



San Mateo Medical Center
A County System of Healthcare

BOARD OF DIRECTORS MEETING

Thursday, June 2, 2016

8:00 AM – 10:00 AM

SAN MATEO MEDICAL CENTER

EXECUTIVE BOARD ROOM

Second Floor, Administration Wing



San Mateo Medical Center
A County System of Healthcare

BOARD OF DIRECTORS MEETING

June 2, 2016 8:00 – 10:00 AM

Executive Board Room – Second Floor, Administration Wing

AGENDA

A. CALL TO ORDER

B. CLOSED SESSION

Items Requiring Action

1. Medical Staff Credentialing Report
2. Quality Report

Dr. Janet Chaikind

Dr. Alex Ding

Informational Items

3. Medical Executive Committee

Dr. Janet Chaikind

C. REPORT OUT OF CLOSED SESSION

D. PUBLIC COMMENT

Persons wishing to address items not on the agenda

E. FOUNDATION REPORT

Bernadette Mellott

F. CONSENT AGENDA

TAB 1

Approval of:

1. May 5, 2016 Meeting Minutes
2. Medical Staff Bylaws and Rules
3. Medical Staff Rules and Regulations

G. MEDICAL STAFF REPORT

Chief of Staff Update

Dr. Janet Chaikind

H. ADMINISTRATION REPORTS

- 1. Financial Report
- 2. Infection Control
- 3. Street Medicine
- 4. Public Health and Communicable Diseases Update
- 5. CEO Report
- 6. Pillar Goals Update

David McGrew.....TAB 2
Dr. Susan FernyakVerbal
Dr. CJ Kunnappilly.....Verbal
Louise RogersVerbal
Dr. CJ Kunnappilly.....TAB 2
Dr. CJ Kunnappilly.....TAB 2

I. HEALTH SYSTEM CHIEF REPORT

Health System Snapshot

Louise Rogers.....TAB 2

J. COUNTY MANAGER’S REPORT

John Maltbie

K. BOARD OF SUPERVISOR’S REPORT

Supervisor Carole Groom

L. ADJOURNMENT

MEDIA ARTICLES

TAB 3

Meetings are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact Michelle Lee, Executive Secretary, at least 48 hours before the meeting at (650) 573-2222 and/or mlee@smcgov.org. Notification in advance of the meeting will enable the County to make reasonable arrangements to ensure accessibility to this meeting and the materials related to it. Attendees to this meeting are reminded that other attendees may be sensitive to various chemical based products.



San Mateo Medical Center
A County System of Healthcare

TAB 1

CONSENT AGENDA

HOSPITAL BOARD OF DIRECTORS
MEETING MINUTES
Thursday, May 5, 2016
Executive Board Room

Board Members Present

Supervisor Carole Groom
John Maltbie
Louise Rogers
Dr. CJ Kunnappilly
Dr. Janet Chaikind
Dr. David Lin
Dr. Alex Ding
Deborah Torres

Staff Present

Peggy Jensen	Michelle Lee	Cecilia Diaz
John Thomas	Gary Horne	Angela Gonzales
Glenn Levy	Tosan Boyo	Priscilla Romero
Liz Evans	Bernie Mellon	Gary Horne
David McGrew	Joan Spicer	Detective Jim Coffman
Dr. Susan Fernyak	Steve Kaplan	Jason Albertson
Dr. Maureen Dudgeon	Noris Larkin	

Members of the Public

Richard Bay

ITEM	DISCUSSION/RECOMMENDATION	ACTION
Call to Order	Supervisor Groom called the meeting to order at 8:00 AM, and the Board adjourned to Closed Session.	
Reconvene to Open Session	The meeting was reconvened at 8:15 AM to Open Session. A quorum was present (see above).	
Report out of Closed Session	Medical Staff Credentialing Report for May 5, 2016. Medical Executive Committee Minutes from April 12, 2016. QIC Minutes from March 22, 2016.	Glenn Levy reported that the Board approved the Credentialing Report and the QIC Minutes. And it accepted the MEC Minutes.
Public Comment	Mr. Richard Bay, private citizen of San Mateo County, commented that he has received the best health care at San Mateo Medical Center. He is also a member of the Patient Experience Improvement team and appreciates the extensive work being done improve patient experience. He would like to see more funding for improvement projects.	
Foundation Report Bernadette Mellott	Donations to the Foundation through Silicon Valley Gives on May 3, will support the Bundle of Joy program. The program helps new mothers get off to a good start before and after the arrival of their newborns. The Annual Foundation Golf Tournament will be on August 29, 2016 at the Stanford Golf Course.	FYI
Consent Agenda	Approval of: 1. Hospital Board Meeting Minutes from April 7, 2016 2. Compliance Report	It was MOVED, SECONDED and CARRIED

		unanimously to approve all items on the Consent Agenda.
Medical Staff Report Dr. Janet Chaikind	Dr. Janet Chaikind is participating in a series of workshops around patient relationship centered communication. She is working towards becoming a coach for patient and provider communications. There are other providers who are attending the workshops as well including Dr. Alpa Sanghavi and Dr. Susan Fernyak.	FYI
Quality Report Dr. Chester Kunnappilly, interim CEO	<p>The Palliative Medicine Department was presented by Dr. Maureen Dudgeon.</p> <p>Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual. It provides relief from pain and other distressing symptoms; affirms life and regards dying as a normal process; intends neither to hasten or postpone death; integrates the psychological and spiritual aspects of patient care. Palliative Care is not just hospice.</p> <p>Palliative Care at SMMC:</p> <ul style="list-style-type: none"> • One full time physician board certified in Palliative Medicine and Hospice works with 0.2 FTE Social Worker with interest in the work. • Services are intended for the ICU, Med/Surg wards, Rehab unit and Psychiatry. • As needed and possible, outpatients are seen in the clinic, the infusion center and the Emergency Department. • Services are in the form of consultation and inpatient follow up and require a request from a physician. • Consultations may include some or all of these issues: Goals of care; Delivering bad news; Advance Care Planning; Family meetings to reconcile opinions; Pain and symptom management; Introduction to hospice care; Identification of a spokesperson or surrogate; Support for colleagues and staff. <p>Growth Opportunities at SMMC:</p> <ul style="list-style-type: none"> • Transition as possible to a full interdisciplinary team consisting of Nurse Practitioner, Social Worker and Chaplain to augment current services provided by one Physician. • Embed in outpatient clinics such as Oncology. • Offer outpatient Palliative Medicine at SMMC and other system clinics. 	FYI
Operations Report John Thomas, Chief Operating Officer	<p>The PCMH M New Patient Connection Center presented by Tosan Boyo and Noris Larkin.</p> <p>What does "Access" mean in Ambulatory Services?</p> <ul style="list-style-type: none"> • Primary Care Urgent Appointment will be made within 48 hours of request for appointment. • Primary Care Non-Urgent Appointment will be made within 10 business days of request for appointment. 	

	<p>Prior to New Patient Connection Center...</p> <ul style="list-style-type: none"> • Phone Access = <30% and Unknown • De-centralized triage and scheduling • No onboarding to new system • Limited awareness of capacity • No Standard Work Validation • Increasing HPSM grievances <p>Goals:</p> <ul style="list-style-type: none"> • Standardized workflows and scheduling protocols • Upgrade existing phone switch (PBX) and call center to improve patient experience • Establish operational dashboard detailing: # incoming calls; # Abandoned calls; # calls on hold; lengths of wait time. • Streamline 46 lines to one for each new Clinic resulting by shortening phone menus and deleting extraneous lines. <p>Milestones:</p> <ul style="list-style-type: none"> • PBX Upgraded in July • Phones replaced in August <ul style="list-style-type: none"> ○ Created New Patient Connection Center: Onboarding, Scheduling, Triaging • Connection feed went live in September <p>Opportunities:</p> <ul style="list-style-type: none"> • Navigating Patients, Culture change for staff and providers, Training is now more important than ever • Space • Keeping up with demand – assigned lives and rising volumes • Enhanced access such as phone-based care and express care • Care Team transformation 	
<p>Health System Louise Rogers Health System Chief</p>	<p>Psychiatric Emergency Response Team(PERT) presented by Jason Albertson and Detective Jim Coffman.</p> <p>Goals: Reduce the risk of violent and tragic outcomes; Promote the moral fusion of clinical care and law enforcement; Provide a ‘third layer of care’ for MH clients and unlinked, underserved populations; Diversion from hospitalization.</p> <p>Areas of Operations:</p> <ul style="list-style-type: none"> • Contract municipalities: Millbrae, San Carlos, Half Moon Bay, Woodside, Portola Valley • Sheriff’s Transit : CalTrain and SamTrans. 	<p>FYI</p>

	<ul style="list-style-type: none"> • Unincorporated areas of San Mateo County. • County-wide security: County facilities, courts, hospitals, public buildings: <p>PERT Work Process: Review of all Sheriff’s Office 5150 reports; Triage : Prior 5150’s with high risk factors; Domestic Violence, stalking, threats, suicidality/homicidality, weapons used or possessed, linkage to care; Review Avatar & Sorian.; Conference and decision making: next steps.</p> <p>COLLABORATIVE EFFORTS: Family/individual support; Coordination with law enforcement responders; Case coordination with existing treatment providers.</p> <p>INDIVIDUAL RESPONSE: Short term case management; Response to Law Enforcement and Provider referrals; Weapons take-away under WI 8102; In-progress calls, response to scene.</p> <p>P.E.R.T. Community Support Activities: Crisis Intervention Training (C.I.T) for Law Enforcement; C.I.T. for Public Safety Dispatchers and P.O.S.T Certified 16 hour course; Consult with Hostage Negotiating Team and tactical units.; Support for agencies dealing with high acuity clients.</p> <p>Challenges: Disparate law enforcement jurisdictions—22 altogether; No access to Medi-Cal and non-insured service of the private hospitals. Can’t see how many times a person has been held; Lack of access to ambulance transport data; P.E.R.T. limited to SMCSO operations area; Little availability of psychiatric resources adjacent to or integrated with primary care.; Working with homeless people in an area where housing is scarce.</p>	
Financial Report David McGrew, CFO	The March FY15/16 financial report was included in the Board packet and David McGrew answered questions from the Board.	FYI
CEO Report Dr. Chester Kunnappilly, interim CEO	Dr. Kunnappilly presented the CEO report which is included in the Board packet and answered questions from the Board. Of note, the Joint Commission response report will be submitted this month. He also updated the Board on the Strategic Goals which were included.	FYI
Health System Report Louise Rogers Health System Chief	<p>Louise Rogers referred to the April 2016 snapshot which was included in the Board packet.</p> <p>Louise Rogers reported that a significant grant (\$966,000) was received for the Respite Center.</p> <p>150 new parking spaces are now available to staff at the lot behind the Chase Bank.</p>	FYI
County Manager John Maltbie	No report.	FYI

Board of Supervisors Supervisor Groom	No report.	FYI
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Supervisor Groom adjourned the meeting at 9:36 AM. The next Board meeting will be held on June 2, 2016.

Minutes recorded by:



Michelle Lee, Executive Secretary

Minutes approved by:



Dr. Chester Kunnappilly, Chief Executive Officer (interim)



MEDICAL STAFF BYLAWS

Revised 06/10/1998; 06/09/1999; 06/28/2000, 07/10/2003; Reviewed 5/24/2004; Revised 5/10/2005; Reviewed 6/20/2006; Reviewed 5/22/2007; Revised 05/27/2008; Reviewed 05/26/2009; Revised 05/25/2010; Revised 05/24/2011; Reviewed 05/02/2012; Revised 06/04/2013; Reviewed 06/05/2014; Revised 07/02/2015; Revised 12/08/2015

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SAN MATEO MEDICAL CENTER
MEDICAL STAFF BYLAWS

PREAMBLE

The Bylaws are adopted in order to provide for the organization of the Medical Staff of San Mateo Medical Center¹ and to provide a framework for self-government in order to permit the Medical Staff to discharge its responsibilities in matters involving effective and efficient quality medical care, and to govern the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with, and accountability to the Board of Directors, and relations with applicants and members of the Medical Staff.

DEFINITIONS

1. **Administrator** means the Chief Executive Officer of San Mateo Medical Center.²
2. **Affiliate to the Medical Staff or AMS:** An individual, other than a licensed physician, dentist, clinical psychologist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Directors, the Medical Staff, and the applicable State Practice Acts; who is qualified to render direct or indirect medical, dental, psychiatric, or podiatric care under the supervision or direction of a Medical Staff Member possessing privileges to provide such care in the Hospital; and who may be eligible to exercise practice privileges and prerogatives in conformity with the rules adopted by the Board of Directors, these Bylaws, and the Medical Staff Rules and Regulations. AMS's are not eligible for Medical Staff membership.
3. **Authorized Representative** means the individual designated by the Medical Center's Board of Directors³ to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.
4. **Chief of Staff** means the chief officer of the Medical Staff elected by members of the Medical Staff.
5. **Clinical Privileges or Privileges** means the permission granted to a Medical Staff member or affiliate, in accordance with these Bylaws, to render specific patient services.
6. **Governing Body** shall mean the operational group known as the Hospital Board of Directors who perform the ongoing functions of governance as defined and specified in the Governing Body Bylaws.
7. **Hospital** means San Mateo Medical Center⁴ and includes all inpatient and outpatient locations and services operated under the auspices of the hospital's license.⁵

1 May 2003
2 May 2003
3 05/15/03
4 May 2003
5 May 2011

SMMC MEDICAL STAFF BYLAWS (cont'd.)

8. **Investigation** means a process specifically instigated by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the Medical Staff, and does not include activity of the Medical Staff Aid Committee.
9. **Medical-Administrative Officer** shall mean a practitioner, employed by or otherwise serving the Hospital on a full or part-time basis, whose duties include certain responsibilities which are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities which require a practitioner to exercise clinical judgment with respect to patient care and include the supervision of professional activities of practitioners and affiliates under his direction.
10. **Medical Executive Committee** means the Executive Committee of the Medical Staff which shall govern the Medical Staff with respect to the professional work performed in the Hospital and shall act on behalf of the Medical Staff in the intervals between annual Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws.
11. **Medical Staff** or **Staff** means the formal organization of physician (MD or DO or their equivalent as defined in Section 3.2.2), dentist, podiatrist, and clinical psychologist who have been granted recognition as members of the Medical Staff pursuant to the terms of these Bylaws.
12. **Member** means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined in Section 3.2.2), dentist, podiatrist, and clinical psychologist holding a current license to practice within the scope of that license, who is a member of the Medical Staff.
13. **Medical Staff Year** means the period from July 1st to June 30th.⁶
14. **Physician** means an individual with an M.D. or D.O. degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.
15. **Prerogative** shall mean a participating right granted by virtue of staff category or otherwise, to a Medical Staff member or affiliate, which is exercisable subject to, and in accordance with, the conditions imposed by these Bylaws and by other Hospital and Medical Staff rules, regulations, or policies.
16. **Resident** is a physician in training who works under the supervision of a Medical Staff member. Resident may be a licensed physician and qualified to obtain privileges in a particular area of medicine but is training in another area of medicine. A resident must seek appointment to the Medical Staff at such time as he/she intends to function as a member of the Medical Staff and is duly licensed and trained.
17. **Telemedicine** is the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video or data communications.⁷

⁶ May 2003

⁷ May 2008

ARTICLE 1 - NAME

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

1.1 DESCRIPTION⁸

- 1.1.1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a staff category depending upon the nature and tenure of practice at the hospital. All new members are assigned to the Provisional Staff. Upon satisfactory completion of the provisional period, the members are assigned to one of the staff categories described in Article 4.
- 1.1.2 Members are also assigned to departments depending upon their specialties. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review.
- 1.1.3 There are also medical staff committees which perform staff-wide responsibilities, and which oversee related activities being performed by the departments.
- 1.1.4 Overseeing all of this is the Medical Executive Committee, comprising the elected officials of the Medical Staff, department chairs, and representatives elected at large.

ARTICLE 2 - PURPOSES AND RESPONSIBILITIES

2.1 PURPOSES

The purposes of the Staff are:

- a) To be the formal organizational structure through which:
 - 1) The benefits of staff membership may be obtained by individual practitioners, and
 - 2) The obligations of staff membership may be fulfilled.
 - 3) Clinical privileges are delineated for all members and AMS's to exercise in the Hospital.
- b) To serve as the primary means for accountability to the Board of Directors for the appropriateness of professional performance and ethical conduct of its members and to strive toward assuring that the pattern of patient care in the Hospital is consistently maintained at quality and efficiency levels, and that there will be a high level of professional performance by all providers granted clinical privileges.
- c) To provide a means or method by which members of the Medical Staff can formulate recommendations for the Hospital's policy-making and planning processes, and through which such policies and plans are communicated to and observed by each member of the Staff.
- d) To constitute a professional collegial body which provides its members educational activities

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

SMMC MEDICAL STAFF BYLAWS (cont'd.)

and professional support in the interest of improving patient care, the skills of persons providing health services, and the promotion of the general health of the community.

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

2.2 RESPONSIBILITIES

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

- a) To participate in the Hospital's quality management program by conducting all required and necessary activities for assessing and improving the effectiveness and efficiency of medical care provided in the Hospital, including, without limitation:
 - 1) Evaluating individual and institutional performance through valid and reliable measurement systems based on objective, clinically-sound criteria.
 - 2) Engaging in the ongoing monitoring of critical aspects of care and enforcement of Medical Staff and Hospital policies.
 - 3) Evaluating physician credentials for initial and continued membership in the Medical Staff organization and for the delineation of clinical privileges for each member and Affiliate to the Medical Staff in the Hospital.
 - 4) A continuing education program, fashioned at least in part on the needs demonstrated through the patient care review and other quality management programs.
 - 5) A utilization review program to allocate inpatient and outpatient medical and health services based upon patient-specific determination of individual medical, social, and emotional needs.
- b) To recommend to the Governing Body action concerning appointments, reappointments, staff category, departmental assignments, clinical privileges, and corrective action.
- c) To account to the Governing Body for the quality and efficiency of patient care rendered to patients in the Hospital through regular reports and recommendations concerning the implementation, operation, and results of the patient care review and other quality management activities.
- d) To initiate and pursue corrective action with respect to members and Affiliates to the Medical Staff, when warranted.
- e) To administer and seek compliance with these Bylaws, through the development and implementation of Rules and Regulations of the Staff, department-specific Rules and Regulations, and other patient care-related Hospital policies.
- f) To assist in identifying community health needs and in setting appropriate institutional goals and implementing programs to meet those needs.

⁹ May 2011

SMMC MEDICAL STAFF BYLAWS (cont'd.)

- g) To exercise the authority granted by these Bylaws as necessary to adequately fulfill the foregoing responsibilities.
- h) To provide access to, and cooperation with, the Hospital and Governing Body towards maintaining an effective mechanism for communication of issues with all parties.
- i) To notify in writing the Department Chair of any medical absence from practice of 30 days or longer.

ARTICLE 3 - MEMBERSHIP

3.1 NATURE OF MEMBERSHIP

No member, including those in a medical-administrative position by virtue of employment or a contract with the Hospital, shall admit or provide medical or health-related services to patients in the Hospital unless he or she is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Appointment to the Medical Staff shall confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws. Medical Staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

3.2 QUALIFICATIONS OF MEMBERSHIP

3.2.1 General Qualifications

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

- a) document and continuously maintain their (1) current California licensure [telemedicine providers who are not licensed in California must be registered as a telemedicine provider with the Medical Board of California¹⁰], (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) adequate physical and mental health status so as to demonstrate to the satisfaction of the Medical Staff that they are professionally and ethically competent to exercise clinical privileges within the Hospital, and that patients treated by them can reasonably expect to receive quality medical care;
- b) can be available within reasonable proximity to the Hospital so that patients treated by them will receive effective, efficient, and continuous quality medical care;
- c) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician-patient relationship, (4) to be willing to participate in and properly discharge those responsibilities addressed in these Bylaws, (5) to accomplish these ends within the resources of the Hospital and with regard to the needs of the patient, and (6) have an approved membership history;

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

SMMC MEDICAL STAFF BYLAWS (cont'd.)

- d) who maintain, in force, professional liability insurance in not less than one million dollars (\$1,000,000) from a carrier acceptable to the Hospital Governing Body. However, the Medical Executive Committee, for good cause shown, may waive this requirement with regard to such member as long as such waiver is not granted or withheld on an arbitrary or discriminatory or capricious basis. In determining whether an individual exception is appropriate, the following facts may be considered:
- 1) whether the member has applied for the requisite insurance;
 - 2) whether the member has been refused insurance, and if so, the reasons for such refusal;
 - 3) whether insurance is reasonably available to the member, and if not, the reasons of its unavailability;
- e) be eligible to receive payments from the federal Medicare and state Medicaid [Medi-Cal] programs;¹¹

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

3.2.2 Particular Qualifications

Physicians: An applicant for physician membership in the Medical Staff, except for the Honorary Staff, must hold an M.D. or D.O. degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. For the purpose of this section, “or the equivalent” shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the Board of Osteopathic Examiners.

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

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

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

3.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the Medical Staff, or be entitled to clinical privileges merely because he or she holds a certain degree, is licensed to practice in this or in any other state, is a

¹¹ May 2011

SMMC MEDICAL STAFF BYLAWS (cont'd.)

member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at this or any other health care facility.

3.4 NON-DISCRIMINATION

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

3.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

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

- a) providing all patients with the quality of care meeting the professional standards of the community and the Medical Staff of this Hospital;
- b) monitoring the quality of care provided by its members and Affiliates;
- c) abiding by the Medical Staff Bylaws, Rules and Regulations; and holding to specific contractual relations with the Hospital, if any, as they relate to patient care, reporting to Administration or the Governing Body on other Hospital-related activities;
- d) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership or personal, department, committee, and/or Hospital functions, including peer review, utilization review, and participating in emergency call coverage or consultation panels and backup functions, for which he or she is responsible by virtue of staff category assignment, election, utilization of Affiliates of the Medical Staff, or exercise or privileges, prerogatives, or other rights in the Hospital, or as may be determined by the Medical Staff.
- e) preparing and completing in a timely fashion medical and other required records for all the patients to whom the member provides care in the Hospital;
- f) abiding by the lawful ethical principles of the California Medical Association or equivalent association for other practitioners;
- g) aiding the Medical Staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, podiatrists, nurses, and other personnel;
- h) working cooperatively with members, Affiliates, nurses, Hospital Administration, and others so as not to adversely affect patient care;
- i) making appropriate arrangements for coverage for his or her patients when required in a way that provides for continuous effective and efficient care and supervision of each patient;

SMMC MEDICAL STAFF BYLAWS (cont'd.)

- j) refusing to engage in improper inducements for patient referral;
- k) attending or participating in continuing education programs that relate, in part, to the clinical privileges granted and to documenting this participation so that it can be considered at the time of reappointment and/or renewal of revision of individual clinical privileges;
- l) abiding by all applicable laws and regulations of governmental agencies; and
- m) refraining from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, Medical Staff member, or visitor) based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment.
- n) participating in such emergency service coverage or consultation panels as may be determined by the Medical Staff;
- o) providing information to and/or testifying on behalf of the Medical Staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 8.1.3, and those, which are the subject of a hearing pursuant to Article 9.
- p) assuring a medical history and physical examination is completed and documented for each patient no more than 30 days before or 24 hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. There must be a complete H&P and an update, if applicable, in the medical record of each patient prior to surgery or procedure requiring anesthesia services, except in emergencies. In the case of emergencies, the HP must be recorded immediately following the procedure and the practitioner must sign, date, and time a statement of the emergency circumstances in the patient's medical record.¹²

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

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

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

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

SMMC MEDICAL STAFF BYLAWS (cont'd.)

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

- q) acquiring a patient's informed consent for all procedures and treatments identified in the Bylaws, Article 15 General Provisions, and abiding by the procedures for obtaining such informed consent.¹⁴
- r) preparing and completing, in a timely and accurate manner, the medical and other required records for all patients to whom the practitioner in any way provides services in the hospital, including compliance with such electronic health record policies and protocols as have been implemented by the hospital.¹⁰
- s) actively participating in and regularly cooperating with the Medical Staff in assisting the hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement, peer review, utilization management, quality evaluation, ongoing and focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time.¹⁵
- t) adherence to Medical Staff Policies as outlined in Section V of the Medical Staff Rules and Regulations.¹⁶

¹³ May 2008, per Title 22/CMS Medical Conditions of Participation; December 2015 updated revision
¹⁴ May 2008, per CMS Interpretive Guidelines to 42 CFR §482.13(b)(2)
¹⁵ May 2008, sections r) & s) added to accommodate Joint Commission Standards MS.3.10 and MS.4.40
¹⁶ May 2011

ARTICLE 4 - CATEGORIES OF MEMBERSHIP

4.1 CATEGORIES

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

4.2 ACTIVE STAFF

4.2.1 Qualifications

The Active Staff shall consist of members who:

- a) meet the general qualifications for membership set forth in Article 3;
- b) have offices or residences which in the opinion of the Medical Executive Committee are located closely enough to the Hospital to provide continuity of quality of care;
- c) regularly care for a minimum of one hundred (100) outpatients/inpatients at this Hospital annually or regularly provide non-clinical professional services to the Hospital or Medical Staff;
- d) at the discretion of the Governing Body; and
- e) except for good cause, as determined by the Medical Staff and approved by the Governing Body, have satisfactorily completed their designated term in the Provisional Staff category.

4.2.2 Prerogatives

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

- a) admit and/or treat patients and/or exercise such clinical privileges as are granted pursuant to Article 7;
- b) attend and vote on matters presented at general and special meetings of the Medical Staff and of the department and committees of which he or she is a member; and
- c) hold Staff, division, or department office and serve as a voting member of committees to which he or she is duly appointed or elected by the Medical Staff or duly authorized representative thereof.

4.2.3 Responsibilities

¹⁷ May 2008

SMMC MEDICAL STAFF BYLAWS (cont'd.)

Each Active Medical Staff member shall:

- a) meet the basic responsibilities set forth in Section 3.5;
- b) actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital in fulfilling its obligations related to patient care, including, but not limited to: emergency service and backup function, providing consultation to other staff members consistent with his or her delineated privileges; patient care audit, peer review, utilization review, quality evaluation, and related monitoring activities required of and by the Medical Staff; in supervising and proctoring initial appointees and/or Affiliates of the Medical Staff; consistent with his or her delineated privileges and discharging such other functions as may be required from time to time; and
- c) pay all staff dues and assessments promptly as outlined in Article 15.

4.3 COURTESY STAFF

4.3.1 Qualifications

The Courtesy Staff shall consist of members who:

- a) meet the general qualifications set forth in subsections a), b), c), and d) of Section 3.2.1;
- b) do not regularly care for patients in or at the Hospital or are not regularly involved in the Medical Staff functions as determined by the Medical Staff;
- c) are members in good standing of an Active Medical Staff of another JCAHO accredited and California licensed hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause subject to approval by the Board of Directors; and
- d) have satisfactorily completed appointment in the Provisional category.

4.3.2 Prerogatives

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

- a) admit and/or treat patients to the Hospital within the limitations of Section 4.3.1 b) and exercise such clinical privileges as are granted pursuant to Article 7; and
- b) attend, in a non-voting capacity, meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings except within committees when the right to vote is specified at the time of appointment.

SMMC MEDICAL STAFF BYLAWS (cont'd.)

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

4.3.3 Responsibilities

Each Courtesy Staff member shall meet the basic responsibilities set forth in Section 3.5.

4.3.4 Limitation

Courtesy Staff members who meet requirements of Active Staff and care for one hundred (100) or more patients at the Hospital shall, upon review of the Medical Executive Committee, be obligated to seek appointment to the appropriate staff category.

4.4 PROVISIONAL STAFF

4.4.1 Qualifications

The Provisional Staff shall consist of members who:

- a) meet the qualifications specified for members of the Active or Courtesy Staff, except that they have not yet satisfactorily completed the proctoring or observation requirements specified in Article 7, have been Medical Staff members for less than one year; and/or have not fulfilled such other requirements as may be set forth in the Bylaws, the Medical Staff, and Department Rules and Regulations, or Hospital policies; and
- b) immediately prior to their application and appointment were not members or were no longer members in good standing of this Medical Staff.

4.4.2 Prerogatives

The Provisional Staff members shall be entitled to:

- a) exercise such clinical privileges as are granted pursuant to Article 7; and
- b) attend meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings except within committees when the right to vote is specified at the time of appointment.

Provisional Staff members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

4.4.3 Responsibilities

Each Provisional Staff member shall be required to discharge the responsibilities which are specified in Section 4.2.3 for Active Staff members. Failure to fulfill those responsibilities shall be grounds for

denial of advancement to Active or Courtesy status and termination of Provisional Staff status.

