KAWEAH DELTA HEALTH CARE DISTRICT

MEDICAL STAFF BYLAWS

Adopted by the Medical Staff: September 27, 2023
Approved by the Board of Directors: September 27, 2023

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ARTICLE 1
GENERAL

1.1 PURPOSES OF THE BYLAWS

These Bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Board of Directors of Kaweah Health Care District in protecting the quality of medical care provided in the District and assuring the competency of the District's Medical Staff. The Bylaws provide for the organization of the Medical Staff of Kaweah Delta Health Care District and provide a framework for self-governance in order to permit the Medical Staff to discharge its responsibilities as defined by these bylaws. These Bylaws provide the professional and legal structure for Medical Staff operations, define Medical Staff relations with the Board of Directors, and define medical staff interactions with applicants, members of the Medical Staff, others who exercise clinical privileges, and Advanced Practice Providers.

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

These Bylaws acknowledge that the provision of quality medical care in the District depends on the mutual accountability, interdependence, and responsibility of the Medical Staff and the Board of Directors for the proper performance of their respective obligations.

1.A. DEFINITIONS

The following definitions apply to terms used in this Policy:

"ADVANCED PRACTICE PROVIDERS" ("APPs") means individuals other than Medical Staff members who are authorized by law and by the District to provide patient care services within the District.

"BOARD" means the Board of Directors of the District or its designated committee. The Board has the overall responsibility for the District.

"CHIEF EXECUTIVE OFFICER" ("CEO") means the individual appointed by the Board to act on its behalf in the overall management of the District. At the direction of the CEO, another individual may be designated to fulfill a responsibility assigned to the CEO in these Bylaws with notification to the Chief of Staff.

"CHIEF MEDICAL OFFICER" ("CMO") means the chief medical officer of the Medical Staff hired by the CEO with the approval of the Board, who serves as a liaison between the Medical

Staff and administration with responsibilities as set forth in his/her job description, the Medical Staff Bylaws, and related documents.

"CLINICAL PRIVILEGES" or "PRIVILEGES" means the authorization granted by the Board, upon recommendation by the Medical Executive Committee and the Credentials Committee, to render specific patient care services, for which the Medical Staff Leaders and Board have developed eligibility and other credentialing criteria and focused and ongoing professional practice evaluation standards.

"CORE PRIVILEGES" means a defined grouping of privileges for a specialty or subspecialty that includes the fundamental patient care services that are routinely taught in residency and/or fellowship training for that specialty or subspecialty and which have been determined by the Medical Staff Leaders and Board to require closely related skills and experience.

"DAYS" means calendar days.

"DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

"DISTRICT" means all Kaweah Delta Health Care District facilities.

"FOCUSED PROFESSIONAL PRACTICE EVALUATION" ("FPPE") means a time-limited period during which a practitioner's professional performance is evaluated. Focused Professional Practice Evaluation is used in two situations: (i) when privileges are newly granted to confirm the individual's competence to exercise them and (ii) when issues are raised about a practitioner's clinical practice.

"MEDICAL EXECUTIVE COMMITTEE" ("MEC") means the Executive Committee of the Medical Staff.

"MEDICAL STAFF" means all physicians, dentists, oral surgeons, podiatrists, and clinical psychologists who have been appointed to the Medical Staff by the Board.

"MEDICAL STAFF LEADER" means any Medical Staff officer, department chair, and committee chair.

"MEMBER" means any physician, dentist, oral surgeon, podiatrist, and clinical psychologist who has been granted Medical Staff appointment by the Board.

"NOTICE" means written communication by regular U.S. mail, e-mail, facsimile, hospital mail, hand delivery, or other electronic method.

"ONGOING PROFESSIONAL PRACTICE EVALUATION" ("OPPE") means a process of ongoing review and analysis of practitioner-specific data that helps to identify any issues or trends in practitioners' performance that may impact on quality of care and patient safety.

"ORAL AND MAXILLOFACIAL SURGEON" means an individual with a D.D.S. or a D.M.D. degree who has completed additional training in oral and maxillofacial surgery.

"ORGANIZED HEALTH CARE ARRANGEMENT" means the term used by the HIPAA Privacy Rule that permits the District and Medical Staff to use joint notice of privacy practices information when patients are admitted to the District. Practically speaking, being part of an OHCA allows the members of the Medical Staff to rely upon the District notice of privacy practices and therefore relieves Medical Staff members of their responsibility to provide a separate notice when members consult or otherwise treat District inpatients.

"PATIENT CONTACT" includes any admission, consultation, procedure, in-person response to the emergency department, evaluation, treatment, or service performed in the District or its outpatient facilities.

"PERMISSION TO PRACTICE" means the authorization granted to Advanced Practice Providers to exercise clinical privileges or a scope of practice.

"PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

"PODIATRIST" means a doctor of podiatric medicine ("D.P.M.").

"PSYCHOLOGIST" means an individual with a Psy.D or Ph.D. in clinical psychology.

"SPECIAL NOTICE" means hand delivery, U.S. certified mail (return receipt requested), sent to the official address of record in the Medical Staff Services Department, or reliable commercial delivery service where delivery may be verified

"SPECIAL PRIVILEGES" means privileges that fall outside of the core privileges for a given specialty that require additional education, training, and/or experience beyond that required for core privileges in order to demonstrate competence.

"SUPERVISING PHYSICIAN" means a member of the Medical Staff with clinical privileges who has agreed in writing to supervise or collaborate with an Advanced Practice Provider and to accept full responsibility for the actions of the Advanced Practice Provider while he or she is practicing in the District.

"SUPERVISION" means the supervision of (or collaboration with) an Advanced Practice Provider by a Supervising Physician that may or may not require the actual presence of the Supervising Physician, but that does require, at a minimum, that the Supervising Physician be readily available for consultation. The requisite level of supervision (general, direct, or personal) shall be determined at the time each Advanced Practice Provider is credentialed and shall be consistent with any applicable written supervision or collaboration agreement that may exist. ("General" supervision means that the physician is immediately available by phone; "direct" supervision means that the physician is on the District's campus; and "personal" supervision means that the physician is in the same room.)

"TELEMEDICINE" means the exchange of medical information from one site to another via electronic communications for the purpose of providing patient care, treatment, and services.

1.B. DELEGATION OF FUNCTIONS

(1) When a function is to be carried out by a member of Medical Staff leadership or by a Medical Staff member, the individual may delegate performance of the function to one or more designees. If a Medical Staff committee cannot act in a timely manner upon a certain task or function, the committee may delegate that particular matter or responsibility to designated individuals to fulfill the function on behalf of the committee.

(2) When a Medical Staff member is unavailable or unable to perform a necessary function unrelated to the provision of direct patient care services, and such unavailability has been confirmed by a Medical Staff Leader, one or more of the Medical Staff Leaders may perform the function personally or delegate it to another appropriate individual.

1.C. MEDICAL STAFF MEMBERSHIP/PRIVILEGING FEES

(1) Medical Staff membership and/or privileging fees shall be as determined by the MEC and may vary by category or privilege status.

(2) Fees shall be payable upon request. Failure to pay fees shall result in ineligibility to apply for Medical Staff reappointment or renewal of clinical privileges.

(3) Signatories to the District's Medical Staff account shall be the Chief of Staff, the Vice Chief of Staff, the Secretary-Treasurer, and the Immediate Past Chief of Staff.

ARTICLE 2
MEDICAL STAFF MEMBERSHIP

2.A. QUALIFICATIONS

2.A.1 Threshold Eligibility Criteria:

To be eligible to apply for initial appointment or reappointment to the Medical Staff, physicians, dentists, oral surgeons, podiatrists, and psychologists must:

(a) have (or be able to provide documentation that they are in the process of obtaining) a current, unrestricted license to practice in California and have never had a license to practice revoked or suspended by any state licensing agency;

(b) where applicable to their practice, have a current, unrestricted full-schedule Drug Enforcement Agency ("DEA") registration;

(c) with reasonable and rare exceptions, be available on a continuous basis, either personally or by arranging appropriate coverage, to respond to the needs of their inpatients in a prompt, efficient, and conscientious manner. ("Appropriate coverage" means coverage by another member of the Medical Staff with appropriate specialty-specific privileges as determined by the Credentials Committee.) Compliance with this eligibility requirement means that the practitioner must document that he or she is willing and able to:

(1) respond within 15 minutes, via phone, to an initial STAT contact from the District and respond within 30 minutes, via phone, to all other initial modes of contact; and

(2) appear in person to attend to a patient within 30 minutes of being requested to do so (or more quickly based upon (i) the acute nature of the patient's condition or (ii) as required for a particular specialty as recommended by the MEC and approved by the Board);

(d) have (or be able to provide documentation that they are in the process of obtaining) current, valid professional liability insurance coverage in a form and in amounts satisfactory to the MEC and the Board;

(e) have never been convicted of, or entered a plea of guilty or no contest to, Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse, nor have been required to pay civil monetary penalties for the same;

(f) have never been, and are not currently, excluded or precluded from participation in Medicare, Medicaid, or other federal or state governmental health care program;

(g) have never been convicted of, or entered a plea of guilty or no contest, to any felony; or to any misdemeanor relating to controlled substances, illegal drugs, insurance or health care fraud or abuse, child abuse, elder abuse, or violence;

(h) have or agree to make appropriate coverage arrangements (as determined by the Credentials Committee) with other members of the Medical Staff for those times when the individual will be unavailable;

(i) demonstrate recent clinical activity in their primary area of practice during the last two years;

(j) meet any current eligibility requirements that are applicable to the clinical privileges being sought;

(k) if applying for privileges in an area that is covered by an exclusive contract, meet the specific requirements set forth in that contract;

(l) document compliance with all applicable training and/or educational protocols that may be adopted by the MEC, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(m) document compliance with any health screening requirements (i.e., TB testing, mandatory flu vaccines, and infectious agent exposures);

(n) have successfully completed:

(1) a residency training program approved by the Accreditation Council for Graduate Medical Education ("ACGME"), the American Osteopathic Association ("AOA"), Royal College of Physicians and Surgeons of Canada, or College of Family Medicine Physicians of Canada in the specialty in which the applicant seeks clinical privileges (individuals currently participating in a fellowship training program may apply to the Medical Staff and request clinical privileges in the specialty area in which they have completed residency training);

(2) a dental or an oral and maxillofacial surgery training program accredited by the Commission on Dental Accreditation of the American Dental Association ("ADA");

(3) a podiatric surgical residency program accredited by the Council on Podiatric Medical Education of the American Podiatric Medical Association; or

(4) a clinical psychology training program accredited by the American Psychological Association;

(o) be certified in the specialty in which the applicant seeks clinical privileges by the appropriate specialty/subspecialty board of the American Board of Medical

Specialties ("ABMS"), the AOA, the American Board of Oral and Maxillofacial Surgery, the ADA, the American Board of Podiatric Surgery, or the American Psychological Association, American Board of Foot and Ankle Surgery, or American Board of Podiatric Medicine, as applicable. Those applicants who are not board certified at the time of application must be actively participating in the examination process leading to board certification within the timeframe determined by the certifying board. Failure to achieve board certification within the required timeframe shall constitute automatic relinquishment of Medical Staff membership and privileges;* and

(p) maintain board certification in their primary area of practice at the District on a continuous basis, and satisfy all requirements of the relevant specialty/subspecialty board necessary to do so (board certification status will be assessed at time of reappointment).* This requirement shall be applicable only to those individuals who apply for initial staff appointment after March 2016. This requirement is not applicable to Medical Staff members appointed prior to March 2016. Those Medical Staff members shall be grandfathered and shall be governed by any board certification requirements that may have been in effect at the time of their initial appointment.

* In exceptional circumstances, initial applicants who are not board certified and existing Medical Staff members seeking recertification may request additional time to obtain certification or recertification for one additional period, not to exceed two years. In order to be eligible to request an extension in these situations, an individual must, at a minimum, satisfy the following criteria:

(1) the individual has been on the District's Medical Staff for at least three consecutive years;

(2) there have been no adverse actions related to the individual's competence or behavior at the District during the individual's tenure;

(3) the individual has not been the subject of an FPPE, formal investigation, or adverse recommendation during the individual's tenure;

(4) the individual provides a letter from the appropriate certifying board confirming that the individual remains eligible to take the certification examination within the next two years;

(5) the appropriate department chair at the District provides a favorable report concerning the individual's qualifications; and

(6) the individual provides at least two letters of support from other members of the Medical Staff who are in good standing, who are not in the same specialty as the individual, and who have had direct experience in observing and working with the individual.

2.A.2 Waiver of Threshold Eligibility Criteria:

Insofar as is consistent with applicable laws, the Board has the discretion to deem an applicant to have satisfied a qualification, based upon the recommendation of the applicable clinical department, Credentials Committee, and the MEC, if it determines that the applicant has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the District. There is no obligation to grant any such waiver, and applicants have no right to have a waiver considered and/or granted. An applicant who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws.

The granting of a waiver in a particular case does not set a precedent for any other applicant or group of applicants. An application for appointment that does not satisfy an eligibility criterion will not be processed unless and until the Board has determined that a waiver will be granted.

2.A.3 Factors for Evaluation:

The six ACGME general competencies (patient care, medical knowledge, professionalism, system-based practice, practice-based learning, and interpersonal communications) will be evaluated as part of the appointment and reappointment processes, as reflected in the following factors:

(a) relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, and clinical judgment, and an understanding of the contexts and systems within which care is provided;

(b) adherence to the ethics of their profession, continuous professional development, an understanding of and sensitivity to diversity, and responsible attitude toward patients and their profession;

(c) good reputation and character;

(d) ability to safely and competently perform the clinical privileges requested;

(e) ability to work harmoniously with others, including, but not limited to, interpersonal and communication skills sufficient to enable them to maintain professional relationships with patients, families, and other members of health care teams; and

(f) recognition of the importance of, and willingness to support, the District's and Medical Staff's commitment to quality care and a recognition that interpersonal skills and collegiality are essential to the provision of quality patient care.

2.A.4 No Entitlement to Appointment:

No individual is entitled to receive an application or to be appointed or reappointed to the Medical Staff or to be granted particular clinical privileges merely because he or she:

(a) is employed by the District or its subsidiaries or has a contract with the District;

(b) is or is not a member or employee of any particular physician group;

(c) is licensed to practice a profession in this or any other state;

(d) is a member of any particular professional organization;

(e) has had in the past, or currently has, Medical Staff appointment or privileges at any hospital or health care facility;

(f) resides in the geographic service area of the District; or

(g) is affiliated with, or under contract to, any managed care plan, insurance plan, HMO, PPO, or other entity.

2.A.5 Nondiscrimination:

No individual shall be denied appointment on the basis of age, gender, race, creed, national origin, citizenship status, sex, color, religion, ancestry, sexual orientation, gender identity or expression, disability that is unrelated to the ability to provide patient care, medical condition, genetic information, marital status, registered domestic partner status, or veteran status.

2.B. GENERAL CONDITIONS OF APPOINTMENT AND REAPPOINTMENT

2.B.1 Basic Responsibilities and Requirements:

As a condition of being granted appointment or reappointment, and as a condition of ongoing membership, every member specifically agrees to the following:

(a) to provide continuous and timely quality care to all patients for whom the individual has responsibility, including effective and efficient hand-offs for safe patient care;

(b) to abide by all Bylaws, policies, and Rules and Regulations of the Medical Staff that are in force during the term of the individual's appointment;

(c) to participate in Medical Staff affairs through committee service, participation in quality improvement and professional practice evaluation activities, being encouraged to participate in graduate medical education activities and initiatives, and by performing such other reasonable duties and responsibilities as may be assigned;

(d) treat all providers (including, but not limited to, Medical Staff members, Advanced Practice Providers, nursing staff, medical residents) and District staff with respect;

(e) to comply with clinical practice or evidence-based protocols and pathways that are established by, and must be reported to, regulatory or accrediting agencies, or patient safety organizations, including those related to national patient safety initiatives and core measures, or clearly document the clinical reasons for variance;

(f) to comply with clinical practice or evidence-based medicine pathways or protocols, in the form of MEC-approved order sets, pertinent to his or her medical specialty, as may be adopted by the MEC, or clearly document the clinical reasons for variance;

(g) to comply with all applicable training and/or educational protocols that may be adopted by the MEC, including, but not limited to, those involving electronic medical records, patient safety, and infection control;

(h) to inform the Medical Staff Services Department, in writing, within 14 days of any of the following occurrences: :

- any action taken regarding the practitioner's license or DEA registration or any changes in licensure status or DEA controlled substance authorization,
- changes in professional liability insurance coverage,
- the filing of a professional liability lawsuit against the practitioner, or any final malpractice judgment or settlement;
- limitation, reduction, or loss of Medical Staff membership or privileges at any other hospital or health care entity or group affiliation,
- knowledge of a criminal investigation involving the member, arrest, charge, indictment, conviction, or a plea of guilty or no contest in any criminal matter other than a misdemeanor traffic citation,
- exclusion or restrictions from participation in Medicare/Medicaid or any sanctions imposed,
- any changes in the practitioner’s ability to safely and competently exercise clinical privileges or perform the duties and responsibilities of appointment because of health status issues, including, but not limited to, impairment due to addiction, alcohol use, or other similar issue (all of which shall be referred for review under the Impaired Provider Policy), and
- any charge of, or arrest for, driving while intoxicated/under the influence (“DWI”) (Any DWI incident will be reviewed by the Chief of Staff and the CEO so that they may understand the circumstances surrounding it. If

they have any concerns after doing so, they will forward the matter for further review under the Impaired Provider Policy);

(i) to immediately submit to an appropriate evaluation, which may include diagnostic testing (such as a blood and/or urine test), or to a complete physical, mental, and/or behavioral evaluation, if at least two Medical Staff Leaders (or one Medical Staff Leader and the CEO) are concerned with the individual's ability to safely and competently care for patients. The health care professional(s) to perform the testing and/or evaluations shall be determined by the Medical Staff Leaders. The Medical Staff member must execute all appropriate releases to permit the sharing of information with the Medical Staff Leaders and pay for the cost of the requested evaluation(s) and/or testing;

(j) to appear for personal or phone interviews in regard to an application for initial appointment or reappointment, if requested;

(k) to maintain a current email address with the Medical Staff Services Department, which will be the primary mechanism used to communicate all Medical Staff information to the member;

(l) to provide a valid mobile phone number with texting capability in order to facilitate physician-to-physician communication, which communication shall be accomplished in a manner consistent with the District's HIPAA policies and procedures;

(m) to refrain from illegal fee splitting or other illegal inducements relating to patient referral;

(n) to refrain from delegating responsibility for hospitalized patients to any individual who is not qualified or adequately supervised;

(o) to refrain from deceiving patients as to the identity of any individual providing treatment or services;

(p) to seek consultation whenever required or necessary;

(q) to complete in a timely and legible manner all medical and other required records, containing all information required by the District and to utilize the electronic record as required;

(r) to cooperate with all utilization oversight activities;

(s) to participate in an Organized Health Care Arrangement with the District and to abide by the terms of the District's Notice of Privacy Practices with respect to health care delivered in the District;

(t) to perform all services and conduct himself/herself at all times in a cooperative and professional manner;

(u) to promptly pay any applicable dues, assessments and/or fines;

(v) to satisfy continuing medical education requirements;

(w) to refrain from discriminating against another member of either the Medical Staff or Advanced Practice Provider Staff on the basis of age, gender, race, creed, national origin, citizenship status, sex, color, religion, ancestry, sexual orientation, gender identity or expression, disability, medical condition, genetic information, marital status, registered domestic partner status, or veteran status;

(x) to communicate with other Medical Staff members and District staff in a safe and effective manner; and

(y) to cooperate with the Chief of Staff, the department chair, the MEC, and the CEO in good faith with respect to summary suspensions and restrictions.

The failure of any Medical Staff member to abide by any of the duties specified above shall be grounds for corrective action, including the suspension or termination of privileges and Medical Staff membership.

2.B.2 Burden of Providing Information:

(a) Individuals seeking appointment and reappointment have the burden of producing information deemed adequate by the District for a proper evaluation of current competence, character, ethics, and other qualifications and for resolving any doubts about an individual's qualifications. Such information must be provided in an appropriate format that is legible and readable. The information to be produced includes such quality data and other information as may be needed to assist in an appropriate assessment of overall qualifications for appointment, reappointment, and current clinical competence for any requested clinical privileges, including, but not limited to, information from other hospitals, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians.

(b) Individuals seeking appointment and reappointment have the burden of providing evidence that all the statements made and information given on the application are accurate and complete.

(c) An application shall be complete when all questions on the application form have been answered, all supporting documentation has been supplied, and all information has been verified from primary sources. An application shall become incomplete if the need arises for new, additional, or clarifying information at any time during the credentialing process. Any application that continues to be incomplete 90 days after the individual has been notified of the additional information required shall be deemed to be withdrawn. If an applicant seeks to resubmit an application that was determined to have been withdrawn for non-substantive missing information, an additional fee of $250 shall be assessed to

reinstate the process. Any such termination of the credentialing process shall not entitle the applicant to review or appeal pursuant to the Bylaws.

(d) The individual seeking appointment or reappointment is responsible for providing a complete application, including adequate responses from references. An incomplete application shall not be processed.

2.C. APPLICATION

2.C.1 Information:

(a) Applications for appointment and reappointment shall contain a request for specific clinical privileges and shall require detailed information concerning the individual's professional qualifications. The applications for initial appointment and reappointment existing now and as may be revised are incorporated by reference and made a part of this Article.

(b) In addition to other information, the applications shall seek the following:

(1) information as to whether the applicant's medical staff appointment or clinical privileges have been voluntarily or involuntarily relinquished, withdrawn, denied, revoked, suspended, subjected to probationary or other conditions, reduced, limited, terminated, or not renewed at any other hospital or health care facility or are currently being investigated or challenged;

(2) information as to whether the applicant's license to practice any relevant profession in any state, DEA registration, or any state's controlled substance license has been voluntarily or involuntarily suspended, modified, terminated, restricted, or relinquished or is currently being investigated or challenged;

(3) information concerning the applicant's professional liability litigation experience, including past and pending claims, final judgments, or settlements; the substance of the allegations as well as the findings and the ultimate disposition; and any additional information concerning such proceedings or actions as the Credentials Committee, the MEC, or the Board may request;

(4) current information regarding the applicant's ability to safely and competently exercise the clinical privileges requested; and

(5) a copy of a government-issued photo identification.

(c) The applicant shall sign the application and certify the application is true and correct and that he or she is able to perform the privileges requested and the responsibilities of appointment.

2.C.2 Grant of Immunity and Authorization to Obtain/Release Information:

By requesting an application and/or applying for appointment, reappointment, or clinical privileges, the individual expressly accepts the conditions set forth in this Section:

(a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the District or the Board, any member of the Medical Staff or the Board, their authorized representatives, and third parties who provide information for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, reports, statements, communications, and/or disclosures involving the individual that are made, taken, or received by the District, its authorized agents, or third parties in the course of credentialing and peer review activities.

(b) Authorization to Obtain Information from Third Parties:

The individual specifically authorizes the District, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued appointment to the Medical Staff, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes third parties to release this information to the District and its authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the District.

