue to practice in the Hospital with the Limitations imposed by the licensing or credentialing authority.



#### 12.6.2 Expunction of Disciplinary Action.

Upon petition, the Medical Executive Committee, in its sole discretion, may expunge previous disciplinary action upon a showing of good cause or rehabilitation.

## ARTICLE 13

### CONFIDENTIALITY

#### 13.1 General

Discussion, deliberation, records and proceedings of all meetings of all Medical Staff committees having the responsibility of evaluation and improvement of quality care rendered in this Hospital, including, but not limited to meetings of the Medical Staff meeting as a committee of the whole, meeting of Departments and Division, meeting of Committees, and meetings of special and ad-hoc committees and including information regarding any Member or applicant to the Medical Staff, shall be confidential to the fullest extent permitted by law.

“Records” includes, but is not limited to, the credentials and quality assurance profiles of individual practitioners and the records of all Medical Staff credentialing, peer review, and quality review activities.

Records will be disclosed only in the furtherance of credentialing, peer review, and quality review activities, and only as specifically permitted under the condition described in this Article, or otherwise required by law.

Records that are disclosed to the Governing Body of the Hospital or its authorized representatives, in order for the Governing Body to discharge its lawful obligations and responsibilities, shall be maintained as confidential.

#### 13.2 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 provision of these Bylaws, except in conjunction with other Hospital, professional society, or licensing authority duties, is unauthorized conduct for any Medical Staff member and is grounds for corrective action.

#### 13.3 Protection

All Medical Staff records shall be maintained in the Medical Staff Office and in the Quality Assurance Department. Such records shall be maintained in locking cabinets under the custody of the Chairpersons of the Credentials Committee and the Patient Safety and Performance Improvement Committee or their designees. The profile cabinets will be locked except during such times as these Chairpersons or their designees are able to monitor access to the records.

## **13.4 Access by persons or Agencies Outside the Jurisdiction of the Hospital**

### **13.4.1 Credentialing or Peer Review at Other Hospitals**

The Medical Staff president, the Credentials Committee Chairperson or the designee of either, may release information contained in a credentials profile in response to a request from another hospital or its Medical Staff. That request must include information that the practitioner is a member of the requesting hospital's Medical Staff, exercise privileges at the requesting hospital, or is an applicant for Medical Staff membership or privileges at that hospital, and must include a release for such records signed by the concerned practitioner.

### **13.4.2 Requests by Hospital Surveyor/Investigators**

Hospital surveyor/investigators are entitled to inspect records (excluding quality assurance profiles, which shall not be made available to any persons or agencies outside the jurisdiction of the Hospital) covered by this Article on the hospital premises in the presence of the Medical Staff President (or designee), provided that:

- A. No originals or copies may be removed from the premises;
- B. Access is only with concurrence of the Administrator (or designee) and the Medical Staff President (or designee); and
- C. The surveyor demonstrates the following to Hospital and Medical Staff representatives;
  - 1) That the surveyor has specific statutory or regulatory authority to review the requested materials;
  - 2) That the materials sought are directly relevant to the matter being investigated;
  - 3) That the materials sought are the most direct and least intrusive means to carry out the pending investigation or survey, bearing in mind that credentials profiles regarding individual practitioners are confidential materials;
  - 4) That sufficient specificity is provided to allow for the production of individual documents without undue burden to the Hospital or Medical Staff; and
  - 5) That in the case of a request for documents with physician identifiers, the need for such identifiers is documented.
  - 6) Additionally, at the discretion of the Medical Staff President and the Administrator, the surveyor may be asked to sign a statement acknowledging notification of the provisions of confidentiality. If he/she declines to sign, it will be noted at the bottom of the prepared statement that the surveyor, identified by name, has declined to sign but has been provided a copy of confidentiality provisions.

### **13.4.3 Subpoenas**

All subpoenas of Medical Staff records shall be referred to the Administrator, who shall have the option of consulting legal counsel for the purpose of formulation a response.

The Administrator shall notify the Medical Staff President when a subpoena for Medical Staff records is received.