4.4.4 Observations of Provisional Staff Members

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

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

4.4.5 Term of Provisional Staff Status

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

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

4.4.6 Action at Conclusion of Provisional Staff Status

- a) At the end of the twelve (12) month Provisional term, the assigned department will review the practitioner observations. Provisional Staff members who have satisfactorily demonstrated, through documented proctoring/profiling, their ability to exercise the clinical privileges initially granted and otherwise appear qualified for continued Medical Staff membership, shall be recommended for Active or Courtesy Staff status as requested and/or appropriate, dependent upon recommendation of the Medical Executive Committee and approval by the Board of Directors.
- b) For all other Provisional members, the appropriate department shall report its findings to the Credentials Committee which shall report to the Medical Executive Committee which, in turn, shall make recommendations to the Board of Directors regarding a modification, extension, or termination of membership status and/or clinical privileges.

4.5 TELEMEDICINE STAFF¹⁸

4.5.1 Qualifications

The Telemedicine Staff shall consist of members who

- a) Meet the general qualifications for membership set forth in Article 3
- b) are members in good standing of another Joint Commission accredited organization
- c) satisfactorily completed appointment in the Provisional category.

4.5.2 Prerogatives

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

- a) exercise such clinical privileges as are granted pursuant to Article 7; and
- b) attend, in a non-voting capacity, meetings of the Medical Staff and the department of which he or she is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings except within committees when the right to vote is specified at the time of appointment.

4.5.3 Responsibilities

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

4.5.4 Limitation

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

4.6 HONORARY AND RETIRED STAFFS

4.6.1 Qualifications

- a) Honorary Staff

The Honorary Staff shall consist of practitioners who do not actively practice at the Hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing or special service to the Hospital, and who continue to exemplify high standards of professional and ethical conduct and promote the ideals of the Hospital.

- b) Retired Staff

The Retired Staff shall consist of members who have retired from active practice and, at the

¹⁸ May 2008

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time of their retirement, were members in good standing of the Active Medical Staff for a period of at least ten (10) continuous years, and who continue to adhere to appropriate professional and ethical standards.

4.6.2 Prerogatives

Honorary and Retired Staff members are not eligible to admit patients to the Hospital or to exercise clinical privileges in the Hospital, or to vote or hold office in this Medical Staff organization, but they may serve upon committees with or without vote at the discretion of the Medical Executive Committee. They may attend staff and department meetings, including open committee meetings and educational programs.

4.7 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these Bylaws, and by the Medical Staff Rules and Regulations, or by other policies of the Hospital. The prerogatives of dental, clinical psychology, or podiatric members of the Medical Staff shall be limited to those for **which they can demonstrate the possession of requisite licensure, education, training, and experience.**

4.8 GENERAL EXCEPTIONS TO THE PREROGATIVES

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

- a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee; and
- b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 7.4.

4.9 MODIFICATION OF MEMBERSHIP CATEGORY

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

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

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

5.1 QUALIFICATIONS OF AMS'S

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

- a) hold a license, certificate, or other legal credentials, if any, as required by California law, which authorize the AMS's which the Board of Directors has identified as eligible to apply for practice privileges;
- b) document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise practice privileges within the Hospital;
- c) are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials;
- d) hold professional liability insurance in the amount of one million dollars (\$1,000,000) self-owned or owned by the practitioner from a carrier acceptable to the Hospital Governing Body to cover the AMS, and verify coverage annually; and
- e) are prepared to disclose (upon request) a history of claims made against the AMS concerning their professional activities and provide documentation of all final judgments and/or settlements involving the AMS.

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

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

SMMC MEDICAL STAFF BYLAWS (cont'd.)

- a) Independent AMS - Those professionals who by State authority and Hospital approval may practice independently; those professionals not required to have designated Practitioners as supervisors.
- b) Dependent AMS - Those professionals not permitted to practice independently, who will have an assigned Practitioner who can demonstrate their qualifications to be responsible and accountable for supervision.

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

5.3 PROCEDURE FOR GRANTING PRACTICE PRIVILEGES TO AMS'S

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

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

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

5.4 PREROGATIVES OF AMS'S

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

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

SMMC MEDICAL STAFF BYLAWS (cont'd.)

- b) service on Medical Staff, department, and Hospital committees;
- c) attendance at the meetings of the department to which he/she is assigned, as permitted by the department Rules and Regulations, and attendance at Hospital education programs in his/her field of practice; and
- d) each AMS is individually assigned to the Medical Staff Department appropriate to his professional training and/or in which the supervisor is a member, and is subject to a provisional period, observation, and formal periodic reviews as determined by the Department and defined in departmental Rules and Regulations.

5.5 RESPONSIBILITIES OF AMS'S

Each AMS shall:

- a) Meet those responsibilities required by the Medical Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 3.5 as are generally applicable to the more limited practice of the AMS including meeting attendance.
- b) Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services.
- c) Participate, as appropriate, in patient care audit and other quality review, evaluation, and monitoring activities required of AMS's in supervising initial appointees of his same occupation or profession, or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.
- d) Attend required orientation, safety and infection control in-services, presented by the Hospital.
- e) Acquire sufficient orientation from the supervising Active member of Medical Staff as directed by the Medical Staff.

5.6 TERMINATION OF PRIVILEGES

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

- a) the Medical Staff membership of the supervising physician is terminated, whether voluntary or involuntary, or when that member no longer is a member of the Active Medical Staff, or when the supervising physician is under review by the Medical Staff;
- b) the supervising physician no longer agrees to act as the supervising physician, for any reason, or the relationship between the AMS and the supervising physician is otherwise terminated, regardless of the reason;

SMMC MEDICAL STAFF BYLAWS (cont'd.)

- c) the contract between the Hospital and supervising physician in a medico-administrative position pursuant to Section 3.5 is terminated; or
- d) the AMS certificate or license expires, is revoked, or suspended.

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

5.7 HEARING RIGHTS

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

5.8 RESIDENTS - PHYSICIANS IN TRAINING

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

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

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

SMMC MEDICAL STAFF BYLAWS (cont'd.)

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

ARTICLE 6 - APPOINTMENT AND REAPPOINTMENT

6.1 GENERAL

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

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

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

6.1.1 Burden of Producing Information

In connection with all applications for membership, membership renewal²⁰ advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for denial of the application. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate by the Medical Executive Committee, which may select the examining physician. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee.²¹

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

6.1.2 Appointment Authority

¹⁹ 05/15/2003

²⁰ May 2011

²¹ May 2011

²² May 2011

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

6.1.3 Duration of Appointment and Reappointment

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

6.2 APPLICATION FOR INITIAL APPOINTMENT AND REAPPOINTMENT

6.2.1 Application Form

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

- a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, required certifications (if any), and continuing medical education information related to the clinical privileges to be exercised by the applicant;
- b) peer references, familiar with the applicant's professional competence and ethical character; and
- c) requests for membership category, department, and clinical privileges;
- d) past or pending professional disciplinary action, previous or current membership rejections, previous or current privilege suspensions, licensure limitations, drug enforcement administration actions, final judgements or settlements made against the applicant in professional liability cases, and any filed and served cases pending, administrative or court cases involving non-compliance with laws or standards related to patient care, government or third-party payor sanctions and/or proceedings, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of Medical Staff membership or privileges or any licensure or registration, and related matter;
- e) current physical and mental health status;
- f) professional liability coverage, if required;
- g) an acknowledgement of the applicant's responsibility to maintain continuous compliance with the conditions of Medical Staff membership and/or clinical privileges, the Medical Staff Bylaws, Rules and Regulations, and that he or she agrees to be bound by the terms thereof, as they may be amended from time to time;
- h) an acknowledgement of the applicant's duty/responsibility to inform the Medical Staff Office or approved designee of any changes in the information provided through the application form

during the application period, or at any subsequent time.

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

6.2.2 Effect of Application

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

- a) signifies his or her willingness to appear for interviews in regard to the application;
- b) authorizes consultation with others who have been associated with him or her and who may have information bearing on his or her competence, qualifications, and performance, and authorizes such individuals and organizations to candidly provide all such information;
- c) consents to inspection of records and documents that may be material to an evaluation of his or her qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- d) releases from any liability, to the fullest extent permitted by law, all persons for their acts performed in connection with investigating and evaluating the applicant;
- e) releases from any liability, to the fullest extent permitted by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- f) consents to the disclosure to other hospitals, medical associations, and licensing boards, and to other similar organizations as required by law, any information regarding his or her professional or ethical standing that the Hospital or Medical Staff may have, and released the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law;
- g) if a requirement then exists for Medical Staff dues, acknowledges responsibility for timely payment;
- h) pledges to provide for continuous quality care for his or her patients;
- i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, seeking consultation whenever necessary, refraining from providing "ghost" surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised or trained practitioners and Affiliates; and

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

6.3 PROCESSING THE APPLICATION

6.3.1. Verification of Information

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

6.3.2 Department Action

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

6.3.3 Credentials Committee Action

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the department chair's and division chief's reports and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department and division affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may request additional documentation from the applicant or recommend that the Medical Executive

Committee defer action on the application.

6.3.4 Medical Executive Committee Action

At its next regular meeting after receipt of the Credentials Committee report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the Credentials Committee for further investigation, and/or elect to interview the applicant. The Medical Executive Committee shall forward to the Administrator, for prompt transmittal to the Board of Directors, a written report and recommendation as to Medical Staff appointment and, if appointment is recommended, as to membership category, department and division affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The committee may defer action on the application. The reasons for each recommendation shall be stated.

6.3.5 Effect of Medical Executive Committee Action

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

When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Directors and the applicant shall be promptly informed by written notice. The applicant shall then be informed of the procedural rights as provided in Article 9. The Board of Directors will take no final action until all of the applicant's rights are waived or exhausted.²⁴

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

²³ May 2011

²⁴ May 2011

request for Medical Staff membership.

6.3.6 Action on the Application

The Board of Directors may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

- a) If the Medical Executive Committee issues a favorable recommendation, and
 - 1) the Board of Directors concurs in that recommendation, the decision of the Board shall be deemed final action,
or
 - 2) the tentative final action of the Board of Directors is unfavorable, the Administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article 9. If the applicant waives his or her procedural rights, the decision of the Board shall be deemed final action.
- b) In the event the Medical Executive Committee recommendation, or any significant part of it, is unfavorable to the applicant, the procedural rights set forth in Article 9 shall apply.
 - 1) If the applicant waives his or her procedural rights, the recommendations of the Medical Executive Committee shall be forwarded to the Board for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.
 - 2) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 6.3.7(b) or an adverse Board of Directors tentative final action pursuant to 6.3.7(a)(2), the Board of Directors shall take final action only after the applicant has exhausted his or her procedural rights as established by Article 9. After exhaustion of the procedures set forth in Article 9, the Board shall make a final decision. The Board's decision shall be in writing and shall specify the reasons for the action taken.

6.3.7 Expedited Review

The Board of Directors may use an expedited process for appointment, reappointment or when granting Privileges when criteria for that process are met. This process, if used, will be further described in the Rules and Regulations.²⁵

6.3.8 Notice of Final Decision

- a) Notice of the final decision shall be given to the Chief of Staff, the Medical Executive and the

²⁵ May 2011

Credentials Committees, the chair of each department concerned, the applicant, and the Administrator.

- b) A decision and notice to appoint or reappoint shall include, if applicable:
 - 1) the staff category to which the applicant is appointed;
 - 2) the department and division to which he or she is assigned;
 - 3) the clinical privileges granted; and
 - 4) any special conditions attached to the appointment.

6.3.9 Reapplication After Adverse Appointment Decision

The following individuals shall not be eligible to reapply for Medical Staff membership and/or clinical privileges affected by the previous action for a period of at least two years from the date the adverse decision became final, the date the application or request was withdrawn, or the date the former Medical Staff member's resignation became effective, whichever is applicable. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

- a) An applicant who (1) has received a final adverse decision regarding appointment or (2) withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or Board of Directors.
- b) A former Medical Staff member who has (1) received a final adverse decision resulting in termination of Medical Staff membership and clinical privileges or (2) resigned from the Medical Staff following the issuance of a Medical Staff or Board of Directors recommendation adverse to the member's Medical Staff membership or clinical privileges.
- c) A Medical Staff member who has received a final adverse decision resulting in (1) termination or restriction of his or her clinical privileges or (2) denial of his or her request for additional clinical privileges.

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

After the two (2) year period, the former applicant, former Medical Staff member, or Medical Staff

member may submit an application for Medical Staff membership and/or clinical privileges, which shall be processed as an initial application. Ordinarily the waiting period shall be two (2) years. However, for practitioners whose adverse action included a specific period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specific conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the Hospital Board, to waive the two (2) year period in other circumstances where it reasonably appears, by objective measures that changed circumstances warrant earlier consideration of an application.²⁶ The former applicant, former Medical Staff member, or Medical Staff member shall also furnish evidence that the basis for the earlier adverse recommendation or action no longer exists and/or of reasonable rehabilitation in those areas which formed the basis for the previous adverse recommendation or action, whichever is applicable. In addition, such applications shall not be processed unless the applicant or member submits satisfactory evidence to the Medical Executive Committee that he or she has complied with all of the specific requirements any such adverse decision may have included, such as completion of training or proctoring conditions. The Medical Executive Committee's decision as to whether satisfactory evidence has been submitted shall be final, subject only to further review by the Board of Directors within forty-five (45) days after the Medical Executive Committee decision was rendered.

6.3.10 Timely Processing of Applications

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

- a) Evaluation, review, and verification of application and all supporting documents: sixty (60) days from receipt of a completed application and all necessary documentation by the Medical Staff Office or approved designee. In the event the relevant materials are not received within sixty (60) days after the application is received, the applicant shall be notified, and the application shall remain pending until either the materials are received by the Medical Staff Office or approved designee or the expiration of six months from the date the application was received. Applications which are not completed within six (6) months after receipt shall automatically be removed from consideration, as specified in Section 6.3.2.
- b) Review and recommendation by the department chair and, where applicable, the division chief: thirty (30) days after receipt of all necessary documentation from the Medical Staff Office or approved designee by the respective chair/chief.
- c) Review and recommendation by Credentials Committee: thirty (30) days after receipt of all necessary documentation from the department chair/division chief by the Credentials chair or designee.
- d) Review and recommendation by Medical Executive Committee: thirty (30) days after receipt of all necessary documentation from the Credentials Committee by the Chief of Staff or designee.

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

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

6.4 APPOINTMENT AND REAPPOINTMENT DECISION AUTHORITY

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

6.5 DURATION OF APPOINTMENT AND REAPPOINTMENT

Except as otherwise provided in these Bylaws, initial appointment and reappointments to the Medical Staff shall be for a period of up to two (2) years.²⁷ Honorary and Retired Staff appointments shall be for life.

6.6 REAPPOINTMENTS AND REQUESTS FOR MODIFICATION OF STAFF STATUS

6.6.1 Application

- a) At least four (4) months prior to the expiration date of the current Staff appointment, reapplication, and privilege request forms developed by the Medical Executive Committee and Hospital shall be mailed or delivered to the member. At least ninety (90) days prior to the expiration date, each Medical Staff member shall submit to the Medical Staff Office or approved designee the completed application forms for granting reappointment to the Staff for the coming appointment period; and requests for re-granting or modifying clinical privileges. The reapplication forms shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 6.2.1, results of Medical Staff quality assurance activity, continuing education, as well as other relevant matters. Upon receipt of the application, the information shall be processed as generally set forth commencing at Section 6.3.2.
- b) A Medical Staff member who seeks a change in Medical Staff status or modification of clinical privileges may submit such a request at any time upon a form developed by the Medical Executive Committee and Hospital, except that such application will not alter the regularly scheduled biennial review of the member. Requests for additional/increased privileges must be supported by evidence which would be necessary for such privileges to be granted on an initial application for the same.

6.6.2 Effect of Application

²⁷ May 2003

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

6.6.3 Standards and Procedures for Review

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

6.6.4 Failure to File Reappointment Application

Failure without good cause to timely file a completed application for reappointment shall result in the automatic suspension of the member's admitting privileges and expiration of other practice privileges and prerogatives at the end of the current staff appointment, unless otherwise extended by the Medical Executive Committee with the approval of the Board of Directors. If the member fails to submit a completed application for reappointment by the due date²⁸ [within 30 days past the date it was due], the member shall be deemed to have resigned membership in the Medical Staff. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article 9 shall apply.

6.7 LEAVE OF ABSENCE

6.7.1 Leave Status

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

6.7.2 Termination of Leave

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

6.7.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement prior to the end of the leave of absence period

²⁸ May 2003

shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall be entitled to the procedural rights provided in Article 9 for the sole purpose of determining whether the failure to request reinstatement was unintentional or excusable, but only if the reinstatement request is within the previously granted appointment period. A request for Medical Staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

6.7.4 Medical Leave

The Medical Executive Committee shall determine the circumstances under which a particular Medical Staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a “medical leave” which is not granted for medical disciplinary cause or reason.

6.7.5 Military Leave of Absence

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

ARTICLE 7 - CLINICAL PRIVILEGES

7.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws, every practitioner, member, and/or AMS providing clinical services at this Hospital by virtue of staff membership or otherwise, shall be entitled to exercise only those clinical privileges specifically requested and granted. Except as otherwise provided in Section 7.6, said privileges and services must be Hospital-specific, within the scope of any license, certificate, or other legal credential authorizing practice in this State and consistent with any restrictions thereon, and shall be subject to the Rules and Regulations of the Clinical Department and the authority of the Department Chair, the Medical Staff, and the Board of Directors.

7.2 CRITERIA FOR PRIVILEGES²⁹

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

7.3 GENERAL COMPETENCIES³⁰

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

7.4 DELINEATION OF PRIVILEGES IN GENERAL

7.4.1 Requests

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

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

Requests for a modification of clinical privileges may be made at any time. All requests must be

²⁹ May 2011

³⁰ May 2011

supported by documentation of training, experience, qualifications, and competency to exercise such privileges and in support of the request.

7.4.2 Basis for Privileges Determination

Requests for clinical privileges shall be evaluated on the basis of the member's, applicant's, or AMS's verified current licensing and/or certification, education, training, experience; demonstrated current professional competence and judgement, peer recommendations, observed clinical performance, and the documented results of patient care (including procedures performed) and other quality review/monitoring and evaluation activities; and coverage by appropriate professional liability insurance and disclosure of his or her malpractice history including any/all settlements made by or on behalf of the professional requesting the privileges. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member, applicant, or AMS exercises clinical privileges.

7.4.3 Telemedicine Privileges³¹

- a) The initial appointment of telemedicine privileges may be based upon:
 - 1) the practitioner's full compliance with this hospital's privileging standards;
 - 2) by using this hospital's standards by relying on information provided by the hospital(s) at which the practitioner routinely practices; or
 - 3) if the hospital where the practitioner routinely practices is accredited by The Joint Commission and agrees to provide a comprehensive report of the practitioner's qualifications, by relying entirely on the privileges of that other hospital.
- b) Reappointment of a Telemedicine Staff member's privileges may be based upon the performance at this hospital, and if insufficient information is available, upon information from the hospital(s) where the practitioner routinely practices.

7.4.4 Procedure

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

7.5 PROCTORING

7.5.1 General Provisions

Except as otherwise determined by the Medical Executive Committee, and approved by the Board of Directors, all providers granted initial, increased, or additional clinical privileges shall be subject to a period of proctoring. Each recipient of new clinical privileges shall be assigned to a Department where performance on an appropriate number of cases as established by the Medical Executive Committee or the Department as designee of the Medical Executive Committee, shall be observed by the Chair of the Department, or the Chair's designee, during the period of proctoring specified in the

³¹ May 2008

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

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

- a) a report signed by the Chair of the Department to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that Department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which the appointment was made; and, if applicable;
- b) a report signed by the chairmen of the other department(s) in which the appointee may exercise clinical privileges, describing the types and number of cases observed and the evaluation of the applicant's performance and a statement that the member has clinical privileges initially granted in those departments.

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

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

7.5.2 Failure to Obtain Certification

- a) If an initial appointee fails within the time of Provisional membership to furnish the certification required for requisite privileges, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the Department, those specific clinical privileges shall automatically terminate, and the member shall be entitled to a hearing, upon request, pursuant to Article 9.
- b) If appropriate certification is obtained for none of the clinical privileges requested by a member of the Provisional staff, that individual's Medical Staff membership shall terminate, and the member shall be entitled to a hearing upon request pursuant to Article 9.
- c) If an AMS fails to obtain appropriate certification for any and/or all of the clinical privileges requested; (1) the specific privileges not certified shall be automatically terminated and/or (2) all of the clinical privileges not certified shall be automatically terminated and the category status of AMS shall be withdrawn; the AMS shall be entitled only to those hearing

rights as defined in Article 5.

7.5.3 Medical Staff Advancement

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

7.6 CONDITIONS FOR PRIVILEGES OF NON-PHYSICIAN PRACTITIONERS

7.6.1 Admissions

Dentists, oral surgeons, podiatrists, and clinical psychologists who are members of the Medical Staff may only admit patients if a physician member of the Medical Staff conducts or directly supervises the admitting history and physical examination (except the portion related to dentistry, podiatry and psychology³²) and assumes responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the non-physician practitioner's lawful scope of practice.

7.6.2 Surgery

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the Chair of the Department of Surgery or the Chair's designee.

7.6.3 Medical Appraisal

All patients admitted for care in the Hospital by a dentist, psychologist, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a non-physician practitioner based upon medical or surgical factors outside of the scope of licensure of the non-physician practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s). All members of the Medical Staff shall cooperate and assist in providing medical care to patients of limited license practitioners.

7.7 TEMPORARY CLINICAL PRIVILEGES

7.7.1 Circumstances

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

³² 05/15/2003

- a) Temporary clinical privileges may be granted to fulfill an important patient care need.³³
- b) Temporary privileges may be granted when an applicant with a complete, clean application is awaiting review and approval of the Medical Executive Committee and the Governing Body.³⁴

7.7.2 Application and Review

- a) Upon receipt of a completed application and supporting documentation from a physician, dentist, podiatrist, or clinical psychologist authorized to practice in California, the Administrator or duly qualified Administrator designee may grant temporary privileges to a practitioner who appears to have qualifications, ability, and judgement, consistent with Section 3.2.1, but only after:
 - 1) prerequisite verification of the application and supportive documentation has been accomplished according to Article 6 and statutory requirements, if any; and
 - 2) the appropriate Department chair or Chief of Staff or a Medical Staff member designee who has contacted at least one person who has recently worked with the applicant, and directly observed the applicant's professional performance over a reasonable period of time, and provided reliable information regarding the applicant's current professional competence, ethical character, and ability to work well with others so as not to adversely affect patient care.
- b) The applicant's file, including the recommendation of the department chair, shall be forwarded to the Credentials Committee Chair or his designee, and the Chief of Staff or his designee; and, if there is mutual agreement, a recommendation to the Board of Directors to confirm the granted temporary privileges to the applicant shall be made.
- c) In the event of a disagreement between the Board of Directors and the recommendations addressed in b) above, regarding the granting of temporary clinical privileges, the decision of the Board of Directors shall prevail.
- d) If the applicant requests temporary privileges in more than one department, interviews shall be conducted and written concurrence shall first be obtained from the appropriate department chair and forwarded as described in Section 7.5.2.a) above.
- e) If the available information is incomplete or casts any reasonable doubts on the applicant's qualifications, action on the request for temporary privileges may be deferred until the doubts have been satisfactorily resolved.³⁵

7.7.3 General Conditions

- a) If granted temporary privileges, the applicant shall act under the supervision of the

³³ May 2003

³⁴ May 2003

³⁵ May 2011

Department Chair to which the applicant has been assigned, and shall ensure that the Chair, or the Chair's designee, is kept informed as to his or her activities within the Hospital.

- b) Temporary privileges shall automatically terminate at the end of the designated period (not to exceed 120 days)³⁶ or unless earlier terminated by the Medical Executive Committee upon recommendation of the Department or Credentials Committee, unless affirmatively renewed following the procedure as set forth in Section 7.7.2. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn.³⁷
- c) Requirements for proctoring and monitoring, including, but not limited to, those in Section 7.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Chief of Staff after consultation with the department chair or his designee.
- d) At any time, for reasons raised about the practitioner's qualification as addressed in Section 7.2.2, temporary privileges may be terminated by 1) the Chief of Staff with the concurrence of the chair of the department or their designees, subject to prompt review by the Medical Executive Committee and the Board of Directors or by 2) the Board of Directors, with a report to the Medical Executive Committee to follow giving the reasons for the action. In such cases, the appropriate department chair or, in the chair's absence, the chair of the Medical Executive Committee, shall assign a member of the Medical Staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement Medical Staff member.
- e) All persons requesting or receiving temporary privileges shall be bound by the Bylaws and Rules and Regulations of the Medical Staff including a pledge for continuous care.
- f) A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff. There is no right to temporary privileges.³⁸

7.7.4 Termination

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

In the event of any such termination, the practitioner's patients then in the Hospital shall be assigned

³⁶ 05/15/2003; May 2015

³⁷ May 2011

³⁸ May 2008

to another practitioner by the department chair responsible for supervision. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

7.7.5 Rights of the Practitioner

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

7.8 DISASTER ³⁹AND EMERGENCY PRIVILEGES

Disaster privileges may be granted when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs. Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon the recommendations of the Chief of Staff (or designee). This process including a description of the two acceptable identifiers, verification process, and monitoring process is outlined in the Medical Staff Rules and Regulations, Section V, Medical Staff Policies, and the Medical Center's Disaster Policy and Procedure Manual.⁴⁰

7.9 HISTORY AND PHYSICAL REQUIREMENTS (Refer to Rules and Regulations for more detail)⁴¹

7.9.1. Inpatient Admission

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

7.9.2. Operative or Invasive Procedures

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

7.10 TRANSPORT AND ORGAN HARVEST TEAMS⁴²

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

³⁹ May 2008, added Disaster Privileges, a-d.

⁴⁰ May 2010, deleted b-d (#a part of 7.6), and added reference to Rules/Regs §V

⁴¹ May 2010

⁴² May 2008

7.11 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENTS

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

7.12 LAPSE OF APPLICATION

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

ARTICLE 8 - CORRECTIVE ACTION

8.1 GENERAL PROVISIONS

8.1.1 Criteria for Initiation

Any person may provide information to the Medical Staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct, reasonably likely to be 1) detrimental to patient safety or to the delivery of quality patient care within the Hospital; 2) unethical or constituting fraud and abuse; 3) contrary to the Medical Staff Bylaws, Rules and Regulations; 4) disruptive to Hospital operations; 5) below applicable professional standards; or 6) resulting in the imposition of sanctions by any governmental authority, an investigative action against such member may be requested by the Chief of Staff, a department chair, the Medical Executive Committee, or any member of the Governing Body.

8.1.2 Initiation

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. The Medical Executive Committee shall make an appropriate record of the reasons and notify both the Administrator and the Governing Body.

8.1.3 Investigation

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff officer, Medical Staff department, or standing or ad hoc committee of the Medical Staff. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the Medical Staff as temporary members of the Medical Staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Article 7.5 should circumstances warrant. If the investigation is delegated to an officer or committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved, however, such investigation shall not constitute a "hearing" as that term is used in Article 9, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension as defined in Section 8.2, termination of the investigative process, or other action, subject to approval by the Board.

8.1.4 Executive Committee Action

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

- a) determining no corrective action be taken and, if the Executive Committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the member's file;
- b) deferring action for no more than sixty (60) days where circumstances warrant;
- c) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads from issuing informal written or oral warning outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response which shall be placed in the member's quality assurance file;
- d) recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring;
- e) recommending reduction, modification, suspension, or revocation of clinical privileges;
- f) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;
- g) recommending suspension, revocation, or probation of Medical Staff membership; and
- h) taking other actions deemed appropriate under the circumstances.

8.1.5 Subsequent Action

- a) If corrective action as set forth in Section 9.2(a) to (1) is recommended by the Medical Executive Committee, that recommendation shall be transmitted to the Board of Directors.
- b) So long as the recommendation is supported by substantial evidence, the recommendation of the Medical Executive Committee shall be adopted by the Board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article 9. If the Board does not find the recommendation supported by substantial evidence, the Board may remand the matter to Medical Executive Committee for further action.

8.1.6 Initiation by the Board of Directors

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the Board may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The Board's request for Medical Staff action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that direction, the Board may initiate corrective action after written notice to the Medical Executive Committee, but this corrective action must comply with Articles 8 and 9 of these Medical Staff Bylaws.

8.2 SUMMARY RESTRICTION OR SUSPENSION

8.2.1 Criteria for Initiation

Whenever a member's conduct appears to require that immediate action be taken to protect the life or well-being of patient(s) or to reduce a substantial and imminent likelihood of significant impairment of the life, health, safety, or any patient, prospective patient, or other person, the Chief of the Medical Staff, the Medical Executive Committee, the head of the department or designee in which the member holds privileges, the Administrator, or the Board of Directors may summarily restrict or suspend the Medical Staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the member, the Board, the Medical Executive Committee, and the Administrator. The summary restriction or suspension shall be for no longer than fourteen (14) days while investigation into the need for further action is taken. Unless otherwise indicated by the terms of the summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of a substitute member.