(c) Authorization to Release Information to Third Parties:

The individual also authorizes District representatives to release information to other hospitals, health care facilities, managed care organizations, government regulatory and licensure boards or agencies, and their agents when information is requested in order to evaluate his or her professional qualifications for appointment, privileges, and/or participation at the requesting organization/facility, and any licensure or regulatory matter.

(d) Exhaustion of Remedies:

If adverse action is taken with respect to a practitioner's Medical Staff membership or privileges, regardless of whether the practitioner is an applicant or a Medical Staff member, the practitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action challenging the action or procedures

used to arrive at the action or asserting any claim against any participants in the decision-making process.

(e) Scope of Section:

All of the provisions in this Section 2.C.2 are applicable in the following situations:

(i) whether or not appointment or clinical privileges are granted;

(ii) throughout the term of any appointment or reappointment period and thereafter;

(iii) should appointment, reappointment, or clinical privileges be revoked, reduced, restricted, suspended, and/or otherwise affected as part of the District's professional review activities; and

(iv) as applicable, to any third-party inquiries received after the individual leaves the Medical Staff about his/her tenure as a member of the Medical Staff.

ARTICLE 3
CATEGORIES OF THE MEDICAL STAFF

Only those individuals who satisfy the qualifications and conditions for appointment to the Medical Staff contained in the Bylaws are eligible to apply for appointment to one of the categories listed below.

3.A. ACTIVE-VOTING STAFF

3.A.1 Qualifications:

The Active-Voting Staff shall consist of physicians, dentists, oral surgeons, podiatrists, and psychologists who:

(a) Meet the general qualifications for membership as set forth in section 2.A.1;

(b) have expressed a willingness to contribute to Medical Staff functions and/or demonstrated a commitment to the Medical Staff and District through service on District or Medical Staff committees and/or active participation in performance improvement or professional practice evaluation functions.

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

3.A.2 Prerogatives:

Active-Voting Staff members may:

(a) admit patients without limitation, except as otherwise provided in the Bylaws, Rules and Regulations, or policies;

(b) attend and vote at all general and special meetings of the Medical Staff and applicable department, division, and committee meetings;

(c) hold office, serve as department chairs and division chairs, serve on Medical Staff committees, and serve as chairs of committees; and

(d) exercise such clinical privileges as are granted to them.

3.A.3 Responsibilities:

Active-Voting Staff members must assume all the responsibilities of membership on the Active-Voting Staff, including:

(a) serving on committees, as requested;

(b) participating in the evaluation of new members of the Medical Staff;

(c) participating in the professional practice evaluation and performance improvement processes (including constructive participation in the development of clinical practice protocols and guidelines pertinent to their medical specialties);

(d) accepting inpatient consultations, when requested by another member of the Medical Staff;

(e) paying application fees, dues, and assessments; and

(f) performing assigned duties.

3.B. ACTIVE NON-VOTING STAFF

3.B.1 Qualifications:

The Active Non-Voting Staff shall consist of physicians, dentists, oral surgeons, podiatrists, and psychologists who:

(a) meet the general qualifications for membership as set forth in section 2.A.1; and

(b) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

3.B.2 Prerogatives and Responsibilities:

Active Non-Voting Staff members:

(a) may attend and participate in Medical Staff, department, and division meetings (without vote);

(b) may not hold office or serve as department chairs, division chairs, or committee chairs (unless waived by the MEC);

(c) may be invited to serve on committees (with vote);

(d) shall cooperate in the professional practice evaluation and performance improvement processes, including the evaluation of new members of the Medical Staff;

(e) shall accept inpatient consultations when requested by another member of the Medical Staff;

(f) may exercise such clinical privileges as are granted to them; and

(g) shall pay application fees, dues, and assessments.

3.C. CONSULTING STAFF

3.C.1 Qualifications:

The Consulting Staff shall consist of physicians, dentists, oral surgeons, podiatrists, and psychologists who:

(a) are of demonstrated professional ability and expertise who provide a service not otherwise available or in very limited supply on the Active Staff ;

(b) provide services at the District only at the request of other members of the Medical Staff; and

(c) at each reappointment time, provide such quality data and other information as may be requested to assist in an appropriate assessment of current clinical competence and overall qualifications for appointment and clinical privileges (including, but not limited to, information from another hospital, information from the individual's office practice, information from insurers or managed care organizations in which the individual participates, and/or receipt of confidential evaluation forms completed by referring/referred to physicians).

3.C.2 Prerogatives and Responsibilities:

Consulting Staff members:

(a) may exercise such clinical privileges as are granted to them to evaluate and treat patients in conjunction with other members of the Medical Staff;

(b) may not hold office or serve as department chairs, division chairs, or committee chairs (unless waived by the MEC);

(c) may attend meetings of the Medical Staff and applicable department and division meetings (without vote) and applicable committee meetings (with vote);

(d) shall cooperate in the professional practice evaluation and performance improvement processes; and

(e) shall pay application fees, dues, and assessments.

3.D. COMMUNITY AFFILIATE STAFF

3.D.1 Qualifications:

The Community Affiliate Staff consists of those physicians, dentists, oral surgeons, podiatrists, and psychologists who:

(a) meet the eligibility criteria set forth in the Bylaws with the exception of Section 2.A.1(c), (d), (j), (k), (l), (m), (n), and (o);

(b) desire to be associated with the District, but who do not intend to establish a clinical practice at the District; and

(c) have indicated or demonstrated a willingness to assume all the responsibilities of membership on the Community Affiliate Staff as outlined in Section 3.D.2.

The primary purpose of the Community Affiliate Staff is to promote professional and educational opportunities, including continuing medical education, and to permit these individuals to access District services for their patients by referral of patients to Active Staff members for admission and care.

3.D.2 Prerogatives and Responsibilities:

Community Affiliate Staff members:

(a) may attend meetings of the Medical Staff and applicable departments (without vote);

(b) may not hold office or serve as department chairs or committee chairs (unless waived by the MEC);

(c) shall generally have no staff committee responsibilities, but may be assigned to committees (with vote);

(d) may attend educational activities sponsored by the Medical Staff and the District;

(e) may refer patients to members of the Active Staff for admission and/or care;

(f) are encouraged to submit their outpatient records for inclusion in the District's medical records for any patients who are referred;

(g) are also encouraged to communicate directly with Active Staff members about the care of any patients referred, as well as to visit any such patients;

(h) may review the medical records and test results (via paper or electronic access) for any patients who are referred in a manner that complies with state and federal health information privacy laws and regulations;

(i) may perform history and physical examinations in the office and have those reports entered into the District's medical records;

(j) may not: admit patients, attend patients, exercise inpatient or outpatient clinical privileges, write inpatient orders, perform consultations, assist in surgery, or otherwise participate in the provision or management of clinical care to patients at the District;

(k) may refer to the District's infusion center and write appropriate orders to the same;

(l) may actively participate in the professional practice evaluation and performance improvement processes;

(m) may refer patients to the District's diagnostic facilities and order such tests; and

(n) must pay application fees, dues, and assessments.

3.E. HONORARY/ADMINISTRATIVE STAFF

3.E.1 Honorary Staff Qualifications:

(a) The Honorary Staff shall consist of practitioners who are members in good standing; have retired from the practice of medicine in this District after serving on the Medical Staff for more than 10 years; and have requested a category change that is approved by the MEC.

(b) Once an individual is appointed to the Honorary Staff, that status is ongoing. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

3.E.2 Administrative Staff Qualifications:

(a) The Administrative Staff shall consist of Physician who fulfill administrative functions at the District.

(b) Once an individual is appointed to the Administrative Staff, that status is ongoing until the individual is no longer fulfilling administrative functions at the District. As such, there is no need for the individual to submit a reappointment application/reappointment processing.

3.E.3 Prerogatives and Responsibilities:

(a) Honorary/Administrative Staff members:

(1) may not consult, admit, or attend to patients;

(2) may attend Medical Staff, department, and division meetings when invited to do so (without vote);

(3) may be appointed to committees (with vote);

(4) are entitled to attend educational programs of the Medical Staff and the District; and

(5) may not hold office or serve as department chairs, division chairs, or committee chairs (unless waived by the MEC).

(b) Members of this staff category are not required to pay application fees, dues, or assessments.

ARTICLE 4
PROCEDURE FOR INITIAL APPOINTMENT

4.A. PROCEDURE FOR INITIAL APPOINTMENT

4.A.1 Application:

(a) Applications for appointment shall be on forms (which may be electronic) that have been approved by the Credentials Committee and the MEC.

(b) An individual seeking initial appointment shall be sent the Medical Staff Bylaws, the Rules and Regulations, and an application form.

(c) Applications may be provided to residents or fellows who are nearing the end of the completion of their training. Such applications may be processed, but final action shall not be taken until all applicable threshold eligibility criteria are satisfied.

(d) Applications may be processed and reviewed by Medical Staff leadership and approved by the Board contingent upon the applicant providing evidence that a California license, completion of residency/fellowship program, adequate professional liability insurance, and work permit (if applicable) have been obtained. Any grant of appointment and/or clinical privileges by the Board shall become effective only upon such demonstration.

4.A.2 Initial Review of Application:

(a) A completed application form with copies of all required documents must be returned to the Medical Staff Services Department accompanied by the application fee.

(b) As a preliminary step, the application shall be reviewed by the Medical Staff Services Department to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria. Incomplete applications shall not be processed. Individuals who fail to return completed applications or fail to meet the threshold eligibility criteria shall be notified that their applications shall not be processed. A determination of ineligibility does not entitle the individual to the hearing and appeal rights outlined in the Bylaws.

(c) The Medical Staff Services Department shall oversee the process of gathering and verifying relevant information, and confirming that all references and other information or materials deemed pertinent have been received.

4.A.3 Steps to Be Followed for All Initial Applicants:

(a) Evidence of the applicant's character, professional competence, qualifications, behavior, and ethical standing shall be examined. This information may be contained in the application, and obtained from peer references, from the same

discipline where practicable and from other available sources, including the applicant's past or current department chairs at other health care entities, residency training director, and others who may have knowledge about the applicant's education, training, experience, and ability to work with others.

(b) An interview(s) with the applicant may be conducted. The purpose of the interview is to discuss and review any aspect of the applicant's application, qualifications, and requested clinical privileges. This interview may be conducted by two or more of the following: the department chair, the Credentials Committee, a Credentials Committee representative, the MEC, an MEC representative, the CMO, and/or the Chief of Staff.

4.A.4 Department Chair Procedure:

(a) The Medical Staff Services Department shall transmit the completed application and all supporting materials to the chair of each department in which the applicant seeks clinical privileges. Each chair shall prepare a written report regarding whether the applicant has satisfied all of the qualifications for appointment and the clinical privileges requested and that includes a recommendation as to appointment, staff category, clinical privileges to be granted, and any special conditions on a form provided by the Medical Staff Services Department.

(b) The department chair shall be available to the Credentials Committee and the MEC to answer any questions that may be raised with respect to the report and findings of the chair.

4.A.5 Credentials Committee Procedure:

(a) The Credentials Committee shall review and consider the report prepared by the relevant department chair and shall make a recommendation.

(b) The Credentials Committee may use the expertise of the department chair, or any member of the service, or an outside consultant, if additional information is required regarding the applicant's qualifications.

(c) The Credentials Committee may recommend the imposition of specific conditions. These conditions may relate to behavior (e.g., personal professionalism) or to clinical issues (e.g., general consultation requirements, appropriate documentation requirements, proctoring, completion of CME requirements). The Credentials Committee may also recommend that appointment be granted for a period of less than two years in order to permit closer monitoring of an individual's compliance with any conditions. Unless these matters involve the specific recommendations set forth in Section 9.A.1(a) of the Bylaws, such conditions do not entitle an individual to request the procedural rights set forth in Article 9 of the Bylaws.

4.A.6 MEC Recommendation:

(a) At its next regular meeting after receipt of the written findings and recommendation of the Credentials Committee, the MEC shall:

(1) adopt the findings and recommendation of the Credentials Committee as its own; or

(2) refer the matter back to the Credentials Committee for further consideration and responses to specific questions raised by the MEC prior to its final recommendation; or

(3) state its reasons in its report and recommendation, along with supporting information, for its disagreement with the Credentials Committee's recommendation.

(b) If the recommendation of the MEC is to appoint, the recommendation shall be forwarded to the Board.

(c) If the recommendation of the MEC is unfavorable and would entitle the applicant to request a hearing in accordance with Section 9.A.1(a) of the Bylaws, the MEC shall send special notice to the applicant through the Chief of Staff and the application will be held until after the applicant has completed or waived a hearing and appeal.

4.A.7 Board Action:

(a) Expedited Review. The Board may delegate to a committee, consisting of at least two Board members, action on appointment, reappointment, and clinical privileges if there has been a favorable recommendation from the Credentials Committee and the MEC and there is no evidence of any of the following:

(1) a pending or previous adverse action against the applicant's license or DEA registration;

(2) an involuntary termination, limitation, reduction, denial, or loss of appointment or privileges at any other hospital or other entity; or

(3) an unusual pattern of, or an excessive number of, professional liability actions against the applicant.

Any decision reached by a Board committee to appoint shall be effective immediately and shall be forwarded to the Board for ratification at its next meeting.

(b) Full Board Review. When there has been no delegation to a Board committee, upon receipt of a recommendation that the applicant be granted appointment and clinical privileges, the Board may:

(1) appoint the applicant and grant clinical privileges as recommended; or

(2) refer the matter back to the Credentials Committee or MEC for additional research or information; or

(3) reject or modify the recommendation.

(c) If the Board determines to reject a favorable recommendation, it should first discuss the matter with the Chair of the Credentials Committee and the Chair of the MEC. If the Board's recommendation remains unfavorable, the Ad Hoc Dispute Resolution process set forth in Section 12.F of the Bylaws shall be followed. If, following the Ad Hoc Dispute Resolution process, the Board's determination remains unfavorable to the applicant, the CEO shall promptly send special notice to the applicant that the applicant is entitled to request a hearing.

(d) Any final decision by the Board to grant, deny, revise or revoke appointment and/or clinical privileges will be disseminated to appropriate individuals and, as required, reported to appropriate entities.

4.A.8 Time Periods for Processing:

Once an application is deemed complete, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

4.B. FOCUSED PROFESSIONAL PRACTICE EVALUATION FOR INITIAL PRIVILEGES

(1) All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to focused professional practice evaluation ("FPPE") by the department chair or by a physician(s) designated by the department chair.

(2) This FPPE may include chart review, monitoring, proctoring, external review, and other information. The clinical activity requirements, including numbers and types of cases to be reviewed, will be determined by the clinical department and approved by the Credentials Committee, MEC, and the Board.

(3) A newly appointed member's appointment and privileges will expire if he or she fails to do the following within the time frame determined by the Credentials Committee, unless the department chair recommends an extension which is granted by the Credentials Committee:

(a) participate in the required number of cases (as applicable); or

(b) cooperate with the monitoring and review conditions.

In such case, the individual may not reapply for initial appointment or privileges for one year.

(4) If a member who has been granted additional clinical privileges fails to fulfill the clinical activity requirements within the time frame determined by the Credentials Committee, unless the department Chair recommends an extension which is granted by the Credentials Committee, the additional clinical privileges will expire and the member may not reapply for the privileges in question for one year.

(5) When, based upon information obtained through the FPPE process, a recommendation is made to terminate, revoke, or restrict clinical privileges for 30 days or more in a 12-month period for reasons related to clinical competence or professional conduct, the member will be entitled to a hearing and appeal under Article 9 of the Bylaws.

ARTICLE 5
CLINICAL PRIVILEGES

5.A. CLINICAL PRIVILEGES

5.A.1 General:

(a) Appointment or reappointment shall not confer any clinical privileges or right to admit or treat patients at the District. Each individual who has been appointed to the Medical Staff is entitled to exercise only those clinical privileges specifically recommended by the MEC and approved by the Board.

(b) For privilege requests to be processed, the applicant must satisfy any applicable threshold eligibility criteria.

(c) Requests for clinical privileges that are subject to an exclusive contract shall not be processed except as consistent with the contract.

(d) Requests for clinical privileges that have been grouped into core privileges will not be processed unless the individual has applied for the full core and satisfied all threshold eligibility criteria (or has obtained a waiver in accordance with Section 5.A.2).

(e) The clinical privileges recommended to the Board shall be based upon consideration of the following factors:

(1) education, relevant training, experience, and demonstrated current competence, including medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal and communication skills, and professionalism with patients, families, and other members of the health care team and acceptable peer evaluations relating to these criteria;

(2) appropriateness of utilization patterns;

(3) ability to perform the privileges requested competently and safely;

(4) information resulting from ongoing and focused professional practice evaluation and other performance improvement activities, as applicable;

(5) availability of qualified staff members with appropriate privileges (as determined by the Credentials Committee) to provide coverage in case of the applicant's illness or unavailability;

(6) adequate professional liability insurance coverage for the clinical privileges requested as may be required by the Board;

(7) the District's available resources and personnel;

(8) any pending or previous adverse action against the applicant's license or DEA registration, or the voluntary or involuntary relinquishment of such licensure or DEA registration;

(9) any information concerning professional review actions or voluntary or involuntary termination, limitation, reduction, or loss of appointment or clinical privileges at another hospital;

(10) practitioner-specific data as compared to aggregate data, when available; and

(11) professional liability actions, especially any such actions that reflect an unusual pattern or excessive number of actions.

(f) The applicant has the burden of establishing his or her qualifications and current competence for all clinical privileges requested.

(g) The report of the chair of the clinical department in which privileges are sought shall be forwarded to the Chair of the Credentials Committee and processed as a part of the initial application for staff appointment.

5.A.2 Privilege Modifications and Waivers:

(a) Scope. This Section applies to all requests for modification of clinical privileges during the term of appointment (increases and relinquishments), resignation from the Medical Staff, and waivers related to eligibility criteria for privileges.

(b) Submitting a Request. Requests for privilege modifications and waivers must be submitted in writing to the Medical Staff Services Department.

(c) Increased Privileges.

(1) Requests for increased privileges must state the specific additional clinical privileges requested and provide information sufficient to establish eligibility, as specified in applicable criteria, and current clinical competence.

(2) If the individual is eligible and the application is complete, it will be processed in the same manner as an application for initial clinical privileges.

(d) Waivers.

(1) Any individual who does not satisfy one or more eligibility criteria for clinical privileges may request that it be waived. Such requests will be processed in accordance with Section 2.A.2 of the Bylaws.

(2) If the individual is requesting a waiver of the requirement that each member apply for the full core of privileges in his or her specialty, the process set forth in this paragraph shall apply.

(i) Written Request: The individual must forward a written request to the Medical Staff Services Department which must indicate the specific patient care services within the core that the member does not wish to provide, state a good cause basis for the request, and include evidence that the individual does not provide the patient care services at issue in any health care facility.

(ii) Review Process: A request for a waiver shall be submitted to the Credentials Committee for consideration. In reviewing the request for a waiver, the Credentials Committee shall specifically consider the factors outlined in Paragraph (f) below and may obtain input from the relevant service chair. The Credentials Committee's recommendation will be forwarded to the MEC, which shall review the recommendation of the Credentials Committee and make a recommendation to the Board regarding whether to grant or deny the request for a waiver. Any recommendation to grant a waiver must include the specific basis for the recommendation.

(e) Relinquishment and Resignation of Privileges.

(1) Relinquishment of Individual Privileges. A request to relinquish any individual clinical privilege, whether or not part of the core, must provide a good cause basis for the modification of privileges. All such requests shall be processed in the same manner as a request for waiver, as described above.

(2) Resignation of Appointment and Privileges. A request to resign Medical Staff appointment and relinquish all clinical privileges must specify the desired date of resignation.

Relinquishment and resignation requests shall be submitted to the Credentials Committee, MEC, and the Board as information.

(f) Factors for Consideration. The Medical Staff Leaders and Board may consider the following factors, among others, when deciding whether to recommend or grant a modification (increases and/or relinquishments) or waiver related to privileges:

(1) the District's mission and ability to serve the health care needs of the community by providing timely, appropriate care within its facilities;

(2) whether sufficient notice has been given to provide a smooth transition of patient care services;

(3) fairness to the individual requesting the modification or waiver, including past service and the other demands placed upon the individual;

(4) fairness to other Medical Staff members who serve on the call roster in the relevant specialty, including the effect that the modification would have on them;

(5) the expectations of other members of the Medical Staff who are in different specialties but who rely on the specialty in question in the care of patients who present to the District;

(6) any perceived inequities in modifications or waivers being provided to some, but not others;

(7) any gaps in call coverage that might/would result from an individual's removal from the call roster for the relevant privilege and the feasibility and safety of transferring patients to other facilities in that situation; and

(8) how the request may affect the District's ability to comply with applicable regulatory requirements, including the Emergency Medical Treatment and Active Labor Act.

(g) Effective Date. If the Board grants a modification or waiver related to privileges, it shall specify the date that the modification or waiver will be effective. Failure of a member to request and obtain privilege modifications or waivers in accordance with this section shall, as applicable, result in the member retaining Medical Staff appointment and clinical privileges and all associated responsibilities.

(h) Procedural Rights. No individual is entitled to a modification or waiver related to privileges. Individuals are also not entitled to a hearing or appeal or other process if a waiver or a modification related to a relinquishment of privileges is not granted.

5.A.3 Clinical Privileges for New Procedures:

(a) Requests for clinical privileges to perform either a procedure not currently being performed at the District or a new technique to perform an existing procedure (hereafter, "new procedure") shall not be processed until (1) a determination has been made by District administration that the procedure shall be offered by the District and (2) criteria to be eligible to request those clinical privileges have been established as set forth in this Section.

(b) As an initial step in the process, the individual seeking to perform the new procedure will prepare and submit a report to the Chief of Staff and CEO and shall address the following:

(1) the appropriate education, training, and experience necessary to perform the new procedure safely and competently;

(2) clinical indications for when the new procedure is appropriate;

(3) whether there is empirical evidence of improved patient outcomes with the new procedure or other clinical benefits to patients;

(4) whether proficiency for the new procedure is volume-sensitive and if the requisite volume would be available;

(5) whether the new procedure is being performed at other similar hospitals and the experiences of those institutions; and

(6) whether the District currently has the resources, including space, equipment, personnel, and other support services, to safely and effectively perform the new procedure.

District administration shall review this report and consult with the Chief of Staff, the department chair, and the Credentials Committee (any of which may conduct additional research as may be necessary) and shall make a preliminary determination as to whether the new procedure should be offered to the community.

(c) If the preliminary determination of the District is favorable, the relevant clinical department(s) will then develop threshold credentialing criteria to determine those individuals who are eligible to request the clinical privileges at the District. In developing the criteria, the Credentials Committee may conduct additional research and consult with experts, as necessary, and develop recommendations regarding:

(1) the minimum education, training, and experience necessary to perform the procedure or service;

(2) the clinical indications for when the procedure or service is appropriate;

(3) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence; and

(4) the manner in which the procedure would be reviewed as part of the District's ongoing and focused professional practice evaluation activities.

(d) The Credentials Committee will forward its recommendations to the MEC, which will review the matter and forward its recommendations to the Board for final action.