#### 13.4.4 Requests from Licensing Boards

Current law allows the California Medical Board, the Board of Osteopathic Examiners, and the Board of Dental Examiners to review certain materials pertaining to Medical Staff hearings concerning corrective action recommendations or decisions. Given the current requirements of law, copies of the following records of a Medical Staff disciplinary hearing shall be made available to the appropriate licensing board upon the specific request of such board:

- A. The Notice of Charges presented to the practitioner before the beginning of a Medical Staff hearing;
- B. Any document, medical record, or other exhibit received in evidence at the hearing; and/or,
- C. Any written opinion, finding, or conclusions of the Medical Staff hearing committee that were made available to the concerned practitioner.

In the event that the concerned practitioner did not request a hearing as per these Bylaws, the Notice of Action or Proposed Action shall be made available

The Medical Staff President, or designee, must review and approve the disclosure before it is made. Any request for documents other than those cited above shall be disclosed only in accordance with this Article.

#### 13.4.5 Other Requests

All other requests for information contained in the Medical Staff records shall be forwarded to the Medical Staff President and the Administrator for an appropriate response.

### **13.5 Access by Persons within the Jurisdiction of the Hospital**

#### 13.5.1 Quality Assurance Profiles

- A. Any practitioner may review his/her Quality Assurance profiles and/or work folder without cause and without approval by giving timely notice in writing to the designee of the Medical Executive Committee. An observer shall be present when the practitioner is reviewing his/her profile. When a Member has reviewed his/her profile as provided under this section, he/she may request a correction or deletion of information in his/her Quality Assurance profile by written request to the Medical Executive Committee. Such a request shall include a statement of the basis for the action requested. The request will be considered and acted upon in accordance with the Bylaws.

- B. Except as noted above, no Member of the Medical Staff, other than those specified in the Bylaws, may be provided with access to a practitioner's Quality Assurance profile and/or work folder. No member of the Hospital Administration or the Governing Body may be provided with access to practitioner's Quality Assurance profile or work folder, except as required by the administrative hearing process in these Bylaws. The individual practitioner under review will be notified in writing whenever this request occurs.
- C. Quality Assurance profiles may be submitted as evidence during a fair hearing conducted pursuant to these Bylaws.

#### 13.5.2 Credential Files

A Medical Staff Member shall be granted access to his/her own credentials files, subject to the following provisions;

- A. The request shall give timely notice to the Medical Staff President or his/her designee;
- B. The Member may review, and receive a copy of, only those documents provided by or personally address to the Member. A summary of all other information, including peer review committee findings, letters of reference, monitoring reports, complaints, etc., shall be provided to the Member in a timely manner, in writing, by the Medical Staff President or designee. Such summary shall disclose the substance, but not the source, of the information summarized;
- C. The review by the Member shall take place in the Medical Staff Office, during normal working hours, in the presence of the Medical Staff President or designee.

13.5.3 When a Member has reviewed his/her file, he/she may address to the Medical Staff President a written request for correction or deletion of information in his/her credentials files. Such request shall include a statement of the basis for the action requested. The Medical Staff President shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee after such review whether to make the correction or deletion requested. The Medical Executive Committee, when so informed, shall either grant or deny the request by a majority vote. The Member shall be notified promptly, in writing, of the decision of the Medical Executive Committee. In any case, a Member shall have the right to add to his/her own credentials profile a statement responding to any information contained in the file.

13.5.4 The Medical Staff President, Department Chairpersons, committee chairpersons, the Chief Medical Officer, and the Administrator shall have access to credentials files to the extent necessary to perform their official duties. Medical Staff committee members shall have access only to the records of committees on which they serve.

13.5.5 No members of the Hospital Administrator or the Governing Body will be given access to a practitioner's credentials file; however, the Governing Body or its designee, consistent

with its ultimate responsibility to oversee quality or care, may wish to have an individual practitioner's credentials profile evaluated for specific reasons of concern. The individual practitioner under review must be immediately notified in writing whenever this request occurs.

## ARTICLE 14

### GENERAL PROVISIONS

#### **14.1 Rules and Regulations**

The Medical Staff must annually review the Rules. The procedure for adopting, amending, and repealing the Rules is set forth in Article 15 of the Bylaws. Once a rule or regulations is adopted or amended by the Governing Body, it is effective and governs applicants and Members of the Medical Staff. If there is a conflict between the Bylaws and the Rules, the Bylaws prevail. The process set forth in Article 15 of the Bylaws is the sole method for the initiation, adoption, amendment, and repeal of medical Staff Rules.