8.2.2 Written Notice of Summary Suspension

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

8.2.3 Medical Executive Committee Action

As soon as practicable after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee shall be convened to review and consider the action. Upon request,

the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a "hearing" within the meaning of Article 9, nor shall any procedural rules apply. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision.

8.2.4 Procedural Rights

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

8.2.5 Initiation by the Board

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

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two (2) working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Article 8.2 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

8.3 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership may be suspended or limited as described, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred. Suspensions cumulatively totaling thirty (30) days in any twelve (12) month period shall be reported to the Medical Board of California.

8.3.1 Licensure

- a) **Revocation and Suspension:** Whenever a member's license or other legal credential authorizing practice in this State is revoked or suspended, Medical Staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.
- b) **Restriction:** Whenever a member's license or other legal credential authorizing practice in this State is limited or restricted by the applicable licensing or certifying authority, any

clinical privileges which the member has been granted at the Hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

- c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- d) Failure to provide evidence of current valid licensure to the Credentials Committee when requested so as to maintain continuous valid Medical Staff status as defined in Article 3, will result in suspension of all privileges and membership.

8.3.2 Controlled Substances

- a) Whenever a member's Drug Enforcement Administration (DEA) certificate is revoked, limited, or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.
- b) Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.
- c) Failure to provide evidence of current valid certification shall result in suspension of the right to prescribe controlled drugs or medications.

8.3.3 Professional Liability Insurance

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

8.3.4 Failure to Pay Dues

Failure to pay dues within sixty (60) days of a written "registered letter" warning, without good cause as determined by the Medical Executive Committee, shall result in automatic revocation of Medical Staff membership.

8.3.5 Medical Records

Members of the Medical Staff are required to complete medical records within such reasonable time as may be prescribed by the Board on recommendation of the Medical Records/Utilization Committee through the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or his designee, after notice of delinquency for failure to complete medical records

within such period. For the purpose of this section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital for future patients. Bona fide vacations or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until medical record completion is current and the member is removed from suspension by the Chief of Staff or his designee.

8.3.6 Executive Committee Deliberation

At the next regular meeting or no longer than sixty (60) days after action is taken or warranted as described in Section 8.3.1, or Sections 8.3.2., 8.3.3., 8.3.4, 8.3.5, the Medical Executive Committee shall convene to review and consider the facts, and may recommend such further corrective action as it may deem appropriate following the procedure set forth in Article 9. For actions of less than two years' duration, the member's membership status and clinical privileges can automatically be reinstated subject to approval by the Hospital Board of Directors upon the recommendation of the Medical Executive Committee. For actions of greater than two years' duration, formal application for appointment in accordance with Article 6 must be made subject to approval by the Hospital Board of Directors upon the recommendation of the Medical Executive Committee.

8.3.7 Failure to Satisfy Special Appearance Requirement

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

ARTICLE 9 - HEARING AND APPELLATE REVIEW

9.1 DEFINITIONS

9.1.1 Exhaustion of Remedies

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

9.1.2 Application of Article

For purposes of this Article, the term "member" may include "applicant," as it may be applicable under the circumstances, unless otherwise stated.

9.1.3 Intra-organizational Remedies

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

9.1.4 Timely Completion of Process

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

9.1.5 Final Action

Recommended adverse action described in Article 9.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Directors.

9.2 GROUNDS FOR HEARING

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

- a) Denial of Medical Staff membership.
- b) Denial of requested advancement in staff membership status or category.
- c) Denial of Medical Staff reappointment.

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- d) Demotion to lower Medical Staff category or membership status.
- e) Suspension of staff membership.
- f) Revocation of Medical Staff membership.
- g) Denial of requested clinical privileges.
- h) Involuntary reduction of current clinical privileges.
- i) Suspension of clinical privileges.
- j) Termination of all clinical privileges.
- k) Involuntary imposition of significant consultation or monitoring requirement excluding monitoring incidental to Provisional status and Section 7.3 - Proctoring.
- l) Any other action which requires a report to be made to the Medical Board of California under the provisions of Section 805 of the California Business and Professional Code.

9.3 REQUESTS FOR HEARING

9.3.1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Article 9.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of (1) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank if required; (2) the reasons for the proposed action including the acts or omissions with which the member is charged; (3) the right to request a hearing pursuant to Article 9.3.2, and that such hearing must be requested within thirty (30) days; and (4) a summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws. If the recommendation or final proposed action is reportable to the Medical Board of California and/or to the National Practitioner Data Bank, the written notice shall state the proposed text of the report(s).

9.3.2 Request for Hearing

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Chief of Staff with a copy to the Board. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation of action involved.

9.3.3 Time and Place of Hearing

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within thirty-five (35) days of the hearing give notice in writing to the member of the time, place, and date of the hearing. Unless extended by the Judicial Review Committee, the date of the commencement of the

hearing shall be not less than thirty (30) days, nor more than sixty (60) days from the date of receipt of the request by the Chief of Staff for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, but not to exceed forty-five (45) days from the date of receipt of the request.

9.3.4 Notice of Charges

Together with the notice stating the place, time, and date of the hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Article 9.4.1.

9.3.5 Judicial Review Committee

When a hearing is requested, the Medical Executive Committee shall appoint a Judicial Review Committee which shall be composed of not less than five (5) members of the Medical Staff who shall gain no direct financial benefit from the outcome, and who have not acted as accuser, investigator, fact finder, initial decision maker, or otherwise have not have actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event that it is not feasible to appoint a Judicial Review Committee from the Active Medical Staff, the Medical Executive Committee may appoint members from other Staff categories or practitioners who are not members of the Medical Staff. Such appointment shall include designation of the chair. Membership on a Judicial Review Committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the member. All other members shall have M.D. or D.O. degrees. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable. All members of the judicial review committee shall disclose in writing to the parties to the hearing those current or impending personal, professional, or financial affiliations of which they are reasonably aware, including contractual, employment or other relationships with the hospital which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the judicial review committee. Potential conflicts so disclosed shall be resolved as set forth in these bylaws.⁴³

9.3.6 Failure to Appear or Proceed

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

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9.3.7 Continuances

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these Bylaws may be permitted by the Judicial Review Committee, upon agreement of the parties, or by the presiding officer on a showing of good cause.

9.4 HEARING PROCEDURE

9.4.1 Pre-hearing Procedure

- a) If either side of the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy the documents or other evidence upon which the charges are based, and shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, any exculpatory evidence in the possession of the Hospital or Medical Staff, and all evidence which will be made available to the Judicial Review Committee.
- b) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the Judicial Review Committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
- c) The Medical Executive Committee shall have the right to inspect and copy, at its expense, any documents or other evidence relevant to the charges which the Member has in his or her possession or control as soon as practicable after receiving the request.
- d) The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable Members, other than the Member under review.
- e) The Hearing Officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the Hearing Officer shall consider:
 - 1) whether the information sought may be introduced to support or defend the charges;
 - 2) the exculpatory or inculpatory nature of the information sought, if any;
 - 3) the burden imposed on the party in possession of the information sought, if access is

granted; and

- 4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.
- f) The Member shall be entitled to a reasonable opportunity to question and challenge the impartiality of Judicial Review Committee members and the Hearing Officer. Challenges to the impartiality of any Judicial Review Committee member or the Hearing Officer shall be ruled on by the Hearing Officer.

9.4.2 Representation

The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The Member shall be entitled to representation by legal counsel in any phase of the hearing, should he/she so choose, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the Member shall be entitled to be accompanied by and represented at the hearing only by a practitioner licensed to practice in the State of California who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the Member is not so represented.

9.4.3 The Presiding and/or Hearing Officer(s)

- a) Presiding Officers - The Presiding Officer at the hearing shall be a Hearing Officer as described in Section 9.4.3 or, if no such Hearing Officer has been appointed, the Chair of the Judicial Review Committee. The Presiding Officer shall act to assure that all participants in the hearing have a reasonable opportunity to be heard and to present all relevant oral and documentary evidence, and that proper decorum is maintained. He or she shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing. He or she shall have the authority and discretion, in accordance with these Bylaws, to make all rulings on questions which, with reasonable diligence, could not have been raised prior to the hearing and which pertain to matters of law, procedure, or the admissibility of evidence.
- b) The Hearing Officer - At the request of the petitioner, the Medical Executive Committee, the Judicial Review Committee, or the Board of Directors, the Administrator or his or her designee may appoint a Hearing Officer to preside at the hearing. The Hearing Officer may be an attorney at law qualified to preside over a quasi-judicial hearing and preferably with experience in Medical Staff matters, but an attorney regularly utilized by the Hospital for legal advise regarding its affairs and activities shall not be eligible to serve as Hearing Officer.

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

vote.

Alternatively, an arbitrator may be used who is selected using a process mutually accepted by the body whose decision prompted the hearing and the practitioner. The arbitrator need not be either a health professional or an attorney. The arbitrator shall carry out all the duties assigned to the Hearing Officer and to the Hearing Committee.⁴⁴

9.4.4 Record of the Hearing

The pre-hearing proceedings as well as the hearing proceedings shall be recorded either by the services of a shorthand reporter or by a tape recorder if requested by either party or deemed appropriate by the Hearing Officer. The cost of the shorthand reporter, if used, and the cost of the transcript, if any, shall be borne by the party requesting it. The Judicial Review Committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

9.4.5 Rights of the Parties

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member or other proponent may be called as a witness by the Judicial Review entity and examined as if under cross-examination. The member shall have the right to submit a written statement at the close of the hearing.

9.4.6 Miscellaneous Rules

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

9.4.7 Burdens of Presenting Evidence and Proof

- a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.
- b) When the hearing involves an applicant, the applicant shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, of his/her qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning his/her current qualifications for membership and privileges. An applicant

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shall not be permitted to introduce information requested by the Medical Staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

- c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

9.4.8 Adjournment and Conclusion

After consultation with the chair of the Judicial Review Committee, the Hearing Officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the Member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence or the receipt of closing written arguments, if submitted, the hearing shall be closed. The Judicial Review Committee shall thereupon, outside of the presence of any other person, except the Hearing Officer, conduct its deliberations and render a decision and accompanying report.

9.4.9 Basis for Decision

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

9.4.10 Decision of the Judicial Review Committee

Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the Member is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the Administrator, the Board, and to the Member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the Member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Judicial Review Committee shall be subject to such rights of appeal or review as described in these Bylaws, but shall otherwise be affirmed by the Board as the final action if it is supported by substantial evidence, following a fair procedure. If the final proposed action adversely affects the clinical privileges of a physician or dentist for a period longer than 30 days and is based on competence or professional conduct, the decision shall state that the action if adopted will be reported to the National Practitioner Data Bank, and shall state the text of the report as agreed upon by the committee. The decision shall also state whether the action, if adopted, shall be reported to the Medical Board of California and shall state the text of the report as agreed by the committee.

9.5 APPEAL

9.5.1 Time for Appeal

Within ten (10) days after receipt of the decision of the Judicial Review Committee, either the Member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Administrator, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board as the final action if it is supported by substantial evidence, following a fair procedure.

9.5.2 Grounds for Appeal

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

- a) substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice;
- b) the decision was not supported by substantial evidence based upon the hearing record, if any, or such additional information as may be permitted pursuant to Section 9.5.5;
- c) lack of substantive rationality of a Medical Staff Bylaw, Rule, or Regulation relied upon by the Judicial Review Committee in reaching its decision; and
- d) action taken arbitrarily, unreasonably, or capriciously.
- e) the test of the report(s) to be filed with the Medical Board of California and/or the National Practitioner Data Bank is not accurate.

9.5.3 Time, Place, and Date Notice

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

9.5.4 Appeal Board

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

- a) not less than three (3) members of the Board of Directors; and
- b) at least two (2) non-physicians.

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

9.5.5 Appeal Procedure

The proceeding by the Appeal Board shall be in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the Judicial Review Committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the Judicial Review hearing; or the Appeal Board may remand the matter to the Judicial Review Committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of his or her position on appeal, and to personally appear and make oral argument. The Appeal Board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The Appeal Board shall present to the Board of Directors its written recommendations as to whether the Board of Directors should affirm, modify, or reverse the Judicial Review Committee decision, or remand the matter to the Judicial Review Committee for further review and decision.

9.5.6 Decision

- a) Except as provided in Section 9.5.6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the Board of Directors shall render a final decision and shall affirm the decision of the Judicial Review Committee if the Judicial Review Committee's decision is supported by substantial evidence, following a fair procedure.
- b) Should the Board of Directors determine that the Judicial Review Committee decision is not supported by substantial evidence, the Board may modify or reverse the decision of the Judicial Review Committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the Judicial Review Committee for reconsideration, stating the purpose for the referral. If the matter is remanded to the Judicial Review Committee for further review and recommendation, the Committee shall promptly conduct its review and make its recommendations to the Board of Directors. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the Chair of the Board of Directors and the Judicial Review Committee.
- c) The decision shall be in writing, shall specify the reasons for the action taken, and shall be forwarded to the Chief of Staff, the Medical Executive and Credential Committees, the

subject of the hearing, and the Administrator.

9.5.7 Right to One Hearing

Except in circumstances where a new hearing is ordered by the Board of Directors or a court because of procedural irregularities or otherwise for reasons not the fault of the member, no member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

9.6 EXCEPTIONS TO HEARING RIGHTS

9.6.1 Medical Administrative Officers and Contract Physicians

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

- a) to the extent that any contract modifications, termination, or restrictions of staff status or clinical privileges proposed by the Hospital, or loss of faculty status, deal with issues relating to professional character, performance or competence; or
- b) to the extent that the Member's Medical Staff membership or clinical privileges which would otherwise exist independent of the contract are to be limited or terminated.

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

9.6.2 Automatic Suspension or Limitation of Practice Privileges

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

9.7 EXPUNCTION OF DISCIPLINARY ACTION

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

9.8 NATIONAL PRACTITIONER DATA BANK REPORTING

9.8.1 Adverse Actions

The authorized representative shall report an adverse action to the National Practitioner Data Bank

only upon its adoption as final action and only using the description set forth in the final action as adopted by the Board of Directors upon the recommendation of the Medical Executive Committee. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

9.8.2 Dispute Process

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, the Chair of the subject's department, and the hospital's authorized representative or their respective designee.

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

ARTICLE 10 - OFFICERS

10.1 OFFICERS OF THE MEDICAL STAFF

10.1.1 Identification

The general officers of the Medical Staff shall be the Chief of Staff, Vice Chief of Staff, and Immediate Past Chief of Staff.⁴⁵

In addition, the Medical Staff department and section officers and committee chairs shall be deemed Medical Staff officers within the meaning of California Law. Whenever possible dual positions will be discouraged.⁴⁶

10.1.2 Qualifications

Officers must be members of the Active Medical Staff at the time of their nominations and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

All Medical Staff officers shall:

- a) be an active Medical Staff member (and remain in good standing as an active Medical Staff member while in office);
- b) understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;
- c) understand and be willing to work towards attaining the mutual goals of the Medical Staff and Hospital's lawful and reasonable policies and requirements;
- d) not have any significant conflict of interest.

10.1.3 Disclosure of Conflict of Interest

All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to 10.1.4-7) shall, at least 20 days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware that could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The Medical Executive Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee. If a nominee with a significant conflict remains on the ballot, the nature of his or her conflict shall be disclosed in writing and circulated with the ballot.

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⁴⁶ May 2003

10.1.4 Nominations

- a) The Medical Staff election year shall be every three (3) years⁴⁷. A Nominating Committee shall be appointed by the Medical Executive Committee not later than ninety (90) days prior to the Annual Staff Meeting to be held during the election year or at least forty-five (45) days prior to any special election. The Nominating Committee shall consist of the current Chief of Staff, the Vice Chief of Staff, and two other members of the Medical Executive Committee, and one member chosen by agreement of the department chairmen from among the Active Medical Staff who are not then members of the Medical Executive Committee. The Nominating Committee shall nominate one or more nominees for each office. The nominations of the committee shall be reported to the Medical Executive Committee at least forty-five (45) days prior to the Annual Meeting and shall be delivered or mailed to the voting members of the Medical Staff at least thirty (30) days prior to the election.
- b) Further nominations may be made for any office by any voting member of the Medical Staff, provided that the name of the candidate is submitted in writing to the chair of the Nominating Committee, is endorsed by the signature of at least twenty-five (25) percent of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the Chair of the Nominating Committee as soon as reasonably practicable, but at least twenty (20) days prior to the date of election. If any nominations are made in this manner, the voting members of the Medical Staff shall be advised by notice delivered or mailed at least ten (10) days prior to the meeting. Nominations from the floor will be recognized if the nominee is present and consents.

10.1.5 Elections

The Chief and Vice Chief⁴⁸ shall be elected at the annual meeting of the Medical Staff which falls during the election year. Voting shall be by secret ballot, written or electronic.⁴⁹ Only authenticated ballots will be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a runoff election shall be held promptly between the two (2) candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

10.1.6 Term of Elected Office

- a) Each officer shall serve a three (3)⁵⁰ year term, commencing on the first day of the Medical Staff year following his or her election. Each officer shall serve in each office until the end of his or her term, or until a successor is elected, unless he shall sooner resign or be removed from office.

⁴⁷ May 2003

⁴⁸ Approved at Annual Meeting 05/10/05

⁴⁹ May 2008

⁵⁰ May 2003

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

10.1.7 Recall of Officers

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

The recall of a Medical Staff officer may also be initiated by a petition signed by at least one-third of the members of the Medical Staff eligible to vote for officer. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the Medical Staff members eligible to vote for Medical Staff officers who actually cast votes at the special meeting in person or by mail ballot.

10.1.8 Vacancies in Elected Office

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

Vacancies, other than that of Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election.

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

If there is a vacancy in the office of Vice Chief of Staff, that office need not be filled by election, but the Medical Executive Committee shall appoint an interim officer to fill this office until the next regular election, at which time the election shall also include the office of Chief of Staff.

10.2 DUTIES OF OFFICERS

10.2.1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the Medical Staff. The Chief of Staff is eligible to receive a stipend from the medical staff dues in the amount specified by the Medical Executive Committee. The Administration may choose to add to this stipend in recognition for the service the Chief of Staff provides the Medical Center.⁵¹ The duties of the Chief of Staff shall include, but not be limited to:

⁵¹ Approved at Annual Meeting 05/10/05

- a) enforcing the Medical Staff Bylaws and Rules and Regulations, implementing sanctions where indicated, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;
- b) calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- c) serving as Chair of the Medical Executive Committee;
- d) serving as an ex-officio member of all other staff committees without vote, unless his or her membership in a particular committee is required by these Bylaws;
- e) interacting with the Administrator and the Board of Directors in all matters of mutual concern within the Hospital;
- f) appointing, in consultation with the Medical Executive Committee, committee members for all standing and special Medical Staff, liaison, and multi-disciplinary committees, except where otherwise indicated, designating the chair of these committees;
- g) representing the views, policies, and quality assurance activity of the Medical Staff to the Board of Directors and to the Administrator;
- h) being a spokesman for the Medical Staff in external professional and public relations;
- i) performing such other functions as may be assigned to the Chief of Staff by these Bylaws, the Medical Staff, or by the Medical Executive Committee; and
- j) serving on the Board of Directors as well as representing the Medical Staff in regard to outside licensing, accreditation, or official review agencies.

10.2.2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a member of the Medical Executive Committee of the Medical Staff and of the Governing Board. The duties shall include, but not be limited to:⁵²

- a) maintaining a roster of members;
- b) keeping accurate and complete minutes of all Medical Executive Committee and Medical Staff meetings, or overseeing that function carried out by administrative staff;
- c) calling meetings on the order of the Chief of Staff or Medical Executive Committee;
- d) attending to all appropriate correspondence and notices on behalf of the Medical Staff;

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- e) receiving and safeguarding all funds of the Medical Staff;
- f) excusing absences from meetings on behalf of the Medical Executive Committee; and
- g) performing such other duties as ordinarily pertain to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

10.2.3 Immediate Past Chief of Staff

The Immediate Past Chief of Staff shall be a member of the Medical Executive Committee and a member of the Governing Board and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these Bylaws, or by the Medical Executive Committee.

ARTICLE 11 - CLINICAL DEPARTMENTS AND DIVISIONS

11.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

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

11.1.1 Clinical Department/Division Formation or Elimination

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

- a) The Medical Staff shall determine the formation or elimination of a department/division to be appropriate based upon consideration of its effects on quality of care in the facility and/or community. A determination of the appropriateness of formation or elimination of a department/division must be based upon the preponderance of the evidence, viewing the records as a whole, presented by any and all interested parties, following notice and opportunity for comment.
- b) The Medical Staff member(s) whose privileges may be adversely affected by a Medical Staff's determination of appropriateness of department/division formation or elimination may request a hearing before the Judicial Review Committee. Such a hearing will be governed by the provisions of Article 9, except that:
 - 1) the hearing shall be limited to the following issues:
 - (a) whether the Medical Staff's determination of appropriateness is supported by the preponderance of the evidence;
 - (b) whether the Medical Staff followed its requirements for notice and comment on the issue of appropriateness.
 - 2) all requests for such a hearing will be consolidated.

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

- c) Except as specified in this Section, the termination of privileges pursuant to formation or elimination of a department/division determined to be appropriate by the Medical Staff shall not be subject to the procedure rights otherwise set forth in Article 9.

11.2 DEPARTMENTS AND DIVISIONS

- a) The current departments are:
 - 1) Department of Medicine
 - 2) Department of Surgery
 - 3) Department of Psychiatry
 - 4) Department of Primary Care and Community Medicine
 - 5) Department of Emergency Medicine⁵³
- b) The Medical Staff Departments may establish divisions by a vote of the department.

11.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

- a) Each member/practitioner (to include those with temporary privileges and any practitioner in training) shall be assigned to one department, and to a division, if any, within such departments. Member/practitioner may also be granted privileges in another department/division consistent with documented training.
- b) Each Affiliate to the Medical Staff shall be assigned to one department, and to a division, if any, within such department as the practitioner supervisor is a member. Assignment to a department and/or division shall not infer any membership status or privileges to the AMS within that department and/or division except as defined in Article 5.
- c) Residents shall be assigned to the department within which they are practicing their experiential training.

11.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

- a) Conducting patient care reviews of members and Affiliates for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The department shall routinely collect information about important aspects of inpatient and outpatient care provided in or by the department, periodically assess this information, develop objective criteria for use in evaluating patient care, and participate in

⁵³ Approved at Annual Meeting 05/10/05

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coordinating and interpreting quality assurance activities with other departments and committees in consultation with the Medical Executive Committee. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member or Affiliate whose work subject to such review is a member of that department, and include, but not be limited to, the specifics of drug utilization, blood utilization, surgical case review, mortality/morbidity, infection control, and medical record clinical pertinence when and as appropriate to the departments.

- b) Recommending to the Medical Executive Committee guidelines for the granting of clinical privileges and the performance of specified services within the department.
- c) Evaluating and making appropriate recommendations regarding the qualification of applicants seeking appointment or reappointment and clinical privileges within that department.
- d) Conducting, participating, and making recommendations regarding continuing education programs pertinent to departmental clinical practice and based at least in part on the results of quality assurance activity including communication of this information to other Departments.
- e) Reviewing and evaluating department adherence to: (1) Medical Staff policies and procedures; (2) sound principles of clinical practice.
- f) Coordinating patient care provided by the department's members with nursing and ancillary patient care services through regularly established communication channels and participation in the Hospital integrated Quality Management Program.
- g) Submitting written reports to the Medical Executive Committee concerning: (1) the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and the Hospital.
- h) Meeting as often as necessary (which may be monthly) but at least quarterly to effectively: consider patient care review findings, and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions; and to receive other Medical Staff departmental or committee reports regarding patient care monitoring and evaluating, upon which consideration and conclusions shall occur and/or recommendations formulated; and to participate in interdepartmental Medical Staff review of patient care practices.
- i) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.
- j) Upholding the Bylaws and discharging appropriate responsibilities within the quality management and peer review functions of the Medical Staff.
- k) Accounting to the Medical Executive Committee for all professional and Medical Staff administrative activities within the department.
- l) Appointing such committees as may be necessary or appropriate to conduct department

functions.

- m) Formulating departmental Rules and Regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Bylaws Committee, Medical Executive Committee, Medical Staff membership, and the Board of Directors.
- n) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve are identified.

11.5 FUNCTIONS OF DIVISIONS

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

11.6 DEPARTMENT CHAIR AND VICE CHAIR

11.6.1 Qualifications

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

11.6.2 Selection

Department Chairmen and Vice Chairmen shall be elected every three (3)⁵⁴ years by those members of the department who are eligible to vote for general officers of the Medical Staff. For the purpose of this election, each department Chair shall appoint a Nominating Committee of three (3) members at least sixty (60) days prior to the meeting at which election is to take place. The recommendations of the Nominating Committee of one or more nominees for Chair and Vice Chair positions shall be circulated to the voting members of each department at least twenty (20) days prior to the election. Nominations may also be made from the floor when the election meeting is held, as long as the nominee is present and consents to the nomination. Election of department Chairmen and Vice Chairmen shall be subject to ratification by the Medical Executive Committee and the Board. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

⁵⁴ May 2003

11.6.3 Term of Office

Each department Chair and Vice Chair shall serve a three (3)⁵⁵ year term which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or clinical privileges in that department. Department officers shall be eligible for reelection.

11.6.4 Removal

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

11.6.5 Duties

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

- a) act as presiding officer at departmental meetings;
- b) report to the Medical Executive Committee and to the Chief of Staff regarding all professional, administrative, and educational activities within the department;
- c) monitor the quality of patient care and professional performance rendered by members and Affiliates with clinical privileges in the department through a planned and systematic process which includes the development of data that can be used in the reappointment process; oversee the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee;
- d) develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice to assure a single level of care, credentials review and privileges delineation, medical education, utilization review, and quality assurance;
- e) be a member of the Medical Executive Committee, and give guidance on the overall medical policies of the Medical Staff and Hospital and make specific recommendations and suggestions regarding his or her department;
- f) transmit to the Medical Executive Committee the department's recommendations concerning practitioner appointment and classification, reappointment, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in his or her department;
- g) enforce the Medical Staff Bylaws, Rules and Regulations, and Policies within his or her department;

⁵⁵ May 2003

- h) implement within the department appropriate actions taken by the Medical Executive Committee;
- i) participate in every phase of administration of the department, including cooperation with nursing and Hospital Administration in matters such as legal and accreditation requirements, personnel (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques;
- j) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;
- k) recommend delineated clinical privileges for each member and Affiliate of the department; and
- l) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

11.7 DIVISION CHIEFS

11.7.1 Qualifications

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

11.7.2 Selection

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

11.7.3 Term of Office

Each Division Chief shall serve a two (2) year term and shall be eligible for reappointment by the Department Chair, unless he or she shall sooner resign, be removed from office, lose Medical Staff membership, department membership or clinical privilege in that division. Division Chiefs shall be eligible for reappointment by the Department Chair and must be affirmed by the Division every two (2) years.

11.7.4 Removal

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

11.7.5 Duties

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Each Division Chief shall:

- a) act as presiding officer at division meetings;
- b) assist in the development and implementation, in cooperation with the Department Chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division.
- c) evaluate the clinical work performed in the division;
- d) conduct investigations and submit reports and recommendations to the Department Chair regarding the clinical privileges to be exercised within his division by members, Affiliates, or applicants to the Medical Staff; and
- e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Department Chair, the Chief of Staff, or the Medical Executive Committee.

ARTICLE 12 - COMMITTEES

12.1 DESIGNATION

The Committees described in this Article and the Rules and Regulations shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the Chair and members of all committees shall be appointed by and may be removed by the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Changes in committee chair shall be reported to the Hospital Board. Medical Staff committees shall be responsible to the Medical Executive Committee; shall regularly submit minutes and reports. Medical Staff committees shall annually notify the Medical Executive Committee of their composition. Findings and/or sources of information pertinent to quality review functions shall be reported directly to the Departments (i.e., Blood Utilization, Surgical Case, etc.). The Medical Executive Committee reserves the right to amend committee decisions or policies directly or by returning a decision to the committee for reconsideration.⁵⁶

12.2 GENERAL PROVISIONS

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

- a) a named committee, but no such committee exists, the Medical Executive Committee shall perform such function or receive such report or recommendation or shall assign the functions of this Committee to a new or existing committee of the Medical Staff or to the staff as a whole; or
- b) the Medical Executive Committee, but a standing or special committee has been formed to perform the functions, the committee(s) so formed shall act in accordance with the authority delegated to it, including, but not limited to, the transmitting of regular reports to the Medical Executive Committee and other pertinent Medical Staff departments, divisions, or committees.