(e) The Board will make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation. If the Board determines to offer the procedure or service, it will then establish the minimum threshold qualifications that an individual must demonstrate in order to be eligible to request the clinical privileges in question.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to perform the procedure or service may be processed.

5.A.4 Clinical Privileges That Cross Specialty Lines:

(a) Requests for clinical privileges that have previously been exercised at the District only by individuals from another specialty shall not be processed until the steps outlined in this Section have been completed and a determination has been made regarding the individual's eligibility to request the clinical privileges in question.

(b) As an initial step in the process, the individual seeking the privilege will prepare and submit a report to the Credentials Committee that specifies the minimum qualifications needed to perform the procedure safely and competently, whether others in the individual's specialty are performing the same privilege at other similar hospitals, and the experiences of those other hospitals in terms of patient care outcomes and quality of care.

(c) The Credentials Committee shall then conduct additional research and consult with experts, as necessary, including those on the Medical Staff (e.g., department chairs, individuals on the Medical Staff with special interest and/or expertise) and those outside the District (e.g., other hospitals, residency training programs, specialty societies).

(d) The Credentials Committee may or may not recommend that individuals from different specialties be permitted to request the privileges at issue. If it does, the Committee may develop recommendations regarding:

(1) the appropriate education, training, and experience necessary to perform the clinical privileges in question;

(2) the clinical indications for when the procedure is appropriate;

(3) the manner of addressing the most common complications that arise which may be outside of the scope of the clinical privileges that have been granted to the requesting individual;

(4) the extent (time frame and mechanism) of focused monitoring and supervision that should occur if the privileges are granted in order to confirm competence;

(5) the manner in which the procedure would be reviewed as part of the District's ongoing and focused professional practice evaluation activities

(which may include assessment of both long-term and short-term outcomes for all relevant specialties); and

(6) the impact, if any, on emergency call responsibilities.

(e) The Credentials Committee shall forward its recommendations to the MEC, which shall review the matter and forward its recommendations to the Board for final action. The Board shall make a reasonable effort to render the final decision within 60 days of receipt of the MEC's recommendation.

(f) Once the foregoing steps are completed, specific requests from eligible Medical Staff members who wish to exercise the privileges in question may be processed.

5.A.5 Clinical Privileges for Dentists and Oral and Maxillofacial Surgeons:

Dentists and oral and maxillofacial surgeons shall be responsible for the dental and oral surgery care of the patient (as relevant), including the appropriate history and physical examination, as well as all other appropriate elements of the patient's record. Dentists and oral and maxillofacial surgeons may write orders within the scope of their licenses and consistent with the Medical Staff Rules and Regulations. They must, nevertheless, have a relationship with a physician on the Medical Staff (established and declared in advance) who is available to respond should any medical issue arise with a patient outside of the individual's scope of privileges.

5.A.6 Physicians in Training:

(a) Physicians in training at the District shall not hold appointments to the Medical Staff and shall not be granted specific privileges. The program director, clinical faculty, and/or attending staff member shall be responsible for the direction and supervision of the on-site and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements, and/or training protocols approved by the District. The applicable program director shall be responsible for verifying and evaluating the qualifications of each physician in training.

(b) A physician in training at the fellowship level may request clinical privileges in an area for which he or she has already completed residency training if he or she can demonstrate that all necessary eligibility criteria as set forth in the Bylaws have been met. Requests for privileges shall be reviewed in accordance with the initial credentialing process outlined in the Bylaws and, if granted, shall be subject to all relevant oversight provisions, including OPPE and FPPE. Clinical privileges may not be granted in the specialty area in which they are currently in training as part of their training program.

5.A.7 Telemedicine Privileges:

(a) A qualified individual may be granted telemedicine privileges regardless of whether the individual is appointed to the Medical Staff.

(b) Telemedicine privileges include providing interpretive, diagnostic, or treatment services by means of telemedicine devices (including interactive audio, video or data communication) by physicians or advanced practice providers to district patients

(c) Requests for initial or renewed telemedicine privileges shall be processed through one of the following options:

(1) A request for telemedicine privileges may be processed through the same process for Medical Staff applications, as set forth in the Bylaws. In such case, the individual must satisfy all qualifications and requirements set forth in the Bylaws, except those relating to geographic location, coverage arrangements, and emergency call responsibilities.

(2) If the individual requesting telemedicine privileges is practicing at a distant hospital that participates in Medicare or a telemedicine entity (as that term is defined by Medicare), a request for telemedicine privileges may be processed using an abbreviated process that relies on the credentialing and privileging decisions made by the distant hospital or telemedicine entity. In such cases, the District must ensure through a written agreement that the distant hospital or telemedicine entity will comply with all applicable Medicare regulations and accreditation standards. The distant hospital or telemedicine entity must provide:

(i) confirmation that the practitioner is licensed in California;

(ii) a current list of privileges granted to the practitioner;

(iii) information indicating that the applicant has actively exercised the relevant privileges during the previous 12 months and has done so in a competent manner;

(iv) a signed attestation that the applicant satisfies all of the distant hospital or telemedicine entity's qualifications for the clinical privileges granted;

(v) a signed attestation that all information provided by the distant hospital or telemedicine entity is complete, accurate, and up-to-date; and

(vi) any other attestations or information required by the agreement or requested by the District.

This information shall be provided to the Credentials Committee and MEC for review and recommendation to the Board for final action. Notwithstanding the process set forth in this subsection, the District may determine that an applicant for telemedicine privileges is ineligible for appointment or clinical privileges if

the applicant fails to satisfy the threshold eligibility criteria set forth in the Bylaws.

(d) Telemedicine privileges, if granted, shall be for a period of not more than two years.

(e) Individuals granted telemedicine privileges shall be subject to the District's peer review activities. The results of the peer review activities, including any adverse events and complaints filed about the practitioner providing telemedicine services from patients, other practitioners or staff, will be shared with the hospital or entity providing telemedicine services.

(f) Telemedicine privileges granted in conjunction with a contractual agreement shall be incident to and coterminous with the agreement.

5.B. TEMPORARY CLINICAL PRIVILEGES

5.B.1 Eligibility to Request Temporary Clinical Privileges:

(a) Applicants. Temporary privileges for an applicant for initial appointment may be granted by the CEO, upon recommendation of the Department Chair, Chief of Staff, and Chief Medical Officer, under the following conditions:

(1) the applicant has submitted a complete application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence, ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no pending or previous adverse action against the applicant's license or DEA registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the application is pending review by the MEC and the Board, following a favorable recommendation and evaluation from the department chair; and

(5) temporary privileges for a Medical Staff applicant will be granted for a maximum period of 120 consecutive days.

(b) Locum Tenens. The CEO, upon recommendation of the Chief of Staff, the CMO, and the applicable department chair, may grant temporary privileges to an individual serving as a locum tenens for a member of the Medical Staff who is on

vacation, attending an educational seminar, or ill, or when necessary to prevent a lack or lapse of services in a needed specialty area. The following conditions apply:

(1) the applicant has submitted an appropriate application, along with the application fee;

(2) the verification process is complete, including verification of current licensure, relevant training or experience, current competence (verification of good standing in the most recent one to two hospitals where the individual practiced during the past year), ability to exercise the privileges requested, and current professional liability coverage; compliance with privileges criteria; and consideration of information from the National Practitioner Data Bank, from a criminal background check, and from OIG queries;

(3) the applicant demonstrates that (i) there are no pending or previous adverse action against the applicant's license or DEA registration, and (ii) he or she has not been subject to involuntary termination of Medical Staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges, at another health care facility;

(4) the applicant will be subject to any focused professional practice requirements established by the District; and

(5) the individual may exercise locum tenens privileges for a maximum of 120 days, consecutive or not, anytime during the 12-month period following the date they are granted, on the condition that the individual must inform the Medical Staff Services Department of any material change that has occurred to any of the information provided on the initial application for locum tenens privilege.

If an individual who has been granted locum tenens privileges has reason to exceed the 120-day maximum time frame referenced above, he or she may request a renewal of locum tenens privileges for an additional time period, not to exceed 120 days. Such requests shall be granted by the CEO, following review and favorable recommendation by the Chief of Staff and the relevant department chair. If any of those individuals have any concerns about the renewal request, it shall be forwarded to the full Credentials Committee for review and recommendation. If an individual is granted an additional 120-day renewal and still requires additional time, he or she must apply for full appointment to the Medical Staff.

(c) Visiting. Temporary privileges may also be granted in other limited situations by the CEO, upon recommendation of the Chief of Staff, the CMO, and the applicable department chair, when there is an important patient care, treatment, or

service need. Specifically, temporary privileges may be granted for situations such as the following:

(1) the care of a specific patient; or

(2) when a proctoring or consulting physician is needed, but is otherwise unavailable.

The following factors will be considered and verified prior to the granting of temporary privileges in these situations: current licensure, relevant training or experience, current competence (verification of good standing in the most recent one to two hospitals where the individual practiced during the past year), current professional liability coverage acceptable to the District, and results of a query to the National Practitioner Data Bank, from a criminal background check, and from OIG queries. The grant of clinical privileges in these situations will not exceed 60 days. In exceptional situations, this period of time may be extended in the discretion of the CEO and the Chief of Staff.

(d) Automatic Expiration. All grants of temporary privileges shall automatically expire upon the date specified at the time of initial granting unless further affirmative action is taken by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, and the CEO with approval of the Board to renew such temporary privileges.

(e) Compliance with Bylaws and Policies. Prior to any temporary privileges being granted, the individual must agree in writing to be bound by the bylaws, rules and regulations, policies, procedures, and protocols of the Medical Staff and the District.

(f) FPPE. Individuals who are granted temporary privileges will be subject to the District policy regarding focused professional practice evaluation.

5.B.2 Supervision Requirements:

Special requirements of supervision and reporting may be imposed on any individual granted temporary clinical privileges.

5.B.3 Withdrawal of Temporary Clinical Privileges:

(a) The CEO may, at any time after consulting with the Chief of Staff, withdraw temporary privileges. Clinical privileges shall then expire as soon as alternate care has been arranged. A withdrawal of temporary privileges shall not give a practitioner the right to a hearing and appeal under the Bylaws unless the withdrawal was for reasons that mandate an 805 report.

(b) If the care or safety of patients might be endangered by continued treatment by the individual granted temporary privileges, the department chair, the Chief of Staff, or the CEO may immediately withdraw all temporary privileges. The

department chair or the Chief of Staff shall assign to another member of the Medical Staff responsibility for the care of such individual's patients until they are discharged or an appropriate transfer arranged. Whenever possible, consideration shall be given to the wishes of the patient in the selection of a substitute physician.

5.C. EMERGENCY SITUATIONS

(1) For the purpose of this section, an "emergency" is defined as a condition which could result in serious or permanent harm to a patient(s) and in which any delay in administering treatment would add to that harm.

(2) In an emergency situation, a member of the Medical Staff may administer treatment to the extent permitted by his or her license, regardless of clinical service status or specific grant of clinical privileges.

(3) When the emergency situation no longer exists, the patient shall be assigned by the department chair or the Chief of Staff to a member with appropriate clinical privileges, considering the wishes of the patient.

5.D. DISASTER PRIVILEGES

(1) When the District's Disaster Plan has been implemented and the immediate needs of patients in the facility cannot be met, the CEO or the Chief of Staff may use a modified credentialing process to grant disaster privileges to eligible volunteer licensed independent practitioners ("volunteers"). Safeguards must be in place to verify that volunteers are competent to provide safe and adequate care.

(2) Disaster privileges are granted on a case-by-case basis after verification of identity and licensure.

(a) A volunteer's identity may be verified through a valid government-issued photo identification document (i.e., driver's license or passport).

(b) A volunteer's license may be verified in any of the following ways: (i) current hospital picture ID card that clearly identifies the individual's professional designation; (ii) current license to practice; (iii) primary source verification of the license; (iv) identification indicating that the individual has been granted authority to render patient care in disaster circumstances or is a member of a Disaster Medical Assistance Team, the Medical Resource Corps, the Emergency System for Advance Registration of Volunteer Health Professionals, or other recognized state or federal organizations or groups; or (v) identification by a current District employee or Medical Staff member who possesses personal knowledge regarding the individual's ability to act as a volunteer during a disaster.

(3) Primary source verification of a volunteer's license will begin as soon as the immediate situation is under control and must be completed within 72 hours from the time the volunteer begins to provide service at the District.

(4) In extraordinary circumstances when primary source verification cannot be completed within 72 hours, it should be completed as soon as possible. In these situations, there must be documentation of the following: (a) the reason primary source verification could not be performed in the required time frame; (b) evidence of the volunteer's demonstrated ability to continue to provide adequate care; and (c) an attempt to obtain primary source verification as soon as possible. If a volunteer has not provided care, then primary source verification is not required.

(5) The Medical Staff will oversee the care provided by volunteer licensed independent practitioners. This oversight shall be conducted through direct observation, mentoring, clinical record review, or other appropriate mechanism developed by the Medical Staff and District.

(6) Disaster Privileges shall automatically expire after 72 hours, unless extended by the CEO or the Chief of Staff.

5.E. CONTRACTS FOR SERVICES

(1) From time to time, the District may enter into contracts with practitioners and/or groups of practitioners for the performance of clinical and administrative services at the District. All individuals providing clinical services pursuant to such contracts will obtain and maintain clinical privileges at the District, in accordance with the terms of the Bylaws.

(2) To the extent that:

(a) any such contract confers the exclusive right to perform specified services to one or more practitioners or groups of practitioners, or

(b) the Board by resolution limits the practitioners who may exercise privileges in any clinical specialty to employees of the District or its affiliates,

no other practitioner except those authorized by or pursuant to the contract or resolution may exercise clinical privileges to perform the specified services while the contract or resolution is in effect. This means that only authorized practitioners are eligible to apply for appointment to the Medical Staff and for the clinical privileges in question. No other applications will be processed.

(3) Prior to the District signing any exclusive contract and/or passing any Board resolution described in paragraph (2) in a specialty area that has not previously been subject to such a contract or resolution, the Board will request the MEC's review of the matter. The MEC (or a subcommittee of its members appointed by

the Chief of Staff) will review the quality of care and service implications of the proposed exclusive contract or Board resolution, and provide a report of its findings and recommendations to the Board within 30 days of the Board's request. As part of its review, the MEC (or subcommittee) may obtain relevant information concerning quality of care and service matters from (i) members of the applicable specialty involved, (ii) members of other specialties who directly utilize or rely on the specialty in question, and (iii) District administration. However, the actual terms of any such exclusive arrangement or employment contract, and any financial information related to them, including but not limited to the remuneration to be paid to Medical Staff members who may be a party to the arrangement or practitioners of the contracting group, are not relevant and shall neither be disclosed to the MEC nor discussed as part of the MEC's review.

(4) After receiving the MEC's report, the Board shall determine whether or not to proceed with the exclusive contract or Board resolution. If the Board determines to do so, and if that determination would have the effect of preventing an existing Medical Staff member from exercising clinical privileges that had previously been granted, the affected member is entitled to the following notice and review procedures (Note: If more than one physician in a relevant specialty area will be affected by the determination of the Board, the following procedures will be coordinated to address all requested meetings in a combined and consolidated manner):

(a) The affected member shall be given at least 30 days' advance notice of the exclusive contract or Board resolution and have the right to meet with the Board (or a committee designated by the Board) to discuss the matter prior to the signing of the contract in question by the District or the Board resolution becoming effective. Any such meetings shall be held within 30 days of the notice to the affected member.

(b) At the meeting, the affected member shall be entitled to present any information that he or she deems relevant to the decision to enter into the exclusive contract or enact the Board resolution.

(c) If, following this meeting, the Board confirms its initial determination to enter into the exclusive contract or enact the Board resolution, the affected member shall be notified that he or she is ineligible to continue to exercise the clinical privileges covered by the exclusive contract or Board resolution. In that circumstance, the ineligibility begins as of the effective date of the exclusive contract or Board resolution and continues for as long as the contract or Board resolution is in effect.

(d) The affected member shall not be entitled to any procedural rights beyond those outlined above with respect to the Board's decision or the effect of the decision on his or her clinical privileges, notwithstanding the provisions in Article 8 of the Bylaws.

(e) The inability of a physician to exercise clinical privileges because of an exclusive contract or resolution is not reportable to the California licensure board or to the National Practitioner Data Bank.

(5) Except as provided in paragraph (1), in the event of any conflict between the Medical Staff Bylaws and the terms of any contract, the terms of the contract shall control.

5.F. PRACTITIONERS IN DEPARTMENTS SUBJECT TO EXCLUSIVE CONTRACTS

In order to exercise clinical privileges in any service or department that is subject to an exclusive contract with the District, a practitioner must be a member of the Medical Staff (with the exception of Advanced Practice Providers and physicians working in a locums capacity for the contracted entity), hold the applicable clinical privileges, and be an employee, partner, contractor, or associate (hereinafter "affiliate") of the group, individual, or entity that holds the exclusive contract (hereinafter "contracted entity"). Upon (1) the departure of the affiliate from the contracted entity, (2) notice from the contracted entity that a practitioner will no longer provide services at the District, or (3) the termination of the exclusive contract with the District, whichever occurs first, when all of the affiliate's clinical privileges are encompassed by the exclusive contract, the affiliate shall be deemed to have voluntarily resigned from the Medical Staff and to have voluntarily relinquished his or her clinical privileges, except when an affiliate qualifies for Honorary Staff under Section 3.E.1(a) of the Bylaws and the Medical Executive Committee, in its discretion, approves a transfer to that category. Such a resignation and relinquishment shall not entitle the practitioner to the procedural rights described in Article 9 of the Bylaws. To the extent the practitioner holds clinical privileges beyond those encompassed by the exclusive contract, his or her departure from the contracted entity or the termination of the exclusive contract will not result in the practitioner's voluntary resignation from the Medical Staff and the practitioner's remaining clinical privileges will remain intact.

ARTICLE 6
PROCEDURE FOR REAPPOINTMENT

6.A. PROCEDURE FOR REAPPOINTMENT

All terms, conditions, requirements, and procedures relating to initial appointment shall apply to continued appointment and clinical privileges and to reappointment.

6.A.1 Eligibility for Reappointment:

To be eligible to apply for reappointment and renewal of clinical privileges, an individual must have, during the previous appointment term:

(a) completed all medical records and be current at the time of reappointment;

(b) completed any continuing medical education requirements;

(c) satisfied all Medical Staff responsibilities, including payment of dues, fines, and assessments;

(d) continued to meet all qualifications and criteria for appointment and the clinical privileges requested as set forth in Section 2.A.1 of the Bylaws;

(e) if applying for clinical privileges, had sufficient patient contacts to enable the assessment of current clinical judgment and competence for the privileges requested. Any individual seeking reappointment who has minimal activity at the District must submit such information as may be requested (such as a copy of his/her confidential quality profile from his/her primary hospital, clinical information from the individual's private office practice, and/or a quality profile from a managed care organization or insurer), before the application shall be considered complete and processed further; and

(f) paid the reappointment processing fee, if any.

6.A.2 Factors for Evaluation:

In considering an individual's application for reappointment, the factors listed in Section 2.A.3 of the Bylaws will be considered. Additionally, the following factors shall be evaluated as part of the reappointment process:

(a) compliance with the Bylaws, rules and regulations, and policies of the Medical Staff;

(b) participation in Medical Staff duties, including committee assignments, consultation requests, quality of medical record documentation, cooperation with case management, participation in quality improvement, utilization, and professional practice evaluation activities, and such other reasonable duties and responsibilities as assigned;

(c) the results of the District's performance improvement and professional practice evaluation activities, taking into consideration practitioner-specific information compared to aggregate information concerning other individuals in the same or similar specialty (provided that other practitioners shall not be identified);

(d) any focused professional practice evaluations;

(e) verified complaints received from patients, families, and/or staff; and

(f) other reasonable indicators of continuing qualifications.

6.A.3 Reappointment Application:

(a) An application for reappointment shall be furnished to members at least four months prior to the expiration of their current appointment term. A completed reappointment application must be returned to the Medical Staff Services Department within 30 days.

(b) Failure to return a completed application at least two months prior to the expiration of the member's current term, allowing adequate time for processing, may result in automatic expiration of appointment and clinical privileges at the end of the then current term of appointment unless the application can still be processed in the normal course, without extraordinary effort on the part of the Medical Staff Services Department and the Medical Staff Leaders.

(c) Reappointment shall be for a period of not more than two years.

(d) If an application for reappointment is submitted timely, but the Medical Staff and/or Board has not acted on it prior to the end of the current term, the individual's appointment and clinical privileges shall expire at the end of the then current term of appointment. Subsequent Board action may be to grant reappointment and renewal of clinical privileges using the filed application in accordance with the expedited process set forth in Section 4.A.7.

(e) The application shall be reviewed by the Medical Staff Services Department to determine that all questions have been answered and that the individual satisfies all threshold eligibility criteria for reappointment and for the clinical privileges requested.

(f) The Medical Staff Services Department shall also oversee the process of gathering and verifying relevant information and shall be responsible for confirming that all relevant information has been received.

6.A.4 Processing Applications for Reappointment:

(a) The Medical Staff Services Department shall forward the application to the relevant department chair and the application for reappointment shall be processed in a manner consistent with applications for initial appointment.

(b) Additional information may be requested from the applicant if any questions or concerns are raised with the application or if new privileges are requested.

6.A.5 Conditional Reappointments:

(a) Recommendations for reappointment and renewed privileges may be contingent upon an individual's compliance with certain specific conditions. These conditions may relate to behavior (e.g., personal code of conduct) or to clinical issues (e.g., general consultation requirements, proctoring, completion of CME requirements). Unless the conditions involve the matters set forth in Section 9.A.1(a) of the Bylaws, the imposition of such conditions does not entitle an individual to the procedural rights set forth in Article 9.

(b) In addition, reappointments may be recommended for periods of less than two years in order to permit closer monitoring of an individual's compliance with any conditions that may be imposed. A recommendation for reappointment for a period of less than two years does not, in and of itself, entitle an individual to the procedural rights set forth in Article 9.

(c) In the event the applicant for reappointment is the subject of an unresolved professional practice evaluation concern, a formal investigation, or a hearing at the time reappointment is being considered, a conditional reappointment for a period of less than two years may be granted pending the completion of that process.

6.A.6 Time Periods for Processing:

Once an application is deemed complete and verified, it is expected to be processed within 120 days, unless it becomes incomplete. This time period is intended to be a guideline only and shall not create any right for the applicant to have the application processed within this precise time period.

ARTICLE 7
ADVANCED PRACTICE PROVIDERS

7.A. CATEGORIES

Subject to approval by the Board, the MEC shall determine those categories of Advanced Practice Providers (APPs) that shall be eligible to exercise privileges within the District. Except as set forth below, APPs shall be subject to the supervision requirements developed in each department and approved by the Interdisciplinary Practice Committee, the Credentials Committee, the MEC, and the Board. A current listing of the categories of APP functioning in the District is set forth in Appendix B to these Bylaws.

7.B. PRIVILEGES AND RESPONSIBILITIES

(a) APPs may exercise only those privileges specifically granted them by the Board. The range of privileges for which each APP may apply and any special limitations or conditions to the exercise of such privileges shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Credentials Committee, the MEC, and the Board.