#### **14.2 Dues or Assessments**

The Medical Executive Committee shall annually 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.

#### **14.3 Construction of Terms and Headings**

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

#### **14.4 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.

#### **14.5 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.

#### **14.6 Special Notices**

Except as otherwise provided in these Bylaws, all notices, demands and requests required or permitted to be mailed shall be in writing addressed to the last known address provided by the Member, sealed, with postage fully paid, and deposited in the United States Postal Service. In the alternative, any notice, demand, or request that is required or permitted to be mailed may be hand-delivered. If the official records of the Medical Staff and the Hospital contain different addresses, the notice, request or demand shall be mailed to both addresses.

## **14.7 Requirements for Elections of Medical Staff President, Department Heads, Division heads and for Bylaws Amendments**

### **14.7.1 Elections by Secret Ballot:**

All elections shall be by secret ballot.

### **14.7.2 Eligibility to Vote:**

Only active Members of the Medical Staff in Good Standing may vote in elections governed by these Bylaws. An active Member of the Medical Staff is one who has been approved for active status by the Governing Body at least seven (7) days before the day ballots are mailed.

### **14.7.3 Mailing Address:**

It is the responsibility of each Member of the Medical Staff to provide the Medical Staff Office with his/her current mailing address. Ballots will be mailed to the last address provided by the Medical Staff Member.

### **14.7.4 Runoff Elections:**

A candidate shall be elected by a majority of the votes cast. If no candidate receives a majority vote on the first ballot, a runoff election shall be conducted as soon as is practical between the two candidates who received the highest pluralities. If the runoff election results in a tie, the election shall be repeated. If there is still a tie, the Medical Staff president will cast the deciding vote. If the election is for the Medical Staff President, the Medical Executive Committee will decide.

### **14.7.5 Voting within Committees and Departments:**

At the discretion of the Department Chair, ballots may be by voice, by hand, or by secret ballot. However, at the request of any voting Member within that committee or Department, that vote shall be by secret ballot. Voting Members are determined in accordance with these Bylaws.

## **14.8 Disclosure of Interest.**

All nominees for election or appointment to Medical Staff offices, Department Chairs, or the Medical Executive Committee 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, and financial affiliations and 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.

## **14.9 Authorization, Immunity, and Releases.**

### 14.9.1 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. Authorized persons and organizations to provide information concerning such practitioner to the Medical Staff;
- C. Agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the hospital who acts in accordance with the provisions of these Bylaws; and
- D. Acknowledges that the provisions of these Bylaws are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

### 14.9.2 Releases.

Each applicant or Member shall, upon request of the Medical Staff or hospital, execute general and specific releases as necessary to carry out the provision of these Bylaws.

## **14.10 Standards for History and Physical Examination.**

14.10.1 The complete history and physical examination (H&P), as required for the patient's medical record, shall be completed within twenty-four (24) hours after admission of the patient, and, in case a patient is admitted for surgery, shall be completed prior to the time surgery is done. When the history and physical examination is dictated, a holding note must be recorded in the medical record at the time of examination. A history and physical may be performed up to thirty (30) days in advance provided a durable and legible copy is inserted into the inpatient medical record no later than twenty (24) hours after admission and is updated as appropriate.

### 14.10.2 Special Standards for Elective Surgery.

The following procedure is to be followed when scheduling a patient for either elective outpatient surgery or elective surgery to be done on the day of admission (for general or regional anesthesia.)

14.10.3 The scheduling surgeon must schedule the patient for a pre-op H&P to be done within thirty (30) days prior to surgery. The surgeon must clearly enter in the medical record:

- A. The procedure being scheduled and type of anesthesia;
- B. The surgical indications;
- C. Whether the patient is to be admitted following the surgery.

10.10.4 It is the responsibility of the surgeon scheduling the procedure to obtain informed consent from the patient at the time it is scheduled, having explained the risks and benefits to the patient.

10.10.5 The pre-op H&P and all ordered tests will be reviewed by the anesthesiologist prior to surgery. The provider performing the H&P and/or the primary care provider may be consulted in evaluation of abnormal results prior to cancellation of surgery.

## ARTICLE 15

### ADOPTION AND AMENDMENT OF BYLAWS AND RULES

#### **15.1 Annual Review.**

These Bylaws and the Rules shall be reviewed annually by the Medical Executive Committee.