12.2.1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a two (2) year term and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the Committee.

12.2.2 Removal

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

⁵⁶ Addition of sentence 4, 6, & 8 approved at Annual Meeting 05/10/05

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

12.2.3 Vacancies

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

12.3 MEDICAL EXECUTIVE COMMITTEE

12.3.1 Composition

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

- a) Voting Members
 - 1) the officers of the Medical Staff;
 - 2) the Department Chairs;
 - 3) up to six (6)* at-large physician members of the Active Medical Staff who shall represent insofar as feasible major services and who shall be nominated and elected for a three⁵⁷-year term in the same manner and at the same time as provided in Sections 10.1.4 and 10.1.5 for the nomination and election of officers;

- b) Non-Voting Members
 - 1) the Medical Staff Standing Committee Chairmen as identified in these Bylaws and the Rules and Regulations;
 - 2) the Medical Director of Long Term Care;
 - 3) the Administrator and the Director of Health Services as ex-officio members; and/or
 - 4) other guests, as invited by the Chief of Staff.

12.3.2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this

⁵⁷ * Change from 7 to 6 members-at-large and term from 2 to 3 years approved at Annual Mtg. 05/10/05

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broad delegation of authority, the duties performed in good faith by the Medical Executive Committee shall include, but not be limited to:⁵⁸

- a) representing and acting on behalf of the Medical Staff in the intervals between Medical Staff meetings, subject to such limitations as may be imposed by these Bylaws or the law;
- b) coordinating and implementing the professional and organizational activities and policies of the Medical Staff;
- c) receiving and acting upon reports and recommendations from Medical Staff departments, divisions, committees, assigned activity groups, and Hospital communications;
- d) recommending action to the Board on matters of a medical-administrative nature;
- e) establishing, subject to Board approval, the structure of the Medical Staff, the mechanism to review credentials and delineate individual clinical privileges, the organization of quality assurance activities and mechanisms used to conduct, evaluate, and review "such activities," termination of Medical Staff membership and fair hearing procedures, as well as other matters relevant to the operation of an organized Medical Staff;
- f) evaluating the quality and appropriateness of medical care rendered to inpatients and outpatients; documenting conclusions, actions, and results for reporting to the Board;
- g) insuring that the clinical qualifications of all members, applicants, and Affiliates are relevant to their responsibilities and privileges in the organizational structure;
- h) reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members and Affiliates, and making recommendations to the Board regarding staff appointments and reappointments, assignments to departments, clinical privileges, and corrective action;
- i) taking reasonable steps to promote ethical conduct, continuing education, and competent clinical performance on the part of all members and Affiliates including the initiation of and participation in Medical Staff corrective or review measures when warranted;
- j) taking reasonable steps to ensure continuing education activities and programs for the Medical Staff and based at least in part on the results of quality assurance activity;
- k) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the Medical Staff;
- l) representing and acting on behalf of the Medical Staff between meetings of the Medical Staff, and reporting to the Medical Staff at each regular staff meeting;⁵⁹

⁵⁸ May 2011: TJC Standard Ms 01.01.01, EP20

⁵⁹ May 2011: TJC Standard Ms 01.01.01, EP23

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- m) assisting in the obtaining and maintaining of accreditation;
- n) developing and maintaining of methods for the protection and care of patients and others in the event of internal or external disaster;
- o) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the Medical Staff;
- p) participating in the development and review of all medical staff and hospital policy, practice, and planning; providing a liaison between the medical staff, Chief Executive Officer, and the hospital Board of Directors; and
- q) reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes.

12.3.3 Meetings

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

12.4 CREDENTIALS/MEDICAL STAFF AID COMMITTEE

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

12.4.1 Composition

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

12.4.2 Duties

The Committee shall:

- a) maintain an individual credential file on each Medical Staff member and Affiliate;
- b) review or monitor and evaluate the qualifications of each practitioner and Affiliate applying for initial appointment, reappointment, granting or re-granting or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;
- c) submit required reports and information on the qualifications of each practitioner and Affiliate applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, and special conditions;
- d) investigate, review, and report on matters referred by the Chief of Staff, Department

Chairmen, or the Medical Executive Committee regarding the qualifications, conduct, professional character, or competence of any applicant or Medical Staff member or Affiliate;

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

12.4.3 Meetings

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

12.5 OTHER COMMITTEES

- a) The Medical Staff shall develop and/or participate in other standing or ad hoc committees and review and evaluate functions as are deemed necessary to the proper provision of patient care, Hospital operations, and/or Medical Staff organization and governance. All committees shall be defined for composition, duties, and reporting responsibilities by the formulating body which shall submit the Committee Charter to the Medical Executive Committee for approval and maintain it with the standing or ad hoc committee.
- b) The Medical Staff shall participate in other Hospital committees which shall address, at a minimum, internal and external disaster plans, Hospital safety, and Interdisciplinary Practice.
- c) Such other committees shall meet as often as necessary to perform their function and shall maintain a written record of their proceedings.

ARTICLE 13 - MEETINGS

13.1 ANNUAL MEETING

There shall be an Annual Meeting of the Medical Staff.⁶⁰ The Chief of Staff or such other officers, department or division heads, or committee chairmen as the Chief of Staff or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the membership. Notice of this meeting shall be given to all members at least twenty (20) days prior to the meeting.

13.2 AGENDA

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

- a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;
- b) administrative or informational reports from the Chief of Staff, departments, committees, the Administrator, the County Manager, the Director of Health Services, and a member of the Board of Supervisors;
- c) election of officers when required by these Bylaws;
- d) reports including recommendations by responsible officers, committees, and departments on the overall results of patient care, audits, and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions as addressed in these Bylaws and by the Rules and Regulations;
- e) old business;
- f) new business; and
- g) appointment or privilege recommendations, if any.

13.3 SPECIAL MEETING

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

⁶⁰ Deletion of holding annual meeting in May deleted per approval at Annual Mtg. 05/10/05.

the notice calling the meeting.

13.4 COMMITTEE AND DEPARTMENT MEETINGS

13.4.1 Regular Meetings

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

13.4.2 Special Meetings

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

13.5 QUORUM

13.5.1 Staff Meetings

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

13.5.2 Department and Committee Meetings

A quorum of thirty (30) percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of twenty-five (25) percent of the voting members of a committee but in no event less than three (3) voting members. For department and division meetings, the quorum shall consist of twenty-five (25) percent of the voting members of a committee but in no event less than three (3) voting members.

13.6 VOTING AND MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Double votes will be disallowed. Votes cast by those serving in dual voting positions will be the vote of the higher position.⁶¹ A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these Bylaws. Committee action may be conducted by telephone conference which shall be deemed to constitute a meeting for the

⁶¹ May 2003

matters discussed in that telephone conference. Valid action may be taken without a meeting by a committee if it is acknowledged by a writing setting forth the action so taken which is signed by at least two-thirds of the members entitled to vote.

13.7 MINUTES

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

13.8 ATTENDANCE REQUIREMENTS

13.8.1 Regular Attendance

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

- a) the Annual Medical Staff meeting;
- b) at least fifty (50) percent of all special staff meetings duly convened pursuant to these Bylaws;
- c) at least fifty (50) percent of all meetings of either department or division, of which he or she is a member, as per Section 11.5; and
- d) at least fifty (50) percent of committee meetings of which he or she is a member.

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

13.8.2 Absence from Meetings

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

13.8.3 Special Attendance

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department, division, or committee meeting, the member may be requested

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to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting with respect to which he was given such notice, unless excused by the Medical Executive Committee upon a showing of good cause, shall be a basis for corrective action.

13.9 CONDUCT OF MEETINGS

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

13.10 EXECUTIVE SESSION

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

ARTICLE 14 - CONFIDENTIALITY, IMMUNITY, AND RELEASES

14.1 AUTHORIZATION AND CONDITIONS

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

- a) authorizes representatives of the Hospital and the Medical Staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- b) authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who acts in accordance with the provision of this Article; and
- d) acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and the exercise of clinical privileges at this Hospital.

14.2 CONFIDENTIALITY OF INFORMATION

14.2.1 General

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

14.2.2 Breach of Confidentiality

Inasmuch as effective peer review and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this Medical Staff and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

14.3 IMMUNITY FROM LIABILITY

14.3.1 For Action Taken

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

14.3.2 For Providing Information

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

14.4 ACTIVITIES AND INFORMATION COVERED

14.4.1 Activities

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

- a) applications for appointment, reappointment, or clinical privileges;
- b) corrective action;
- c) hearings and appellate reviews;
- d) utilization review;
- e) other department, or division, committee, or Medical Staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- f) peer review, quality review, and credentialing organizations (Medical Board of California, National Practitioner Data Bank, and similar reports).

14.4.2 Releases

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

ARTICLE 15 - GENERAL PROVISIONS

15.1 RULES AND REGULATIONS⁶²

15.1.1 Medical Staff Rules and Regulations⁶³

The Medical Staff shall initiate and adopt such Rules and Regulations as it may deem necessary for the proper conduct of its work and shall at least annually review and revise its Rules and Regulations to comply with current Medical Staff practice. Recommended changes to the Rules and Regulations may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff.⁶⁴ Additionally, hospital administration may develop and recommend proposed Rules, and in any case should be consulted as to the impact of any proposed Rules on hospital operations and feasibility. Proposed rules shall be submitted to the Medical Executive Committee for review and action as follows:

- a. Except as provided in Section 15.1.1d, below, with respect to circumstances requiring urgent action, the Medical Executive Committee shall not act on the proposed Rule until the Medical Staff has had a reasonable opportunity to review and comment on the proposed Rule. [This review and comment opportunity may be accomplished by posting proposed Rules on the Medical Staff website at least fifteen (15) days prior to the scheduled Medical Executive Committee meeting, together with instructions how interested members may communicate comments. A comment period of at least fifteen (15) days shall be afforded, and all comments shall be summarized and provided to the Medical Executive Committee prior to Medical Executive Committee action on the proposed Rule.]
- b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least twenty-five percent (25%) of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed Rule, it shall notify the Medical Staff. The Medical Executive Committee and the Medical Staff each has the option of invoking or waiving the conflict management provisions of Section 15.1.4.
 - 1) If conflict management is not invoked within 30 days it shall be deemed waived. In this circumstance, the Medical Staff's proposed Rule shall be submitted for vote, and if approved by the Medical Staff pursuant to Section 15.1.1b.3, the proposed rule shall be forwarded to the Governing Body for action. The Medical Executive Committee may forward comments to the Governing Body regarding the reasons it declined to approve the proposed Rule.
 - 2) If conflict management is invoked, the proposed Rule shall not be voted upon or forwarded to the Governing Body until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Governing Body.
 - 3) With respect to the proposed Rules generated by petition of the Medical Staff, approval of the Medical Staff requires the affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least 14 days' advance written notice, accompanied by the proposed Rule, has been given, and at least 51 percent

⁶² May 2011

⁶³ May 2011

⁶⁴ May 2011: TJC Standard 01.01.01

votes have been cast.

- c. Following approval by the Medical Executive Committee or the favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the Governing Body or automatically within 60 days if no action is taken by the Governing Body. If there is a conflict between the bylaws and the rules, the bylaws shall prevail.
- d. Where urgent action is required to comply with law or regulation, the Medical Executive Committee is authorized to provisionally adopt a Rule and forward it to the Governing Body for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described in Section 15.1.2a), the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least twenty-five percent (25%) of the voting members of the Medical Staff require the Rule to be submitted for possible recall; provided however, the approved Rule shall remain effective until such time as superseding Rule meeting the requirements of the law or regulation that precipitated the initial urgency has been approved pursuant to any applicable provision of this Section 15.1.1.

15.1.2 Department Rules

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

15.1.3 Medical Staff Policies

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

15.1.4 Conflict Management⁶⁵

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least 25% of the voting members of the Medical Staff regarding a proposed or adopted Rule or policy, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to five (5) members of the voting Medical Staff who shall serve as the petitioners' representative(s). The Medical Executive Committee shall be represented by an equal number of Medical Executive Committee members. The Medical Executive Committee's and the petitioners' representative(s) shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the hospital. Resolution at this level requires a majority vote of the Medical Executive Committee's representatives at the meeting and a majority vote of the petitioners' representatives. Unresolved differences shall be submitted to the Governing Body for final resolution.

⁶⁵ May 2011: TJC Standard MS 01.01.01

15.2 MEDICAL STAFF POLICIES⁶⁶

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

15.3 INFORMED CONSENT⁶⁷

- a) Based on input from the Medical Staff and Hospital Departments, the Medical Staff shall develop a list of procedures requiring informed consent of the patients. This list may be adopted, amended or repealed by majority vote of the Medical Executive Committee and approval by the Governing Board and upon adoption shall have the force and effect of Medical Staff Bylaws. This list shall include, but is not limited to, informed consent requirements with respect to the following procedures:
 - 1) surgery (including sterilization and hysterectomy)
 - 2) blood transfusions
 - 3) antipsychotic medications
 - 4) abortion
 - 5) breast cancer treatment
 - 6) silicon implants and collagen injections
 - 7) convulsive therapy
 - 8) implantation of cells, tissue, or organs
 - 9) such other procedures as may be identified in the respective departmental or service policies and procedures.
- b) The informed consent policy shall assure that the patient (or his/her representative) receives information necessary to make informed decisions about his/her care.
- c) Informed consents will be documented in the medical record.

15.4 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of Medical Staff membership, subject to the approval of the Medical Staff, and to determine the manner of expenditure of such funds received. However, such expenditures must be appropriate to the purposes of the Medical Staff and shall not jeopardize the nonprofit tax exempt status of the hospital.⁶⁸

⁶⁶ May 2008

⁶⁷ May 2008

⁶⁸ May 2011: Business & Professions Code Section 228.5

15.5 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these Bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these Bylaws. These Bylaws apply with equal force to both sexes wherever either term is used. The use of the term "days" in these Bylaws refers to calendar days, as opposed to workdays or weekends, except where specifically defined.

15.6 AUTHORITY TO ACT

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

15.7 DIVISION OF FEES

Any division of fees by members of the Medical Staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the Medical Staff.

15.8 NOTICES

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

Medical Staff Office
San Mateo County General Hospital
222 West 39th Avenue
San Mateo, CA 94403

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

15.9 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices, department chairmanships, the Medical Executive Committee, or Judicial Review Committees shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the Medical Executive Committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff.

15.10 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

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

15.11 CONFIDENTIALITY

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

- a) The records of the Medical Staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.
- b) Access to such records shall be limited to duly appointed officers and committees of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- c) Information which is disclosed to the governing body of the hospital or its appointed representatives—in order that the governing body may discharge its lawful obligations and responsibilities—shall be maintained by that body as confidential.
- d) Information contained in the credential file of any members may be disclosed with the member's consent or to any medical staff or professional licensing board or as required by law. However, any disclosure outside of the Medical Staff shall require the authorization of the Chief of Staff and the concerned department chair and notice to member.
- e) A Medical Staff member shall be granted access to the individual's credentials file, subject to the following provisions:
 - 1) Timely notice of such shall be made by the member to the Chief of Staff or the Chief of Staff's designee;
 - 2) The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information—including peer review committee findings, letters of reference, proctoring reports, complaints, etc.—shall be provided to the member, in writing, by the designated officer of the Medical Staff (at the time the member reviews the credentials file/within a reasonable period of time, as determined by the Medical Staff). Such summary shall disclose the substance, but not the source, of the information summarized;
 - 3) The review by the member shall take place in the Medical Staff Office, during normal work hours, with an officer or designee of the Medical Staff present.
- f) In the event a notice of action or proposed action is filed against a member, access to that member's credentials file shall be governed by Section 9.4.1.

15.12 LEGAL COUNSEL⁶⁹

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

15.13 DISPUTES WITH THE GOVERNING BOARD⁷⁰

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

- a. Invoking the Dispute Resolution Process
 - 1) The Medical Executive Committee may invoke formal dispute resolution, upon its own initiative, or upon written request of 25% of the members of the Active Staff.
 - 2) In the event the Medical Executive Committee declines to invoke formal dispute resolution, such process shall be invoked upon written petition of 50% of the members of the Active Staff.
- b. Dispute Resolution Forum
 - 1) Ordinarily, the initial forum for dispute resolution shall be the regular joint meetings between the Chief of Staff, Vice Chief of Staff, Hospital CEO, and CMO.
 - 2) However, upon request of at least 2/3 of the members of the Medical Executive Committee, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body. A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon request of (a) at least a majority of the Medical Executive Committee plus two members of the Governing Body; or (b) at least a majority of the Governing Body plus two members of the Medical Executive Committee.
- c. The parties' representatives shall convene as early as possible, shall gather and share relevant information, and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute the Governing Body shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the Governing Body determination shall not be arbitrary or capricious, and shall be in keeping with its legal responsibilities to act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital.⁷¹

⁶⁹ May 2011

⁷⁰ May 2011

⁷¹ May 2011: Business & Professions Code Section 2282.5 and TJC Standard MS 01.01.01

ARTICLE 16 - ADOPTION AND AMENDMENT OF BYLAWS

16.1 PROCEDURE

The Medical Staff shall have the initial responsibility and delegated authority to formulate, adopt and recommend Medical Staff bylaws and amendments which shall be effective when approved by the Governing Body, which approval shall not be unreasonably withheld. Such responsibility and authority shall be exercised in good faith and in a reasonable, timely and responsible manner, reflecting the interests of providing patient care of the general recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the Governing Body.⁷²

- a) INITIATED BY MEDICAL STAFF - On the request of the Chief of Staff, the Medical Executive Committee, the Bylaws Committee, or on timely written petition signed by at least twenty-five (25) percent of the members of the Medical Staff in good standing who are entitled to vote, consideration shall be given to the adoption, amendment, or repeal of these Bylaws.
 - i) Proposed amendments shall be submitted to the Governing Body for comments at least 30 days before they are distributed to the Medical Staff for a vote. The Governing Body has the right to have its comments at least 30 days regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.
 - ii) Proposed amendments submitted upon petition of the voting Medical Staff members shall be provided to the Medical Executive Committee at least 30 days before they are submitted to the Governing Body for review and comment. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the Governing Body when the proposed amendments are submitted to the Governing Body for comments; and to have its comments circulated to the Medical Staff with the proposed amendments at the time they are distributed to the Medical Staff for vote.⁷³

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

- b) INITIATED BY GOVERNING BODY AND/OR HOSPITAL ADMINISTRATION⁷⁴ - If these Bylaws are not in compliance with the requirements imposed by law, regulations, order of court of law, for accreditation, for tax purposes, or otherwise reasonably necessary, the Governing Body may request appropriate amendment. Additionally, hospital administration may develop and recommend proposed Bylaws, and in any case should be consulted as to the impact of any proposed Bylaws on hospital operations and feasibility.⁷⁵ The Medical Staff shall take action on that amendment at its next annual meeting, following requisite notice as outlined in 16.1.a.⁷⁶

⁷² May 2011
⁷³ May 2011
⁷⁴ May 2011
⁷⁵ May 2011
⁷⁶ 05/15/2003

16.2 ACTION ON BYLAW CHANGE

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

16.3 APPROVAL

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

16.4 EXCLUSIVITY

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

16.5 ANNUAL REVIEW

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

16.6 TECHNICAL AND EDITORIAL AMENDMENTS⁷⁷

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling, or other error or grammar or expression or inaccurate cross-references. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing to the Medical Staff and to the Governing Board. Such amendments would be effective upon adoption by the Medical Executive Committee, provided however, they may be rescinded by vote of the Medical Staff or the Governing Board within 120 days of the date of adoption by the Medical Executive Committee. [For purposes of this Section, "vote of the Medical Staff" shall mean a majority of the votes cast, provided at least 25 percent of the voting members of the Medical Staff cast ballots.]

16.7 EFFECT OF THE BYLAWS

⁷⁷ May 2008

SMMC MEDICAL STAFF BYLAWS (cont'd.)

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

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

**SAN MATEO MEDICAL CENTER
MEDICAL STAFF**

**GENERAL
RULES AND REGULATIONS**

Revised 06/10/98; reviewed 1999; reviewed 2000; revised 06/20/2001, revised 06/27/2002, revised 05/25/2004
Revised 05/10/2005, revised 01/05/2006, revised 02/01/2007, revised 05/03/2007, revised 05/26/2009, revised 05/25/2010;
Revised 05/24/2011; reviewed 05/12/2012; revised 06/04/2013; revised 06/05/2014; revised 07/02/2015; revised 12/08/2015

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SAN MATEO MEDICAL CENTER
MEDICAL STAFF GENERAL RULES AND REGULATIONS

SECTION I - ADMISSION AND DISCHARGE OF PATIENTS

A. ADMISSION OF PATIENTS

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

1. Scope of Service

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

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

2. Limitations to Members

A patient may be admitted to the Medical Center only by a physician of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Medical Center.

3. Responsibility for Care and Treatment

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

4. Provisional Diagnosis

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

5. Bed Allocation

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

6. Emergency Admissions

- a. Practitioners admitting emergency cases shall be prepared to justify through the Medical Records Committee, to the Medical Executive Committee, and the Medical Center Administration that the Medical Center admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
- b. A patient to be admitted on an emergency basis who does not have a private practitioner may select any practitioner in the applicable department or service to attend to him. Where no such selection is made, a Medical Staff member on duty in the department or service will be assigned to the patient, on a rotation basis. The chairman of each department shall provide a schedule for such assignments, to include only current Medical Staff members.

7. Timely Professional Care

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

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

8. Admission to and Discharge from Specialty Units

a. Intensive Care Unit (ICU)¹

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

b. ECG Telemetry

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

c. Short Stay Unit (SSU)

¹ M.E.C. revision 04/10/2007

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

B. DISCHARGE OF PATIENTS

1. Written Orders

Patients shall be discharged only on a written order of the attending practitioner or a physician whom he designates as his alternate.

2. AMA/AWOL

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

3. Timeliness of Discharge

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

4. Management of Patient Death

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

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

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

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

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

² M.E.C. 02/05/2002

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

c. Universal Donors

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

SECTION II - MEDICAL RECORDS

A. RESPONSIBILITY

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

B. HISTORY AND PHYSICAL⁴⁵

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

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

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

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

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

³ M.E.C. revision 01/09/2007

⁴ M.E.C. revision 03/09/2004

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

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

C. PROGRESS NOTES ⁷

Inpatient Admission

All inpatients shall have a daily progress note that includes assessment of symptoms related to the reason for admission, assessment of new symptoms arising during the hospitalization, a physical exam specific to reason for admission and relevant to any new symptoms developing during the hospitalization, review of pertinent laboratory results, current impression, and treatment plan.

Operative and Invasive Procedures

Brief Pre-procedure note

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

Brief Post-procedure note

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

D. OPERATIVE REPORTS

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

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

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

E. CONSULTATIONS

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

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings

⁷ M.E.C. revision 03/09/2004

⁸ M.E.C. 05/12/2009 (added language)

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

F. ENTRIES

1. Dating, Timing

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

2. Authentication⁹

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

3. Final Diagnosis

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

4. Discharge Summary¹⁰

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

It is strongly encouraged that the discharge summary be dictated within 72 hours of the time of discharge but in no case later than 14 days.

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

In cases where the discharge summary is not dictated at time of discharge and outpatient follow-up is to occur in less than 72 hours, it is required that the Discharge Summary Sheet be filled out in its entirety at time of discharge. In such cases the patient is asked to bring their copy of the Discharge Summary to the outpatient visit.

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

5. Interval History and Physical on Readmissions

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

⁹ M.E.C. revision 09/11/2001

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

G. CONFIDENTIALITY AND CONSENT

1. Written Consent

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

2. Records Management

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

3. Records Access, Including Research

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

H. COMPLETENESS OF THE RECORD

1. Permanent Filing

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

2. Use of Order Sets¹²

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

3. Post-discharge Timely Completion and Suspension for Unmet Standard¹⁴

a. Expectations¹⁵

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

Physicians are expected to complete their record deficiencies weekly.

b. Definitions

¹¹ May 2015

¹² May 2015

¹³ May 2015

¹⁴ M.E.C. revision 05/12/2009

¹⁵ May 2015

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

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

c. Sanctions¹⁶

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

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

Physicians with one or more deficiencies assigned to them for more than 21 days shall be sent a "Notice of Pending Suspension" on a Monday by the Chief of Staff informing the physician that, should his or her record deficiencies remain incomplete one week from the date of the notice, the physician shall be sanctioned until his or her record deficiencies are cleared and shall not be able to perform the following:

- Admit non-emergency patients to the hospital.
- Perform consultations.
- Schedule new procedures or operations.
- Treat patients in clinic.
- Attend in clinics.

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

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

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

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

Procedural Considerations¹⁷

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

¹⁶ May 2015

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

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

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

SECTION III - GENERAL CONDUCT OF CARE

A. CONSENTS FOR TREATMENT

1. Admission Consent

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

2. Procedural and Therapeutic Consents

Specific consents for special treatments and/or surgical procedures shall be obtained. Any procedures performed in the operating room or in radiology involving intravenous contrast material requires informed consent.¹⁸ Informing the patient of the nature and risks inherent in treatments and procedures shall be the responsibility of the appropriate physician, practitioner, or affiliate.

Patients unable to provide own consent (i.e., minors, forensic custody, conserved, incompetent, etc.) shall not undergo special treatments or surgical procedures requiring specific consent without court or public guardian/conservator authorization. The process of informed consent remains the responsibility of the appropriate physician, practitioner, or affiliate to obtain and coordinate with the Department of Nursing and the Court, public guardian, or conservator.

B. ORDERS FOR TREATMENT¹⁹

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

1. Written and Verbal Orders

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

2. Illegible or Improperly Written Orders

Practitioners' and affiliates' orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse or applicable ancillary department staff. The use of "Renew," "Repeat," and "Continue orders" are not acceptable when transferring a patient in or out of the Intensive²² Care Unit, or as the initial orders written after surgery.

¹⁸ May 2015

¹⁹ M.E.C. revision 11/28/2000

²⁰ M.E.C. revision 09/11/2001

²¹ M.E.C. revision 11/18/2003

²² M.E.C. revision 04/10/2007

3. Automatic Cancellation

All previous orders are canceled when patients go to surgery and when transferred in or out of the Intensive²³ Care Unit (refer to separate DNR policy).

4. Medications - Standard and Research

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

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

b. Inpatient Automatic Stop Medication Orders

Antibiotic orders shall automatically stop at twenty-four (24) hours for prophylactic use, five (5) days for empiric use, and seven (7) days for therapeutic use. All ordered scheduled drugs (narcotics, sedatives, etc.) and Coumadin shall automatically stop at seven (7) days.

5. Restraints Orders

Refer to *Patient Care Function Manual Volume 1, Care of Patient (policy #3.37), “Physical Restraint and/or Seclusion, and Supportive/Protective Devices Policy for Acute Medical and Surgical Care and Behavior Management.”*

C. CONSULTATIONS

1. General

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

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

2. Required Consultation

²³ M.E.C. revision 04/10/2007

²⁴ M.E.C. revision 11/13/2001

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

- a. When the patient is not a good risk for operation or treatment;
- b. Where the diagnosis is obscure after usual/customary diagnostic procedures have been completed;
- c. Where there is doubt as to the choice of therapeutic measures to be utilized;
- d. In unusually complicated situations where specific skills of other practitioners may be needed;
- e. In instances in which the patient exhibits severe psychiatric symptoms;
- f. When reasonably requested by the patient or his family.

3. Pediatric and Maternal Child Care

Pediatric consultation shall be required for the admission of any child under twelve (12) years of age. The admitting physician shall be responsible for requesting the pediatric consultation.

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

4. Consideration for Suicidal Patients

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

D. REGULATORY COMPLIANCE ²⁵

1. Emergency Medical Treatment and Labor Act (EMTALA)

a. Designation of “Qualified Staff”

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

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

²⁵ M.E.C. revision 01/23/2001

reported to the Medical Executive Committee.]

b. On-Call Staff Responsibility

Medical Staff who agree to provide on-call coverage for specialty services or for back-up are responsible for responding, examining, and treating patients with emergency conditions. Each service area that uses on-call coverage shall adhere to policies that establish response times and mechanisms to assure such coverage is provided. Where lapses in on-call coverage do occur, they shall be documented and reported to the appropriate Administrative and Medical Staff leaders for investigation and corrective action. The Medical Executive Committee shall ensure the effectiveness of the on-call schedule including the using of disciplinary action when deemed necessary.