(b) Applications for initial granting of APP privileges and biennial renewal thereof shall be submitted and processed in a parallel manner to that provided for Medical Staff members. With the exception of Certified Registered Nurse Anesthetists ("CRNAs"), to qualify for credentialing consideration, the APP must have a supervision agreement with a physician who is appointed to the Medical Staff (the "Supervising Physician").

(c) Each APP shall be assigned to the department(s) appropriate to his or her occupational or professional training and, unless otherwise specified in these Bylaws, shall be subject to terms, conditions, and responsibilities paralleling those specified for Medical Staff members as they may logically be applied to APPs and appropriately tailored to the particular APP's profession. Each APP may attend department meetings without a vote and serve on Medical Staff committees with a vote as appointed by the Chief of Staff.

(d) APPs shall not be appointed to the Medical Staff or entitled to the rights, privileges, and/or prerogatives of Medical Staff appointment.

7.C. SUPERVISION REQUIREMENTS

(a) These supervision requirements do not apply to CRNAs.

(b) Any activities permitted to be performed by APPs at the District shall be performed only under the supervision or direction of a Supervising Physician.

(c) APPs may function at the District only so long as (i) they are supervised by a Supervising Physician who is currently appointed to the Medical Staff, and (ii)

they have a current, written supervision agreement with the Supervising Physician.

(d) As a condition of clinical privileges, the APP and the Supervising Physician must provide the District with a copy of any written supervision agreement required by state law as well as notice of any revisions or modifications that are made to such agreements. This notice must be provided to the Medical Staff Services Department within three days of any such change.

7.D. RESPONSIBILITIES OF SUPERVISING PHYSICIAN

(a) Physicians who wish to utilize the services of an APP (other than a CRNA) in their clinical practice at the District must notify the Medical Staff Services Department in advance and must ensure that the individual has been appropriately credentialed in accordance with this Article before the APP participates in clinical or direct patient care of any kind in the District.

(b) The Supervising Physician will remain responsible for all care provided by the APP in the District.

(c) Supervising Physicians who wish to utilize the services of APPs in the inpatient setting specifically agree to abide by applicable standards of practice set forth in Medical Staff and hospital policies.

(d) The number of APPs acting under the supervision of one Supervising Physician, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the District. The Supervising Physician will make any appropriate filings with the Medical Board of California regarding the supervision and responsibilities of the APP, to the extent that such filings are required.

(e) It will be the responsibility of the Supervising Physician to ensure that the APP maintains professional liability insurance coverage in amounts required by the Board. The insurance must cover any and all activities of the APP in the District. The Supervising Physician will furnish evidence of such coverage to the District. The APP will act in the District only while such coverage is in effect.

7.E. PEER REVIEW PROCEDURES

APPs are subject to peer review procedures paralleling those specified for Medical Staff members in Article 8, as they may be logically be applied to APPs and appropriately tailored to the particular APP's profession.

7.F. AUTOMATIC SUSPENSION

An APP's privileges shall be automatically suspended, without review under Section 7.H or any other section of these Bylaws, for the same reasons that apply to Medical Staff

members in Section 8.E. In addition, the APP's privileges shall be automatically suspended without review in the event:

(a) The Medical Staff membership or clinical privileges of all Supervising Physicians is terminated; or

(b) All Supervising Physicians no longer agree to act as the Supervising Physician for any reason; or

(c) The relationship between the APP and all Supervising Physicians is otherwise terminated.

In the event of (a), (b), or (c) the APP will have thirty (30) days from the date of the automatic suspension to submit notice of a new Supervising Physician, to include appropriate documentation, or the APP's privileges shall be automatically terminated without review under Section 7.H or any other section of these Bylaws.

7.G. ADMINISTRATIVE SUSPENSION

(a) The Chief of Staff, the relevant department chair, the Chair of the Interdisciplinary Practice Committee, the CEO, the CMO, and the MEC each has the authority to impose an administrative suspension of all or any portion of the clinical privileges of any APP whenever a question has been raised about such individual's clinical care or professional conduct.

(b) An administrative suspension will become effective immediately upon imposition, will immediately be reported to the CMO, the CEO, and the Chief of Staff, and will remain in effect unless or until modified by the MEC. The imposition of an administrative suspension does not entitle an APP to the procedural rights set forth in Section 7.H.

(c) Upon receipt of notice of the imposition of an administrative suspension, the Chief of Staff will forward the matter to the MEC, which will review and consider the question(s) raised and thereafter make a recommendation to the Board.

7.H. PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

(a) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an APP to the procedural rights set forth in Article 9.

(b) An APP shall have a right to an informal hearing to challenge any recommendation or action by the MEC not to grant or renew clinical privileges or to restrict or terminate clinical privileges by filing a written grievance with the MEC within fifteen (15) days of notice of such recommendation or action. Upon receipt of the grievance, the MEC shall arrange an informal hearing to be conducted before a hearing committee composed of two or more persons appointed by the MEC or the Medical Staff Officers. The hearing committee may, but need not, be comprised of APPs or members of the Medical Staff. However,

in cases involving clinical competency or performance, and subject to feasibility, the MEC should attempt to include at least one individual who is a professional peer of the affected APP. This informal hearing need not be conducted in accordance with the provisions of Article 9. Rather, the following procedure shall apply: The APP shall be informed of the general nature and circumstances giving rise to the action and the APP may present information relevant thereto at the informal hearing. Evidence in support of the adverse recommendation will be presented by a representative of the MEC, the Credentials Committee, or the Interdisciplinary Practice Committee, as determined by the Chief of Staff. Neither the APP nor Medical Staff may be represented by counsel at the informal hearing. A record of the proceeding shall be made. The hearing committee's findings and conclusion shall be reported to the APP and MEC, and shall be forwarded to the Board for final action.

(c) The rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for privileges and the terms, prerogatives, or conditions of such decision.

(d) The employment of an APP by the District shall be governed by the District's employment policies and manuals and the terms of the individual's employment relationship and/or written contract. To the extent that the District's employment policies or manuals, or the terms of any applicable employment contract, conflict with this Section, the employment policies, manuals and descriptions and terms of the individual's employment relationship and/or written contract shall control.

ARTICLE 8
PEER REVIEW PROCEDURES FOR QUESTIONS INVOLVING MEDICAL STAFF MEMBERS

8.A. COLLEGIAL INTERVENTION

(1) This Article encourages the use of progressive steps by Medical Staff Leaders, beginning with collegial and educational efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions that have been raised.

(2) Collegial intervention efforts are a part of ongoing and focused professional practice evaluation activities.

(3) Collegial intervention efforts involve reviewing and following up on questions raised about the clinical practice and/or conduct of Medical Staff members and pursuing counseling, education, and related steps, such as the following:

(a) advising colleagues of all applicable policies, such as policies regarding appropriate behavior, communication issues, emergency call obligations, and the timely and adequate completion of medical records; and

(b) sharing comparative quality, utilization, and other relevant information, including any variations from clinical protocols or guidelines, in order to assist individuals to conform their practices to appropriate norms.

(4) A log of collegial intervention efforts shall be maintained. In addition, if the relevant Medical Staff Leader(s) determines that it is necessary to formally document a collegial intervention effort, such documentation shall be maintained in a confidential file. The individual shall have an opportunity to review any such documentation that is prepared and to respond in writing. The response shall be maintained in that individual's file along with the original documentation.

(5) Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate Medical Staff Leaders.

(6) Should a recommendation be made or an action taken that entitles a Medical Staff member to a hearing in accordance with Article 9, the member is entitled to be accompanied by legal counsel at that hearing. However, Medical Staff members do not have the right to be accompanied by counsel when the Medical Staff leadership is engaged in collegial intervention efforts or other progressive steps. These efforts are intended to resolve issues in a constructive manner and do not involve the formal hearing process. In addition, there shall be no recording (audio or video) of any meetings that involve collegial intervention or progressive steps activities.

(7) The relevant Medical Staff Leader(s) shall determine whether to direct that a matter be handled in accordance with another policy (e.g., Code of Conduct Policy, Impaired Practitioner Policy, Peer Review Process Policy), or to direct it to the MEC for further review.

8.B. ONGOING AND FOCUSED PROFESSIONAL PRACTICE EVALUATIONS

All ongoing and focused professional practice evaluations shall be conducted in accordance with the peer review policy and the ongoing professional practice evaluation policy. Matters that cannot be appropriately resolved through collegial intervention or through the peer review or ongoing professional practice evaluation policy shall be referred to the MEC for its review in accordance with Section 8.C below. Such interventions and evaluations, however, are not mandatory prerequisites to MEC review.

8.C. INVESTIGATIONS

8.C.1 Initial Review:

(a) Whenever a serious question has been raised, or where collegial efforts or actions under the Code of Conduct or Ongoing Professional Practice Evaluation (OPPE) / Focused Professional Practice Evaluation (FPPE) policy have not resolved an issue regarding:

(1) the clinical competence or clinical practice of any member of the Medical Staff, including the care, treatment or management of a patient or patients;

(2) the safety of patients;

(3) known or suspected unethical behavior by any member of the Medical Staff including but not limited to fraudulent billing, theft or destruction of hospital property, violation of patient privacy laws, or knowingly providing false information;

(4) conduct by any member of the Medical Staff that is disruptive to the orderly operation of the District or its Medical Staff, including the inability of the member to work harmoniously with others; or

(5) known or suspected violation of any other Medical Staff Bylaws, Rules and Regulations or Policies, or applicable District Policies.

the matter may be referred to the Chief of Staff, the chair of the department, the chair of a standing committee, or the CMO. No member of the Medical Staff who makes such a referral confidentially and in good faith shall be subject to retaliation or other disciplinary action.

(b) In addition, if the Board becomes aware of information that raises concerns about any Medical Staff member, the matter shall be referred to the Chief of Staff, the

chair of the department, the chair of a standing committee, the CMO, or the CEO for review and appropriate action in accordance with this Article.

(c) The person to whom the matter is referred shall conduct or arrange for an inquiry, which shall include the Chief of Staff (if the Chief of Staff was not the individual to whom the matter was originally forwarded) or designee. Results of the inquiry will be forwarded to the MEC for information or further action.

(d) No action taken pursuant to this Article shall constitute an investigation.

8.C.2 Initiation of Investigation:

(a) When a question involving clinical competence or professional conduct is referred to, or raised by, the MEC, the MEC shall review the matter and determine whether to conduct an investigation, to direct the matter to be handled pursuant to another policy (e.g., Code of Conduct, Impaired Practitioner Policy, Peer Review Process Policy), or to proceed in another manner. In making this determination, the MEC may discuss the matter with the individual. An investigation shall begin only after a formal determination by the MEC to do so.

(b) The MEC shall inform the individual that an investigation has begun. Notification may be delayed if, in the MEC's judgment, informing the individual immediately would compromise the investigation or disrupt the operation of the District or Medical Staff.

(c) The Chief of Staff shall update the CEO on actions taken in connection with an investigation.

(d) In the event that the MEC fails to initiate an investigation in response to concerns raised about a Medical Staff member's competence, performance, or professional conduct in accordance with this Article and the Board determines that such decision is contrary to the weight of the evidence, the Board may direct the MEC to initiate such an investigation. Prior to doing so, the Board shall first consult with the MEC about the matter after providing its reasons for requesting the investigation to the MEC in writing, and shall not act in an unreasonable manner.

8.C.3 Investigative Procedure:

(a) Once a determination has been made to begin an investigation, after notifying the CEO, the MEC shall either investigate the matter itself, request that the Credentials Committee conduct the investigation, or appoint an ad hoc committee to conduct the investigation, keeping in mind the conflict of interest guidelines outlined in Article 14. Any ad hoc committee may include individuals not on the Medical Staff. Whenever the questions raised concern the clinical competence of the individual under review, the ad hoc committee shall include a peer of the individual (e.g., physician, dentist, oral surgeon, or podiatrist).

(b) The committee conducting the investigation ("investigating committee") shall have the authority to review relevant documents and interview individuals. It shall also have available to it the full resources of the Medical Staff and the District, as well as the authority to use outside consultants, if needed. An outside consultant or agency may be used whenever a determination is made by the District and investigating committee that:

(1) no available member of the Medical Staff possesses the clinical expertise needed to conduct the review;

(2) the individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff;

(3) the individuals with the necessary clinical expertise on the Medical Staff would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded; or

(4) the thoroughness and objectivity of the investigation would be aided by such an external review.

If the investigating committee determines that it is necessary to obtain an external review, the individual shall be informed of the same and shall be given the opportunity to review and provide written comments on the external reviewer report.

(c) The investigating committee may require a physical, mental, and/or behavioral examination of the individual by health care professional(s) acceptable to it. The individual being investigated shall execute a release (in a form approved or provided by the investigating committee) allowing (i) the investigating committee (or its representative) to discuss with the health care professional(s) conducting the examination the reasons for the examination; and (ii) the health care professional(s) conducting the examination to discuss and provide documentation of the results of such examination directly to the investigating committee. The cost of such health examination shall be borne by the individual. Failure to execute necessary releases or to obtain the requested evaluation shall result in the automatic relinquishment of the individual's clinical privileges in accordance with Section 8.E.3.

(d) The individual shall have an opportunity to meet with the investigating committee before it makes its report. Prior to this meeting, the individual shall be informed of the general questions being investigated. At the meeting, the individual shall be invited to discuss, explain, or refute the questions that gave rise to the investigation. No recording (audio or video) or transcript of the meeting shall be permitted or made. A summary of the interview shall be prepared by the investigating committee and included with its report. This meeting is not a hearing, and none of the procedural rules for hearings shall apply. The individual

being investigated shall not have the right to be accompanied by legal counsel at this meeting.

(e) The investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of the commencement of the investigation, provided that an outside review is not necessary. When an outside review is necessary, the investigating committee shall make a reasonable effort to complete the investigation and issue its report within 30 days of receiving the results of the outside review. These time frames are intended to serve as guidelines and, as such, shall not be deemed to create any right for an individual to have an investigation completed within such time periods. In the event the investigating committee is unable to complete the investigation and issue its report within these time frames, it shall inform the individual and the Chief of Staff of the reasons for the delay and the approximate date on which it expects to complete the investigation.

(f) At the conclusion of the investigation, the investigating committee shall prepare a report with its findings, conclusions, and recommendations.

(g) In making its recommendations, the investigating committee shall strive to achieve a consensus as to what is in the best interests of patient care and the smooth operation of the District, while balancing fairness to the individual, recognizing that fairness does not require that the individual agree with the recommendation. Specifically, the committee may consider:

(1) relevant literature and clinical practice guidelines, as appropriate;

(2) all of the opinions and views that were expressed throughout the review, including report(s) from any outside review(s);

(3) any information or explanations provided by the individual under review; and

(4) other information as deemed relevant, reasonable, and necessary by the investigating committee.

8.C.4 Recommendation:

(a) The MEC may accept, modify, or reject any recommendation it receives from an investigating committee. Specifically, the MEC may:

(1) determine that no action is justified;

(2) issue a letter of guidance, counsel, warning, or reprimand;

(3) impose conditions for continued appointment;

(4) impose a requirement for monitoring, proctoring, or consultation;

(5) impose a requirement for additional training or education;

(6) impose a summary suspension and/or restriction;

(7) recommend reduction of clinical privileges;

(8) recommend suspension of clinical privileges for a term;

(9) recommend revocation of appointment and/or clinical privileges; or

(10) make any other recommendation that it deems necessary or appropriate.

(b) If the MEC makes a recommendation that would entitle the individual to request a hearing, the MEC shall send special notice to the individual through the Chief of Staff and the recommendation shall be held until after the individual has completed or waived a hearing and appeal unless the action taken is to impose a summary suspension, in which case the process set forth in Section 8.D shall apply.

(c) If the MEC makes a recommendation that does not entitle the individual to request a hearing, it shall take effect immediately and shall remain in effect unless modified by the Board. In such case, the individual may provide a written response to the action, which shall be maintained in the individual's confidential file, and may request that the MEC reconsider the matter; however, it is within the discretion of the MEC to grant any such request.

(d) In the event the Board considers a modification to the recommendation of the MEC that would entitle the individual to request a hearing, the Ad Hoc Dispute Resolution process set forth in Section 12.F shall be followed. If, following that process, the Board's recommendation remains unfavorable, the Chief of Staff shall inform the individual by special notice. No final action shall occur until the individual has completed or waived a hearing and appeal.

(e) When applicable, any recommendations or actions that are the result of an investigation or hearing and appeal shall be monitored by Medical Staff Leaders on an ongoing basis through the District's performance improvement activities or pursuant to the applicable policies regarding conduct, as appropriate.

8.D. SUMMARY SUSPENSION OR RESTRICTION OF CLINICAL PRIVILEGES

8.D.1 Grounds for Summary Suspension or Restriction:

(a) Whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual, the MEC, or the Chief of Staff, the chair of a clinical department, or the CEO shall have the authority to (1) afford an individual an opportunity to voluntarily refrain from exercising privileges pending an investigation;* or (2) summarily suspend or restrict all or any portion of an individual's clinical privileges as a precaution.

(b) In the event that no individuals or committees authorized to impose a summary suspension are available under the circumstances referenced above, the Board may impose a summary suspension, provided that attempts have first been made to contact the individuals listed in paragraph (a) above. A summary suspension imposed by the Board must be reviewed and ratified by the MEC within two working days of imposition (excluding weekends and holidays) or it shall terminate automatically. If the MEC declines to ratify such a summary suspension, it may opt to initiate an investigation in accordance with Section 8.C.

(c) A summary suspension or restriction can be imposed at any time including, but not limited to, immediately after the occurrence of an event that causes concern, following a pattern of occurrences that raises concern, or following a recommendation of the MEC that would entitle the individual to request a hearing.

(d) Summary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It only reflects a determination based on the information available at the time that it was imposed and is subject to change when all information has been considered.

(e) A summary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the CEO, and the Chief of Staff, and will remain in effect unless it is modified by the MEC.

(f) The MEC shall provide the individual in question with a brief written description of the reason(s) for the summary suspension, including the names and medical record numbers of the patient(s) involved (if any), within one working day of the imposition of the suspension.

* An agreement to voluntarily refrain from exercising privileges in such situations may require an 805 report if it extends for a cumulative total of 30 days or more for any 12-month period and is agreed to on the basis of a medical disciplinary cause or reason.

8.D.2 MEC Procedure:

(a) The MEC will review the matter resulting in a summary suspension or restriction (or the individual's agreement to voluntarily refrain from exercising clinical privileges) within a reasonable time under the circumstances, not to exceed seven days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the MEC. The individual may propose ways other than summary suspension or restriction to protect patients and/or employees, depending on the circumstances. Neither the MEC nor the individual shall be accompanied by counsel at this meeting, and no recording (audio or video) or transcript of the meeting shall be permitted or made.

(b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the MEC shall determine the appropriate next steps,

which may include, but not be limited to, commencing a focused review or a formal investigation or recommending some other action that is appropriate under the circumstances. The MEC shall also determine whether the summary suspension or restriction should be continued, modified, or terminated pending the completion of the focused review or investigation (and hearing and appeal, if applicable).

(c) If a summary suspension extends for more than 14 days, the individual shall receive formal notice of the right to request a hearing pursuant to Article 9.

8.D.3 Care of Patients:

(a) Immediately upon the imposition of a summary suspension or restriction, the Chief of Staff, the relevant department chair, or the CMO will assign to another individual with appropriate clinical privileges responsibility for care of the suspended individual's hospitalized patients, or to aid in implementing the summary restriction, as appropriate. The assignment will be effective until the patients are discharged. The wishes of the patient will be considered in the selection of a covering physician.

(b) All members of the Medical Staff have a duty to cooperate with the Chief of Staff, the department chair, the MEC, and the CEO in enforcing summary suspensions or restrictions.

8.E. AUTOMATIC SUSPENSION

8.E.1 Failure to Complete Medical Records:

Failure to complete medical records after notification by the medical records department of delinquency shall result in automatic suspension of all clinical privileges. Suspension shall continue until all delinquent records are completed and reinstatement accomplished in accordance with the Medical Staff Rules and Regulations. Failure to complete the medical records that caused the suspension within the time required by the Rules and Regulations shall result in automatic resignation from the Medical Staff.

8.E.2 Action by Government Agency or Insurer/Failure to Satisfy Threshold Criteria:

(a) An individual's appointment and clinical privileges shall be automatically suspended, without the right to a hearing and appeal, immediately upon the occurrence of any of the following:

(1) Licensure:

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

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

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

(2) Controlled Substance Authorization:

(i) Revocation, restriction, suspension, or expiration. Whenever a member's DEA certificate is revoked, limited, suspended, or expired, the member shall automatically be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.

(ii) Probation. Whenever a member's DEA certificate is subject to probation, the member's right to prescribe medications shall automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.

(3) Insurance Coverage: Termination or lapse of an individual's professional liability insurance coverage or other action causing the coverage to fall below the minimum required by the District or cease to be in effect, in whole or in part.

(4) Medicare and Medicaid Participation: Termination, exclusion, or preclusion by government action from participation in the Medicare/Medicaid or other federal or state health care programs.

(5) Criminal Activity: Conviction or a plea of guilty or no contest pertaining to any felony, or to any misdemeanor involving (i) controlled substances; (ii) illegal drugs; (iii) Medicare, Medicaid, or insurance or health care fraud or abuse; (iv) child abuse; (v) elder abuse; or (vi) violence against another

(6) Health Screening Requirements. Failure to submit required documentation demonstrating compliance with health screening requirements within the timelines established in the Medical Staff policies.

(b) Notice of Automatic Suspension. Special Notice of an automatic suspension shall be given to the affected individual, but such notice shall not be required for the suspension to become effective under paragraphs (1) through (4) above.

(c) If the occurrence giving rise to the automatic suspension is resolved within 60 days, the individual may request reinstatement. If the occurrence is not resolved or the individual has not requested reinstatement within 60 days of the date of automatic suspension, the individual shall be deemed to have voluntarily resigned from the Medical Staff. Special Notice of the voluntary resignation shall be given to the affected physician, and regular notice of this occurrence will be given to the MEC, CEO, and Board.

(d) Request for Reinstatement.

(1) Requests for reinstatement following the expiration of a license, controlled substance authorization, insurance coverage, or suspension for failure to comply with health screening requirements will be processed by the Medical Staff Services Department. If any questions or concerns are noted, the Medical Staff Services Department will refer the matter for further review in accordance with (e)(2) below.

(2) All other requests for reinstatement shall be reviewed by the relevant department chair, the Chair of the Credentials Committee, the Chief of Staff, and the CMO. If all these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the District. This determination shall then be forwarded to the Credentials Committee, the MEC, and the Board for ratification. If any of the individuals reviewing the request have any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the full Credentials Committee, MEC, and Board for review and recommendation.

8.E.3 Failure to Provide Requested Information:

Failure to timely satisfy a special request for information pertaining to an individual's qualifications for continued appointment and/or privileges or to a specific event in response to a written request from the Credentials Committee, the MEC, or any other committee authorized to request such information, or a request from the CMO or the CEO at the request of one of those committees, shall result in automatic suspension of all clinical privileges. The suspension will continue in effect until the information is provided to the satisfaction of the requesting party. If the requested information is not provided within 30 days of the date of the automatic suspension, the individual shall be deemed to have voluntarily resigned from the Medical Staff.