#### **15.2 Procedure.**

Upon the request of the Medical Staff President, the Medical Executive Committee, the Administrative Affairs Committee, or upon timely written petition signed by at least 10% 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 or Rules.

#### **15.3 Medical Staff Action.**

These Bylaws and Rules may be adopted, amended, or repealed by:

15.3.1 The affirmative vote of a majority of the active Staff Members in Good Standing present at a regular or special Staff Meeting at which a quorum attends, provided that the proposed documents or amendments are made available to Staff Members entitled to vote thereon no less than two (2) weeks before balloting with or at the time of notice of the meeting; or

15.3.2 The affirmative vote of a majority of ballots returned by Members in Good Standing, provided that a copy of the proposed documents or amendments are made available to each Staff member entitled to vote thereon no less than two (2) weeks before balloting, and provided that no less than two (2) weeks' time interval exists between the date the ballot was mailed to active Members and the due date of the ballot.

All elections to adopt amend or repeal the Bylaws or Rules and Regulations shall be conducted in accordance with these Bylaws.

#### **15.4 Approval.**

By laws and Rules changes adopted by the Medical Staff shall not become effective until approved by the Governing Body. Neither the Medical Staff nor the Governing Body may unilaterally amend the Bylaws or Rules.



**15.5 Exclusivity.**

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, and/or repeal of the Bylaws or Rules.

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## **Rules and Regulations**

These Rules and Regulations are adopted pursuant to Article 15 of the Medical Staff Bylaws. These Rules use the same Definitions as the ones described in the Bylaws. The Rules specifically include those policies and procedures that are referenced herein.

### **1. General Rules**

#### **A. Admissions**

1. All admissions of patients are subject to rules delineated in the Medical Staff Bylaws, specific department policies and hospital policies.

#### **B. Continuous Responsibility for Patients**

##### **1. Inpatient**

- a. The attending physician is responsible for the complete and continuing care of his/her patients. He/she is required to keep appropriate personnel informed as to where he/she can be reached in case of emergency and shall designate at least one physician to render emergency or other necessary patient care if he/she is not available. Each patient shall be reassessed daily.

##### **2. Outpatient**

- a. Primary Care Providers are responsible for their panel of patients as described in the Ambulatory Care Policies.

#### **C. Medical Records**

##### **1. General Provisions**

- a. Abbreviations
  - i. An “Unacceptable Abbreviations List” is posted throughout the hospital and clinics. Copies may be obtained from Medical Records.
- b. Records Belonging to Health Services Department
  - i. Refer to Hospital Policy 705 – Removal, Retention and Destruction of Protected Health Information. All medical records and other records relating to the admission, care and discharge of a patient are the property of the Contra Costa County Health Services Department and may be removed from the Health Services Department’s jurisdiction and safekeeping only in accordance with a subpoena, court order or other statute. In case of readmission of any patient, all previous records shall be available to the attending physician.
- c. Electronic Signature
  - i. Approved electronic signature of medical records is acceptable for chart completion.

## **2. Completion of Records**

- a. Inpatient Records
  - i. Responsibilities of the Members of Medical Staff and General Provisions
- b. Content of Staff Entry
  - i. The attending physician shall be responsible for preparing a complete medical record for each patient as described in Hospital Policy 706 – Medical Record Content. This record shall include at least the following minimum information.
  - ii. Patients shall be discharged only upon the order of the attending physician or another physician acting as his/her representative. At the time the patient is discharged, the attending physician shall complete the medical record, indicate the reason for admission, state the final diagnosis, record treatment and/or procedures performed, describe the condition of the patient on discharge, including specific comparison with condition on admission and any specific instructions given the patient and/or family (e.g., diet, medication, physical activity and follow-up care.) When pre-printed instructions are given to the patient, the record should so indicate and a sample of the instruction sheet in use at the time must be kept on file in the Medical Records Department. All medical record entries must be signed and dated.
  - iii. When a patient has been hospitalized a discharge summary is required.
  - iv. All surgery performed shall be fully described by the operating surgeon in the patient's medical record. Such description shall include a detailed account of the technique used, identification of tissues and foreign material removed, if any, and a description of the findings. Such description shall be done immediately after surgery is concluded. A brief interim operative note shall be placed in the medical record immediately after surgery is concluded if the complete note is not immediately visible in the electronic health record.
  - v. At the discretion of the attending physician, tissues and foreign materials removed in surgery shall be submitted, together with adequate clinical information, to the pathologist on duty. The Pathology Department may establish appropriate guidelines.
  - vi. In addition to the operating surgeon's report, the record of every operation involving use of an anesthetic other than local shall include a proper anesthetic record and a post-anesthetic follow-up report.
  - vii. Standards for History and Physical Examination. The complete history and physical examination (H&P), as required for the patient's medical record, shall be completed within twenty-four (24) hours after admission of the patient, and, in case a patient is