2. Organized Health Care arrangement (OHCA)

a. Description

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

b. Authorization and Conditions

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

SECTION IV - COMMITTEES

The Committees described in this Section are considered Medical Staff Committees. Description of assignments, terms, removal, and vacancies is in Article 12 of the Medical Staff Bylaws. Committee members as defined in the composition of each committee are allowed to vote on committee business. Committee members designated as non-voting may not vote. This applies to physician and non-physician committee members. Any active member of the Medical Staff may join a committee by appointment of the Chief of Staff with approval of the Medical Executive Committee or by attending two meetings and petitioning the committee chair for appointment. Admission to a committee may be put up to a vote of the members of that committee at the discretion of the committee chair. If membership changes are made at the committee level, a report shall be submitted to the Medical Executive Committee for approval. A roster of committee members indicating the Chair, who attends, and who may vote shall be submitted to the Medical Executive Committee annually²⁶.

A. BYLAWS COMMITTEE

1. Composition

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

2. Duties

The duties of the Bylaws Committee shall include:

- a. conducting an annual review of the Medical Staff Bylaws, as well as the Rules and Regulations and forms promulgated by the Medical Staff, its departments and divisions, and reporting to the Governing Body;
- b. submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and
- c. receiving and evaluating for recommendation to the Medical Executive Committee suggestions for modification of the items specified in subdivision (a).

3. Meetings

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

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

B. CONTINUING MEDICAL EDUCATION COMMITTEE ²⁷

1. Composition

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

2. Duties

The duties of the Committee shall include:

- a. planning, implementing, coordinating, and promoting ongoing special clinical and scientific programs for the Medical Staff. This includes:
 1. identifying the educational needs of the Medical Staff;
 2. formulating clear statement of objectives for each program;
 3. assessing the effectiveness of each program;
 4. choosing appropriate teaching methods and knowledgeable faculty for each program; and
 5. documenting staff attendance at each program.
- b. assisting in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
- c. establishing liaison with the quality improvement program of the medical center in order to be apprised of problem areas in patient care which may be addressed by a specific continuing medical education activity.
- d. maintaining close liaison with other Medical Center Medical Staff and department committees concerned with patient care.
- e. making recommendations to the Medical Executive Committee regarding library needs of the Medical Staff.
- f. advising administration of the financial needs of the continuing medical education program.

3. Meetings

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

²⁷ M.E.C. addition 10/14/2003

C. CRITICAL CARE COMMITTEE

1. Composition

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

2. Duties

The duties of the Critical Care Committee shall be to:

- a. review and evaluate activities, policies, practices, and procedures with respect to the quality, safety, and appropriateness of patient care services provided by the Special Care Units;
- b. review and evaluate all Code Blue events within the Division of Medical Centers and Clinics and recommend changes;
- c. make recommendations or propose actions to resolve problems identified in the review process;
- d. evaluate the effectiveness of such recommendations and proposed actions; and
- e. review and evaluate the CPR training programs required of the Medical Staff Department and/or Medical Staff Division Rules and Regulations.

3. Meetings

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

D. ETHICS COMMITTEE²⁸

1. Composition

The Committee shall consist of physicians and other staff members as the Medical Executive Committee may deem appropriate. It may include nurses, lay representatives, social workers, clergy, ethicists, attorney, administrators, and representatives from the Medical Center's Board of Directors. The chair shall be appointed mutually by the Chief of Staff and Chief Executive Officer²⁹.

²⁸ M.E.C. addition 09/09/2003

²⁹ M.E.C. revision 12/13/2005

2. Duties

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

3. Meetings

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

E. INFECTION CONTROL COMMITTEE

1. Composition

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

2. Duties

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

- a. development of a Medical Center-wide infection control program;
- b. evaluation and approval of the applicability and appropriateness of all surveillance activities and action taken to prevent and control infections;
- c. delegation of responsibility to a qualified individual, task force, or department to carry out actions on any recommendations from the group, the Chief of Staff, the Medical Executive Committee, or other departments and committees as appropriate;
- d. approval of the use of infection control resources;
- e. a review minimally triennially of Medical Center-wide infection control policies and procedures; and

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

3. Meetings

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

F. INTERDISCIPLINARY PRACTICE COMMITTEE

1. Composition

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

- a. Director of Nursing.
- b. Equal number of physicians and nurses, appointed respectively by the Chief of Staff and Director of Nursing.
- c. Allied health professionals as deemed appropriate.

2. Duties

The duties of the Interdisciplinary Practice Committee shall include:

- a. The Committee shall oversee the establishment and administration of standardized procedures for registered nurses at the Medical Center. Specifically, the Committee shall:
 - 1) Identify nursing functions that require the adoption of standardized procedures;
 - 2) Establish written policies and procedures setting forth the required form of each standardized procedure, including the subjects to be covered;
 - 3) Review and approve (as to both form and content) all proposed standardized procedures covering the extended role of registered nurses at the Medical Center, with approval to be given by the Chief Executive Officer (or designee), a majority of physician members of the Committee, and a majority of registered nurse members of the Committee, after consultation with appropriate persons in the medical and nursing specialties under review;
 - 4) Recommend to the Executive Committee written policies and procedures for the designation of registered nurses who are authorized to perform functions under each standardized procedure;

- 5) Assume responsibility for identifying and designating registered nurses who are qualified to practice according to standardized procedures, both on an initial and on a continuing basis;
 - 6) Insure that the names of registered nurses approved to perform functions according to each standardized procedure are on file in the appropriate nursing unit.
- b. The Committee shall oversee the practice of allied health professionals at the Medical Center. Specifically, the Committee shall:
- 1) Make recommendations to the Executive Committee concerning any protocols that should be developed to govern the practice of allied health professionals at the Medical Center, and supervise the development of such protocols;
 - 2) Review applications for appointment or reappointment to allied health professional status and clinical privileges, in accordance with governing protocols;
 - 3) Initiate corrective action against allied health professionals at the Medical Center, in accordance with governing protocols;
 - 4) Monitor the role of allied health professional categories permitted to practice at the Medical Center and make recommendations to the Executive Committee concerning that role; and
 - 5) Serve as liaison between the allied health professionals at the Medical Center and the Medical Staff.
- c. The Committee shall assist in defining the responsibilities of physicians and of registered nurses in areas of ambiguity or overlap.
- d. The Committee shall establish a means of securing recommendations from health care professionals and personnel at the Medical Center who practice in the clinical field or specialty under review concerning matters within the Committee's jurisdiction.
- e. The Committee shall establish policies and procedures governing the discharge of the above responsibilities and setting forth the procedure for the approval of any Committee recommendations.

3. Meetings

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

G. OPERATING ROOM COMMITTEE ³⁰

1. Composition

The Operating Room Committee shall consist of at least the Chair of the Department of Surgery, a representative from the General Surgery Service, a representative of Anesthesia Services, and the Clinical Services Manager for Surgical Services or designee. Additional representatives from other services (e.g., Clinic Manager, Emergency Department) as recommended by the Chair or Chief of Staff. The Chair of this committee shall be appointed by the Chief of Staff.

2. Duties

The duties of the Operating Room Committee shall be to:

- a. Have a forum for discussion of topics in a working session prior to the monthly Department of Surgery meeting. Topics for discussion include but are not limited to:
 - Block Utilization
 - Policy Development
 - Review of standing reports
 - Input for Capital equipment
 - Review of new products and technology
 - Review of PI and Risk Management issues
- b. Facilitate communication and dissemination of O.R. policies and procedures.

3. Meetings

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

H. PHARMACY/THERAPEUTICS COMMITTEE

1. Composition

This Committee shall consist of at least five (5) members, including representatives from the Departments, Nursing Service, Pharmacy, and Administration. It may include non-voting representatives from relevant Medical Center services. The Committee Chair shall be a practitioner appointed by the Chief of Staff.

2. Duties

The duties of this Committee shall include:

- a. assisting in the formulation of professional practices and policies regarding the

³⁰ M.E.C. addition 04/13/2004.

evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Medical Center, Clinics, and Crystal Springs Rehabilitation Center, including antibiotic usage and diagnostic testing materials;

- b. advising the Medical Staff and the pharmaceutical service on matters pertaining to the choice of available drugs;
- c. making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;
- d. periodically developing and reviewing a formulary or drug list for use in the Medical Center;
- e. evaluating clinical data concerning new drugs or preparations requested for use in the Medical Center;
- f. shall be informed/notified about the use and control of investigational drugs and research in the use of recognized drugs;³¹
- g. maintaining a record of all activities relating to drug utilization evaluation functions, including the appropriateness of the use of antibiotics and other drugs and diagnostics through the analysis of patterns of drug practice; and submitting periodic reports and recommendations to the Medical Executive Committee, Quality Assurance Committee, and/or appropriate Medical Staff Department concerning those activities including findings, recommendations, actions, and results, Medical Center-wide, department, and practitioner-specific;
- h. reviewing adverse drug reactions;

3. Meetings

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

I. QUALITY IMPROVEMENT COMMITTEE ³²

1. Composition ³³

The Vice Chief of Staff shall serve as Chair of the Quality Improvement Committee. The Quality Improvement Committee shall consist of:

³¹ M.E.C. revision 09/09/2003.

³² M.E.C. revision 01/23/2001. M.E.C. revision of name only 09/10/2002.

³³ M.E.C. revision 09/09/2003.

Voting Members³⁴

- a. the Chairs of the respective Medical Staff Departments, or their designee(s), Medical Director of Long Term Care; and Chair of the Utilization Management Committee.
- b. the CEO to represent Medical Center Administration, and liaison with Governing Body;
- c. Administrative Vice Presidents for Ambulatory Services, Ancillary/Support Services, Long Term Care Services, Patient Care Services, and Quality Department, or their designee(s).

Nonvoting Members

Others including Nursing Executives, Administration, Quality Management, and as may be recommended by the Quality Improvement Committee itself, the Chief of Staff or the Medical Executive Committee.

2. Duties

The Quality Improvement Committee shall perform the following duties:

- a. receive reports of all Medical Staff and departmental quality assessment and improvement activities;
- b. monitor and evaluate the effectiveness and adequacy of quality review activities conducted throughout the Division of Medical Centers and Clinics, including Medical Staff responsibilities;
- c. refer to the appropriate Medical Staff or other committee the responsibility for assessing concerns and monitoring resolutions;
- d. identify trends and priorities for improvement;
- e. submit quarterly reports to the Medical Executive Committee on quality review activities;
- f. annually review the Division of Medical Centers and Clinics' Quality Improvement Plan for comprehensiveness.
- g. recommend approval of action plans for root cause analyses and focus reviews.³⁵

3. Meetings

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

³⁴ M.E.C. revision re: voting designation 12/13/2005

³⁵ M.E.C. addition 12/13/2005

J. WELL-BEING COMMITTEE

1. Composition

- a. The Well-Being Committee shall be composed of no fewer than three active medical staff members, a majority of whom, including the chair, shall be physicians and one of whom shall be a psychiatrist whenever possible.
- b. Except for initial appointments, each member shall serve a term of three years, and the terms shall be staggered to achieve continuity. Insofar as possible, members of this committee shall not actively participate on other peer review or quality improvement committees while serving on this committee.

2. Duties

- a. The Well-Being Committee is charged to develop a process that provides education about physician health, addresses prevention of physical, psychiatric or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition. These processes should include mechanisms for the following:
 - Educating medical staff and hospital staff about illness and impairment recognition issues specific to practitioners
 - Self-referral by a practitioner, and referral by other medical staff and hospital staff
 - Upon its own initiative, upon request of the involved practitioner, or upon request of a medical staff or department committee or officer, providing such advice, counseling or referrals to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern
 - Evaluating the credibility of a complaint, allegation or concern, including such investigation as reasonably deemed necessary
 - Monitoring the affected practitioner and the safety of patients until the rehabilitation or any corrective action process is complete
 - Confidentiality; however, if the committee receives information that demonstrates that the health or impairment of a medical staff member may pose a risk of harm to hospital patients (or prospective patients), that information shall be referred to the Chief of Staff, who will determine whether corrective action is necessary to protect patients.
- b. The Well-Being Committee shall review the responses from applicants concerning physical or mental disabilities and recommend what, if any, reasonable accommodations may be indicated in order to assure that the practitioner will provide care in accordance with the hospital and medical staff's standard of care.

3. Meetings

The committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable, and shall routinely report on its activities to the Medical Executive Committee.

SECTION V- MEDICAL STAFF POLICIES

A. DISRUPTIVE PROVIDER BEHAVIOR³⁶

General:

The Medical Staff is committed to supporting a culture that values integrity, honesty, and open and fair dealing with patients, families, physicians, and employees. Each member of the Medical Staff strives to behave professionally and collegially as a way to achieving an outstanding patient experience. To accomplish this, the Medical Staff works toward a workplace that is free of harassment and discrimination. This includes behavior that could be perceived as inappropriate, harassing, or disrespectful. Behaviors such as these undermine our culture of safety and detract from patient satisfaction.

Purpose:

The purpose of this policy is to set forth the expectations of all members of the Medical Staff during any and all interactions with other persons at the medical center. This policy also addresses conduct that does not meet the expected standards of the Medical Staff. The primary focus of this policy is to ensure protection of patients, employees, and Medical Staff members. The well-being of the Medical Staff member whose conduct is in question is also a concern.

Code of Conduct:

The Medical Staff at SMMC has a code of conduct that defines unacceptable and disruptive and inappropriate behaviors. This code sets forth the following requirements with respect to staff behaviors:

1. Physicians/practitioners will not exhibit inappropriate, unprofessional, dishonest or disruptive behavior while on Medical Center premises or in any of their interactions with Medical Center patients.
2. Physicians/practitioners will refrain from the use of profanity or similarly offensive language while on hospital premises. Physicians/practitioners will not shout or otherwise raise their voices in anger with any individual at the medical center. This includes making discourteous comments, including but not limited to, name calling, or give discourteous orders or demands to any individual at San Mateo Medical Center.
3. Physicians/practitioners will not, under any circumstances, criticize any individual at the Medical Center in front of any other individual at the medical center. Job and performance feedback should be given in a confidential setting. The physician/practitioner will address any criticisms of or concerns about employees or staff members to the appropriate supervisor in a courteous manner and in private.
4. Physicians/practitioners will not record any derogatory comments or judgments of the patient or another practitioner in patient medical records.

³⁶ M.E.C. approved 05/12/2009

5. Physicians/practitioners shall not threaten, physically or otherwise, any individual at the Medical Center.
6. Physicians/practitioners shall address any concerns or grievances they have with the administration, other physicians/practitioners or Medical Center employees in a direct and professional manner with the individual involved, in an effort to resolve the matter. Failing those efforts, physicians/practitioners shall present to the Chief of Staff or Chief of Service any concerns or grievances that they wish to be addressed about San Mateo Medical Center administration, other physicians/practitioners, and/or San Mateo Medical Center employees.
7. Physicians/practitioners shall not violate confidentiality. They shall not repeat information shared in a closed session or confidential peer review session outside of the session.

All other behaviors that reasonable individuals would consider offensive to others or disruptive to the operation of the medical center shall be avoided. Offensive behavior may include profanity, sexual comments, sexual images, racial slurs, ethnic slurs, or gender specific comments of an offensive nature. They may be oral, written, an image, or a gesture. Offensive comments may include matters that would offend based on race, creed, color, religion, age, gender, sexual orientation, culture, national origin, or handicap. Disagreements amongst the Medical Staff are to be resolved with dignity, courtesy and respect. There should be no arguments or disruptive behaviors in public or work areas that may be overheard by uninvolved individuals.

Procedure:

All Medical Staff members have an obligation to report behavior that violates this policy to their department chair. For minor or first time violations, the Department Chair may use their discretion as to whether they open a code of conduct investigation. They are strongly encouraged to err on the side of reporting.

The initial report of a code of conduct violation may be verbal, but a brief written statement should comprise the formal report. It should contain:

- Date of the report
- Date of the alleged behavior
- The name of the physician in question
- The name of the individual bringing the complaint
- The names of who was involved in the alleged behavior
- The names of who was present during the alleged behavior
- A description of the behavior
- An assessment of any patient risk

This report is to be submitted to the Medical Staff Office, which will distribute it to the Department Chair and the Chief of Staff. Other non-medical staff employees shall report conduct that violates this policy according to their area policy. Once a supervisor brings a written complaint of inappropriate behavior to the Medical Staff, it may serve to begin the medical staff process. It must contain the above information.

Behavior that any individual believes poses an immediate danger to patient safety should be referred to the Department Chair or the Chief of Staff. Behavior that violates this policy but does not pose an immediate danger to patient safety should be routed through the Department Chair.

Upon receiving a complaint of inappropriate conduct, the Chief of Staff or Department Chair shall decide whether immediate action is required. If immediate action is required, administrative leave or other appropriate action may be instituted. Suspension is limited to 14 days per Section 8 of the bylaws.

The Department Chair in conjunction with the Chief of Staff will review the report and conduct an appropriate investigation as indicated. Any investigation should be initiated 14 days of receipt of the complaint and completed in a timely manner. At the discretion of the Chief of Staff, the investigation may be conducted in concert with the Medical Center administration.

Actions:

If after the investigation, the Department Chair or Chief of Staff concludes that no incident of inappropriate conduct has occurred, no documentation of the incident will be recorded. If no investigation is done, no documentation is required. If an investigation is completed and no evidence of inappropriate conduct is found, a letter stating this will be placed in the physician's file.

Once an investigation is complete in cases where it is determined that an incident of inappropriate conduct has occurred, a written summary of the findings will be placed in the physician's credentialing file. The original complaint will likewise be placed in the physician's file.

If the Department Chair and Chief of Staff deem that inappropriate conduct has occurred, they should both meet with the member of the Medical Staff in questions and communicate:

- The inappropriate behavior
- The expected behavior going forward
- The consequences of any repeat conduct
- Any necessary monitoring or follow-up
- Any perceived retaliation will result in immediate disciplinary action

The substance of this meeting shall be documented in a written form.

The Department Chair in conjunction with the Chief of Staff will provide the Medical Staff member with a written summary of the meeting and a copy will be placed on file in the Medical Staff Office.

The Department Chair or Chief of Staff may mandate a course of correction such as anger management training, psychiatric evaluation, drug testing, privilege probation, or any other intervention that ensures patient safety and/or physician rehabilitation. If the ability to practice medicine is restricted, the county counsel shall be contacted about the need to report under the California Business and Professional Code Section 805.

If a course of correction is mandated, an informational report shall be made by the Chief of Staff to the MEC in closed session. On a case-by-case basis, involvement of the Chief Medical Officer or Administration is allowed.

Consequences:

Medical Staff members who do not act in accordance with the policy, including not participating in the interview process will be suspended [in accordance with Article 8 of the Medical Staff Bylaws] and

have a letter of complaint submitted to the MEC for disciplinary action.

Once a provider has three valid complaints registered against them and has met with the Chief of Staff and/or Department Chair twice, the policy in Article 8 of the Medical Staff Bylaws will be applied and the MEC should consider action.

The Article 8 procedures may supersede this policy and if deemed appropriate, the Chief of Staff, a department chair, the Medical Executive Committee, or any member of the Governing Body may begin that process after the first complaint.

B. COMPLETION OF THE MEDICAL RECORD³⁷

Refer to Section II-Medical Records, Subsection H-Completeness of the Record.

C. DISASTER PRIVILEGES³⁸

General:

It is the policy of San Mateo Medical Center to permit the Chief Executive Officer (or designee) to grant disaster privileges on a case-by-case basis based upon the recommendations of the Chief of Staff (or designee) when the hospital's disaster plan has been activated and the organization is unable to handle the immediate patient care needs. This policy outlines San Mateo Medical Center's plan to grant disaster privileges to individuals who do not currently possess medical staff privileges at San Mateo Medical Center but are deemed qualified and competent, for the duration of the disaster situation. Granting of these privileges will be handled on a case-by-case basis and are not a "right" of the requesting provider.

Procedure:

When the hospital's emergency management plan has been activated, and it has been determined that disaster privileging will be required, the following process for any licensed independent practitioner (LIP) who is not on the medical staff of San Mateo Medical Center and who presents his/herself as a volunteer to render services will be utilized:

1. The LIP who wants to request Disaster Privileges must present a valid government-issued identification issued by a state, federal, or regulatory agency (i.e., a driver's license or passport), and at least one of the following:
 - Current hospital photo ID card that clearly identifies professional designation
 - Current California medical license
 - Primary source verification of the license
 - An ID that certified the LIP is a member of a state or federal disaster medical assistance team (DMAT), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
 - An ID that certifies that LIP has been granted authority by a federal, state, or municipal entity to administer patient care in emergencies
 - Identification by a current hospital or medical staff member who possesses personal knowledge regarding the volunteer's identity and ability to act as a licensed

³⁷ May 2015: Section V, Subsection B combined with Section II, Subsection H

³⁸ M.E.C. approved 05/11/2010

independent provider during a disaster

2. The Medical Staff oversees the performance and professional practice, care, and treatment and services provided by the volunteer LIP through direct observation, mentoring, and clinical record review. The Chief of Staff or designee shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster privileges. Based on the oversight of each volunteer LIP, the medical staff will determine how long the granted disaster privileges shall continue.
3. Volunteer Licensed Independent Practitioners granted disaster privileges will wear identification badges denoting their status as part of the Disaster Medical Assistance Team. LIP's who are already on the medical staff and who have been identified as a member of the medical staff will be provided a name badge in the event that their Medical Center's identification is not available.
4. Primary source verification of licensure and the verification process of the credentials and privileges of practitioners who receive disaster privileges occurs as soon as the immediate situation is under control. The verification process is identical to that described in Medical Staff Bylaws, Section 7.5 (Temporary Privileges) for granting temporary privileges to meet an important patient care need.
5. All disaster privileges immediately terminate once the emergency management plan is no longer activated. However, the Medical Center may choose to terminate disaster privileges prior to that time.
6. A list of all volunteer practitioners who received disaster privileges during the emergency management/disaster event will be maintained.
7. When emergency management plan has been activated, providers who receive temporary privileges pursuant to this policy will be covered for professional and general liability for acts undertaken in this capacity on behalf of San Mateo Medical Center.

D. MEDICAL STAFF PEER MONITORING³⁹

Purpose

Implementation of a Continuous Quality Program for the Medical Staff including Affiliates to the Medical staff that through the activities of the Medical Staff, the Ongoing Professional Practice Evaluation (OPPE) of individuals granted clinical privileges are assessed, Focused Professional Practice Evaluation (FPPE) of individuals with clinical privileges is conducted; and the results of such assessments and evaluations is used to improve professional competency, practice, and care.

³⁹ M.E.C. 07/13/2010

Policy

San Mateo Medical Center Medical Staff defines the circumstances requiring monitoring and evaluation of a practitioner's professional performance. Ongoing professional practice evaluation (OPPE) information is factored into the decision to maintain existing privilege(s), to revise existing privilege(s), or to revoke an existing privilege prior to or at the time of renewal. Relevant information resulting from the focused professional practice evaluation (FPPE) process is integrated into performance improvement activities, consistent with policies and procedures that are intended to preserve confidentiality and privilege of information.

Definitions

- A. **Ongoing Professional Practice Evaluation (OPPE)** is the routine monitoring and evaluation of competency for current medical staff. Ongoing professional practice evaluation includes a documented summary of ongoing data collected for the purpose of assessing a practitioner's clinical competence and professional behavior. The information gathered during this process is factored into decisions to maintain, revise, or revoke existing privileges prior to or at the end of the two-year reappointment cycle.
- B. **Focused Professional Practice Evaluation (FPPE)** is the time-limited evaluation of a practitioner's competence in performing any specific privilege. This process is implemented for all initially requested privileges and whenever a question arises regarding a practitioner's ability to provide safe, high quality patient care.
- C. **Peer Review** is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care.

Procedure

- A. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
- B. Peer review will be conducted in a timely manner. The goal is for review of routine cases to be initiated and the initial review completed within 14 days from the date the Peer Review Form is generated. When the case is sent for referral, review of the case should be completed within 60 days. Exception may occur based on case complexity or reviewer availability.
- C. The involved practitioner will receive practitioner-specific feedback as needed.
- D. The Medical Staff will use the practitioner-specific peer review results in making its recommendations to the governing board regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
- E. The hospital will keep practitioner-specific peer review and other quality information concerning a practitioner in a secure, locked file.

- F. Only the final determinations of the medical staff departmental quality review committees and the Credentials Committee, and any subsequent actions are considered part of an individual practitioner's quality file.
- G. Peer review information in the individual practitioner quality file is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee to the extent necessary to carry out their assigned responsibilities.
- H. No copies of peer review documents will be created and distributed unless authorized by medical staff or hospital policy.

Conflict of Interest

- A. It is the obligation of the individual reviewer or committee member to disclose to the committee a potential conflict of interest. For example, it is a conflict of interest if the reviewer may not be able to render an unbiased opinion due to either involvement in the patient's care or a relationship with the practitioner involved as a direct competitor or partner.
- B. It is the responsibility of the medical staff departmental quality review committee to determine on a case-by-case basis whether a relative conflict is substantial enough to prevent the individual from participation. When either an absolute or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decision other than to provide specific information requested.

Ongoing Professional Practice Evaluation [OPPE]

- A. Medical Staff approved clinical indicators: The medical staff has approved indicators for the departments/services (see Appendix A). Cases are identified by the Quality Management Department and other sources, and are forwarded to the Medical Staff Office for peer review (see Appendix B).
- B. Adverse events including a sentinel event as defined in policy, or a near miss with potential for major or permanent injury.
- C. Events required by regulatory agencies to be reported
- D. Cases identified by external third party quality reviews
- E. Unusual Occurrence Reports of clinically significant events
- F. Significant patient/family or staff complaints
- G. Autopsy findings
- H. Results of blood utilization review
- I. Results of pre-op and post-op diagnosis review
- J. Medical records completion data
- K. Process measures for evidence based practices including core measures
- L. Continuing medical education
- M. An unusual, adverse, egregious individual case or clinical pattern of care as defined by the medical staff department chairs, specialty chiefs, QIC Committee Chair, or Chief Medical Officer
- N. Correspondence regarding commendations and patient complaints.

Focused Professional Practice Evaluation [FPPE]

FPPE is initiated for all initially requested privileges and when the results of ongoing professional practice evaluation trigger additional review. FPPE includes each of the following elements:

A. Criteria for conducting performance monitoring

1. Criteria for new providers

- New members of the Medical Staff shall remain on the provisional staff for a period of one year
- During the term of provisional appointment, the person receiving the provisional privileges shall be monitored by the Chief of Service/Department Chair in which he has clinical privileges, and by the medical staff departmental peer review committees as to his clinic competence, general behavior, and conduct in the hospital. Monitoring shall include all aspect of medical care.
- Surgeries will be directly and concurrently proctored by a member of the active medical staff as assigned by the chief of the appropriate service.
- The chief of service/department chair shall design a proctoring program that reflects the education and experience of the applicant. The proctoring program will be reviewed by the Credentials Committee and will become part of the recommendation for provisional appointment. Monitoring of other aspects of medical care will be performed by the medical staff departmental quality review committee that is conducting the peer review. The Credentials Committee shall review the performance of the provisional staff member.
- No more than 50% of the applicant's cases shall be proctored by his/her associates or partners, unless previously approved by the MEC.

2. Criteria for new privileges

Criteria are established by the medical staff for monitoring all initially requested privileges. These criteria include proctoring, chart review and discussion with others involved in the care of patients.

3. Criteria for existing privileges

Quality Management Department and other services will collect OPPE data on an ongoing basis; analyze and aggregate data by practitioner every six months for each medical staff member (including affiliate staff) and report the results to the medical staff department chairs.

If the results of OPPE indicate a potential issue with practitioner performance, medical staff departmental quality review committee(s) may initiate a FPPE to determine whether there is a problem with current competency of the practitioner for either specific privileges or for more global dimensions of performance.

If the results of individual case reviews for a practitioner exceed thresholds established by the medical staff as described below, the department will review to determine whether further focused review is needed.

The triggers for further review include:

- For rate based indicators, practitioners whose rate is greater than two standard deviations above the aggregate rate will be identified for review by the peer review committee. The denominator is the total number of procedures or visits for a practitioner over a twelve month period. The numerator is the total number of cases identified for review. The rate will be compared to the aggregate rate for all selected practitioners for the same period.
- Practitioners that have had at least one case referred for review based on the current rating system outlined on the Case Review Form within the review period will be identified for the peer review committee to determine whether further focused review is needed.
- Single incidents will also be triggers for medical staff departmental peer review. These include sentinel events, wrong side-site procedures, and significant departures from established standards of professional behavior.

B. Method for establishing the specific monitoring plan

The service chief is responsible for establishing a monitoring plan specific to the requested privilege or specific to a given practitioner when the results of OPPE require focused review. The monitoring plan is reviewed and approved by the service/department quality review committee.

C. Method for establishing the duration of performance monitoring

The service chief is responsible for establishing a monitoring timeframe or duration specific to the requested privilege or specific to a given practitioner when the results of OPPE require focused review. The duration is part of the monitoring plan reviewed and approved by the service/department peer review committee.