8.E.4 Failure to Complete or Comply with Training or Educational Requirements:

Failure to complete and/or comply with training or educational requirements that are adopted by the MEC and apply to the Medical Staff at large (or to those members of the Medical Staff who have been granted clinical privileges), including, but not limited to, those pertinent to electronic medical records, patient safety, and infection control, shall result in the automatic suspension of all clinical privileges. The suspension will continue

in effect until documentation of compliance is provided to the satisfaction of the requesting party. If documentation of compliance is not received by the medical staff office within 30 days after communication per medical staff notification policy, the individual shall be deemed to have voluntarily resigned from the Medical Staff.

8.E.5 Failure to Attend Special Meeting:

Whenever there is a concern regarding the clinical practice or professional conduct involving any individual, a Medical Staff Leader may require the individual to attend a special meeting with one or more of the Medical Staff Leaders and/or with a standing or ad hoc committee of the Medical Staff. No legal counsel shall be present at this meeting, and no recording (audio or video) or transcript shall be permitted or made. The notice to the individual regarding this meeting shall be given by Special Notice at least three days prior to the meeting and shall inform the individual of the issues to be discussed at the meeting as well as the fact that attendance at the meeting is mandatory. Failure of the individual to attend the meeting without good cause shall result in the automatic suspension of all clinical privileges until such time as the individual complies with the special meeting request. If the individual does not attend the special meeting within 30 days of the date of automatic suspension, the individual shall be deemed to have voluntarily resigned from the Medical Staff.

8.E.6 Medical Executive Committee Deliberation

When a member's Medical Staff membership and/or clinical privileges are automatically suspended, or the member is deemed to have voluntarily resigned from the Medical Staff under Sections 8.E.3 through 8.E.5, the member is not entitled to hearing rights under Article 9. However, the member may request a meeting with the Medical Executive Committee to address the limited question of whether grounds for the action occurred. The formal hearing procedures described at Article 9 shall not apply, and the decision of the Medical Executive Committee shall then become and remain effective pending the final decision of the Board.

8.F. LEAVES OF ABSENCE

(1) An individual appointed to the Medical Staff may request a leave of absence by submitting a written request to the relevant department chair, through the Medical Staff Services Department. With the exception of an unplanned Medical Leave of Absence, members are expected to submit this request prior to the anticipated start of the leave in order to permit the individual to make adequate coverage arrangements necessary for patient care and assure adequate coverage of any administrative activities. The request must state the beginning and ending dates of the leave, which shall not exceed one year, and the reasons for the leave.

(2) The Chief of Staff shall determine whether a request for a leave of absence shall be granted. In determining whether to grant a request, the Chief of Staff shall consult with the relevant department chair. The granting of a leave of absence, or

reinstatement, as appropriate, may be conditioned upon the individual's completion of all medical records.

(3) Except for maternity leaves, members of the Medical Staff must report to the Medical Staff Services Department any time they are away from Medical Staff and/or patient care responsibilities for longer than 30 days and the reason for such absence is related to their physical or mental health or otherwise to their ability to care for patients safely and competently. Under such circumstances, the Chief of Staff may trigger an automatic medical leave of absence.

(4) During the leave of absence, the individual shall not exercise any clinical privileges. The electronic medical record may continue to be accessed during a leave of absence, as appropriate, unless otherwise determined by the Chief of Staff. In addition, the individual shall be excused from all Medical Staff responsibilities (e.g., meeting attendance, committee service, and any applicable emergency service call obligations) during this period.

(5) Individuals seeking reinstatement from a leave of absence shall submit a written request before the end of the leave, accompanied by a summary of their professional activities during the leave, and any other information that may be requested by the Medical Staff and/or District. If the leave of absence was for health reasons (except for maternity leave), the request for reinstatement must be accompanied by a report from the individual's physician indicating that the individual is physically and/or mentally capable of resuming a hospital practice and safely exercising the clinical privileges requested. In the event the individual has been on a medical leave of absence under supervision of the Well Being Committee, the request for reinstatement must be first considered by the Well Being Committee, which will make a recommendation as to reinstatement to the relevant department chair and Chief of Staff.

(6) Requests for reinstatement shall be reviewed by the relevant department chair and the Chief of Staff. If these individuals make a favorable recommendation on reinstatement, the Medical Staff member may immediately resume clinical practice at the District. If either individual reviewing the request has any questions or concerns, those questions shall be noted and the reinstatement request shall be forwarded to the MEC for final determination. If a request for reinstatement is not granted, for reasons related to clinical competence or professional conduct, the individual shall be entitled to request a hearing and appeal under Article 9.

(7) Absence for longer than one year shall result in automatic relinquishment of Medical Staff appointment and clinical privileges unless an extension is granted by the relevant department chair, the Chief of Staff, and the CMO. Extensions shall be considered only in extraordinary cases where the extension of a leave is in the best interest of the District.

(8) If an individual's current appointment is due to expire during the leave, the individual must apply for reappointment, otherwise appointment and clinical privileges shall lapse at the end of the appointment period.

(9) Failure to request reinstatement from a leave of absence in a timely manner shall be deemed a voluntary resignation of Medical Staff appointment and clinical privileges.

(10) Leaves of absence are matters of courtesy, not of right. In the event that it is determined that an individual has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no right to a hearing and appeal under Article 9.

ARTICLE 9
HEARING AND APPEAL PROCEDURES

9.A. INITIATION OF HEARING

9.A.1 Grounds for Hearing:

(a) An individual is entitled to request a hearing whenever the MEC or the Board makes one of the following recommendations for a medical disciplinary cause or reason:

(1) denial of initial appointment to the Medical Staff;

(2) denial of reappointment to the Medical Staff;

(3) revocation of appointment to the Medical Staff;

(4) denial of requested clinical privileges;

(5) revocation of clinical privileges;

(6) suspension of clinical privileges if it requires an 805 Report;*

(7) summary suspension of clinical privileges if it requires an 805 Report;*

(8) restriction of clinical privileges, if it requires an 805 Report;* or

(9) denial of reinstatement from a leave of absence if the reasons relate to clinical competence or professional conduct.

* Suspensions or restrictions shall not entitle the practitioner to request a hearing unless they remain in effect for a cumulative total of 30 days or more for any 12-month period (or, in the case of a summary suspension, if it extends for more than 14 days), and thus must be reported to the Medical Board of California.

(b) No other recommendations shall entitle the individual to a hearing.

(c) If the Board makes any of these determinations without an adverse recommendation by the MEC, an individual would also be entitled to request a hearing. For simplicity, this Article refers to adverse recommendations of the MEC. When a hearing is triggered by an adverse recommendation of the Board, any reference in this Article to the "MEC" shall be interpreted as a reference to the "Board."

9.A.2 Actions Not Grounds for Hearing:

None of the following actions or determinations shall constitute grounds for a hearing, and they shall take effect without hearing or appeal. The individual shall be entitled to

submit a written explanation or rebuttal to the action or determination to be placed into his or her file:

(a) issuance of a letter of guidance, counsel, warning, or reprimand;

(b) withdrawal of temporary privileges;

(c) automatic relinquishment or expiration of appointment or privileges;

(d) denial of a request for leave of absence, for an extension of a leave, or for reinstatement from a leave if the reasons do not relate to clinical competence or professional conduct;

(e) summary suspension of less than 14 days;

(f) the voluntary acceptance of a performance improvement plan option;

(g) determination that an application is incomplete;

(h) termination of any contract or from a contracted group;

(i) determination of ineligibility for membership or clinical privileges based on a failure to meet threshold eligibility criteria, a lack of need or resources, or because of an exclusive contract;

(j) change in assigned staff category;

(k) any requirement to complete a health assessment or evaluation pursuant to any Bylaws-related document; and

(l) grant of conditional appointment or reappointment or of an appointment or reappointment period that is less than two years.

9.B. THE HEARING

9.B.1 Notice of Recommendation:

The Chief of Staff shall promptly give Special Notice of a recommendation that entitles an individual to request a hearing. This notice shall contain:

(a) a description of the action or recommendation;

(b) a statement that the action or recommendation, if adopted, shall be taken and will be reported to the Medical Board of California pursuant to Business and Professions Code section 805;

(c) the general reasons for the recommendation or action;

(d) a statement that the individual has the right to request a hearing on the recommendation within 30 days of receipt of the notice and that failure to request such a hearing shall result in the waiver of the right to a hearing; and

(e) a copy of this Article.

9.B.2 Request for Hearing:

An individual has 30 days following receipt of the Special Notice to request a hearing. The request shall be in writing to the Chief of Staff and shall include the name, address, and telephone number of the individual's counsel, if any. Failure to timely request a hearing shall constitute waiver of the right to a hearing and be deemed an acceptance of the recommendation or action, and the recommendation or action shall be transmitted to the Board for final action.

9.B.3 Notice of Hearing and Statement of Reasons:

(a) The Chief of Staff shall schedule the hearing and provide, by Special Notice to the individual requesting the hearing, the following:

(1) the time, place, and date of the hearing;

(2) a proposed list of witnesses who are expected to give testimony at the hearing and a brief summary of the anticipated testimony;

(3) the names of the Hearing Panel members (or Hearing Officer) and/or Presiding Officer if known; and

(4) a statement of the specific reasons for the recommendation, including the acts or omissions with which the individual is charged, a list of patient records (if applicable), and a general description of the information supporting the recommendation. This statement does not bar presentation of additional evidence or information at the hearing, so long as the additional material is relevant to the recommendation or the individual's qualifications and the individual has a sufficient opportunity to review and rebut the additional information. A supplemental notice may be issued at any time, provided the individual is given sufficient time to prepare to respond.

(b) The hearing shall begin no sooner than 30 days, nor longer than 60 days after receipt of the request for hearing, unless a hearing date outside of this time frame has been specifically agreed to in writing by the parties. A hearing is deemed to have commenced when Hearing Panel members undergo voir dire questioning.

9.B.4 Hearing Panel, Presiding Officer, and Hearing Officer/Arbitrator:

(a) Hearing Panel:

The Chief of Staff shall appoint a Hearing Panel in accordance with the following guidelines:

(1) The Hearing Panel shall consist of at least three members and may include any combination of:

(i) Medical Staff members, provided such members have not actively participated in the matter at any previous level; and/or

(ii) physicians not connected with the District (i.e., physicians not on the Medical Staff); however, the majority of any such Panel must be comprised of members of the Medical Staff.

(2) Where feasible, the Panel shall include an individual practicing the same specialty as the individual requesting the hearing.

(3) Knowledge of the underlying peer review matter, in and of itself, shall not preclude the individual from serving on the Panel.

(4) Employment by, or other contractual arrangement with, the District or an affiliate shall not preclude an individual from serving on the Panel.

(5) The Panel shall not include any individual who is in direct economic competition with the individual requesting the hearing.

(6) The Panel shall not include any individual who is professionally associated with, related to, or involved in a referral relationship with, the individual requesting the hearing, members of the MEC, or key witnesses.

(7) The Panel shall not include any individual who is demonstrated to have an actual bias, prejudice, or conflict of interest that would prevent the individual from fairly and impartially considering the matter.

(8) In addition, the appointment of the Hearing Panel shall comply with the guidelines set forth in the conflict of interest provisions found in Article 14.

(9) The Chief of Staff shall appoint one or more alternates to the Hearing Panel who meet the standards described in this section and who can serve if a Hearing Panel member becomes unavailable. The alternate(s) may attend all sessions of the hearing and may attend and participate in deliberations. The alternate(s) shall not vote unless a Hearing Panel member is absent from or otherwise unable to vote due to failure to meet the attendance requirements of Section 9.D.4.

(b) Presiding Officer:

(1) The Chief of Staff shall appoint a Presiding Officer who shall be an attorney, subject to the approval of the Board. The Presiding Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing and may not currently represent or have previously represented the District in any legal matters. The Presiding Officer shall also not act as an advocate for either side at the hearing.

(2) The Presiding Officer shall:

(i) allow the participants in the hearing to have a reasonable opportunity to be heard and to present evidence, subject to reasonable limits on the number of witnesses and duration of direct and cross-examination;

(ii) prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant or abusive or that causes undue delay;

(iii) maintain decorum throughout the hearing;

(iv) determine the order of procedure;

(v) rule on objections to the service of Hearing Panel members, the Hearing Officer, and the Presiding Officer and all matters of law, procedure, access to information and documentation, and the admissibility of evidence;

(vi) consider argument by counsel on procedural points within or outside the presence of the Hearing Panel at the Presiding Officer's discretion.

(vii) take any action(s) warranted by the circumstances if he or she determines that either party is not proceeding in an efficient and expeditious manner.

(3) The Presiding Officer may participate in the private deliberations of the Hearing Panel and be a legal advisor to it, but shall not be entitled to vote on its recommendations.

(c) Hearing Officer/Arbitrator:

(1) As an alternative to a Hearing Panel, for matters limited to issues involving professional conduct, the Chief of Staff may exercise his/her discretion to schedule the hearing before a Hearing Officer selected by a process mutually acceptable to the affected practitioner and the MEC. The Hearing Officer may not be, or represent clients who are, in direct economic competition with the individual requesting the hearing.

(2) If a Hearing Officer is appointed instead of a Hearing Panel, all references in this Article to the "Hearing Panel" or "Presiding Officer" shall be deemed to refer to the Hearing Officer, except that in this circumstance the Hearing Officer shall make the decision.

(d) Voir Dire:

The subject physician shall be entitled to a reasonable opportunity to question and object to the impartiality of the Hearing Panel members, Hearing Officer, and the Presiding Officer. . The Presiding Officer shall rule on any objections and give notice to the parties.

(e) Compensation:

The Hearing Panel, Presiding Officer, and/or Hearing Officer may be compensated for their service by the District. Such compensation shall not be dependent on the outcome of the hearing. The individual requesting the hearing shall be informed of such compensation and may opt to contribute to any such compensation should the individual wish to do so.

9.B.5 Counsel:

The Presiding Officer, Hearing Officer, and counsel for either party may be an attorney at law who is licensed to practice, in good standing, in California.

9.C. PRE-HEARING PROCEDURES

9.C.1 General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner, but consistent with California law. Formal rules of evidence or procedure shall not apply.

9.C.2 Time Frames:

The following time frames, unless modified by the Presiding Officer or by mutual written agreement of the parties, shall govern the timing of pre-hearing procedures:

(a) the pre-hearing conference shall be scheduled at least 21 days prior to the hearing;

(b) the parties shall exchange witness lists and proposed documentary exhibits at least 10 days prior to the pre-hearing conference; and

(c) any objections to witnesses and/or proposed documentary exhibits must be provided at least five days prior to the pre-hearing conference.

9.C.3 Witness List:

(a) At least 10 days before the pre-hearing conference, the individual requesting the hearing shall provide a written list of the names of witnesses expected to offer testimony on his or her behalf.

(b) The witness list shall include a brief summary of the anticipated testimony.

(c) The witness list of either party may, in the discretion of the Presiding Officer, be amended at any time during the course of the hearing, provided that notice of the change is given to the other party.

9.C.4 Provision of Relevant Information:

(a) Prior to receiving any confidential documents, the individual requesting the hearing must agree that all documents and information shall be maintained as confidential and shall not be disclosed or used for any purpose outside of the hearing. The individual must also provide a written representation that his/her counsel and any expert(s) have executed Business Associate agreements in connection with any patient Protected Health Information contained in any documents provided.

(b) Upon receipt of the above agreement and representation, the individual requesting the hearing shall be provided, at his or his expense, with a copy of the following:

(1) all patient medical records referred to in the statement of reasons;

(2) reports of experts relied upon by the MEC;

(3) copies of relevant minutes (with portions regarding other physicians and unrelated matters deleted); and

(4) copies of any other documents relied upon by the MEC and/or relevant to the statement of reasons in the MEC's possession or under its control.

The failure to provide access to this information at least 30 days before the hearing shall constitute good cause for a continuance.

(c) The individual shall have no right to discovery beyond the above information. No information shall be provided regarding other practitioners on the Medical Staff. In addition, there is no right to depose, interrogate, or interview witnesses or other individuals prior to the hearing.

(d) The MEC shall have the right to inspect and copy, at its expense, any documentary information relevant to the charges and that the individual has in his or her possession or control as soon as practicable after receipt of the MEC's request therefor.

(e) The Presiding Officer shall rule on any disputes regarding access to information and documentation. When ruling on such disputes, the Presiding Officer shall, among other factors, consider the following:

(1) Whether the information sought may be introduced to support or defend the charges.

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

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

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

(f) At least 10 days prior to the pre-hearing conference (or as otherwise agreed upon by both sides), each party shall provide the other party with its proposed exhibits. All objections to documents or witnesses shall be submitted in writing at least five days in advance of the pre-hearing conference. The Presiding Officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

(g) Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

(h) Neither the individual, nor any other person acting on behalf of the individual, may contact District employees or Medical Staff members whose names appear on the MEC's witness list or in documents provided pursuant to this section concerning the subject matter of the hearing, until the District has been notified and has contacted the individuals about their willingness to be interviewed. The District will advise the individual who has requested the hearing once it has contacted such employees or Medical Staff members and confirmed their willingness to meet. Any employee or Medical Staff member may agree or decline to be interviewed by or on behalf of the individual who requested a hearing. If an employee or Medical Staff member agrees to be interviewed, a representative of the MEC may also be present. If a District employee agrees to be interviewed and requests counsel be present, District counsel may also be present.

9.C.5 Pre-Hearing Conference:

(a) The Presiding Officer shall require the individual and MEC or their representatives (who may be counsel) to participate in a pre-hearing conference, which shall be held no later than 21 days prior to the hearing.

(b) At the pre-hearing conference, the Presiding Officer shall address any procedural questions, including any objections to exhibits or witnesses.

(c) The Presiding Officer shall establish the time to be allotted to each witness's testimony and cross-examination. It is expected that the hearing shall last no more than 15 hours, with each side being afforded approximately seven and a half hours to present its case, in terms of both direct and cross-examination of witnesses. Both parties are required to prepare their case so that a hearing shall be concluded after a maximum of 15 hours. In addition, it is expected that all live testimony in the hearing will be concluded within a 120-day time period.

(d) The Presiding Officer may, after considering any objections, grant limited extensions upon a demonstration of good cause and to the extent compelled by fundamental fairness.

9.C.6 Stipulations:

The parties and their counsel, if applicable, shall use their best efforts to develop and agree upon stipulations, so as to provide for an orderly and efficient hearing by narrowing the issues on which live testimony is reasonably required.

9.C.7 Provision of Information to the Hearing Panel:

The following documents shall be provided to the Hearing Panel in advance of the hearing: (a) exhibits offered by the parties following the pre-hearing conference, except those to which an objection has been sustained by the Presiding Officer; and (b) stipulations agreed to by the parties.

9.D. HEARING PROCEDURES

9.D.1 Rights of Both Sides and the Hearing Panel at the Hearing:

(a) At a hearing, both sides shall have the following rights, subject to reasonable limits determined by the Presiding Officer:

(1) to call and examine witnesses, to the extent they are available and willing to testify;

(2) to introduce exhibits;

(3) to cross-examine any witness on any matter relevant to the issues;

(4) to present and rebut evidence determined by the Presiding Officer to be relevant;

(5) to be provided with all evidence provided to the Hearing Panel; and

(6) o have representation by counsel who may call, examine, and cross-examine witnesses and present the case. If the affected practitioner is not accompanied by legal counsel at the hearing, the MEC may also not be accompanied by legal counsel at the hearing (however, either party may

consult with legal counsel in preparation for the hearing and appeal process, including having legal counsel participate in the pre-hearing conference).

(b) If the individual who requested the hearing elects not to testify, he or she may be called and questioned by the MEC.

(c) The Hearing Panel may question witnesses, request the presence of additional witnesses, and/or request documentary evidence, all of which must occur during the hearing session, subject to objections by either party, which shall be resolved by the Presiding Officer.

9.D.2 Record of Hearing:

A certified shorthand reporter shall be present to make a record of the hearing. The cost of the reporter's attendance shall be borne by the District. The cost of preparing the transcript shall be borne by the requesting party. Oral evidence shall be taken only on oath or affirmation administered by any person entitled to notarize documents in this state.

9.D.3 Failure to Appear:

Failure, without good cause (as determined by the Hearing Panel), to appear and proceed at the hearing shall constitute a waiver of the right to a hearing and the matter shall be transmitted to the Board for final action.

9.D.4 Presence of Hearing Panel Members:

A majority of the Hearing Panel shall be present throughout the hearing. In unusual circumstances when a Hearing Panel member must be absent from any part of the hearing, he or she shall read the entire transcript of the portion of the hearing from which he or she was absent.

9.D.5 Persons to Be Present:

Attendance at the hearing shall be restricted to those individuals involved in the proceeding and the Chief of Staff (or designee).. In addition, administrative personnel who are not testifying as witnesses in the matter may be present as requested by the Chief of Staff, subject to their agreement to maintain the confidentiality of the proceeding.

9.D.6 Order of Presentation:

The MEC shall first present evidence in support of its recommendation or action. Thereafter, the burden shall shift to the individual who requested the hearing to present evidence. Initial applicants shall not be permitted to introduce information not produced upon request of the MEC during the application process, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

9.D.7 Admissibility of Evidence:

The hearing shall not be conducted according to rules of evidence. Evidence shall not be excluded merely because it is hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The guiding principle shall be that the record contains information sufficient to allow the Hearing Panel and Board to decide whether the individual is qualified for appointment and clinical privileges.

9.D.8 Post-Hearing Statement:

Each party shall have the right to submit a written statement, and the Hearing Panel may request that statements be filed, following the close of the hearing.

9.D.9 Postponements and Extensions:

Postponements and extensions of time may be requested by anyone, but shall be permitted only by the Presiding Officer on a showing of good cause, or by mutual agreement of the parties.

9.D.10

At the discretion of the Chief of Staff, all hearing sessions may be conducted by virtual videoconference platform instead of in person. In that circumstance, all hearing participants, including the parties and their legal counsel, if any, the Hearing Panel members or Hearing Officer/Arbitrator, Presiding Officer, the witnesses, and the court reporter, may attend the hearing sessions remotely, so long as all participants can see each other, can hear and be heard during the proceedings, and have access to all evidence admitted at the hearing, either by electronic means or hard copies. The Presiding Officer has authority and discretion to rule on questions regarding the implementation of the virtual proceedings.

9.E. HEARING CONCLUSION, DELIBERATIONS, AND DECISION

9.E.1 Basis of Hearing Panel Decision:

If the hearing involves the denial of an application for initial appointment, the applicant bears the burden of persuading the Hearing Panel, by a preponderance of the evidence, of their qualifications by producing information that allows for adequate evaluation and resolution of reasonable doubts concerning their current qualifications for initial appointment and clinical privileges. For all other hearings, the MEC bears the burden of persuading the Hearing Panel, by a preponderance of the evidence, that the recommendation or action is reasonable and warranted.