admitted for surgery, shall be completed prior to the time surgery is done. When the history and physical examination is done a holding note must be recorded in the medical record at the time of examination. History and physical may be performed up to thirty (30) days in advance provided a durable and legible copy is inserted into the inpatient medical record no later than twenty-four (24) hours after admission of the patient, and, in case a patient is admitted for surgery, shall be completed prior to the time surgery is done. When the history and physical examination is done a holding note must be recorded in the medical record at the time of examination. A history and physical may be performed up to thirty (30) days in advance provided a durable and legible copy is inserted into the inpatient medical record no later than twenty-four (24) hours after admission and is updated as appropriate. At a minimum the H&P will include the following sections: HPI, Problem List, Allergies, Medications, Physical Exam, and Assessment/Plan.

viii. Special Standards for Elective Surgery. The following procedure is to be followed when scheduling a patient for either elective outpatient surgery or elective surgery to be done on the day of admission (for general or regional anesthesia.)

1. The scheduling surgeon must schedule the patient for a pre-op H&P to be done within thirty (30) days prior to the surgery. The surgeon must clearly enter in the medical record:
  - a. The procedure being scheduled and type of anesthesia;
  - b. The surgical indications;
  - c. Whether the patient is to be admitted following the surgery.
2. It is the responsibility of the surgeon scheduling the procedure to obtain informed consent from the patient at the time it is scheduled, having explained the risks and benefits to the patient.
3. A History and Physical shall be done on all pre-op patients.
4. Pre-op lab work should be scheduled within two weeks prior to surgery.
5. The pre-op H&P and all ordered tests will be reviewed by the anesthesiologist prior to surgery. The provider performing the H&P and/or the primary care provider may be consulted in evaluating abnormal results prior to cancellation of surgery.

### **3. Delinquency**

- a. All charts must be completed within the time limits specified below. A “complete medical record” is defined as one that meets all criteria as set forth.

#### **i). Inpatient and Surgery**

| <b>Document</b>  | <b>Time Due</b>   |
|--|---|
| Discharge Summary.....                                       | Thirteen (13) days post discharge   |
| Inpatient History/Physical.....                              | Twenty-four (24) hours post admission   |
| Interval History/Physical.....                               | Less than twenty-four (24) hours prior to surgery   |
| Operative Report.....  | Immediately after surgery   |
| Pre-anesthesia evaluation.....                               | Must be completed prior to being placed under anesthesia unless extreme emergency                           |
| Post-Anesthesia note.....                                    | 6 hours after conclusion of anesthesia  |
| Verbal orders.....   | Authenticated by twenty-four (24) hours for IV Fluid or IV drug orders; all others within 48 hours          |
| Other inpatient documentation as required by law, including; | At hospital discharge   |
| a) Diagnostic and therapeutic orders;                        | } Must be signed within thirteen (13) days and are delinquent after the fourteenth (14 <sup>th</sup> ) day. |
| b) Clinical observations and results of therapy;             |   |
| c) Reports of procedures, tests, and their results;          |   |
| d) Conclusions at the termination of care.                   |   |
| e) All inpatient dictations.                                 |   |

**ii. Outpatient Records**

- a. Providers are encouraged to chart as soon as possible after visit. At a minimum, the diagnosis and treatment plan shall be charted at the time of the visit. The provider note must be complete within twenty-four (24) hours.
- b. Outpatient notes should contain the following elements:
  - i. Patient identification.
  - ii. Date of visit.
  - iii. Relevant history or pertinent update of the illness or injury.
  - iv. Physical findings, if applicable.
  - v. Results of tests and other studies, if applicable.
  - vi. Diagnostic assessment.
  - vii. Treatment plan, including prescriptions.
  - viii. Results of treatment rendered during the visit, if applicable.
  - ix. Patient teaching, including instructions given to the patient and/or family and follow-up care.