D. Circumstances requiring external peer review

The Medical Executive Committee (MEC), Credentials Committee, or any peer review committee can make determinations on the need for external peer review. These determinations will be forwarded to the Quality Management Department and Chief Medical Officer for review and recommendation. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the MEC. Circumstances requiring external peer review may include the following:

1. Litigation – cases involving litigation or the potential for a claim as determined by risk management
2. Ambiguity – when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly affect a practitioner’s membership or privileges
3. Lack of internal expertise – when no one on the medical staff has adequate

expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as described above.

4. New technology – when a medical staff member requests permission to use new technology or perform a procedure new to the hospital and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved
5. Miscellaneous issues – when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the MEC or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

Quality Management

Quality Department supports the Practitioner Evaluation Process by:

- A. Providing aggregate data for rate based indicators
- B. Providing referral cases for review
- C. Providing the Medical Staff Office data for practitioner files

APPENDIX A – Service Indicators

Department of Emergency Medicine

Department of Medicine

Department of Primary Care/Community Medicine

Department of Psychiatry

Department of Surgery

Specialty of Obstetrics/Gynecology

Specialty of Pediatrics

APPENDIX B Peer Review Process for Individual Case Review

1. **Case Identification** -Referrals from Quality Management (unusual occurrence reports), case management, patient relations, **Credentials Committee**, and specific informal requests for review are preliminarily screened to determine if they qualify for case review based on medical staff review indicators.
2. Quality Management Department reviews referrals to determine need for practitioner review. If practitioner review is required, a Peer Review Form is generated and is routed to the Medical Staff Office for assignment of case review.
3. **Practitioner Reviewer Assignment** – Cases will be initially assigned for review based on a list maintained by Medical Staff Services. Reviewers may be assigned by the MEC, Department Chair, or Specialty Chief. If the initial reviewer determines the case has issues outside of the reviewer’s expertise, the reviewer will request the MEC, Department Chair or Specialty Chief to assign an appropriate second reviewer.

4. Practitioner reviewer performs case review and completes the Peer Review Form with appropriate recommendations.
5. Reviews indicating potential controversial or inappropriate care or questions regarding practitioner care are presented to the medical staff departmental quality review committee* for discussion. If the medical staff departmental quality review committee feels that care may be controversial or questions are raised, it will communicate with the involved practitioner(s). The involved practitioner(s) is informed of the key questions regarding the case.
6. After the initial response from the practitioner(s), if the medical staff departmental quality review committee determines it needs further clarification, it may allow the practitioner to provide a second response to specific, predetermined questions within a specified timeframe.
7. The medical staff departmental quality review committee will make the final determination of the overall practitioner care issues.
8. The rating system for determining results of individual case reviews is outlined on the Case Review Form.
9. **Communicating Findings to Practitioners** – For cases determined to be inappropriate or controversial care, practitioners are informed of the decision **in a meeting with the service chief or designee. Decisions *can be* relayed in a letter if extenuating circumstances warrant, and this type of communication is deemed appropriate.** Copies will be sent to the confidential peer review file.
10. Medical Staff Services department will enter the results of all final review findings into the database used for tracking and reappointment reports.

*The medical staff departmental quality review committees are formed by the respective departments to conduct peer review. These may be standing departmental committees or ad hoc committees convened to conduct the review. Departmental members are selected by the department chair and those who serve on these committees shall have no conflict of interest.



San Mateo Medical Center
A County System of Healthcare

TAB 2

ADMINISTRATION REPORTS

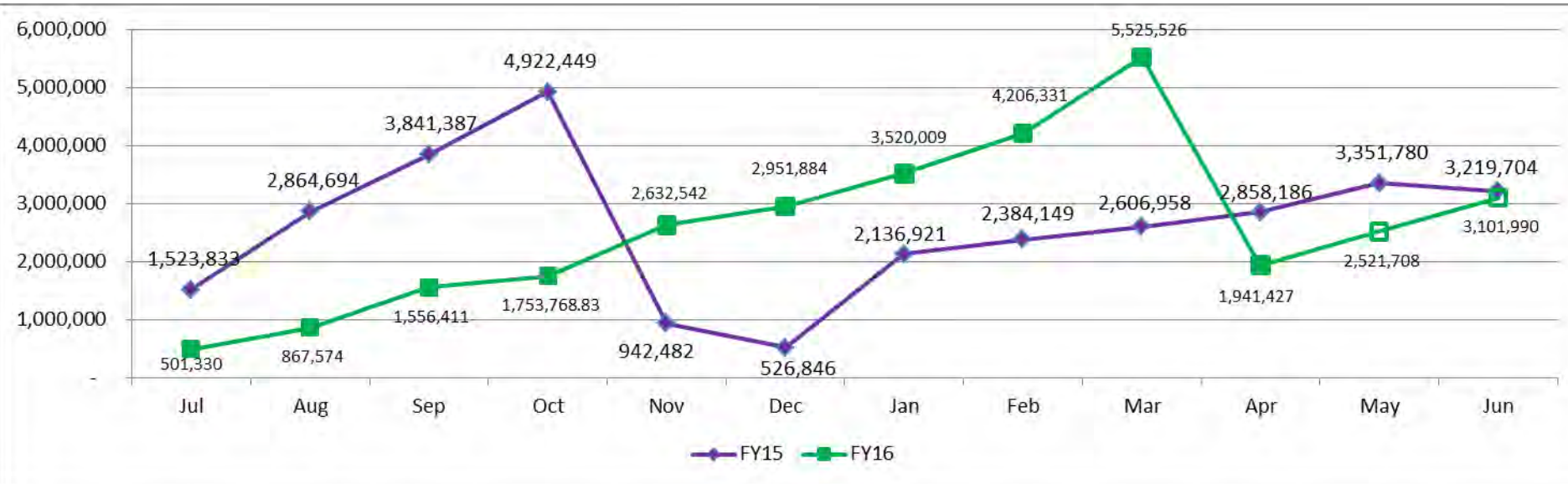


San Mateo Medical Center
A County System of Healthcare

**April FY 2015-16
Financial Report**

**Board Meeting
June 2, 2016**

Financial Highlights – Net Income Trend

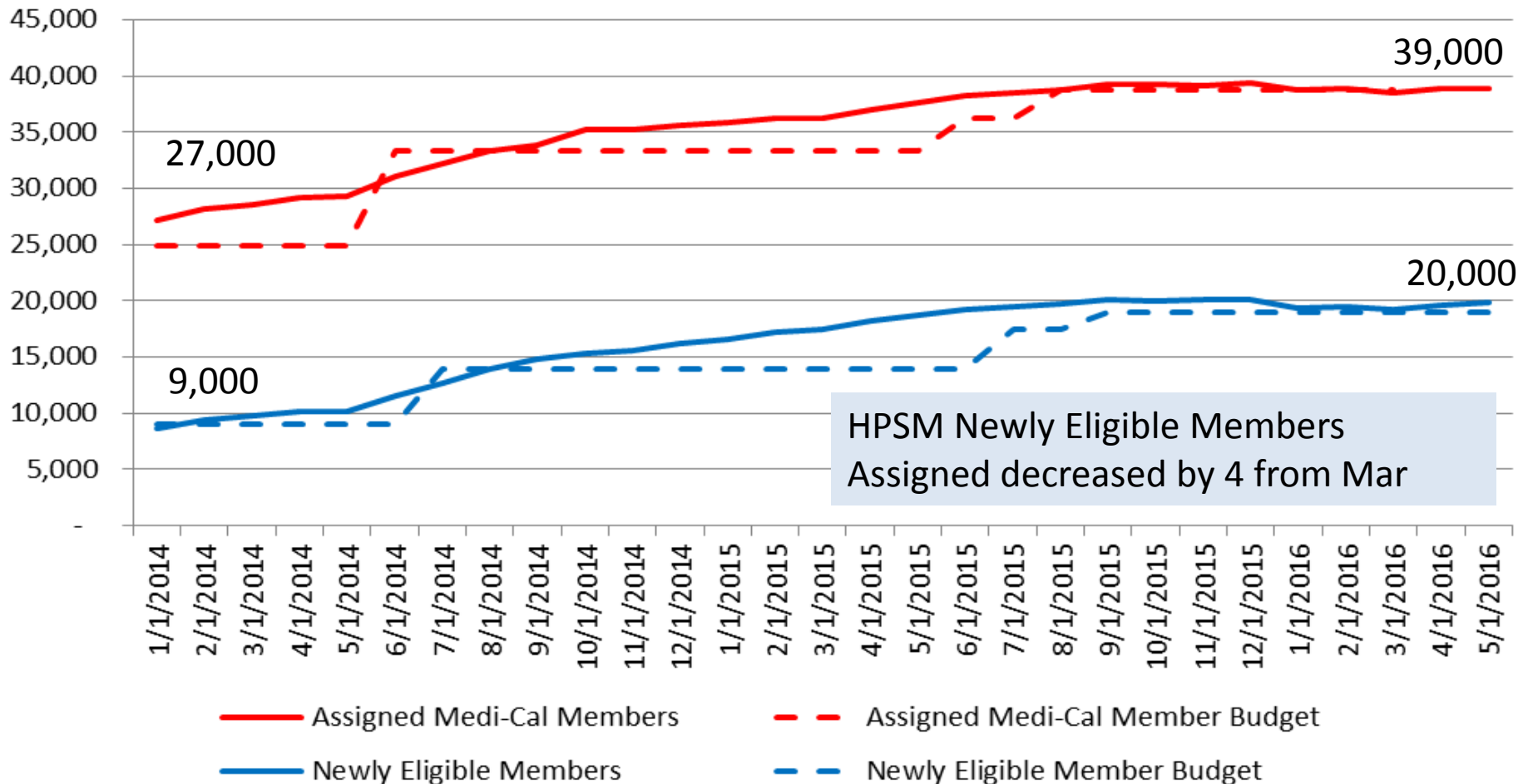


Financial Drivers for April:

- Inpatient Revenue – Volume
- Additional reserves booked: FQHC DSH Claiming, partially offset by favorable Waiver 2020 adjustments
- Other general expenses - accounting adjustments
- Other Fees and Purchased Services – ISD charges

SMMC Medi-Cal Members

HPSM Newly Eligible and Assigned Members

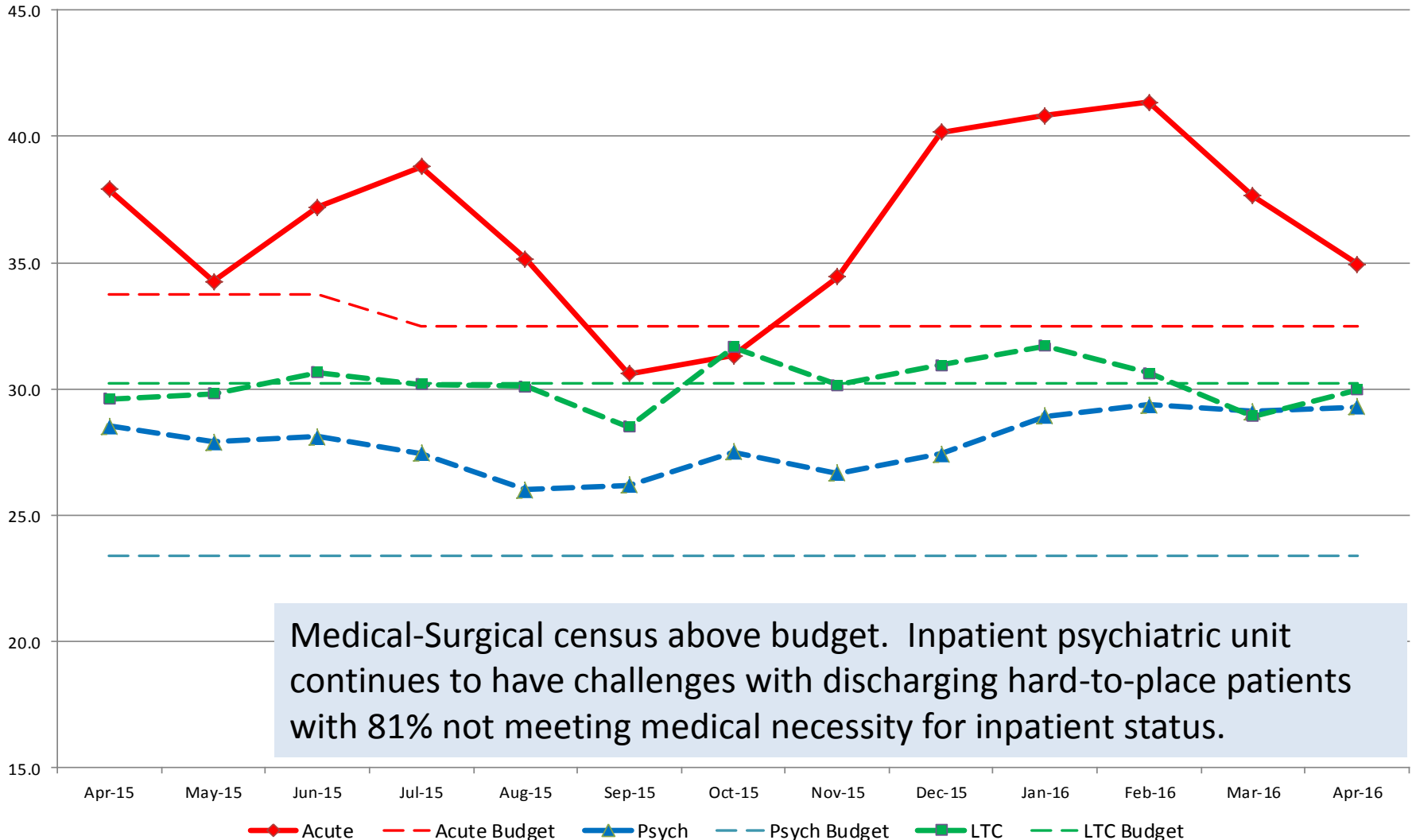


San Mateo Medical Center
 Inpatient Census
 April 30, 2016

MONTH			
Actual	Budget	Variance	Stoplight
2,826	2,607	219	8%

YEAR TO DATE			
Actual	Budget	Variance	Stoplight
28,852	26,501	2,351	9%

Patient Days

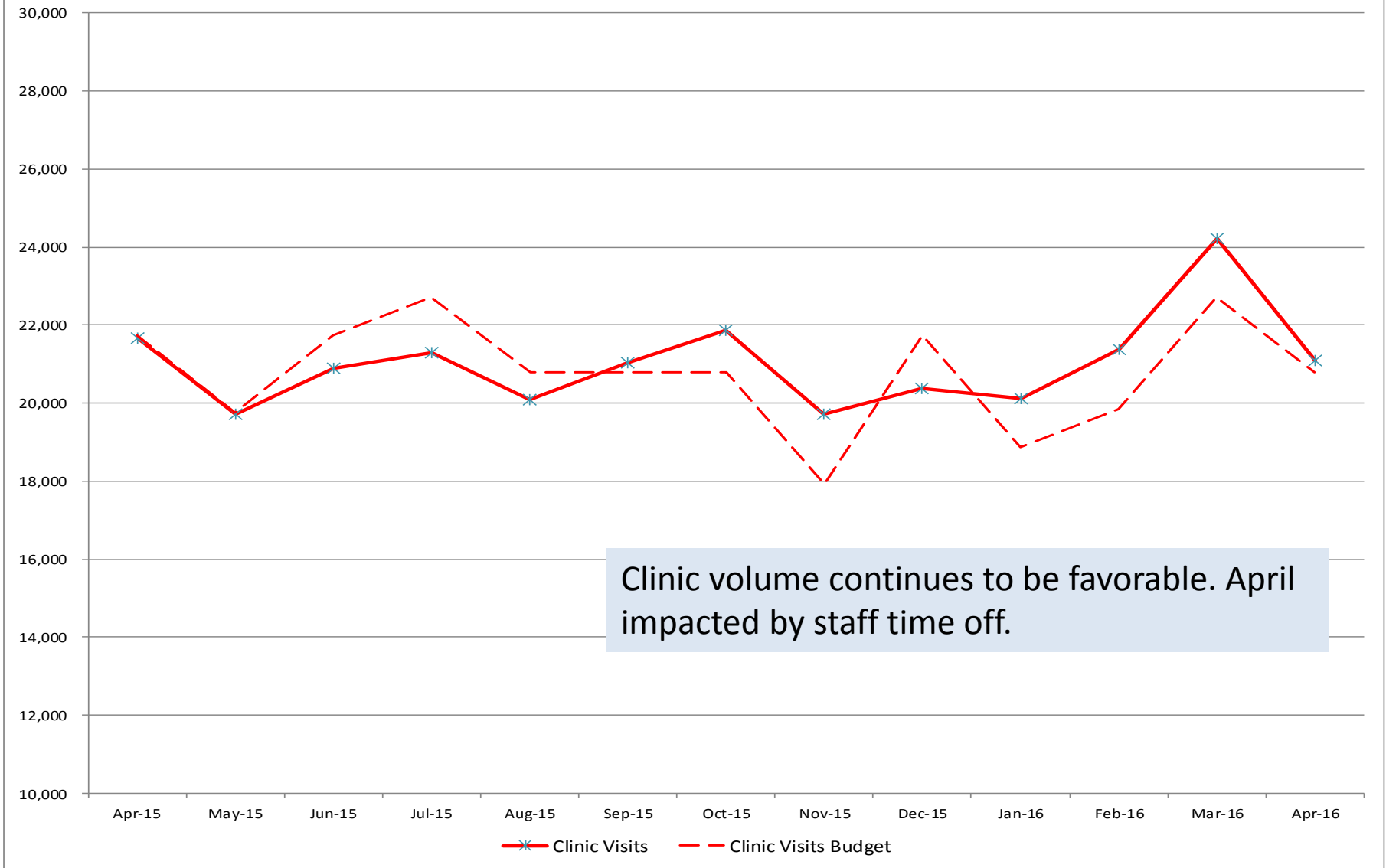


**San Mateo Medical Center
Clinic Visits
April 30, 2016**

MONTH			
Actual	Budget	Variance	Stoplight
21,094	20,707	387	2%

YEAR TO DATE			
Actual	Budget	Variance	Stoplight
211,146	206,087	5,059	2%

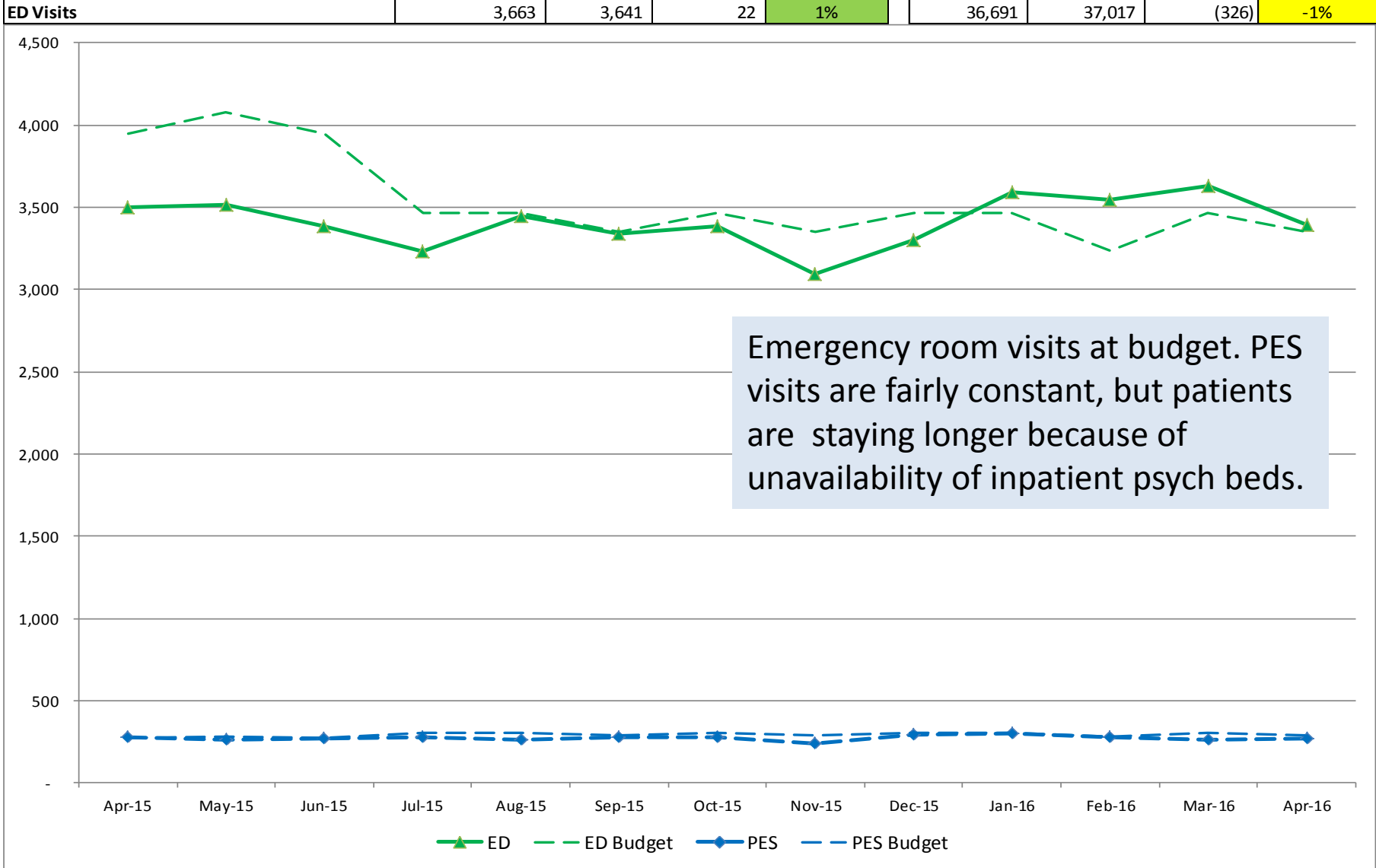
Clinic Visits



**San Mateo Medical Center
Emergency Visits
April 30, 2016**

MONTH			
Actual	Budget	Variance	Stoplight
3,663	3,641	22	1%

YEAR TO DATE			
Actual	Budget	Variance	Stoplight
36,691	37,017	(326)	-1%

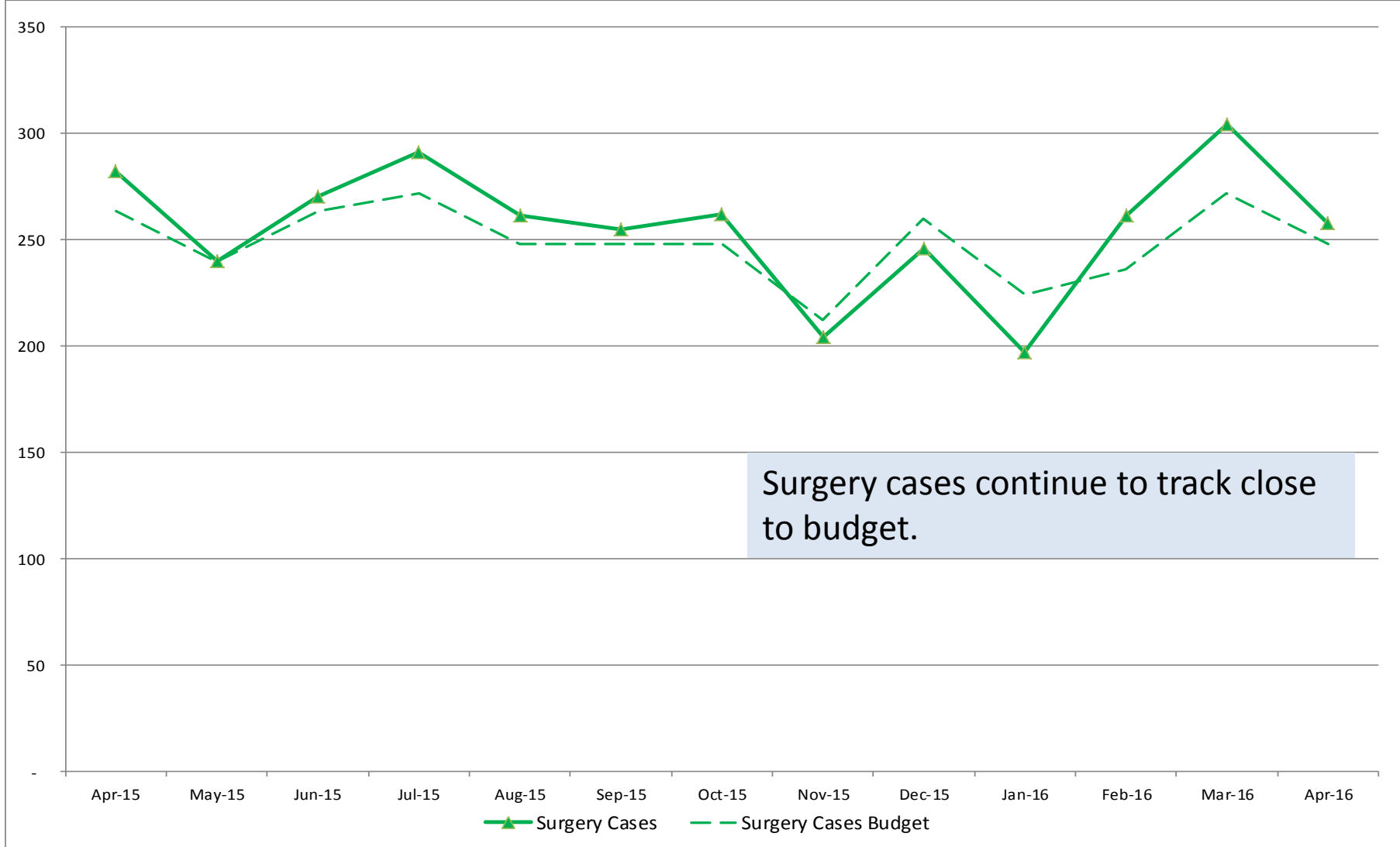


San Mateo Medical Center
Surgery Cases
April 30, 2016

MONTH			
Actual	Budget	Variance	Stoplight
258	248	10	4%

YEAR TO DATE			
Actual	Budget	Variance	Stoplight
2,539	2,467	72	3%

Surgery Cases



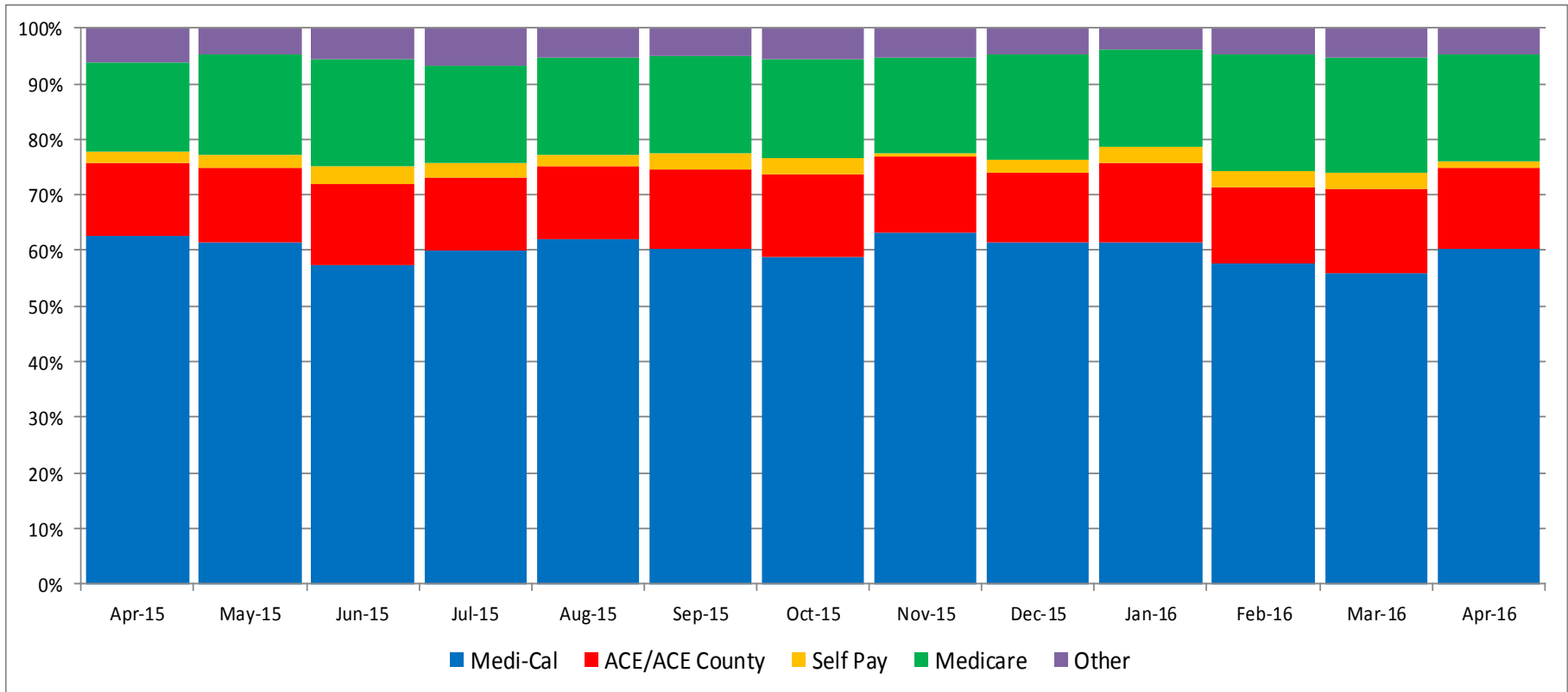
APPENDIX

San Mateo Medical Center

Payer Mix

April 30, 2016

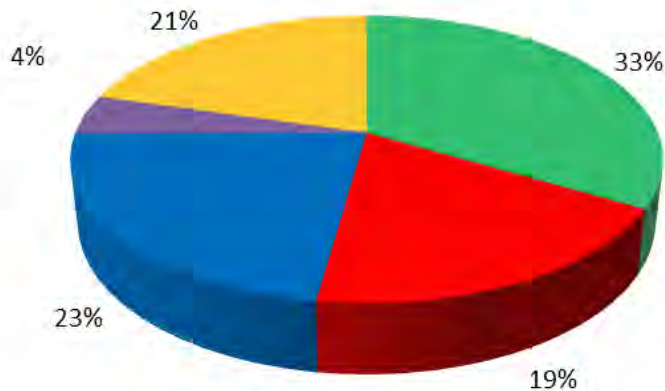
Payer Type by Gross Revenue	MONTH				YEAR TO DATE			
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
	A	B	C	D	E	F	G	H
15 Medicare	19.1%	16.6%	2.5%		18.5%	16.6%	1.9%	
16 Medi-Cal	60.4%	59.9%	0.4%		60.0%	59.9%	0.1%	
17 Self Pay	1.4%	3.5%	-2.1%		2.4%	3.5%	-1.1%	
18 Other	4.8%	5.9%	-1.2%		5.2%	5.9%	-0.8%	
19 ACE/ACE County	14.4%	14.1%	0.3%		13.9%	14.1%	-0.2%	
20 Total	100.0%	100.0%			100.0%	100.0%		



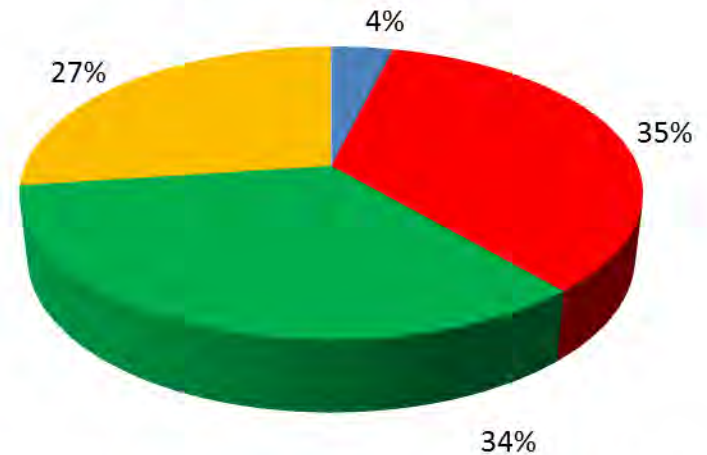
Revenue Mix

60,000
Managed
Care
Lives

Sources of Revenue



Managed Care Mix



■ Fee For Service ■ Capitation ■ Supplemental ■ Other ■ County Contribution

■ Medicare ■ Capitation ■ Traditional ■ ACE County

- **Managed Care** programs represent 65% of our Operating Revenue
- **Capitation** is a pre-payment reimbursement model that pays providers a set amount for each enrolled person assigned to them, per period of time, whether or not that person seeks care.