9.E.2 Deliberations and Decision of the Hearing Panel:

Within 20 days after final adjournment of the hearing (which may be designated as the time the Hearing Panel hears closing arguments or receives any post-hearing statements, whichever is later), the Hearing Panel shall conduct its deliberations outside the presence of any other person except the Presiding Officer. Thereafter, the Hearing Panel shall render a written decision affirming or rejecting the action(s) or recommendation(s) that are the subject of the appeal. The report shall contain findings of fact, a conclusion articulating the connection between the evidence produced at the hearing and the decision reached, and an explanation of the procedure for appealing the decision.

9.E.3 Disposition of Hearing Panel Report:

The Hearing Panel shall deliver its report to the Chief of Staff. The Chief of Staff shall send by Special Notice a copy of the decision to the individual who requested the hearing. The Chief of Staff shall also provide a copy of the report to the MEC.

9.F. APPEAL PROCEDURE

9.F.1 Time for Appeal:

Within 10 days after receipt of the Hearing Panel's report, either party may request an appeal. The request must be in writing, must be directed to and received by the Chief of Staff on or before the 10th calendar day after receipt of the Hearing Panel's report, and delivered in person, by overnight deliver, or by certified mail, return receipt requested, The request shall include a statement of the reasons for appeal and the specific facts or circumstances that justify further review. If an appeal is not received within that 10-day period, an appeal is deemed to be waived and the Hearing Panel's report and recommendation shall be forwarded to the Board for final action.

9.F.2 Grounds for Appeal:

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal shall be limited to the following:

(a) there was substantial failure by the Hearing Panel to comply with the procedures outlined in the Medical Staff Bylaws during the hearing so as to deny a fair hearing; and/or

(b) the findings or recommendation of the Hearing Panel are not supported by substantial evidence.

9.F.3 Time, Place and Notice:

Whenever an appeal is requested as set forth in the preceding sections, the Board shall schedule and arrange for an appeal. Within thirty (30) days after receipt of the request for appeal, the individual shall be given Special Notice of the time, place, and date of the

appellate review. The appellate review shall be held not less than 30 nor more than 60 days from the date notice was provided; however, when the request for appeal involves an individual subject to a summary suspension, the appellate review shall be held as soon as arrangements can reasonably be made, not to exceed 15 days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

9.F.4 Appellate Review Procedure:

(a) The Board may serve as the Review Panel or the Chair of the Board may appoint a Review Panel composed of not less than three members of the Board, to consider the record upon which the recommendation before it was made and recommend final action to the Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Review Panel, so long as that person did not take part in a prior hearing on the same matter.

(b) The proceedings by the Review Panel shall be in the nature of an appellate review based upon the record of the Hearing Panel, the Hearing Panel's report, the written statements, if any, submitted as provided below, and such other material as may be presented and accepted within the terms of this section.

(c) The Chair of the Review Panel or a hearing officer shall be the Presiding Officer. The Presiding Officer shall determine the order of procedure during the review, make all required rulings, and maintain decorum, and shall endeavor to assure that the appeal is conducted in an efficient and expeditious manner. If the Presiding Officer determines that either party is not proceeding in an efficient and expeditious manner, the Presiding Officer may take such discretionary action as seems warranted by the circumstances.

(d) Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, Each party shall have the right to present a written statement in support of its position on appeal. The party requesting the appeal shall submit a statement first and the other party shall then have ten days to respond. The parties or their representatives shall have the right to personally appear and make oral statements not to exceed 30 minutes in favor of their positions at the appellate review.

(e) When requested by either party, the Review Panel may, in its discretion, accept additional oral or written evidence subject to the same rights of cross-examination provided at the Hearing Panel proceedings. Such additional evidence shall be accepted only if the Review Panel determines that the party seeking to admit it has demonstrated that it is relevant, new evidence that could not have been presented at the hearing or that any opportunity to admit it at the hearing was improperly denied.

(f) The Review Panel board shall present to the Board, the MEC, and the party requesting the appeal, its written recommendations as to whether the Board

should affirm, modify, or reverse the Hearing Panel's decision, or remand the matter to the Hearing Panel for further review and decision.

9.G. BOARD ACTION

9.G.1 Final Decision of the Board:

(a) Within 30 days after the Board (i) considers the appeal as a Review Panel, (ii) receives a recommendation from a separate Review Panel, or (iii) receives the Hearing Panel's report when no appeal has been requested, the Board shall consider the matter and take final action.

(b) The Board may review all relevant information, including the findings and recommendations of the MEC, Hearing Panel, and Review Panel (if applicable).

(c) The Board may affirm, modify, reverse the Hearing Panel's decision, or remand the matter for further review by the Hearing Panel or any other individual or body designated by the Board for reconsideration, stating the purpose for the referral. The Board shall give great weight to the Hearing Panel's decision, and shall not act arbitrarily or capriciously. The Board shall sustain the decision of the Hearing Panel unless it finds that the decision is not supported by substantial evidence or that there has been a substantial failure to follow the procedures outlined in the Bylaws so as to deny a fair hearing. The Board may exercise its independent judgment in determining whether a practitioner was afforded a fair hearing. If the Board determines that the practitioner was not afforded a fair hearing in compliance with this Article, the Board shall remand the matter. In matters related to clinical competence, the Board's discretion shall be limited to determining whether the Hearing Panel's decision was supported by substantial evidence.

(d) The Board shall render its final decision in writing, including specific reasons, and forward copies thereof to each side involved in the appeal.

9.G.2 Further Review:

Except where the matter is referred by the Board to any individual or committee for further action and recommendation, the final decision of the Board shall be effective immediately and shall not be subject to further review. If the matter is referred for further action and recommendation, such recommendation shall be promptly made to the Board in accordance with the instructions given by the Board.

9.G.3 Right to One Hearing and One Appeal Only:

No member of the Medical Staff shall be entitled to more than one hearing and one appellate review on any matter. If the Board denies initial appointment to the Medical Staff or reappointment or revokes the appointment and/or clinical privileges of a current member of the Medical Staff, that individual may not apply for staff appointment or for those clinical privileges for a period of five years unless the Board provides otherwise.

ARTICLE 10
OFFICERS

10.A. DESIGNATION

The officers of the Medical Staff shall be the Chief of Staff, the Vice Chief of Staff, the Secretary-Treasurer, and the Immediate Past Chief of Staff.

10.B. ELIGIBILITY CRITERIA

Only those members of the Active-Voting Staff who satisfy the following criteria initially and continuously shall be eligible to serve as an officer of the Medical Staff, unless an exception is recommended by the MEC. They must:

(1) at the time of nomination, be appointed in good standing to the Active-Voting Staff, and have served on the Active-Voting Staff for at least two years;

(2) be certified by an appropriate specialty board or possess comparable competence, as determined through the credentialing and privileging process;

(3) have no pending adverse recommendations concerning Medical Staff membership or clinical privileges at the District;

(4) not presently be serving as Medical Staff officers, Board members, department chairs, or committee chairs at any other hospital and shall not so serve during their term of office;

(5) be willing to faithfully discharge the duties and responsibilities of the position;

(6) have experience in a leadership position, or other involvement in performance improvement functions;

(7) have demonstrated an ability to work well with others; and

(8) disclose any financial relationship (i.e., an ownership or investment interest or a compensation arrangement) with an entity that competes with the District or any affiliate. This does not apply to services provided within a practitioner's office and billed under the same provider number used by the practitioner. The MEC shall evaluate any such disclosed financial relationships to determine whether they are significant enough that the individual should be disqualified from serving in the relevant leadership position.

All such individuals are encouraged to obtain education relating to Medical Staff leadership, credentialing, and/or professional practice evaluation functions prior to or during the term of the office.

10.C. DUTIES

10.C.1 Chief of Staff:

The Chief of Staff shall:

(a) act in coordination and cooperation with the CEO in matters of mutual concern involving the care of patients throughout the District;

(b) represent and communicate the views, policies, concerns, and needs, and report on the activities, of the Medical Staff to the CEO and the Board;

(c) be accountable to the Board, in conjunction with the MEC, for the quality and efficiency of clinical services and performance throughout the District and for the effectiveness of the performance improvement, professional practice evaluation, and case management program functions;

(d) call and preside at all regular and special meetings of the general Medical Staff and the MEC, and assume responsibility for the agenda of all such meetings;

(e) appoint all committee chairs and members;

(f) serve as chair of the MEC (with vote, only as necessary to break a tie), be a member of the Joint Conference Committee, and be a member of all other Medical Staff committees, *ex officio* (without vote);

(g) be a signatory on the District's Medical Staff fund/account;

(h) promote adherence to the Bylaws, policies, and Rules and Regulations of the Medical Staff and to the policies and procedures of the District;

(i) recommend Medical Staff representatives to District committees;

(j) act on behalf of the MEC in urgent situations that occur in intervals between MEC meetings; and

(k) perform all functions authorized in all applicable policies.

10.C.2 Vice Chief of Staff:

The Vice Chief of Staff shall:

(a) assume all duties of the Chief of Staff and act with full authority as Chief of Staff in his or her absence;

(b) serve as the vice chair of the MEC;

(c) be expected to succeed the Chief of Staff at the conclusion of the term of Vice Chief of Staff, subject to an affirmation vote of the MEC;

(d) serve as chair of the Professional Staff Quality Committee and be a member of the Joint Conference Committee and the Bylaws Committee;

(e) act on behalf of the MEC in urgent situations that occur in intervals between MEC meetings;

(f) be a signatory on the District's Medical Staff fund/account; and

(g) assume all such additional duties as are assigned by the Chief of Staff or the MEC.

10.C.3 Secretary-Treasurer:

The Secretary-Treasurer shall:

(a) serve as a member of the MEC, the Joint Conference Committee, and other Medical Staff or District committees as may be requested;

(b) attend to all appropriate correspondence and notices on behalf of the Medical Staff, as may be requested;

(c) be expected to succeed the Vice Chief of Staff at the conclusion of the term of Secretary-Treasurer, subject to an affirmation vote of the MEC;

(d) be a signatory on the District's Medical Staff fund/account;

(e) oversee expenditures from the District's Medical Staff fund/account; and

(f) perform such additional duties as are assigned by the Chief of Staff or the MEC.

10.C.4 Immediate Past Chief of Staff:

The Immediate Past Chief of Staff shall:

(a) serve as an advisor and mentor to the Chief of Staff and the other officers;

(b) serve as a voting member of the MEC, the Chair of the Nominating Committee and the Bylaws Committee, and a member of the Joint Conference Committee;

(c) be a signatory on the District's Medical Staff fund/account; and

(d) perform such additional duties as are assigned by the Chief of Staff or the MEC.

10.D. NOMINATIONS

(1) The Nominating Committee shall consist of the five most recent Past Chiefs of Staff, including the Immediate Past Chief of Staff (who shall serve as Chair).

(2) The Nominating Committee shall convene at least 60 days prior to the election (which shall occur during the month of May) and shall select the names of one or more qualified nominees for the office of Secretary-Treasurer and, when necessary, Vice Chief of Staff (e.g., should the MEC not affirm the succession of the Secretary-Treasurer to the position or the Secretary-Treasurer opts not to succeed to the position of Vice Chief of Staff). All nominees must meet the eligibility criteria in Section 10.B and agree to serve, if elected. Notice of the nominees shall then be provided to the Medical Staff at least 30 days prior to the election.

(3) Additional nominations may be submitted to the Nominating Committee by members of the Active-Voting Staff at least 15 days prior to the election. Such petitions shall be submitted to the Nominating Committee via the relevant department chair(s). In order for a nomination to be added to the ballot, the candidate must meet the qualifications in Section 10.B.

(4) Nominations from the floor shall not be accepted if an election is held at an official meeting nor shall write-in candidates be accepted if the election is accomplished by written or electronic ballot.

10.E. ELECTION

(1) The election shall be held solely by written or electronic ballot returned to the Medical Staff Office. Ballots shall be returned in the manner designated on the ballot which may include in person, by mail, by facsimile, or by e-mail. All ballots must be received in the Medical Staff Office by the day of the election. Those who receive a majority of the votes cast shall be elected.

(2) In the alternative, at the discretion of the MEC, elections may be held at an official meeting. Such decision must be made by the MEC at the time that the Nominating Committee is convened (i.e., 60 days prior to the election). Candidates receiving a majority of written or verbal votes cast at the official meeting shall be elected. If no candidate receives a simple majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes.

10.F. TERM OF OFFICE

Officers shall serve for a term of two years or until a successor is elected.

10.G. REMOVAL

(1) Removal of an elected officer may be effectuated by a two-thirds vote of the MEC or by a two-thirds vote of the Active-Voting Staff. Grounds for removal shall be:

(a) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(b) failure to continue to satisfy any of the criteria in Section 10.B;

(c) failure to perform the duties of the position held;

(d) suspected conduct that the MEC has determined is detrimental to the interests of the District and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(2) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC or the Active-Voting Staff, as applicable, prior to a vote on removal.

10.H. VACANCIES

A vacancy in the office of Chief of Staff shall be filled by the Vice Chief of Staff and a vacancy in the office of Vice Chief of Staff shall be filled by the Secretary-Treasurer. In the event there is a vacancy in the office of Secretary-Treasurer, the MEC shall appoint an individual to fill that office for the remainder of the term or until a special election can be held, at the discretion of the MEC.

ARTICLE 11
CLINICAL DEPARTMENTS

11.A. DEPARTMENTS

The Medical Staff shall be organized into the following departments:

Anesthesiology

Cardiovascular Services

Critical Care, Pulmonary & Adult Hospitalists

Emergency Medicine

Family Medicine

Internal Medicine

Obstetrics and Gynecology

Pediatrics

Psychiatry & Neurosciences

Radiology

Surgery & Pathology

11.B. CREATION AND DISSOLUTION OF CLINICAL DEPARTMENTS AND DIVISIONS

(1) Clinical departments and divisions shall be created and may be consolidated or dissolved by the MEC upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a clinical department or division should be created:

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department or division (this number must be sufficiently large to enable the department or division to accomplish its functions as set forth in Section 11.D);

(b) the level of clinical activity that will be affected by the new department or division is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department or division vote in favor of the creation of a new department or division;

(d) it has been determined by the Medical Staff leadership and the CEO that there is a clinical and administrative need for a new department or division; and

(e) the voting Medical Staff members of the proposed department or division have offered a reasonable proposal for how the new department or division will fulfill all of the designated responsibilities and functions, including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a clinical department or division is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the clinical department or division to enable it to accomplish the functions set forth in the Bylaws and related policies;

(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the members in the department or division;

(c) the department or division fails to fulfill all designated responsibilities and functions, including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chair of the department or chief of the division; or

(e) a majority of the voting members of the department or division vote for its dissolution.

11.C. ASSIGNMENT TO CLINICAL DEPARTMENT

(1) Upon initial appointment to the Medical Staff, each member shall be assigned to a clinical department. Assignment to a particular clinical department does not preclude an individual from seeking and being granted clinical privileges typically associated with another clinical department.

(2) An individual may request a change in clinical department assignment to reflect a change in the individual's clinical practice.

11.D. FUNCTIONS OF CLINICAL SERVICES

The clinical departments shall be organized for the purpose of implementing processes (i) to monitor and evaluate the quality and appropriateness of the care of patients served by the clinical departments, and (ii) to monitor the practice of all those with clinical

privileges or a scope of practice in a given service area, consistent with the provisions in these Bylaws and related documents.

11.E. QUALIFICATIONS OF CLINICAL DEPARTMENT CHAIRS AND VICE CHAIRS

Each clinical department chair and vice chair shall satisfy all the eligibility criteria outlined in Section 10.B, unless waived by the MEC after considering the recommendation of the Chief of Staff.

11.F. APPOINTMENT AND REMOVAL OF CLINICAL DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Clinical department chairs and vice chairs shall be elected by the voting members of the department via an electronic or sealed written ballot, with the outcome subject to approval by the MEC.

(2) Any department chair or vice chair may be removed by a two-thirds vote of the clinical department members or by a two-thirds vote of the MEC. Grounds for removal shall be:

(a) failure to comply with applicable policies and Bylaws;

(b) failure to continue to satisfy any of the criteria in Section 10.B;

(c) failure to perform the duties of the position held;

(d) suspected conduct that the MEC has determined is detrimental to the interests of the District and/or its Medical Staff; or

(e) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(3) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which such action is to be considered. The individual shall be afforded an opportunity to speak to the department or the MEC, as applicable, prior to a vote on removal.

(4) Clinical department chairs and vice chairs shall serve for a term of two years or until a successor is elected. Department chairs may be re-elected.

(5) The chairs of Anesthesiology, Pathology, Pediatrics, Psychiatry, Surgery, and Radiology shall be elected in even-numbered years and the chairs of Cardiovascular Services, Critical Care, Pulmonology, & Adult Hospitalists, Emergency Medicine, Family Medicine, Internal Medicine, and Obstetrics & Gynecology shall be elected in odd-numbered years. Chairs serving at the time of the adoption of these Bylaws shall not be required to stand again for election until their current terms would have expired under the prior Bylaws.

11.G. DUTIES OF CLINICAL DEPARTMENT CHAIRS AND VICE CHAIRS

(1) Clinical department chairs and vice chairs shall work in collaboration with Medical Staff Leaders and other District personnel to collectively be responsible for the following:

(a) coordinating all clinically-related activities of the department;

(b) coordinating all administratively-related activities of the department;

(c) continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges, including performing ongoing and focused professional practice evaluations (OPPE and FPPE), as outlined in the Medical Staff peer review and ongoing professional practice evaluation policies;

(d) recommending criteria for clinical privileges that are relevant to the care provided in the department;

(e) evaluating requests for clinical privileges for each member of the department;

(f) assessing and recommending off-site sources for needed patient care, treatment, and services not provided by the clinical department or the District;

(g) integrating the department into the primary functions of the District;

(h) coordinating and integrating the services provided;

(i) developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the clinical department;

(j) making recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services;

(k) assisting in the evaluation of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care, treatment, and services;

(l) continuously assessing and improving the quality of care, treatment, and services provided within the clinical department;

(m) maintaining quality monitoring programs, as appropriate;

(n) providing for the orientation and continuing education of all persons in the clinical department;

(o) making recommendations for space and other resources needed by the department;

(p) cooperating with the preparation of an Emergency Department on-call roster to ensure appropriate coverage; and

(q) performing all functions authorized in the Bylaws, including collegial intervention efforts.

(2) Clinical department vice chairs shall carry out any and all functions that may be delegated by the relevant department chair which shall include, at a minimum, serving as members of the Credentials and Peer Review Committees.

ARTICLE 12
MEDICAL STAFF COMMITTEES

12.A. MEDICAL STAFF COMMITTEES AND FUNCTIONS

(1) This Article outlines the Medical Staff committees that carry out ongoing and focused professional practice evaluations and other performance improvement functions that are delegated to the Medical Staff by the Board..

(2) Procedures for the appointment of committee chairs, appointment of committee members, and terms of appointment are set forth in Section 12.B.

(3) This Article details the standing members of each Medical Staff committee. However, other Medical Staff members or District personnel may be invited to attend a particular Medical Staff committee meeting in order to assist such committee in its discussions and deliberations regarding the issues on its agenda. All such individuals are an integral part of the credentialing, quality assurance, and professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of such committees.

(4) Unless otherwise provided in a specific committee composition, voting members of committees are limited to Medical Staff members.

12.B. EXPECTATIONS AND REQUIREMENTS FOR COMMITTEE MEMBERSHIP

To be eligible to serve on a Medical Staff committee, members must acknowledge and agree to the following:

(1) have the willingness and ability to devote the necessary time and energy to committee service, recognizing that the success of a committee is highly dependent upon the full participation of its members;

(2) complete any orientation, training, and/or education related to the functions of the committee in advance of the first meeting;

(3) come prepared to each meeting – review the agenda and any related information provided in advance so that the committee's functions may be performed in an informed, efficient, and effective manner;

(4) attend meetings on a regular basis to promote consistency and good group dynamics;

(5) participate in discussions in a meaningful and measured manner that facilitates deliberate thought and decision-making, and avoid anecdotal or sidebar conversations;

(6) voice disagreement in a respectful manner that encourages consensus-building;

(7) understand and strive for "consensus" decision-making, thereby avoiding the majority vote whenever possible;

(8) speak with one voice as a committee and support the actions and decisions made (even if they were not the individual's first choice);

(9) be willing to complete assigned or delegated committee tasks in a timely manner between meetings of the committee;

(10) bring any conflicts of interest to the attention of the committee chair in advance of the committee meeting, when possible;

(11) if the individual has any questions about his or her role or any concerns regarding the committee functioning, seek guidance directly from the committee chair outside of committee meetings;

(12) participate in the development of an annual committee work plan and ensure that the committee plans are in alignment with the strategic goals of the District and Medical Staff; and

(13) maintain the confidentiality of all matters reviewed and/or discussed by the committee.

12.C. APPOINTMENT OF COMMITTEE CHAIRS AND MEMBERS

(1) Unless otherwise indicated, all committee chairs and members shall be appointed by the Chief of Staff. Committee chairs shall be selected based on the criteria set forth in Section 10.B, unless such criteria are waived by the MEC, and must signify their willingness to meet basic expectations of committee membership as set forth in Section 12.B. The MEC shall review the composition of Medical Staff committees at least once a year and may make recommendations for changes or additions to the constitution of each committee.

(2) Unless otherwise indicated, committee chairs and members shall be appointed for initial terms of two years, but may be reappointed for additional terms. All appointed chairs and members may be removed and vacancies filled by the Chief of Staff, at his/her discretion, subject to the approval of the MEC.

(3) Unless otherwise indicated, all District and administrative representatives on the committees shall be appointed by the CEO, in consultation with the Chief of Staff. If nursing representatives are appointed to Medical Staff committees, such individuals will be appointed by the Chief Nursing Officer ("CNO"). All such representatives shall serve on the committees, without vote.

(4) Unless otherwise indicated, the Chief of Staff, the CMO, and the CEO (or their respective designees) shall be members, *ex officio*, without vote, on all committees.

12.D. MEETINGS, REPORTS, AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in these Bylaws shall meet as necessary to accomplish its functions and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely report after each meeting to the MEC and the Board and to other committees and individuals as may be indicated.

12.E. MEDICAL EXECUTIVE COMMITTEE

12.E.1 Composition:

(a) The MEC shall consist of:

- the Chief of Staff;
- the Vice Chief of Staff;
- the Secretary-Treasurer of the Medical Staff;
- the Immediate Past Chief of Staff;
- the Chairs of the Credentials, Peer Review, and Graduate Medical Education Committees; and
- the department chairs (in the event that a department chair cannot attend a meeting, he or she may request that the vice chair attend in his or her absence and serve as a voting member of the MEC at that meeting).

(b) The Chief of Staff will chair the MEC.

(c) The CEO, COO, CMO, CNO, and Medical Director of Quality and Patient Safety or the CQO shall be *ex officio* members of the MEC, without vote.

(d) Other Medical Staff members or District personnel may be invited to attend a particular MEC meeting (as guests, without vote) in order to assist the MEC in its discussions and deliberations regarding an issue(s) on its agenda. These individuals shall be present only for the relevant agenda item(s) and shall be excused for all others. Such individuals are an integral part of the professional practice evaluation process and are bound by the same confidentiality requirements as the standing members of the MEC, including a requirement to sign any necessary confidentiality agreement.