#### **4. Disciplinary Proceedings**

##### **a. Process**

- i. An incomplete chart is considered delinquent fourteen (14) days after the due date as specified at 1.C.3.a. Automatic initiation of disciplinary proceedings for the responsible practitioner will occur as soon as a chart becomes delinquent.
- ii. A letter will be sent to the practitioner responsible for the delinquent records from Health Information Management. The Medical Staff Office will also contact the practitioner, using the contact information provided to the office by the practitioner. Practitioners are responsible for making sure their contact information is up to date.
- iii. The letter shall state:
  - A. The list of delinquent records;
  - B. That failure to complete delinquencies within seven (7) days will result in suspension of all Medical Staff Privileges and Staff Membership by the Medical Staff President until the stated delinquent charts are completed.
- iv. If delinquent records referred to in the letter are not completed with seven (7) days, the Medical Staff President shall immediately suspend all Medical Staff Privileges and Membership until the delinquent charts are properly completed. The Medical Staff President will notify the appropriate Department Heads, the Executive Director of the Hospital, Chief Medical Officer and the Residency Director as appropriate.

##### **b. Further Sanctions**

- i. Any practitioner suspended for a cumulative total of thirty (30) days or more during any 12-month period will be reported to the Medical Board of California by the Medical Staff President.

#### **D. Medical Orders**

##### **1. Inpatient**

- a. All orders must be reconciled when a patient is transferred into or out of the Critical Care units (ICU and IMCU.)
  - i. Orders can be dictated or telephoned to a health professional listed below and later signed by the attending physician, or, in case of treatment required in the absence of the attending physician, by the physician then responsible for the patient's care/ Verbal orders shall be accepted and entered by a licensed nurse, occupational therapist, physical therapist, licensed respiratory therapist or speech therapist, registered pharmacist or registered dietician only and such action will be limited to urgent circumstances.
  - ii. Verbal orders are not valid for orders to limit or remove lifesaving procedures.

- iii. There are no routine or standing orders regarding patient care or ordering of diagnostic tests.

**2. Outpatient**

- a. Outpatient orders should be entered in the medical records. Any verbal orders must be co-signed by the M.D. or FNP within twenty-four (24) hours.

**E. CPR**

1. Although a "Basic CPR" certificate is not required for Medical Staff membership, it is strongly encouraged for all those physicians in patient care. Individual Departments may require it for membership.

**F. Disaster Assignments: Refer to Hospital Disaster Plan**

1. Contra Costa Regional Health Center & Health Centers maintains a disaster plan based upon the Hospital Emergency Incident Command System (HEICS) which delineates the administrative structure for disaster responses. Each individual Department also has in place disaster and evacuation plans.
2. Employed members of the Medical Staff are designated automatically as disaster workers in the event of a disaster. Other members of the Medical Staff are eligible to participate in disaster work, as is volunteer staff under the guidelines of disaster credentialing as delineated in the Medical Staff Bylaws.

**G. Consultation Policy**

1. All providers are expected to seek consultation and advice whenever they encounter a situation in the course of caring for a patient in whom they are not confident of their own ability or knowledge. They should also seek consultation when it becomes evident that the patient is not comfortable with the diagnosis or management of his or her problem. Consultation may be obtained from Members of the Staff who are privileged to care for the problem for which the advice is sought, and his or her report shall be included in the medical record. The consultation report should be placed in the medical report.
2. Except where consultation is precluded by emergency circumstances, the attending physician shall consult with another qualified physician in all of the following cases:
  - a. All major surgical cases in which the patient is not a good risk.
  - b. In all cases in which the diagnosis is obscure or in which there is doubt as to the best therapeutic measures to be utilized.

## H. Operating Room Policies

### 1. *Consents:*

- a. Except in cases of emergency, no surgery shall be performed except pursuant to written informed consent from the patient or his/her legal representative, and all other persons, if any, from whom consent is required.
  - i. History and physical examination;
  - ii. Pre-operative diagnosis;
  - iii. All necessary Laboratory and X-ray work;
  - iv. Pre-anesthetic evaluation in all cases receiving a general anesthetic;
- b. If, in any surgical cases, the foregoing requirements are not met prior to the time scheduled for surgery, the operation shall be canceled by the Operating Room Supervisor or designee and rescheduled unless the attending physician documents that such delay would be detrimental to the patient.