San Mateo Medical Center
Income Statement
April 30, 2016

	MONTH				YEAR TO DATE								
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight					
	A	B	C	D	E	F	G	H					
1	Income/Loss (GAAP)	(3,609,077)	(0)	(3,609,076)						1,916,449	-3	1,916,452	
2	HPSM Medi-Cal Members Assigned to SMMC	38,922	38,773	149	0%	389,440	387,730	1,710	0%				
3	HPSM Newly Eligible Medi-Cal Members Assigned to SMMC	19,661	19,018	643	3%	197,806	190,180	7,626	4%				
4	Patient Days	2,826	2,607	219	8%	28,852	26,501	2,351	9%				
5	ED Visits	3,663	3,641	22	1%	36,691	37,017	(326)	-1%				
6	ED Admissions %	5.5%	-	-		6.1%	-	-					
7	Surgery Cases	258	248	10	4%	2,539	2,467	72	3%				
8	Clinic Visits	21,094	20,707	387	2%	211,146	206,087	5,059	2%				
9	Ancillary Procedures	68,682	60,894	7,788	13%	671,596	606,235	65,361	11%				
10	Acute Administrative Days as % of Patient Days	5.5%	9.0%	3.5%	39%	8.8%	9.0%	0.2%	2%				
11	Psych Administrative Days as % of Patient Days (Days that do not qualify for inpatient status)	80.7%	58.0%	-22.7%	-39%	76.3%	58.0%	-18.3%	-32%				
Pillar Goals													
12	Patient & Capitation Revenue PMPM	(0)	174	(174)	-100%	149	174	(25)	-15%				
13	Operating Expenses PMPM	322	342	20	6%	334	342	9	3%				
14	Full Time Equivalentents (FTE)	1,122	1,164	42	4%	1,096	1,164	68	6%				

San Mateo Medical Center
Income Statement
April 30, 2016

	MONTH				YEAR TO DATE			
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight
	A	B	C	D	E	F	G	H
21 Inpatient Gross Revenue	8,803,300	7,848,949	954,350	12%	90,942,540	78,489,494	12,453,046	16%
22 Outpatient Gross Revenue	24,658,903	24,719,016	(60,113)	0%	243,442,072	247,190,165	(3,748,093)	-2%
23 Total Gross Revenue	33,462,203	32,567,966	894,237	3%	334,384,612	325,679,659	8,704,953	3%
24 Patient Net Revenue	(4,531,291)	8,270,730	(12,802,021)	-155%	66,836,781	82,707,300	(15,870,519)	-19%
25 Net Patient Revenue as % of Gross Revenue	-13.5%	25.4%	-38.9%	-153%	20.0%	25.4%	-5.4%	-21%
26 Capitation Revenue	4,528,765	4,439,557	89,209	2%	45,062,235	44,395,568	666,668	2%
27 Supplemental Patient Program Revenue (Additional payments for patients)	12,863,622	5,264,148	7,599,474	144%	61,259,985	52,641,483	8,618,502	16%
28 Total Patient Net and Program Revenue	12,861,096	17,974,435	(5,113,339)	-28%	173,159,002	179,744,351	(6,585,349)	-4%
29 Other Operating Revenue (Additional payment not related to patients)	1,185,427	1,097,157	88,270	8%	10,850,995	10,971,569	(120,574)	-1%
30 Total Operating Revenue	14,046,523	19,071,592	(5,025,069)	-26%	184,009,997	190,715,920	(6,705,923)	-4%

San Mateo Medical Center
Income Statement
April 30, 2016

	MONTH				YEAR TO DATE				
	Actual	Budget	Variance	Stoplight	Actual	Budget	Variance	Stoplight	
	A	B	C	D	E	F	G	H	
Operating Expenses									
31	Salaries & Benefits	13,590,187	14,268,186	677,999	5%	138,820,844	142,681,861	3,861,017	3%
32	Drugs	620,366	648,254	27,888	4%	7,134,501	6,482,545	(651,956)	-10%
33	Supplies	815,466	906,478	91,012	10%	8,907,766	9,064,784	157,018	2%
34	Contract Provider Services	2,916,781	2,800,013	(116,768)	-4%	28,168,336	28,000,128	(168,207)	-1%
35	Other fees and purchased services	3,048,334	4,147,418	1,099,084	27%	37,993,836	41,474,182	3,480,347	8%
36	Other general expenses	794,287	455,369	(338,918)	-74%	4,893,529	4,553,688	(339,841)	-7%
37	Rental Expense	180,612	173,805	(6,808)	-4%	1,749,520	1,738,047	(11,472)	-1%
38	Lease Expense	817,105	817,105	(0)	0%	8,171,049	8,171,049	(0)	0%
39	Depreciation	225,658	241,114	15,455	6%	2,256,585	2,411,138	154,554	6%
40	Total Operating Expenses	23,008,798	24,457,742	1,448,945	6%	238,095,965	244,577,424	6,481,459	3%
41	Operating Income/Loss	(8,962,274)	(5,386,150)	(3,576,124)	-66%	(54,085,968)	(53,861,504)	(224,464)	0%
42	Non-Operating Revenue/Expense	447,524	480,477	(32,953)	-7%	6,945,682	4,804,766	2,140,917	45%
43	Contribution from County General Fund	4,905,674	4,905,674	-	0%	49,056,735	49,056,735	-	0%
44	Total Income/Loss (GAAP) (Change in Net Assets)	(3,609,077)	0	(3,609,076)	-	1,916,449	-3	1,916,452	-



June 2016

LEAP UPDATES & EXCELLENT CARE

Highlighted Accomplishments:

- **Phone Based Care:** A pilot program, designed and launched in August of 2015 to develop an effective and efficient way to provide phone based care to patients surpassed a significant goal: the annual target for the program was to achieve 500 visits total; as of today (after only 9 months) 803 visits have taken place, on track to achieve nearly 1,000 visits in the first year.
- **Medication Safety:** Following an improvement event in February, the number of times that a medication order is required to be entered through a non-standard process has decreased from 8 times per day to 4 -a 50% reduction.
- **SAFE Reports Resolution:** The quality of how SAFE reports are resolved has been consistently improving from a 35% baseline in September of 2015. This weekly-tracked metric achieved a 100% quality score for the first week of May.
- **Length of Stay for 2AB patients:** care not medically necessary in 2AB decreased in April from 10% to 6%. There is ongoing improvement work on discharge placement for HPSM patients aimed at continuing to move this metric in the desired direction.

Specialty Referral Process Improvement Event

An interdisciplinary team of people from a variety of departments representing the Call Center, Specialty Clinics, the Emergency Department, Primary Care, 2AB, IT, among others, came together to improve the process for how patients are referred to Specialty Care at SMMC. The team worked diligently to create a new, streamlined and mistake-proofed process that will allow for all referrals to go through a single transparent and consistent pathway. The team developed standard work as well as technological changes to the various electronic health systems involved to ensure that all referrals are complete (with a clear clinical need, the relevant history of treatment provided, etc.) as well as created an opportunity for the specialist and the referring provider to communicate directly to answer clinical questions. This will allow help to avoid unnecessary face to face visits.

Outreach to Newly Assigned Members

In an effort to welcome patients once they are assigned to SMMC by the Health Plan of San Mateo, a new project utilizing a third party vendor launched with great results. To begin, 1000 Pediatric patients were identified and called. Of those patients, 70% were reached, resulting in 69 actual appointments given. The plan includes spreading to include adult patients in the coming weeks with information about SMMC.

Excellent Care

- **Joint Commission Follow Up Milestones:** On May 23rd, the Joint Commission officially accepted the first of our two written responses to findings from our March survey. This is another important step toward completion of this survey cycle and I want to thank all of the staff and leadership involved in getting us to this point.

- **New Nurse Call System To Improve Patient Safety And Experience:**

A new and modern nurse call system for acute and skilled nursing units went live at the beginning of May. This system has replaced the outdated and unsupported 16 year old system. It allows improved communication between the patients and their caregivers and a much safer environment

PATIENT CENTERED CARE & STAFF ENGAGEMENT

- **Phuong Hathaway selected as a winner in the Silicon Valley Business Journal's Excellence in Healthcare Awards:** We had previously acknowledged Phuong's nomination for this award and we are now pleased to announce that she has been selected as a winner for her efforts to advance the patient experience at SMMC. Phuong will be recognized at Business Journal's upcoming "Health Tech: Wearable Technology and Digital Healthcare" event on June 10th.
- **Kate Johnson recognized with Silver Aster Award:** Kate Johnson, the medical center's Communications Graphic Designer has been awarded a Silver Aster Award. The Aster Awards is an "elite competition dedicated to recognizing the nation's most talented healthcare marketing professionals for outstanding excellence in advertising." Kate was recognized for her work on SMMC's Joint Commission Survey Prep Campaign. Winners will be published in an upcoming edition of Marketing HealthCare Today.
- **Successful Nurses Day Celebration:** Friday May 6th was Nurse's Day. This was a great opportunity for SMMC to recognize its outstanding nurses. The day began with a breakfast hosted by our Chief Nursing Officer, Joan Spicer and then continued with a raffle and pastries and coffee later in the Day. Thank you to all the benefactors who donated prizes to the raffle and to everyone who made this a successful day. The event was truly an opportunity to recognize the critical contributions of all our nurses. Thank you all! (I have also attached a copy of an inspiring Nurse's Day blog from our Chief Nursing Officer: Joan Spicer)
- **Hospital Week: Food and Fun for All:** The medical center celebrated hospital week the week of May 9th. The executive team (including the Chief of the Health System) enjoyed serving pizza to all staff in the cafeteria on Wednesday May 11th. In addition, we enjoyed visiting off campus sites with a catered lunch throughout the week. It was a great opportunity to interact with staff and take a moment to thank them for all the great work they do every day.
- **Selected patient/family stories of gratitude:**
 - **From the Emergency Department:**
 - All very good the people, the doctors all the personnel are very nice.
 - The doctor asked me if I would like a blanket because he sensed I was **cold**. He even...placed the blankets over my body and legs
 - I noticed that the emergency area is clean. The janitors clean/mops the floor frequently, empty out the trash cans like every hour & wipes door handles. The security guards are diligently perform their job by limiting one guest per patient.
 - **From 2A/B and the Intensive Care Unit (from a single patient!):**

- Bonnie is very caring and compassionate person. He knows his job and duties as a CNA and represents SMMC 2AB with flying colors. I never see or hear Bonnie complain. He comes in the room with a big smile, inspite of how busy he is. Bonnie is very neat and represents his unit professionally. This morning I requested him to assist me to take my shower. He prepared everything and I was so relaxed the whole time. He is an excellent worker. Very kind hearted. He is a good role model and example to the other CNA employees.
 - Ben-the morning duty nurse is also good and very compassionate and a good example and lead to all the student nurses practicing in his dept.
 - Leslie another nurse needs commendation too. She is quiet but very thorough and knows what she is supposed to do.
 - Vicky-patient nurse on weekends like a mother, very considerate and soft spoken.
 - Melody-morning nurse is also good with her job
 - Nancy Y my night nurse is a darling very soft spoken and loving.
 - As a whole, SMMC has the best service hospital as far as I'm concerned. BRAVO!
- **From 3A/B:**
 - I loved *Erma RN. She cares about her patients and goes beyond in her level of care
 - Nursing staff really seemed to care about patients
 - Loved the exercise excellent recreational staff.
 - Great place - felt like home away from home
 - **From Coastside Clinic:**
 - Dr Walgass (Wolgast) is an amazing caring doctor who timely care about her paitients, she carefully listen, suggest additional steps to trouble shoot symptoms . she indeed takes extra effort to make an outstanding visit. wish we had more doctors like her who deeply care about her paitients regardless of their financial status and whether or not they r on medi call or have private insurance. job superbly well done Dr. Walguss - certainly appreciate all your kind services and outstanding effort.
 - Staffs are polite, very compassionate.
 - **From Daly City Clinic:**
 - Sarah Okabayashi Williams is very professional, shows real concern and care, respectful and actively listens, most pleasant, very capable, and clearly explains answers to my concern and treatment.
 - Overall my experience with my provider, staff, and clinic are highly efficient, satisfying, and commendable! As a patient, I feel a sense of satisfaction that I was given very good care and service.
 - I'm at the Daly city clinic and just met the most helpful security/information guy. He could tell that I had no idea where I was going so he pointed out where I needed to go then followed up with all the other services that are available here. .

- **From Fair Oaks Health Center:**
 - *Dr. Haddad is the best doctor that I ever have had. She is an angel
 - *Frankie was very **professional** and listened to me with **concern** without comment
 - Smiles all the time from all of them

- **From South San Francisco Clinic:**
 - Ms. Lemmon was very personable, attentive, kind, knowledgeable, empathetic all important to me during this time in my life.
 - They very good people all.

- **From the Innovative Care Center:**
 - All the above I do say are true; *Doctor M. Monge knows and understands why I am there for, makes me know that my health is what she cares about.
 - The entire clinic is part of my family and mine theirs, we all care about each other. I feel at home not tense, no matter what the news.
 - I could not ask for more. This health provider is the best thus far I have encountered, especially in the follow-up and concern of the physician

- **From Main Campus Pediatrics:**
 - Thanks *Doctor Dudum, *Alexandra *Saba Maria, *Elcy and *Pricila
 - It is always pleasant attention from the nurses especially *Saba Maria thanks

- **From Main Campus OB/Gyn:**
 - Dr. O is AMAZING, I could not ask for a better doctor then Dr. O. He made me feel at ease even though the procedure is uncomfortable and a bit painful he explained everything and made sure I was comfortable as possible. He was funny and kind, gentle and listened.
 - Personally the attention they gave me is excellent, my eternal gratitude to *Dr. Lock W Scott.
 - All good.

- **From the Ron Robinson Senior Care Center:**
 - Thank you very much to the San Mateo Hospital Staff especially my Dr also nurses all the time i show up for my appointment they're very helpful and good hospitality receptions etc no words to to say on behalf of my family we give u a sincere thnks for all your good and hard work May our Good Lord bless you guys abundantly and your families
 - Staff is wonderful!
 - I really love the courtesy and attentions the clerical staff in the registration area provide to all patients !!

- **From the Surgical Specialty Clinic:**
 - *Dr. Buckley care and treatment were excellent. I'm very, very pleased with him.
 - Very nice and warm people
 - I recommend the care provider to others because he is a good provider and concern on my condition.

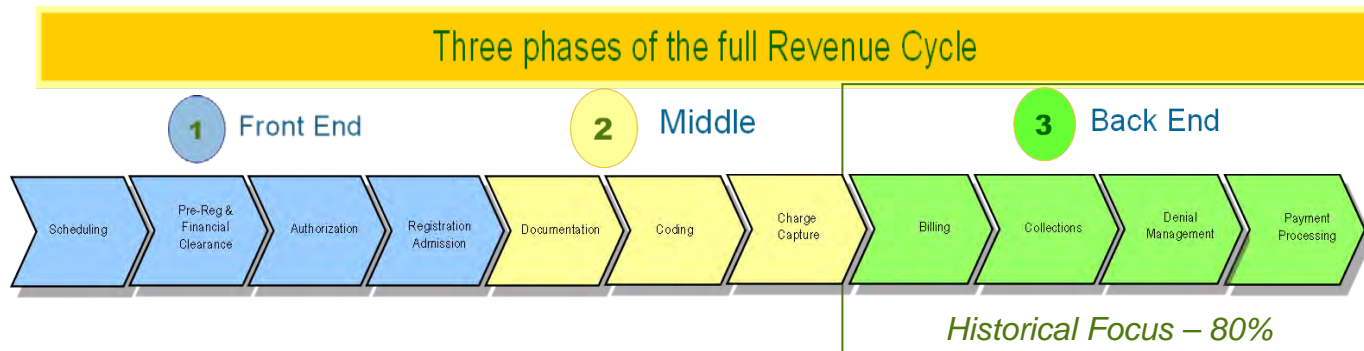
- **From the Medical Specialty Clinic:**
 - he always listen to what i said about my health problems
 - very good

FINANCIAL STEWARDSHIP

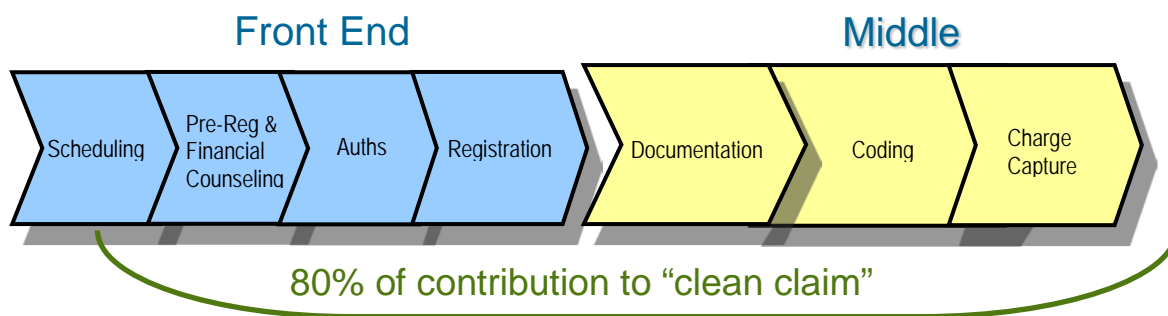
Revenue Cycle Transformation

Last month we provided an overview of the Financial Stewardship initiative focused on improving our patient billing and collection processes – otherwise known as the “Revenue Cycle”. This month we will do a deeper dive into our key priorities in our transformation effort. These priorities can be grouped into four areas: 1) design workflows to improve efficiencies by moving major tasks towards the Front End; 2) create standard work to decrease process defects; 3) implement software tools to automate workflows and to monitor performance; and 4) drive performance towards industry standard benchmarks.

The historical revenue cycle operation focused on “Back End” efforts, generally because billing and cash flow were the purview of the finance organization. Work in the Back End accounted for 80% of the effort to generate a clean claim. IT systems were designed to support back-end processes and had inadequate reporting tools to help identify defects.



Industry-leading revenue cycle operations of today have shifted this focus to the Front End and Middle segments, where its more efficient and less costly to do it right the first time.

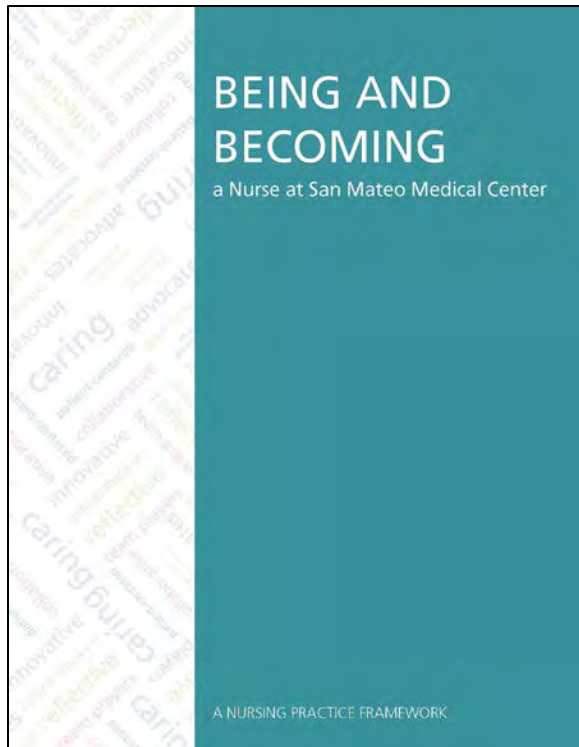


Our Financial Stewardship Initiative is currently working on decreasing the time a claim is held because of registration, coding and authorization “defects” as well as increase efforts to follow-up on outstanding balances. Through these efforts we now consistently hit our coding target of 3 days, we decreased authorization holds by 20% from the previous month and May cash collections increased 40% from April. We will continue to provide updates to the Board at regular intervals.

Global Payment Program (GPP)

California’s 1115 Waiver Renewal, called “Medi-Cal 2020”, was approved by the Centers for Medicare and Medicaid Services on Dec. 30, 2015. One component of Medi-Cal 2020 is the establishment of the GPP, which created a statewide pool of funding for the remaining uninsured by combining federal DSH and uncompensated care funding, where select Designated Public Hospital systems can achieve their “global budget” by meeting a service threshold that incentivizes movement from high cost, avoidable services to providing higher value, preventative services.

Under the new Waiver, CMS hired the consulting firm Navigant to conduct a study of uncompensated care financing for public hospitals. The objective of this report will be to support a determination of the appropriate level of Uncompensated Care Pool funding for public hospitals in years two through five of the Waiver. Navigant issued its report on May 15th and CMS will provide a formal determination of the funding levels for demonstration years two through five within 60 days. We are currently analyzing Navigant’s report to determine the potential impact to SMMC’s FY17 budget and future funding levels.



JUNE 2, 2016

FROM THE CHIEF NURSING OFFICER

Today Nurses around the world stop to reflect on what nursing means to them, and what it has given them. At SMMC, RNs and LVNs are invited to join other Nurses in the Education classrooms for breakfast this morning (7:00AM to 9:00AM) or for dessert this afternoon (2:00PM to 6:00PM) to

celebrate this day of reflection we recognize as Nurses Day.

This is a landmark day for SMMC Nurses, and especially for me as the Chief Nursing Officer.

After 2 years, the work of over 50 members of the Nursing Shared Decision Making Councils, as well as our commitment to our nursing practice and patients, our organization's strategic direction has been summarized and published in the document ***Being and Becoming a Nurse at San Mateo Medical Center: A Nursing Practice Framework***.

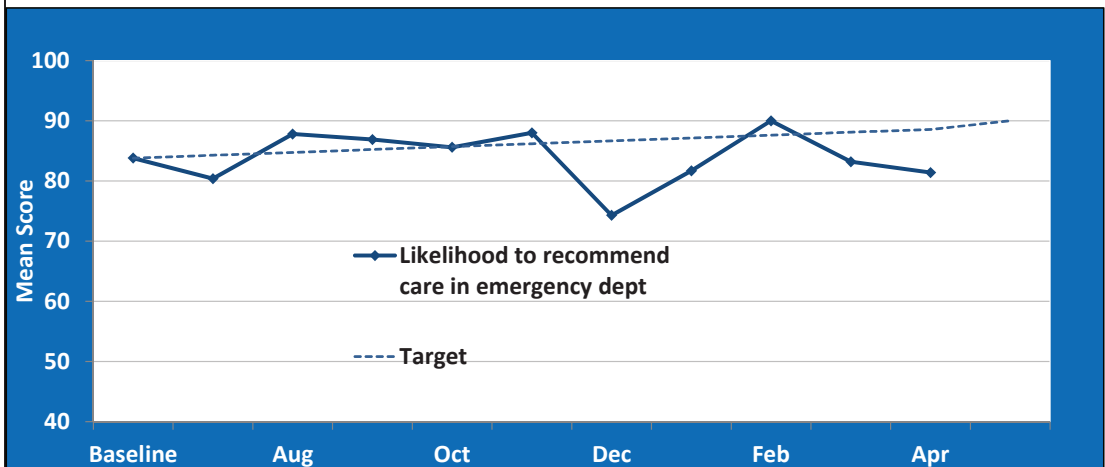
This framework is special because very few Nurses working at the bedside ever engage in developing a practice framework. The document provides a description of the full dimensions of nursing practice at SMMC. During this coming year, Nurses will have an opportunity to receive their copy of ***Being and Becoming*** along with an orientation to its content and purpose. Members of the Shared Decision Making Councils will receive their copy today.

Please join us in the education classrooms, for we have much to celebrate this year. Some examples include many committing time and financial resources pursuing advanced education and specialty certifications, as well as presenting work (by invitation) at regional conferences. Within the organization our practices are being reviewed and anchored in best practices and research evidence. Nurses in the clinics have been transforming their practice settings to care teams and a medical home model. All of these efforts support our belief that we need to be the best Nurses we can be to support SMMC patients achieve outcomes that positively affect their health.

Regards,

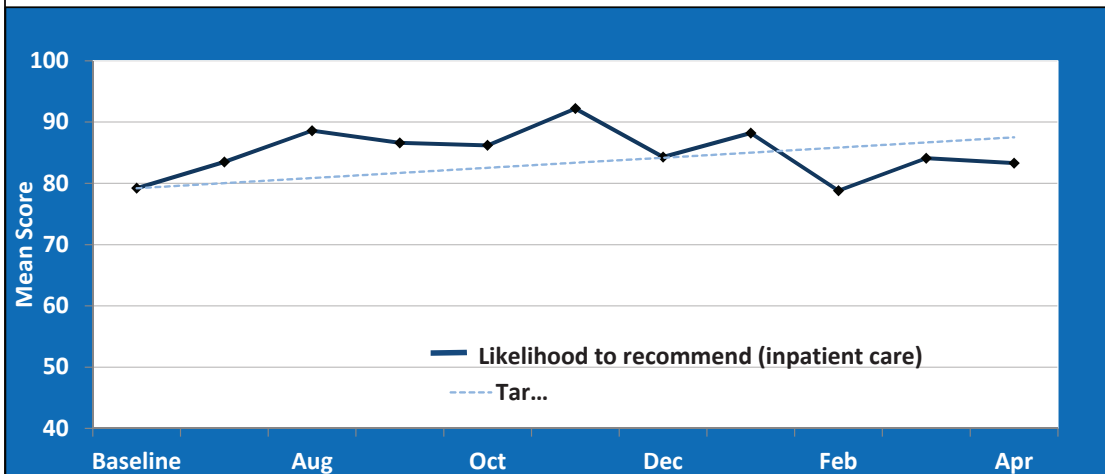
Joan Gygax Spicer, RN, MBA, PhD, NEA-BC

We focus on what matters most to our patients and their families, and partner with them to provide compassionate care in a culturally competent way.