12.E.2 Duties:

(a) The MEC is delegated the primary authority over activities related to the functions of the Medical Staff and for performance improvement of the professional services provided by individuals with clinical privileges. This authority may be removed by amending these Bylaws and related policies.

(b) The MEC is responsible for the following:

(1) acting on behalf of the Medical Staff in the intervals between Medical Staff meetings;

(2) recommending directly to the Board on at least the following:

(i) the Medical Staff's structure;

(ii) the mechanism used to review credentials and to delineate individual clinical privileges;

(iii) applicants for Medical Staff appointment and reappointment;

(iv) delineation of clinical privileges for each eligible individual;

(v) participation of the Medical Staff in District performance improvement activities and the quality of professional services being provided by the Medical Staff;

(vi) the mechanism by which Medical Staff appointment may be terminated;

(vii) hearing procedures; and

(viii) reports and recommendations from Medical Staff committees, departments, and other groups, as appropriate;

(3) consulting with Administration on quality-related aspects of contracts for patient care services;

(4) reviewing (or delegating the review of) quality indicators to ensure uniformity regarding patient care services;

(5) providing leadership in activities related to patient safety;

(6) collaborating in the process of analyzing and improving patient satisfaction;

(7) ensuring that, at least every five years, the Bylaws, policies, and associated documents of the Medical Staff are reviewed and updated;

(8) providing and promoting effective liaison among the Medical Staff, Administration, and the Board;

(9) complying with reasonable requests from the Board directed to the MEC as a whole that are seeking assistance with Medical Staff matters; and

(10) performing such other functions as are assigned to it by these Bylaws or other applicable policies.

12.E.3 Meetings:

The MEC shall meet at least ten times a year, and shall maintain a permanent record of its proceedings and actions.

12.E.4 Removal:

(a) Removal of a member of the MEC may be effectuated by a two-thirds vote of the MEC. Grounds for removal shall be:

(1) failure to comply with applicable policies, Bylaws, or Rules and Regulations;

(2) failure to continue to satisfy any of the criteria in Section 10.B;

(3) failure to perform the duties of the position held;

(4) suspected conduct that the MEC has determined is detrimental to the interests of the District and/or its Medical Staff; or

(5) an infirmity that renders the individual incapable of fulfilling the duties of that office.

(b) At least 10 days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the MEC prior to a vote on removal.

12.F. AD HOC DISPUTE RESOLUTION COMMITTEE ("AHDRC")

12.F.1 Composition:

The Ad Hoc Dispute Resolution Committee shall be composed of two members appointed by the Board and two members appointed by the MEC. The four members shall appoint a fifth member. In even numbered years, the AHDRC chair shall be designated by the Board Chair and in odd numbered years the AHDRC chair shall be designated by the Chief of Staff.

12.F.2 Duties:

(a) All disputes between the Board/Administration and the Medical Staff (the "Parties") relating to the Medical Staff's rights of self-governance as defined in California Business & Professions Code Section 2282.5 ("Disputes") that have not been resolved by informal meetings and discussions, as well as conflicts between the MEC and the Medical Staff as defined in Section 17.C that are not fully resolved pursuant to that section, shall be addressed and resolved in accordance with the meet and confer process of an AHDRC, as described in this section.

(b) In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party stating the nature of the Dispute and describing the matter in detail. Within 30 days following receipt of such notice, both Parties shall appoint representatives to an AHDRC, as described above. A separate AHDRC shall be established for each Dispute for which notice is given pursuant to this section. Accordingly, more than one AHDRC may be operative at a time. Neither Party shall initiate any legal action related to the Dispute until the AHDRC has completed its efforts to resolve the Dispute.

(c) When formed, an AHDRC shall promptly receive and review written requests for initiation of the meet and confer/dispute resolution process. The AHDRC, with such assistance and input as it may request, shall then meet in good faith to recommend a resolution of the Dispute. Such efforts shall continue, as necessary, for up to 60 days. The AHDRC shall report the results of its efforts and its recommendations to both the MEC and the Board. Both Parties are obligated to consider the AHDRC's recommendations carefully and to give them great weight. Unless requested by the Parties to continue its deliberations, the AHDRC shall dissolve 30 business days following the reporting of its results and recommendations.

(d) Each Party shall bear its own legal expenses. Unless the Parties agree otherwise, approved expenses of the AHDRC (such as consulting fees or expenses related to the appointment of the fifth committee member) shall be paid by the District.

12.G. BEHAVIOR COMMITTEE

12.G.1 Composition:

The Behavior Committee shall consist of the officers of the Medical Staff. The Chief of Staff shall serve as chair.

12.G.2 Duties:

The Behavior Committee shall:

(a) Receive, evaluate, and Track & Trend Medical Staff behavior events.

(b) Triage events and recommend actions as outlined in MS 47 Code of Conduct policy.

12.H. BYLAWS COMMITTEE

12.H.1 Composition:

The Bylaws Committee shall consist of at least five members of the Active-Voting Staff, including at least the Vice Chief of Staff, the Immediate Past Chief of Staff, and a senior member of management, who shall serve as an *ex officio* member at the invitation of the chair. The Immediate Past Chief of Staff shall serve as chair.

12.H.2 Duties:

The Bylaws Committee shall:

(a) conduct an annual review of the Medical Staff Bylaws and related governance documents, submitting recommendations to the MEC for changes in these documents as necessary to reflect the District's current practice with respect to Medical Staff organization and functions; and

(b) receive and evaluate for recommendation to the MEC suggestions for modification of the items specified in the annual review.

12.I. CASE MANAGEMENT COMMITTEE

12.I.1 Composition:

The Case Management Committee shall consist of at least three Active-Voting Staff members, selected to be broadly representative of the clinical specialties on the Medical Staff.

12.I.2 Duties:

The Case Management Committee shall:

(a) conduct utilization management studies designed to evaluate the appropriateness of admissions to the Hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors that may contribute to the effective utilization of services;

(b) communicate the results of its studies and other pertinent data to the MEC and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(c) establish a utilization review plan which shall be approved by the MEC;

(d) obtain, review, and evaluate information and raw statistical data obtained or generated by the Hospital's case management system; and

(e) be responsible for overseeing the conditions of participation for Medicare and Medi-Cal for utilization review and discharge planning.

12.J. CREDENTIALS COMMITTEE

12.J.1 Composition:

The Credentials Committee shall be comprised of at least five members of the Active-Voting Staff which shall include, when possible, the vice chairs of the clinical departments and which may include additional Active-Voting Staff members as necessary, selected on a basis that will ensure representation of the clinical departments. The committee shall also include, as *ex officio* members without vote, the Vice Chair of the Peer Review Committee, the CMO, and a member of the Board.

12.J.2 Duties:

The Credentials Committee shall:

(a) review the credentials of all applicants for Medical Staff appointment, reappointment, and clinical privileges, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations to the MEC and to the Board, through the MEC;

(b) review requests for waivers of any threshold eligibility criteria and make recommendations on the same to the MEC;

(c) review the credentials of all applicants seeking to practice as Advanced Practice Providers, conduct a thorough review of the applications, interview such applicants as may be necessary, and make reports of its findings and recommendations;

(d) review, as may be requested by the MEC, all information available regarding the current clinical competence and behavior of persons currently appointed to the Medical Staff and, as a result of such review, make a report of its findings and recommendations.

12.K. EXECUTIVE OPERATIONS COMMITTEE (EOC)

12.K.1 Composition:

The EOC shall consist of the Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, and Immediate Past Chief of Staff with the Chief Executive Officer and Chief Medical Officer as x-officio members.

12.K.2 Duties:

The EOC shall serve as a working group to address daily operational issues and develop projects prior to presentation to the Department or MEC. The EOC may meet with stakeholders to accomplish information/data gather in order for the Department and MEC to function more efficiently and expeditiously. The EOC shall review incidents and issues prior to review by the full MEC. Additional obligations of the EOC include on-call and code of conduct issues. The EOC shall forward a summary of their meeting to the MEC.

12.K.3 Meetings:

The EOC shall meet as often as needed, but at least monthly.

12.L. GRADUATE MEDICAL EDUCATION COMMITTEE ("GMEC")

12.L.1 Composition:

The GMEC shall be comprised of one resident representative from each program, and two residents elected by their peers and appointed by the Chief of Staff (all resident members must be in good standing with the residency program during the course of appointment), the Program Directors, the Secretary-Treasurer of the Medical Staff, the ACGME Designated Institutional Official ("DIO"), the Director of Graduate Medical Education ("GME"), the CMO, a Board representative, the Medical Director of Quality and Patient Safety, and representatives of any necessary departments, which may include Emergency Medicine, Family Medicine, Internal Medicine, Pediatrics, Psychiatry, Critical Care/Pulmonary/Adult Hospitalists, and Surgery, who shall be elected by the relevant department and appointed by the Chief of Staff. The GMEC shall recommend one of its members to serve as the chair (who shall be a member of the Medical Staff) and the Chief of Staff shall appoint the chair to a two-year term. The chair shall be eligible for reappointment.

12.L.2 Duties:

In collaboration with the GMEC, the DIO has authority and responsibility for oversight and administration of the Sponsoring Institution's ACGME accredited programs as well as responsibility for ensuring compliance with the ACGME Institutional, Common, and Specialty/Subspecialty specific program requirements. It is the purpose of the GMEC to provide a high quality and safe educational environment conducive to preparing physicians for the independent practice of medicine.

12.M. HEALTH INFORMATION MANAGEMENT COMMITTEE

12.M.1 Composition:

The Health Information Management Committee, when possible, shall be comprised of the Director of Health Information Management and at least one representative from each clinical department, the nursing service, the medical records department, and Hospital administration, all of whom are voting members.

12.M.2 Duties:

The Health Information Management Committee shall:

(a) review and evaluate medical records, or a representative sample, to determine whether they meet the standards of the Medical Staff and relevant regulatory and accreditation requirements;

(b) review and make recommendations for Medical Staff and Hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, indexing, storage, destruction, availability and methods of enforcement; and

(c) provide liaison with Hospital administration and medical records personnel in the employ of the Hospital on matters relating to medical records practices.

12.N. INFECTION PREVENTION COMMITTEE

12.N.1 Composition:

The Infection Prevention Committee shall be comprised of at least three members, including representatives from the departments of medicine, surgery, obstetrics/gynecology, pediatrics, pathology, nursing service, administration, and the Infection Control Coordinator. It may include non-voting consultants in microbiology and non-voting representatives from relevant hospital services.

12.N.2 Duties:

The Infection Prevention Committee shall:

(a) develop a hospital-wide infection prevention program and maintain surveillance over the program;

(b) develop a system for reporting, identifying, and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

(c) develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

(d) develop written policies defining special indications for isolation requirements;

(e) coordinate action on findings from the Medical Staff's review of the clinical use of antibiotics;

(f) act upon recommendations related to infection prevention received from the Chief of Staff, the MEC, departments and other committees; and

(g) review sensitivities of organisms specific to the facility.

12.O. INTERDISCIPLINARY PRACTICE COMMITTEE

12.O.1 Composition:

The Interdisciplinary Practice Committee shall be comprised of an equal number of physicians and/or Advanced Practice Providers appointed by the MEC and registered nurses appointed by the CNO and the CEO. Licensed or certified health professionals other than registered nurses who are performing or will perform functions shall also be included as members. The CMO shall be an *ex officio* member of the committee.

12.O.2 Duties:

The Interdisciplinary Practice Committee shall be responsible for overseeing the establishment and administration of standardized procedures for registered nurses and oversee the practice of Advanced Practice Providers. Specifically, the committee shall:

(a) establish and administer standardized procedures for registered nurses as follows:

(i) prescribe a required form for standardized procedures, including the subject to be covered;

(ii) identify the nursing functions that require the adoption of standardized procedures and ensure that registered nurses perform them only in accordance with standardized procedures;

(iii) establish a method for the review and approval of all proposed standardized procedures;

(iv) review and recommend approval of all proposed standardized procedures covering registered nurses at the District;

(v) ensure that the CNO has a system in place for identifying and designating the registered nurses who are qualified to practice under each standardized procedure, both on an initial and a continuing basis; and

(vi) ensure that the names of registered nurses approved to perform functions according to each standardized procedure are on file in the office of the CNO or at some other designated place;

(b) oversee Advanced Practice Providers who practice at the District, as follows:

(i) identify specific categories of Advanced Practice Providers that might perform services at the District and make appropriate recommendations;

(ii) make recommendations concerning the minimum standards of practice applicable to Advanced Practice Providers at the District;

(iii) make recommendations concerning the supervision required for Advanced Practice Providers at the District;

(iv) review applications for permission to practice and renewal of permission to practice and privileges granted to practitioners from accepted categories in accordance with applicable Medical Staff bylaws, rules/regulations and policies; and

(v) conduct investigations and review concerns related to the practice of Advanced Practice Providers, in accordance with applicable Medical Staff bylaws, rules/regulations and policies;

(c) recommend policies and procedures for the granting of expanded role privileges to Registered Nurses; and

(d) review and recommend approval of standardized procedures under which Registered Nurses practice in expanded roles.

12.P. JOINT CONFERENCE COMMITTEE

12.P.1 Composition:

The Joint Conference Committee shall be composed of a member of the Board of Directors, the Medical Staff Officers, the CMO (*ex officio*), and the CEO (*ex officio*). The member from the Board and the Chief of Staff shall have voting privileges. Other District representatives and/or Medical Staff members may attend as determined by the chair.

12.P.2 Duties:

The Joint Conference Committee shall constitute a forum for the discussion of matters of District and Medical Staff policy, practice and planning and the primary forum for interaction between the Board and the Medical Staff on such matters as may be referred by the MEC or the Board.

12.Q. PEER REVIEW COMMITTEE ("PRC")

12.Q.1 Composition:

The PRC shall be comprised of at least five members of the Active-Voting Staff, which shall include, when possible, the vice chairs of the clinical departments and which may include additional Active-Voting Staff members as necessary, selected on a basis that will ensure representation of the clinical departments. In addition, an Advanced Practice Provider recommended by the CNO and appointed by the Chief of Staff will serve as a voting member. The Quality and Patient Safety Medical Director and the CMO shall serve as *ex officio* members, without vote. The PRC chair shall only vote to affect the outcome. The chair will be a member of the Active-Voting Staff and will be appointed by the Chief of Staff from committee members who have served for more than one year. The chair will be a voting regular member of the MEC. The committee shall elect a vice-chair

who will preside at PRC meetings when the chair is not available, and who shall also serve as a non-voting member of the Credentials Committee.

12.Q.2 Duties:

The Peer Review Committee shall:

(a) develop indicators that measure standards of care based on best practices, whether internally developed or externally imposed, in conjunction with individual departments and care groups;

(b) review aggregated results of indicators of best practice to determine trends relevant to physician performance and identify any individual outliers;

(c) review cases in which an individual patient's care has been or may have been compromised by the care provided, either by individual or aggregate (group) practitioners;

(d) identify opportunities for improvement, either for individuals or in the aggregate, and communicate the issues and need for a plan for improvement to the appropriate individuals, groups, or departments;

(e) assure that plans for improvement are developed in a timely manner and monitor progress;

(f) develop and oversee policies and procedures for outside case review;

(g) work collaboratively with the hospital's performance improvement department in collecting and refining information regarding physician performance;

(h) review screening tools, referral systems and performance indicators for relevance at least annually, in collaboration with the Medical Staff department chairs, and make recommendations to the MEC; and

(i) work collaboratively with the Credentials Committee Chair and Medical Staff department chairs to define appropriate content and format for individual physician performance feedback reports.

12.R. PHARMACY AND THERAPEUTICS COMMITTEE

12.R.1 Composition:

The Pharmacy and Therapeutics Committee shall be comprised of at least three representatives from the Medical Staff, one voting representative from the pharmaceutical service, and non-voting representative to include the CNO, COO, or their designees.

12.R.2 Duties:

The Pharmacy and Therapeutics Committee shall:

(a) assist in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the District, including antibiotic usage;

(b) advise the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) periodically develop and review a formulary or drug list for use in the District;

(e) evaluate clinical data concerning new drugs or preparations requested for use in the District;

(f) establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) be involved in the development and monitoring of pharmacy standardized procedures;

(h) maintain a record of all activities relating to pharmacy and therapeutics functions and submit periodic reports and recommendations to the MEC concerning those activities; and

(i) review untoward drug reactions.

12.S. PROFESSIONAL STAFF QUALITY COMMITTEE

12.S.1 Composition:

(a) The Professional Staff Quality Committee shall be comprised of the following voting members: the Vice Chief of Staff (who shall serves as the Chair of the Committee), the Chief of Staff, the Secretary-Treasurer, the Immediate Past Chief of Staff, the Chief Quality Officer, the Quality and Patient Safety Medical Director, the Director of Quality and Patient Safety, the Director of Risk, the Director of Medical Staff Services, and an IS representative.

The following members of this committee are ad-hoc members that will attend when requested to address areas pertinent to their services: All Kaweah Delta Medical Directors, the Director of Pharmacy, and the Director of Nursing Practice.

(b) The following committee members shall participate in setting the agenda for meetings: the Vice Chief of Staff, the Quality and Patient Safety Medical Director, the Quality and Patient Safety Director, the Chief of Staff, the Secretary-Treasurer, and the CQO.

(c) The Professional Staff Quality Committee may appoint subcommittees to help fulfill the responsibilities and duties set forth below. All duly authorized subcommittees shall report to the Professional Staff Quality Committee at a frequency designated by that committee.

12.S.2 Duties:

The Professional Staff Quality Committee shall:

(a) recommend for approval of the MEC plans for maintaining quality patient care throughout the District. These may include mechanisms to (i) establish systems to identify potential problems in patient care or significant departures from established patterns of clinical practice; (ii) set priorities for action on problem correction; (iii) refer priority problems for assessment and corrective action to appropriate departments or committees; (iv) monitor the results of quality assessment and improvement activities throughout the District, i.e., blood utilization review; and (v) coordinate quality improvement activities that ensure that the findings, conclusions, recommendations, and actions taken to improve the organization's performance are communicated to the appropriate Medical Staff members; and

(b) submit regular confidential reports to the MEC on the quality of medical care provided and on quality review activities conducted.

(c) measure, assess, and improve the following:

(i) patient safety, including processes to respond to patient safety alerts, meet patient safety goals, and reduce patient safety risks;

(ii) the District's and individual practitioners' performance on Joint Commission and Centers for Medicare & Medicaid Services ("CMS") core measures;

(iii) medical assessment and treatment of patients;

(iv) medication usage, including review of significant adverse drug reactions, medication errors, and the use of experimental drugs and procedures;

(v) the utilization of blood and blood components, including review of significant transfusion reactions;

(vi) operative and other invasive procedures, including tissue review and review of discrepancies between pre-operative and post-operative diagnoses;

(vii) appropriateness of clinical practice patterns;

(viii) significant departures from established patterns of clinical practice;

(ix) the use of developed criteria for autopsies;

(x) sentinel events, including root cause analyses and responses to unanticipated adverse events;

(xi) nosocomial infections and the potential for infection;

(xii) unnecessary procedures or treatment;

(xiii) appropriate resource utilization;

(xiv) education of patients and families;

(xv) coordination of care, treatment, and services with other practitioners and District personnel;

(xvi) accurate, timely, and legible completion of medical records;

(xvii) the required content and quality of history and physical examinations, as well as the time frames required for completion, all of which are set forth in Appendix A to these Bylaws;

(xviii) review of findings from the ongoing and focused professional practice evaluation activities that are relevant to an individual's performance; and

(xix) communication of findings, conclusions, recommendations, and actions to improve performance to appropriate Medical Staff members, the MEC, and the Board.

12.T. TRAUMA COMMITTEE

12.T.1 Composition:

The Trauma Committee shall be comprised of a general surgeon, the Emergency Department Medical Director (or designee), an orthopedic surgeon, a pediatrician, an anesthesiologist, the ICU Medical Director, the OR Director, the Emergency Department Director, the Trauma Care Service Nurse Coordinator, critical care and ER registered nurses, the COO and any additional members as may be necessary identified by the chair. The chair of the committee shall be a member of the Active-Voting Staff.

12.T.2 Duties:

The Trauma Committee shall:

(a) facilitate revision, development, and approval of integrated trauma care policies and procedures;

(b) coordinate review of trauma charts, the care of trauma patients, and the utilization of trauma services;

(c) conduct preliminary peer review for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to trauma patients. The committee shall routinely collect information about important aspects of patient care provided to trauma patients, periodically assess this information, and develop objective criteria for use in evaluating patient care provided to trauma patients;

(d) provide a forum for review and evaluation of performance improvement and ongoing quality of trauma care provided within the District;

(e) plan and provide continuing medical education programs;

(f) address regulatory standards and requirements and facilitate compliance;

(g) provide leadership for future community trauma needs; and

(h) appoint a subcommittee of the Trauma Committee to function as the Trauma Peer Review Subcommittee with responsibility and oversight of the peer review process for trauma-related cases, providing a report on the same to the Peer Review Committee and the MEC on a regular basis.

12.U. WELL-BEING COMMITTEE

12.U.1 Composition:

The Well-Being Committee shall be comprised of not less than five members of the Active-Voting Staff, a majority of which, including the chair, shall be physicians. The membership of the Committee shall specifically include, when possible, one member from the Department of Psychiatry, the most recent five Immediate Past Chiefs of Staff who no longer serve on the MEC, if willing, and one voting member over the age of 70, when possible. Each member shall serve a term of two years, and the terms shall be staggered as deemed appropriate by the MEC to achieve continuity. The Chief of Staff will appoint a Past Chief of Staff to serve as chair of the committee. The chair of the committee may be appointed to serve longer than a two-year term. Insofar as possible, members of the committee shall not serve as active participants on other peer review or quality improvement committees while serving on this committee.

12.U.2 Duties:

The Well-Being Committee shall receive reports related to the health, well-being, or impairment of credentialed practitioners and, as it deems appropriate, may evaluate such reports. With respect to matters involving individual Medical Staff members, 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 poses an unreasonable risk of harm to District patients, that information may be referred to the MEC for formal action. The committee shall also consider general matters related to the health and well-being of the Medical Staff and, with the approval of the MEC, develop educational programs or related activities.

12.V. CREATION OF STANDING COMMITTEES

The MEC may, by resolution and without amendment of these Bylaws, establish additional committees to perform one or more staff functions, subject to the approval of the Board. In the same manner, the MEC may dissolve or rearrange committee structure, duties, or composition as needed to better accomplish Medical Staff functions, also subject to the approval of the Board. Any function required to be performed by these Bylaws that is not assigned to an individual, a standing committee, or a special committee shall be performed by the MEC.

12.W. SPECIAL COMMITTEES

Special committees shall be created and their members and chairs shall be appointed by the Chief of Staff and/or the MEC. Such special committees shall confine their activities to the purpose for which they were appointed and shall report to the MEC.

ARTICLE 13
MEETINGS

13.A. MEDICAL STAFF YEAR

The Medical Staff year is July 1 to June 30.

13.B. MEDICAL STAFF MEETINGS

13.B.1 Regular Meetings:

The Medical Staff shall meet on an as-needed basis, as determined by the Medical Staff Officers, but at least quarterly.