### 2. *Prompt attendance of surgeon and attendants:*

Surgeons and attendants must be in the operating room and ready to commence surgery at the time scheduled.

## I. Supervision of Resident Physicians

1. Resident physicians shall have appropriate supervision present at all times regardless of patient complexity or resident competency. All medical care provided by resident staff is under the supervision of licensed physician members of the Medical Staff who have privileges for the patient care being rendered and the Residency Director. Such care shall be in accordance with the provision of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association and the American Osteopathic Association. Residents must be supervised by members of the Medical Staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability and experience.

### 2. Inpatient Supervision

Resident physicians shall identify a licensed physician member of the Medical Staff who has privileges for the patient care being rendered or the Residency Director as the attending of record on the admission orders of all patients admitted to the hospital. All critically ill patients admitted by the resident physician shall be discussed with an attending physician. Teaching rounds shall be held daily.

- a.
- b. All "DNR/DNI" orders entered by resident physicians shall document concurrent discussion with a licensed physician member of the Medical Staff who has privileges for the patient care being rendered and the Residency Director.



- c. Medical Staff co-signatories are needed for all resident physicians for the following medical records and documents:
  - i. Inpatient History and Physical
  - ii. Consultative Reports
  - iii. Procedure notes and operative reports
- 3. Outpatient Supervision
  - a. Detailed and specific resident supervision policies are located in the Graduate Medical Education (GME) Policies and Procedures manual. A copy of this manual is located in the residency office or an electronic version is available upon request.
    - i. Prescriptions
      - A. All first year residents, even if they have a post-graduate training license, must have all prescriptions co-signed.
    - ii. Family Medicine Clinics
      - A. All resident physicians must have a preceptor with appropriate privileges assigned to supervise and precept them. This preceptor must be immediately available and have adequate time for teaching.
      - B. All medical record entries by medical students must be co-signed by a provider with privileges.
    - iii. Specialty Clinics
      - A. A staff physician will directly supervise all residents working in a specialty clinic. The resident physicians are expected to discuss all patients with the supervising physician before the patient leaves. The supervising physician should be identified on the consultation.
      - B. All medical record entries by medical students must be co-signed by a provider with privileges.

**J. On-Call Response Time**

- 1. Departments shall determine and monitor appropriate on-call procedures for their specific services.

**K. Processing and Delivery of Ordered Blood Products**

- 1. Blood products ordered by any physician shall be provided by the Blood Bank/Transfusion Service without delay. If questionable indications for transfusion are felt to be present, the pathologist, while processing of this order proceeds without delay, will attempt to discuss this issue with the ordering physician. If, after discussion, the pathologist still believes the request to be questionable, he/she will report this case to the appropriate Department or committee for review.
- 2. The physician who has primary responsibility for the patient has the final say in decision making, although we encourage a team approach utilizing dialogue between the clinician and the transfusion service.

## **L. Collection and Expenditures of Medical Staff Funds**

### **1. Application Fees**

- a. Each application may be assessed an application non-refundable processing fee. This fee shall be Three Hundred Dollars (\$300) and shall also be considered as payment of any dues, for which the applicant shall be liable during the period of the initial appointment, should the applicant be appointed to the staff. The fee for applications for Courtesy, Honorary, Temporary, Administrative, Allied Health Professional, and Telemedicine Staff shall be One Hundred and Fifty Dollars (\$150)
- b. In the event that the applicant is not accepted, no portion of this applications fee shall be refunded. In special circumstances as defined by the Credentials Committee and the Medical Executive Committee, this application fee may be waived.