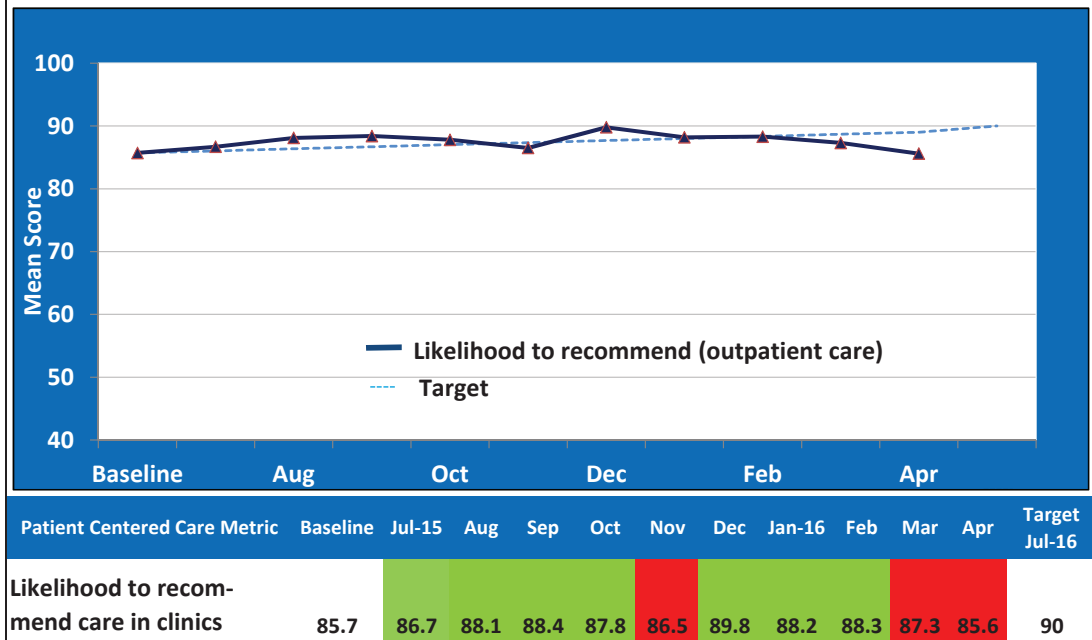
Patient Centered Care Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	Target Jul-16
Likelihood to recommend care in emergency dept	83.8	80.4	87.8	86.9	85.6	88.0	74.3	81.7	90.0	83.2	81.4	90

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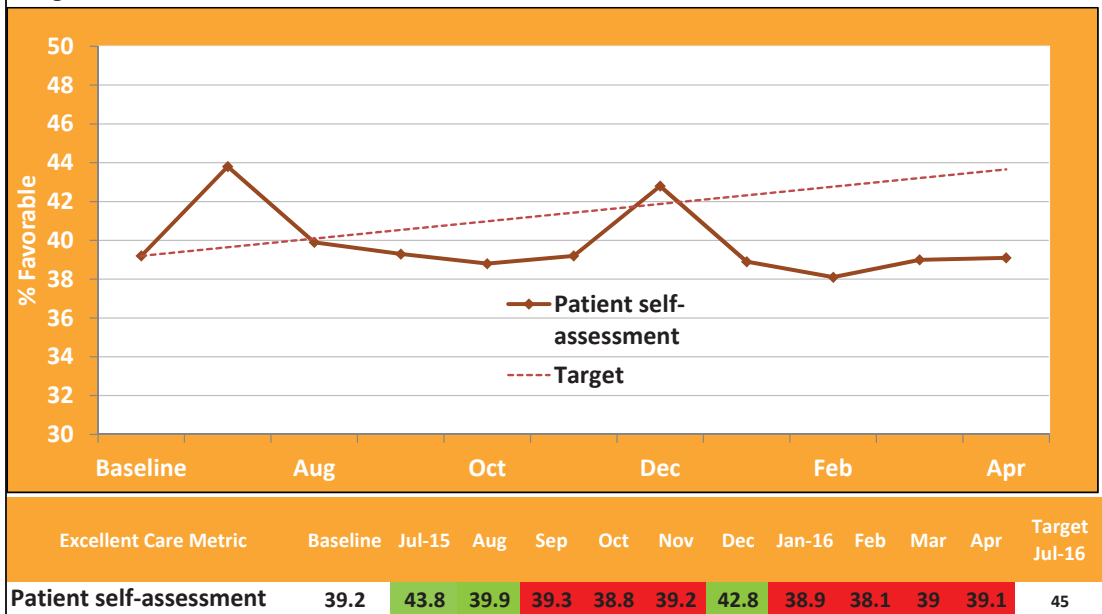


Patient Centered Care Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	Target Jul-16
Likelihood to recommend care in inpatient	79.2	83.5	88.6	86.6	86.2	92.2	84.3	88.2	78.8	84.1	83.3	90

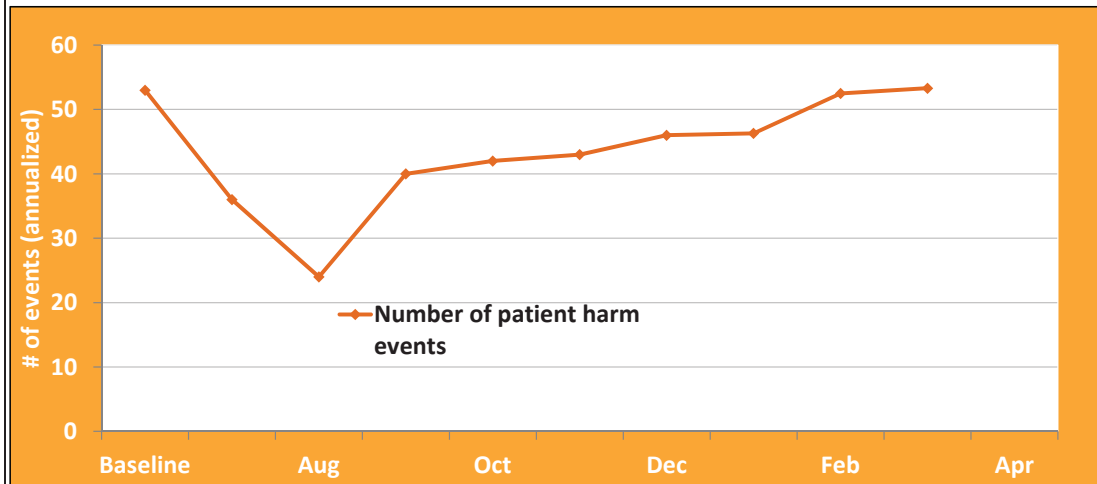
We focus on what matters most to our patients and their families, and partner with them to provide compassionate care in a culturally competent way.



We partner with our patients to achieve their health goals by providing a safe environment and integrated, evidence-based care.

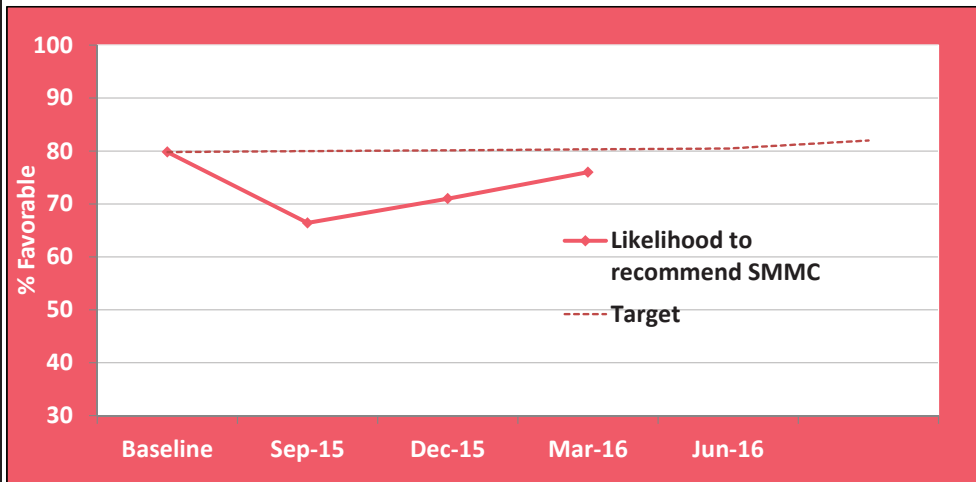


We partner with our patients to achieve their health goals by providing a safe environment and integrated, evidence-based care.



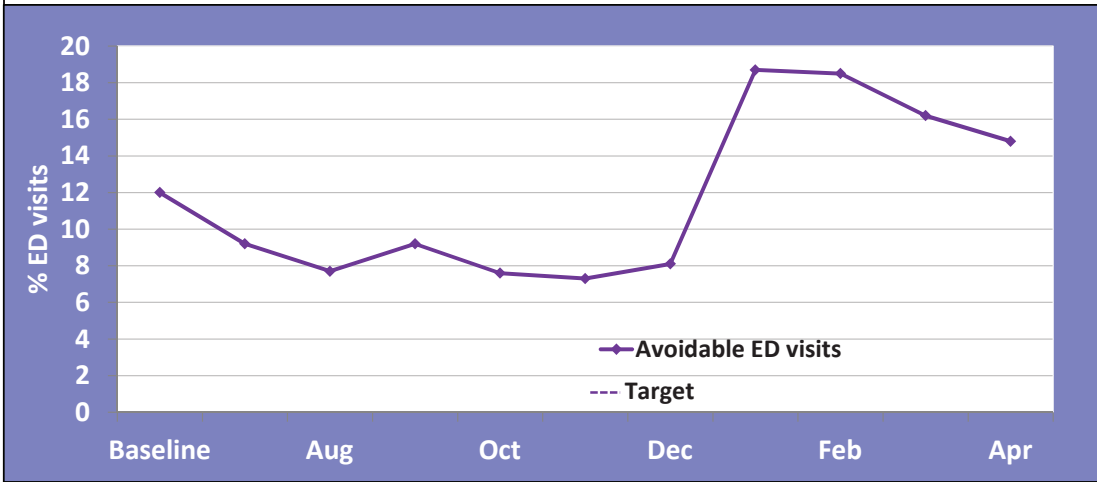
Excellent Care Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	Target Jul-16
Number of patient harm events	53	36	24	40	42	43	46	46.3	52.5	53.3		40

We are a great place to work and we are passionate about serving our community.



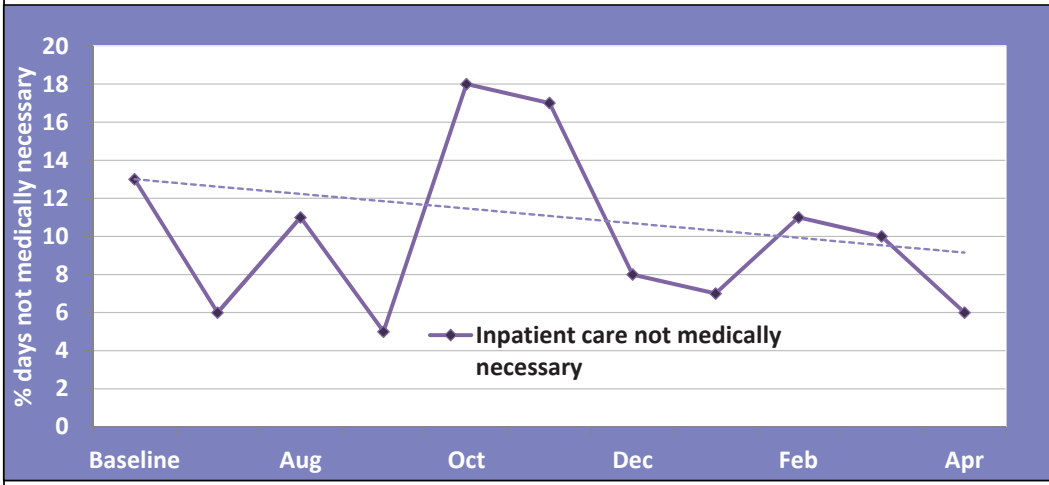
Staff Engagement Metric	Baseline	Sep-15	Dec-15	Mar-16	Jun-16	Target
Likelihood to recommend SMMC	79.8	66.4	71	76		82

We ensure our patients get the right care at the right time and place.



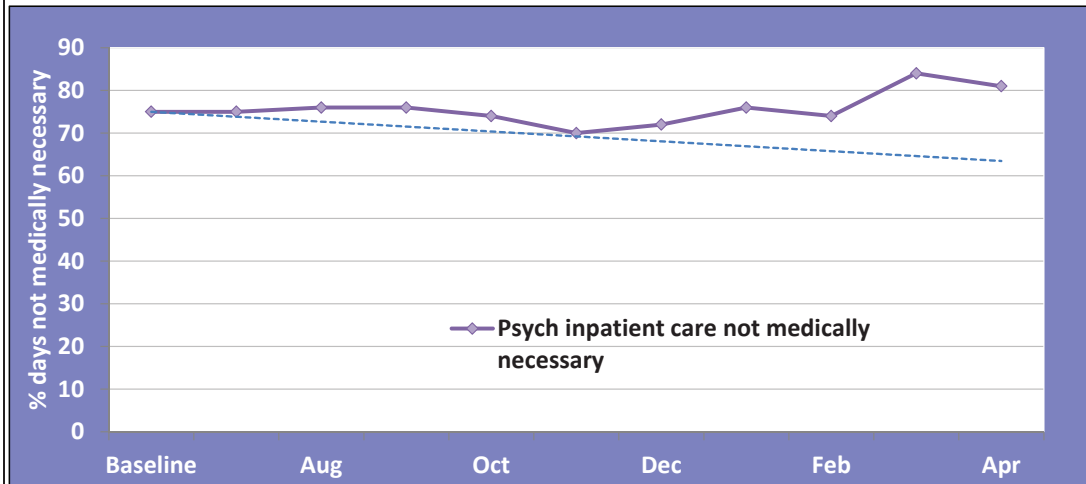
Right Care, Time, Place Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	Target Jul-16
Avoidable ED visits	12.0	9.2	7.7	9.2	7.6	7.3	8.1	18.7	18.5	16.2	14.8	?

We ensure our patients get the right care at the right time and place.



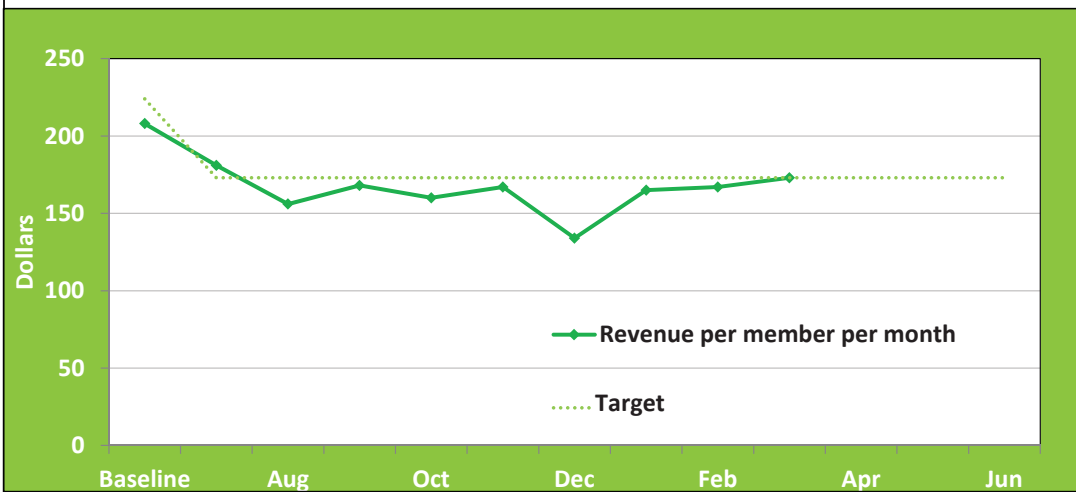
Right Care, Time, Place Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	Target Jul-16
Inpatient care not medically necessary	13.0	6	11	5	18	17	8	7	11	10	6	8

We ensure our patients get the right care at the right time and place.



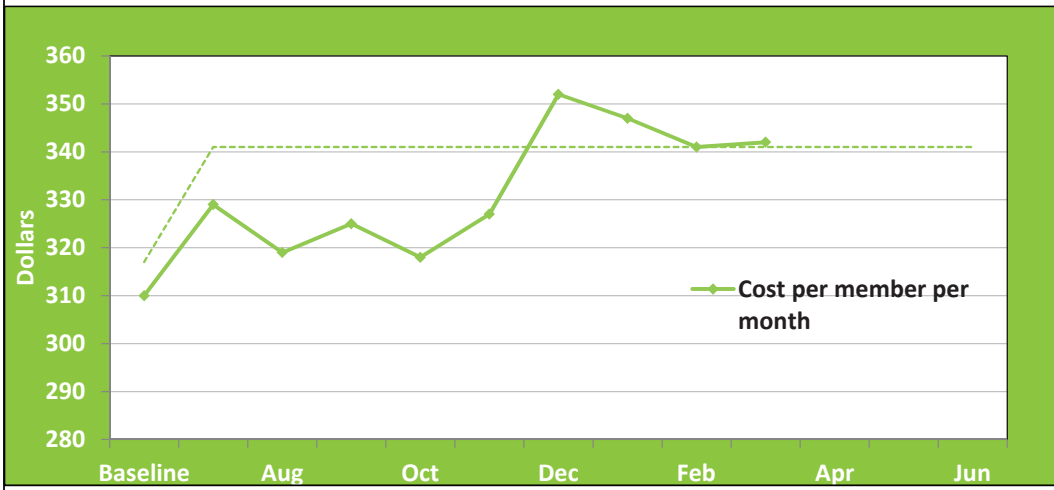
Right Care, Time, Place Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	Target Jul-16
Psych inpatient care not medically necessary	75.0	75.0	76	76	74	70	72	76	74	84	81	60

We partner with our patients to deliver high value care in a financially responsible manner.



Financial Stewardship Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	May	Jun	Target Jul-16
Revenue per member per month	208	181	156	168	160	167	134	165	167	173				173

We partner with our patients to deliver high value care in a financially responsible manner.



Financial Stewardship Metric	Baseline	Jul-15	Aug	Sep	Oct	Nov	Dec	Jan-16	Feb	Mar	Apr	May	Jun	Target Jul-16
Cost per member per month	310	329	319	325	318	327	352	347	341	342				341



COUNTY OF SAN MATEO HEALTH SYSTEM

To: SMMC Board Members
 From: Louise Rogers, Chief
 Subject: Health System Monthly Snapshot – May 2016

Indicator	Number	Change from previous month	Change from last year
ACE Enrollees	19,661 <i>(April 2016)</i>	2.2%	5.2%
SMMC Emergency Department Visits	3,663 <i>(April 2016)</i>	-5.9%	-2.9%
New Clients Awaiting Primary Care Appointment	130 <i>(May 2016)</i>	242.1%	-69%

County’s Medi-Cal Substance Use Disorder Treatment Plan Approved First in the State

San Mateo County residents who are low income and struggle with substance use will soon have more places to go for help. In April, San Mateo County became the first county in the state to receive approval from the California Department of Health Care Services and Federal Centers for Medicare and Medicaid Services to create a local Drug Medi-Cal Organized Delivery System (DMC-ODS) program. Once the DMC-ODS program is implemented later this year, residents will have greater access to a wider range of high-quality services. Before full implementation, Behavioral Health and Recovery Services (BHRS) and the state will finalize contract details and continue to help facilities become certified in DMC-ODS, joining 15 existing facilities that have already been certified.

Parents Celebrate Healthier Relationships with their Children

This month, over 200 people joined together to celebrate **BHRS’ Parent Project** - funded by Measure A. The Parent Project provides parents with skills and resources to help support their child and create a healthy family. Families who have graduated from the program gathered from all over the county - from Half Moon Bay to East Palo Alto – to celebrate their accomplishment and connect with others who have faced similar challenges. Parents and children enjoyed local arts and music and were able to get more resources and speak with staff about their experience. Here’s what one parent said after taking the course:

“I am a single parent of two teenagers. When I thought my children’s lives were at risk, I felt lonely with no answers to all the problems in our lives. I took the Parent Project class when my children were struggling, and I finally found hope. This class will help parents have a better relationship with their children, and help them succeed.” - Yolanda R.



All San Mateo County children have access to high-quality health care

On May 16, the state made health insurance a reality for all California youth by expanding Medi-Cal to all children regardless of immigration status. San Mateo County Health Coverage Unit cued up 95% of our eligible Healthy Kids participants to obtain full-scope Medi-Cal to ensure there are no gaps in health coverage for those who need it most. The commitment of the Board of Supervisors and each of our core local funders – Peninsula Health Care District, Sequoia Health Care District and First5 of San Mateo County – has been steadfast. Our network of partners in our safety net clinics, schools and community-based organizations has included passionate advocates who have worked every day to earn and keep the trust of the families seeking access to healthcare for their children by making the enrollment process as easy as possible. Committed staff at the Human Services Agency and the Health Plan of San Mateo have been integral partners to the Health System and helped us demonstrate how local government can work to prove the value of policy actions that put our youngest and least advantaged first. We are seeing the fruition of this advocacy and hard work by this law making healthcare available to children across California.



San Mateo Medical Center
A County System of Healthcare

TAB 3

**MEDIA
ARTICLES**

Printed from THE DAILY JOURNAL, dtd. 05/13/2016

Feds help county expand addiction services: First waiver in state to use federal dollars for extended treatment of substance abuse

May 13, 2016, 05:00 AM By Bill Silverfarb Daily Journal Staff

San Mateo County is the first in California to receive a waiver from the federal government to expand treatment for individuals on Medi-Cal struggling with drug addiction.

Currently, people with substance use disorders with Medi-Cal health coverage have limited treatment options available, according to a statement by the county Health System's Behavioral Health and Recovery Services.

Last month, the county was given approval by the state Department of Health Services and federal Centers for Medicare and Medicaid Services to create a local "Drug Medi-Cal Organized Delivery System program.

"Addiction is a chronic condition. This will allow us to take a long-term approach to dealing with addiction," said Stephen Kaplan, director of recovery services for the county.

The government's system of treatment for substance use was designed long ago and has not changed as treatments have changed, Kaplan said.

"This opens up and provides more types of interventions. This will give access to a continuum of services that currently is not available, Kaplan said.

The waiver will be implemented later this year, he said.

"There is still some work ahead," he said.

Medi-Cal beneficiaries in need of treatment will be able to access withdrawal management, short-term residential treatment, intensive outpatient, medication assisted treatment, narcotic treatment service, physician consultation and outpatient services, along with case management and recovery support, according to Clara Boyden, the county's Alcohol and Other Drug Programs manager.

The program will help remove barriers that can discourage people from getting the services they need. When access to care improves, so does the quality of life for those the program will serve, Kaplan said.

On Tuesday, the San Mateo County Board of Supervisors approved \$5 million in loans to five nonprofit agencies the county contracts with to provide drug and alcohol treatment.

The emergency loans were given due to spiraling real estate costs.

Under the terms of the loans, the organizations will pay no interest and no debt service as long as they continue to provide treatment services, with the loans forgiven in 30 years.

The county's largest contract for substance abuse treatment currently is with Project Ninety at \$2.7 million. The agency has contracted with the county for more than 30 years to provide services to adult men who may be homeless, straight from prison or jail, unemployed or have limited language skills who grapple with substance use.

On Tuesday, Project Ninety was loaned by the county \$131,342 for repairs and \$2.4 million to take over loans on six properties.

Before the new program is implemented later this year, county and state officials will finalize the details of a contract that will include provider rates for services, client confidentiality protections, quality performance measures and regulatory compliance requirements.

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Meals on Wheels to transition: Nonprofit to take over San Mateo Medical Center's program

May 10, 2016, 05:00 AM Daily Journal staff report

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Across the country, home-delivered meals are served by a patchwork of different organizations in each county. There are five organizations delivering meals throughout San Mateo County, according to the county's Health System.

Maltbie will give a brief report to the Board of Supervisors Tuesday on the transition.

Currently, Menlo Park-based Peninsula Volunteers, Inc. is expanding its delivery services to Burlingame, Hillsborough, Foster City and San Mateo by June.

Peninsula Volunteers will provide the meals to about 250 individuals who participate in the medical center's program, said Marilyn Baker-Venturini, the Menlo Park-based nonprofit's director.

In the fall, the Health System's Aging and Adult Services will issue a request for proposals for home-delivered meals countywide, which will include a request for the northern part of the county.

Peninsula Volunteers is expected to bid for the contract.

For future delivery staff and volunteers, county staff are available and willing to provide any type of training that will enhance the home-delivered meal service to our community, according to the Health System.

"We want to provide the best service we can for older adults who cannot shop and cook for themselves," Baker-Venturini said.

Peninsula Volunteers will provide the meals to individuals in most of the county except those on the coastside, she said.

Every week, Peninsula Volunteers delivers over 1,700 hot, nutritious meals to primarily homebound seniors and adults with disabilities in San Mateo County.

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San Mateo County looks for new partners for Meals on Wheels

By Brendan P.
Bartholomew

Changes are being cooked up to programs that deliver meals to the homes of Peninsula seniors.

Meals on Wheels can be a crucial lifeline for Peninsula seniors, but some clients receive different service, depending on what city they live in. That could soon change, however, as the county looks for new partners to serve such cities as its Medical Center phases out the county's service.

But it remains unclear how seniors in some northern Peninsula cities will receive delivered meals once the service is eliminated from the Medical Center.

Nonprofit Meals on Wheels programs throughout the U.S. and overseas deliver free or subsidized meals to clients who are unable to prepare their own meals, and who are typically disabled or seniors or both.

There are different service levels because Meals on Wheels in San Mateo County is administered by a patchwork of different organizations.

In Pacifica and Half Moon Bay, for instance, Meals on Wheels programs — run by their respective cities — deliver hot meals to clients five days per week, and each visit from a volunteer driver is akin to an informal wellness check, as the drivers are trained to notice signs a client might need help.

But in some other Peninsula towns, some Meals on Wheels clients are served by the San Mateo County Medical Center, which delivers a week's worth of frozen meals with each weekly drop-off.

Additionally, those deliveries are made by paid couriers, who are not trained to perform wellness checks.

That level of service is less than ideal, said Jim Lange, Pacifica's senior director of client services, who noted Meals on Wheels drivers are often the first to realize a senior might need medical or social services intervention.

"We're often there before the paramedics," Lange said.

It can be hard, and even frightening, for some seniors to admit they need help, Lange said. And the positions of friendship and trust occupied by Meals on Wheels personnel can enable them to persuade seniors to accept help when family members and authorities have failed to convince them.

"Last week, a client was refusing help until Ann showed up," Lange said, referring to program coordinator Ann Cooney.

The San Mateo County Medical Center became a Meals on Wheels provider to fill a service gap created when Catholic Charities discontinued its meal deliveries in the county several years ago.

And while the county hospital can't offer the level of personalized service provided by Pacifica's program, county Aging and Adult Services Director Lisa Mancini said she's grateful for its years of service.

"I so appreciate the Medical Center's partnership in helping us serve the central and north parts of our county," Mancini said.

In March, the county announced the Medical Center's Meals on Wheels program would soon be phased out as the county looks to contract with other organizations to serve the Medical Center's former clients.

Mancini said the county expects to issue a request for proposals in the fall.

Some of the Medical Center's clients have already transitioned to Peninsula Volunteers, a Menlo Park-based nonprofit that recently began delivering meals in Burlingame and Hillsborough, and will add Foster City, San Mateo, and Millbrae in May, June, and July, respectively.

Interim Executive Director Peter Olson said Peninsula Volunteers would respond to the county's request for proposals, but the organization has no current plans to operate farther north than San Bruno.

That leaves Daly City, Colma, South San Francisco, and Brisbane in need of providers, and it is not clear which organizations might step into those roles.

Cooney suspects there are seniors in need who are not currently being served. The program coordinator noted Daly City and Pacifica each have roughly the same number of Meals on Wheels clients, yet Daly City has more than twice Pacifica's population, and presumably a lot more seniors who would qualify for the program.

"There's a gap between need and service delivery," Cooney said. "So my question is, how can we work together to close that gap?"

Peninsula Volunteers is looking for additional volunteer drivers. To volunteer, visit www.penvol.org/volunteer.