13.B.2 Special Meetings:

Special meetings of the Medical Staff may be called by the Chief of Staff, the MEC, or by a petition signed by at least 20% of the voting staff.

13.C. DEPARTMENT AND COMMITTEE MEETINGS

13.C.1 Regular Meetings:

Except as otherwise provided in these Bylaws, each department and committee shall meet as necessary to accomplish its functions, at times set by the chair.

13.C.2 Special Meetings:

A special meeting (i.e., a meeting called for the discussion and/or vote on a specific issue or matter of concern) of any department or committee may be called by or at the request of the chair, the Chief of Staff, the MEC, or by a petition signed by not less than 25% of the voting staff members of the department or committee (but in no event fewer than two members).

13.C.3 Executive Sessions:

Medical Staff committees and clinical departments may conduct business in formally designated executive sessions, which shall be limited to the voting members of such committees or departments as well as necessary support staff and other invitees as necessary.

13.D. PROVISIONS COMMON TO ALL MEETINGS

13.D.1 Notice of Meetings:

(a) Medical Staff members shall be provided notice of all regular meetings of the Medical Staff and regular meetings of departments and committees at least seven days in advance of the meetings. The means of notification shall be at the discretion of the Medical Staff Services Department and may be accomplished

through written, electronic, or telephonic means, including, but not limited to, posting and electronic scheduling. All notices shall state the date, time, and place of the meetings.

(b) When a special meeting of the Medical Staff, a department, or a committee (other than the MEC) is called, the required notice period shall be reduced to 48 hours (i.e., must be given at least 48 hours prior to the special meeting). The required notice period for special meetings of the MEC shall be reduced to 24 hours. In addition, posting may not be the sole mechanism used for providing notice of any special meeting.

(c) The attendance of any individual at any meeting shall constitute a waiver of that individual's objection to the notice given for the meeting.

13.D.2 Quorum and Voting:

(a) For any regular or special meeting of the Medical Staff, department, or committee, those voting members present (but not fewer than two) shall constitute a quorum. The exception to this general rule is that for meetings of the MEC, Credentials Committee, Peer Review Committee, and the Graduate Medical Education Committee, the presence of at least 50% of the voting members of the committee shall constitute a quorum.

(b) Recommendations and actions of the Medical Staff, departments, and committees shall be by consensus when possible. In the event it is necessary to vote on an issue, that issue will be determined by a majority vote of those voting members present.

(c) In the discretion of the chair, as an alternative to a formal meeting, the voting members of the Medical Staff, a department, or a committee may also be presented with a question by mail, facsimile, e-mail, hand-delivery, telephone, or other technology approved by the Chief of Staff, and their votes returned to the chair by the method designated in the notice. Except for amendments to these Bylaws and actions by the MEC, the Credentials Committee, the Peer Review Committee, and the Graduate Medical Education Committee (as noted in (a)), a quorum for purposes of these votes shall be the number of responses returned to the chair by the date indicated (but not fewer than two). The question raised shall be determined in the affirmative and shall be binding if a majority of the responses returned has so indicated.

(d) Meetings may be conducted by e-mail, telephone conference, or videoconference.

13.D.3 Agenda:

The chair for the meeting shall set the agenda for any regular or special meeting of the Medical Staff, department, or committee.

13.D.4 Rules of Order:

Robert's Rules of Order shall not be binding at meetings and elections, but may be used for reference in the discretion of the chair for the meeting. Rather, specific provisions of these Bylaws and Medical Staff, department, or committee custom shall prevail at all meetings. The chair shall have the authority to rule definitively on all matters of procedure.

13.D.5 Minutes, Reports, and Recommendations:

(a) Minutes of all meetings of the Medical Staff, departments, and committees shall be prepared and shall include a record of the attendance of members and the recommendations made and the votes taken on each matter. The minutes shall be deemed final upon approval by the relevant body.

(b) A summary of all recommendations and actions of the Medical Staff, departments, and committees shall be transmitted to the MEC. The Board shall be kept apprised of the recommendations of the Medical Staff and its clinical departments and committees.

(c) A permanent file of the minutes of all meetings shall be maintained by the Medical Staff Office.

13.D.6 Confidentiality:

All Medical Staff business conducted by committees or departments is considered confidential and proprietary and should be treated as such. However, members of the Medical Staff who have access to, or are the subject of, credentialing and/or peer review information understand that this information is subject to heightened sensitivity and, as such, agree to maintain the confidentiality of this information. Credentialing and peer review documents, and information contained therein, must not be disclosed to any individual not involved in the credentialing or peer review processes, except as authorized by these Bylaws or other applicable Medical Staff policy. A breach of confidentiality with regard to any Medical Staff information may result in the imposition of disciplinary action.

13.D.7 Attendance Requirements:

(a) Attendance at all meetings of the MEC, the Credentials Committee, and the Peer Review Committee is required. All members are required to attend at least 50% of all regular and special meetings of these committees per appointment term. Failure to attend the required number of meetings may result in replacement of the member.

(b) Each Active-Voting Staff member is expected to attend and participate in Medical Staff meetings and applicable department and committee meetings each year.

ARTICLE 14
CONFLICT OF INTEREST

14.A. General Principles:

(1) All those involved in credentialing and professional practice evaluation activities must be sensitive to potential conflicts of interest in order to be fair to the individual whose qualifications are under review, to protect the individual with the potential conflict, and to protect the integrity of the review process.

(2) It is also essential that peers participate in credentialing and professional practice evaluation review activities in order for these activities to be meaningful and effective. Therefore, whether and how an individual can participate must be evaluated reasonably, taking into consideration common sense and objective principles of fairness.

14.B. Immediate Family Members:

No immediate family member (spouse, parent, child, sibling, or in-law) of a practitioner whose application or care is being reviewed shall participate in any aspect of the review process, except to provide information.

14.C. Contractual Relationship with the District:

A contractual arrangement with the District or an affiliate shall not, in and of itself, preclude an individual from participating in credentialing and professional practice evaluation activities. Rather, participation by such individuals shall be evaluated as outlined in the paragraphs below.

14.D. Actual or Potential Conflict Situations:

With respect to a practitioner whose application or care is under review, actual or potential conflict situations involving other members of the Medical Staff include, but are not limited to, the following:

(1) significant financial relationships (e.g., members of small, single specialty group; referral relationship; partners in business venture);

(2) being a direct competitor;

(3) close friendship;

(4) history of personal conflict;

(5) personal involvement in the care of a patient that is subject to review;

(6) raising the concern that triggered the review; or

(7) prior participation in review of the matter at a previous level.

Any such individual shall be referred to as an "Interested Member" in the remainder of this Article for ease of reference.

14.E. Guidelines for Participation in Credentialing and Professional Practice Evaluation Activities:

An Interested Member shall have the obligation to disclose any actual or potential conflict of interest. When an actual or potential conflict situation exists as outlined in the paragraph above, the following guidelines shall be used.

(1) Initial Reviewers. An Interested Member may participate as an initial reviewer as long as there is a check and balance provided by subsequent review by a Medical Staff committee. This applies, but is not limited, to the following situations:

(a) participation in the review of applications for appointment, reappointment, and clinical privileges because of the Credentials Committee's and MEC's subsequent review of credentialing matters; and

(b) participation as a case reviewer in professional practice evaluation activities because of the Peer Review Committee's subsequent review of peer review matters.

(2) Credentials Committee or Peer Review Committee Member. An Interested Member may fully participate as a member of these committees because these committees do not make any final recommendation that could adversely affect the clinical privileges of a practitioner, which is only within the authority of the MEC. However, the chairs of these committees always have the discretion to recuse an Interested Member if they determine that the Interested Member's presence would inhibit full and fair discussion of the issue or would skew the recommendation or determination of the committee.

(a) Ad Hoc Investigating Committee. Once a formal investigation has been initiated, an Interested Member may not be appointed as a member of an ad hoc investigating committee, but may be interviewed and provide information to the ad hoc investigating committee if necessary for the committee to conduct a full and thorough investigation.

(b) MEC. An Interested Member will be recused and may not participate as a member of the MEC when the MEC is considering a recommendation that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

(c) Board. An Interested Member will be recused and may not participate as a member of the Board when the Board is considering a recommendation

that could adversely affect the clinical privileges of a practitioner, subject to the rules for recusal outlined below.

14.F. Guidelines for Participation in Development of Privileging Criteria:

Recognizing that the development of privileging criteria can have a direct or indirect financial impact on particular physicians, the following guidelines apply. Any individual who has a personal interest in privileging criteria, including criteria for privileges that cross specialty lines or criteria for new procedures, may:

(1) provide information and input to the Credentials Committee or an ad hoc committee charged with development of such criteria;

(2) participate in the discussions or actions of the Credentials Committee or an ad hoc committee charged with development of such criteria because these committees do not make the final recommendation regarding the criteria (however, the chair of the Credentials Committee or ad hoc committee always has the discretion to recuse an Interested Member in a particular situation, in accordance with the rules for recusal outlined below); and

(3) participate in the discussions or actions of the MEC when it is considering its final recommendation to the Board regarding the criteria or participate in the final discussions or action of the Board related to the criteria.

14.G. Rules for Recusal:

(1) When determining whether recusal in a particular situation is required, the Chief of Staff or committee chair shall consider whether the Interested Member's presence would inhibit full and fair discussion of the issue before the committee, skew the recommendation or determination of the committee, or otherwise be unfair to the practitioner under review.

(2) Any Interested Member who is recused from participating in a committee or Board meeting must leave the meeting room prior to the committee's or Board's final deliberation and determination, but may answer questions and provide input before leaving.

(3) Any recusal will be documented in the committee's or Board's minutes.

(4) Whenever possible, an actual or potential conflict should be brought to the attention of the Chief of Staff or committee chair, a recusal determination made, and the Interested Member informed of the recusal determination prior to the meeting.

14.H. Other Considerations:

(1) Any member of the Medical Staff who is concerned about a potential conflict of interest on the part of any other member, including but not limited to the

situations noted in the paragraphs above, must call the conflict of interest to the attention of the Chief of Staff (or to the Vice Chief of Staff if the Chief of Staff is the person with the potential conflict) or the applicable committee/Board chair. The member's failure to provide such notice will constitute a waiver of the claimed conflict. The Chief of Staff or the applicable committee/Board chair has the authority to make a final determination as to how best to manage the situation, guided by this Article, including recusal of the Interested Member, if necessary.

(2) No staff member has a right to compel the recusal of another staff member based on an allegation of conflict of interest. Rather, that determination is within the discretion of the Medical Staff Leaders or Board chair, guided by this Article.

(3) The fact that an individual chooses to refrain from participation, or is excused from participation in any credentialing or peer review activity, shall not be interpreted as a finding of actual conflict that inappropriately influenced the review process.

ARTICLE 15
CONFIDENTIALITY AND PEER REVIEW PROTECTION

15.A. CONFIDENTIALITY

Actions taken and recommendations made pursuant to these Bylaws shall be strictly confidential. Individuals participating in, or subject to, credentialing and professional practice evaluation activities shall make no disclosures of any such information (discussions or documentation) outside of committee meetings, except:

(1) when the disclosures are to a member of the Medical Staff for the purpose of researching, investigating, conducting duly authorized credentialing and professional practice evaluation activities, or implementing directions from a Medical Staff Committee;

(2) when the disclosures are to a District employee who is authorized by the Medical Staff by way of the Medical Staff Bylaws, Rules, and/or policies to access confidential peer review information and who has agreed not to further disclose such information; or

(3) when the disclosures are authorized by a Medical Staff or District policy that has been approved by the MEC.

Any breach of confidentiality shall be reviewed by the MEC and may result in a professional review action and/or appropriate legal action. Such breaches are unauthorized and do not waive the peer review privilege. Any member of the Medical Staff who becomes aware of a breach of confidentiality must immediately inform the CEO or the Chief of Staff (or the Vice Chief of Staff if the Chief of Staff is the person committing the claimed breach).

15.B. PEER REVIEW PROTECTION

(1) All credentialing and professional practice evaluation activities pursuant to these Bylaws shall be performed by "peer review committees" in accordance with California law. These committees include, but are not limited to:

(a) all standing and ad hoc Medical Staff and District committees that have been assigned protected peer review activities;

(b) all clinical departments of the Medical Staff;

(c) hearing panels;

(d) the Board and any committees that engage in peer review activities, but only with regard to those protected peer review activities; and

(e) any individual acting for or on behalf of any such entity, including but not limited to department chairs and vice chairs, committee chairs and

members, Medical Staff Officers, the CMO, and experts or consultants retained to assist in peer review activities.

All reports, recommendations, actions, minutes (and all drafts thereof) made, taken, or received by peer review committees and correspondence sent by such committees are confidential and covered by the applicable provisions of California law.

All peer review committees shall also be deemed to be "professional review bodies" as that term is defined in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §11101 *et seq.*

ARTICLE 16
INDEMNIFICATION

Provided the Covered Individual to be indemnified has endeavored in good faith to comply with all laws and regulations, the applicable Medical Staff Bylaws, Rules and Regulations, and policies of the Medical Staff, the District shall, to the extent allowable by law, indemnify, defend, and hold harmless Covered Individuals from and against losses and expenses (including attorneys' fees, judgments, settlements, regulatory fines, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending, or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or other Medical Staff functions as described in these Bylaws, the Rules and Regulations, and related policies of the Medical Staff including, but not limited to, (1) as a member of or witness for a Medical Staff department, division, committee or hearing panel, (2) as a member of or witness for the District Board or any District task force, group, or committee, and (3) as a person providing information to any Medical Staff or District group, committee, officer, Board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness, or character of a Medical Staff member or applicant. The Covered Individual may seek indemnification for such losses and expenses under this Bylaws provision, statutory and case law, any available liability insurance or otherwise as the Covered Individual sees fit, and concurrently or in such sequence as the Covered Individual may choose. Payment of any losses or expenses by the Covered Individual is not a condition precedent to the District's indemnification obligations hereunder.

For purposes of this Article, "Covered Individual" shall include the Medical Staff organization, administrative personnel, Medical Staff members, witnesses, consultants, hearing officers, arbitrators, hearing panel members, and invited participants in the Medical Staff functions described above.

All issues regarding coverage, indemnification, or defense arising from this Article shall be resolved by an Ad Hoc Dispute Resolution Committee described in Section 12.F.

ARTICLE 17
AMENDMENTS

17.A. MEDICAL STAFF BYLAWS

(1) Neither the MEC, the Medical Staff, nor the Board shall unilaterally amend these Bylaws.

(2) Amendments to these Bylaws may be proposed by the MEC or by a petition signed by at least 25% of the voting members of the Medical Staff.

(3) All proposed amendments to these Bylaws must be reviewed by the MEC prior to a vote by the Medical Staff. The MEC shall present all proposed amendments to the voting staff by written ballot or e-mail to be returned to the Medical Staff Office by the date indicated by the MEC. Along with the proposed amendments, the MEC may, at its discretion, provide a written report on the amendments either favorably or unfavorably. To be adopted, the amendment must receive a two-thirds (66%) majority of the votes cast. Voting will be performed as set forth in Section 17.D.

(4) The MEC shall have the power to adopt technical, non-substantive amendments to these Bylaws that are needed because of reorganization, renumbering, punctuation, spelling, or other errors of grammar or expression.

(5) All amendments shall be effective only after approval by the Board, which approval shall not be unreasonably withheld.

(6) If the Board has determined not to accept a recommendation submitted to it by the MEC or the Medical Staff, the MEC may request a conference between the officers of the Board and the Medical Staff Officers through the use of a Joint Conference Committee. Such conference shall be for the purpose of further communicating the Board's rationale for its contemplated action and permitting the Medical Staff Officers to discuss the rationale for the recommendation. Such a conference will be scheduled by the CEO within two weeks after receipt of a request. Following the Joint Conference Committee review process, the Board shall make a decision on the recommendation within 60 days. If the Board declines to adopt such a recommendation, it shall state the reasons for that determination in writing, which shall be provided to the MEC or Medical Staff, as applicable.

17.B. OTHER MEDICAL STAFF DOCUMENTS

(1) In addition to the Medical Staff Bylaws, there shall be policies, procedures, and Rules and Regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and Rules and Regulations shall be considered an integral part of the Medical Staff Bylaws, but will be amended in accordance with this section.

(2) An amendment to the Medical Staff Rules and Regulations shall be made in the same manner as the Medical Staff Bylaws as set forth in Section 17.A.

(3) All other policies of the Medical Staff may be adopted and amended by a majority vote of the MEC. No prior notice is required.

(4) Adoption of, and changes to, the Medical Staff Rules and Regulations, and other Medical Staff policies will become effective only when approved by the Board.

(5) The present Medical Staff Rules and Regulations are hereby readopted and placed into effect insofar as they are consistent with these Bylaws, until such time as they are amended in accordance with the terms of these Bylaws. To the extent any existing Rule or Regulation is inconsistent with these Bylaws, it is of no force or effect.

17.C. CONFLICT MANAGEMENT PROCESS

(1) When there is a conflict between the Medical Staff and the MEC with regard to:

(a) proposed amendments to the Medical Staff Bylaws or Rules and Regulations;

(b) a new policy proposed or adopted by the MEC; or

(c) proposed amendments to an existing policy that is under the authority of the MEC,

a special meeting of the Medical Staff to discuss the conflict may be called by a petition signed by not less than 25% of the voting members of the Medical Staff. The agenda for that meeting will be limited to attempting to resolve the differences that exist with respect to the amendment(s) or policy at issue.

A petition to initiate the conflict management process shall designate two Active-Voting Medical Staff members to serve as representatives of the petitioners, describe the nature of the conflict, and state the reasons why the conflict management process should be utilized to address it.

(2) With respect to each particular conflict, the MEC shall determine and specify a process that the MEC deems most appropriate to the issues and circumstances. At a minimum, the conflict management process shall do all of the following:

(a) Provide a reasonably timely, efficient and meaningful opportunity for the parties to express their views;

(b) Require good-faith participation by representatives of the parties; and

(c) Provide for a written decision or recommendation by the MEC on the issues within a reasonable time, including an explanation of the MEC's rationale for its decision or recommendation.

(3) At the MEC's discretion, the process for management of a conflict between the MEC and Medical Staff members may include the involvement of a third party to facilitate or mediate the conflict management efforts.

(4) This conflict management process shall be a necessary prerequisite to any proposal to the Board by Medical Staff members for adoption or amendment of a Bylaw, Rules provision or policy not supported by the MEC, including, but not limited to, a proposed Bylaws amendment intended to remove from the MEC some authority that has been delegated to it by the Medical Staff.

(5) This conflict management section is limited to the matters noted above. It is not to be used to address any other issue, including, but not limited to, professional review actions concerning individual members of the Medical Staff.

(6) Nothing in this section is intended to prevent individual Medical Staff members from communicating positions or concerns related to the adoption of, or amendments to, the Medical Staff Rules and Regulations or other Medical Staff policies directly to the Board. Communication from Medical Staff members to the Board will be directed through the CEO, who will forward the request for communication to the Chair of the Board. The CEO will also provide notification to the MEC by informing the Chief of Staff of all such exchanges. The Chair of the Board will determine the manner and method of the Board's response to the Medical Staff member(s).

17.D. VOTING PROCEDURE FOR AMENDMENTS

(1) Ballots will be sent to all Active-Voting Medical Staff via e-mail. Notifications will then be sent to all Active-Voting Staff via text message to inform them a ballot was emailed.

(2) The Medical Staff Services Office will send email ballots and text notifications 3 times, with at least 72 hours elapsing between emails.

(3) The voting will be considered final 72 hours after the third notifications are sent.

ARTICLE 18
ADOPTION

These Medical Staff Bylaws are adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws, Rules and Regulations, policies, manuals, or District policies pertaining to the subject matter thereof.

Adopted by the Medical Staff: September 27, 2023

Approved by the Board: September 27, 2023

APPENDIX A
HISTORY AND PHYSICAL EXAMINATIONS

A. General Documentation Requirements

1. A complete medical history and physical examination ("H&P") must be performed and documented in the patient's medical record within 24 hours after admission, observation, or prior to surgery or an invasive procedure requiring anesthesia services by an individual who has been granted privileges by the District to perform histories and physicals.

2. The H&P will include certain elements listed on the current Medical Executive Committee approved Required Elements for History & Physical Examination Reports.

   - if applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion, which will be documented in the plan of treatment;

   - medical necessity certification for inpatient admissions to include: (i) estimated time patient will need to be hospitalized; (ii) inpatient admission is reasonable and medically necessary; and (iii) reason for inpatient admission.

3. In the case of a pediatric patient, the H&P report must also include: (i) developmental age; (ii) length or height; (iii) weight; (iv) head circumference (if appropriate); and (v) immunization status.

B. H&Ps Performed Prior to Admission, Observation, or Surgery/Invasive Procedure

1. Any H&P performed more than 30 days prior to an admission or registration does not meet the requirements of this provision.

2. If an H&P has been completed within the 30-day period prior to admission or registration, a durable, legible copy of this report may be used in the patient's medical record. However, in these circumstances, the patient must also be evaluated within 24 hours after the time of admission, observation, or prior to surgery/invasive procedure, whichever comes first, and an update recorded in the medical record by an individual who has been granted clinical privileges by the District to perform histories and physicals.

3. The update of the H&P shall be based upon an examination of the patient and must reflect (i) any changes in the patient's condition since the date of the original history and physical that might be significant for the planned course of treatment or (ii) state that there have been no changes in the patient's condition.

C. Cancellations, Delays, and Emergency Situations

1. When the H&P is not recorded in the medical record before a surgical or other invasive procedure (including, but not limited to, procedures performed in the operative suites, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until an appropriate H&P is recorded in the medical record, unless the attending physician states in writing that an emergency situation exists.

2. In an emergency situation, when there is no time to record either a complete or an abbreviated H&P, the attending physician will record an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's heart rate, respiratory rate, and blood pressure. Immediately following the emergency procedure, the attending physician is then required to complete and document a complete H&P.

D. Ambulatory and Same Day Procedure Documentation Requirements

For ambulatory or same day procedures, a Pre-operative History and Physical Form, approved by the Documentation Standards Committee, may be utilized. The practitioner shall document, at a minimum, certain elements as listed on the current MEC Required Elements of Outpatient History and Physical Examination Report.

E. Prenatal Records

The current obstetrical record will include a complete prenatal record. The prenatal record may be a legible copy of the admitting physician's office record transferred to the District before admission. An interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

F. Skilled Nursing Facility

The attending physician shall perform a patient evaluation, including a written report of a physical examination, within five days prior to admission or within 72 hours following admission. The initial history and physical must be completed by the attending physician.

G. Long Term Care/Subacute

The attending physician shall perform an initial evaluation and prepare a written report of physical examination of the patient within 72 hours of admission to the long-term care unit and within 48 hours of admission to the subacute unit.

APPENDIX B
APPROVED CATEGORIES OF ADVANCED PRACTICE PROVIDERS

Certified Nurse Midwife (CNM)

Certified Registered Nurse Anesthetist (CRNA)

Nurse Practitioner (NP)

Physician Assistant (PA)

Ambulatory Care Pharmacist