### **2. Medical Staff Dues**

- a. The Medical Executive Committee shall have the power to determine the amount of biennial reappointment dues. The following dues are currently in effect:
  - i. Active Staff:  
Two Hundred Dollars (\$200) for each two-year reappointment
  - ii. Courtesy, Honorary, Temporary, Administrative, Allied Health Professional, and Telemedicine Staff:  
One Hundred Dollars (\$100) for each two-year reappointment

### **3. Reappointment Late Processing Fees**

- a. Pursuant to the Bylaws and the Rules, the Medical Staff is authorized to collect late processing fees. An application for reappointment is late when less than one hundred fifty (150) calendar days remain until the end of Members' term. In addition to the regular reappointment fee, the following late processing fees are assessed:
  - i. At one hundred fifty (150) days from the end of a term – Fifty dollars (\$50) – (may be waived in extenuating circumstances, such as vacation);
  - ii. At one hundred twenty (120) days from the end of the term – Fifty dollars (\$50) more for a total penalty of one hundred dollars (\$100) – (may not be waived);
  - iii. At ninety (90) days from the end of the term – Fifty dollars (\$50) more for a total penalty of one hundred fifty dollars (\$150),
  - iv. At ninety (90) days, all fees must be paid in full and application must be complete or reappointment application is not processed and the membership is deemed to have expired automatically at the end of the term. If the member submits a new application for membership in the medical staff within six (6) months of the expiration of the appointment, he/she must pay the one hundred fifty dollar (\$150) penalty in addition to the application fee.

#### **4. Expenditure of Funds**

- a. The Medical Executive Committee shall determine the method of disbursement of Medical Staff funds. The Medical Executive Committee may appoint a Medical Staff Funds Advisory Committee to advise the Medical Executive Committee regarding such expenditures.
- b. If an Advisory Committee is appointed, it shall study the various possible uses for the funds and recommend specific expenditures, including specific dollar amounts, to the Medical Executive Committee on an annual basis or more often as appropriate.
- c. The Medical Executive Committee shall retain ultimate control of these funds. The Medical Executive Committee may deposit these funds in any accounts it deems suitable.
  - i. Any account shall have the following co-signers:
    - A. The Medical Staff President
    - B. The Medical Staff President-Elect
    - C. The Immediate Past President of the Medical Staff
    - D. The Chair(s) of the Administrative Affairs Committee
    - E. Two Medical Staff Coordinators as designated by the Medical Executive Committee
  - ii. Any two (2) of these co-signers may distribute Medical Staff funds provided at least one co-signer is a Member of the Medical Staff. Any disbursement of funds greater than five hundred dollars (>\$500) must be approved in advance by the Medical Executive Committee. Any disbursement of funds of five hundred dollars or less (<=\$500) may be authorized by any two (2) of the cosigners listed above. Any such disbursement of funds without the advance approval of the Medical Executive Committee must be reported to the Medical Executive Committee by the Medical Staff President at the next regularly scheduled Medical Executive Committee meeting.

#### **M. Medical Staff Evaluation and Development**

1. Each Member of the active Medical Staff shall be reviewed no less often than every eleven (11) months by his/her Department Head on a form approved by the Medical Executive Committee. The purpose of this evaluation shall be to facilitate verbal and documented communications between the Department Head and the Staff Member in an attempt to acknowledge the Staff Member's areas of excellence and to identify those areas which can be improved.
2. The Medical Staff President shall evaluate the Department Heads in the same manner after consultation with the Members of his/her department. If the Department Head is also the Medical Staff President, an individual designated by the Credentials Committee shall evaluate him or her.
3. Upon completion, the evaluator and the Medical Staff Member shall meet face to face and each receives a copy of the evaluation, with additional copy to be placed in the individual's

credentials file. The copy in the credentials file shall be used by the Credentials Committee during the reappointment process. The Staff Member may request modification of this.

4. This evaluation shall be sent to the credentials file and the information in the credentials files shall be used for Medical Staff purposes only.

#### **N. Other Policy Manuals**

1. From time to time, policies are legally created and adopted by the Governing Body, the Administration, Nursing, and particular administrative departments. To the extent that these policies are not in conflict with the Medical Staff Bylaws, the Rules, or Medical Staff Policies, the Medical staff shall abide by the extraneous policy. If these extraneous policies are in conflict with the Bylaws, the Rules, or Medical Staff Policies, the Medical Executive Committee shall review the conflicting policies and recommend appropriate changes. When the extraneous policies have a negative impact upon the quality of patient care, the Medical Executive Committee shall also review the policy and make appropriate recommendation to assure quality care. In all cases, the Medical Staff must abide by the requirements of the Bylaws and the Rules.

APPROVED: COUNTY COUNSEL: *1/4/2021*

APPROVED: CCRMCHCs MEC: *3/1/2021*

APPROVED: Board of Supervisors *5/18/2021*