BOARD OF DIRECTORS' MEETING
AGENDA
THURSDAY, APRIL 6, 2017
REGULAR SESSION 6:00 P.M.

COMMUNITY MEETING ROOM
177 First St. W., Sonoma, CA

In compliance with the Americans Disabilities Act, if you require special accommodations to participate in a District meeting, please contact Interim District Clerk Vivian Woodall at (707) 935.5005 at least 48 hours prior to the meeting.	**RECOMMENDATION**	
AGENDA ITEM		
1. CALL TO ORDER	*Hirsch*	
2. PUBLIC COMMENT SECTION	*Hirsch*	
3. CONSENT CALENDAR A. Board Minutes 03.02.17 B. Board Minutes 03.08.17 C. Board Minutes 03.09.17 D. FC Minutes 01.24.17 E. FC Minutes 02.28.17 F. QC Minutes 01.25.17 G. QC Minutes 02.22.17 H. Executed Policies & Procedures I. Medical Staff Credentialing Report J. Medical Staff Bylaws and Rules and Regulations	*Hirsch*	Action
4. CHA PERSPECTIVES ON THE CURRENT STATE OF HEALTH CARE	*McLeod*, CHA *Abraham*, Hospital Council	Inform
5. SOUTH LOT PROPOSAL STUDY SESSIONS	*Hirsch*	Inform/Action
6. STRYKER SYSTEM PRESENTATION	*Kobe*	Inform
7. FY 2018 ROLLING STRATEGIC PLAN	*Mather*	Inform/Action
8. FINANCIAL REPORT FEBRUARY 28, 2017	*Jensen*	Inform
9. ADMINISTRATIVE REPORT APRIL 2017	*Mather*	Inform
10. COMMITTEE REPORTS: • Northern California Health Care Authority (JPA) – Meeting Report • Change Bylaws of Northern California Health Care Authority	*Boerum* *Boerum*	Inform Inform/Action
11. BOARD COMMENTS • SVH Oppose Letter Regarding AB 387 (Hirsch)	*Board Members*	Inform
12. ADJOURN	*Hirsch*	

3.

CONSENT

BOARD OF DIRECTORS' MEETING
MINUTES
THURSDAY, MARCH 2, 2016
REGULAR SESSION 6:00 P.M.

COMMUNITY MEETING ROOM
175 First Street West Sonoma CA

	RECOMMENDATION	
MISSION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER The meeting was called to order at 6:03 p.m. Joshua Rymer is excused.	*Hirsch*	
2. PUBLIC COMMENT SECTION	*Hirsch*	
No public comment.		
3. CONSENT CALENDAR A. Board Minutes 01.05.17 B. Board Minutes 02.02.17 C. Executed Policies & Procedures D. Medical Staff Credentialing Report	*Hirsch*	Action
		MOTION: by Nevins and 2nd by Hohorst to approve. All in favor.
4. SUSTAINABLE SONOMA PRESENTATION	*Sonoma Ecology Center*	Inform
Ms. Caitlin Cornwall gave a presentation on Sustainable Sonoma and mentioned that the project has already been adopted by the Sonoma Valley Health Roundtable. It is a broad project of full-spectrum sustainability (economic, environmental, and societal). The project challenge is how to preserve what is great about Sonoma Valley while adapting to new pressures and solving the chronic problems facing us. The project is about to launch a website and has plans for a public meeting in the fall 2017. Other priorities for this year include establishing a steering committee and advisory board, and creating a home/office independent of any one organization.		
5. CHIEF REVENUE OFFICER'S QUARTERLY REPORT	*Donaldson*	Inform
Ms. Donaldson provided a review of the FY2017 strategies and accomplishments to date.		
6. SOUTH LOT APPRAISAL	*Boerum*	Inform/Action
Mr. Boerum presented a request for a new appraisal of the South Lot. Mr. Hohorst thought appraisals were helpful to a buyer; however, a competitive bidding process is more useful for a seller in getting a fair market value, and the other Board members agreed. No motion was made and the item was withdrawn.		No motion, item withdrawn.
7. SOUTH LOT RFP REVIEW PROCESS	*Hirsch*	Inform
Ms. Hirsch reported that Hospital attorneys had been consulted. The		

CFO has received questions about the project; those questions will be compiled and posted on the Hospital website with answers. The Board meeting following the proposal due date is May 4, 2017. A study session will be scheduled between April 15 and May 4 with no action taken. All of the proposals will be reviewed at the May 4 meeting with SVH attorneys present. All Board members agreed with the process. Two study sessions will be scheduled if many proposals are received. A time limit of up to 30 minutes, including questions, will be set for each presenter. Presentations will be requested prior to the meetings. If any proposal is not received by April 15, it will be disqualified. Proposals should be addressed to the Board and mailed to, or dropped at, SVH administration no later than 5:00 pm on April 15.		
8. FINANCIAL REPORT JANUARY 31, 2017	*Jensen*	Inform
Mr. Jensen reviewed the financial report for the month of January. January was a better month than December for collections; cash is at 20.2 days, accounts receivable at 49.7 days, and accounts payable at 43.1 days. The ER received 1000 visits in January which is the highest monthly total ever recorded. Approximately $48,000 was saved in medications (supplies) due to eligibility for the 340(b) drug program. The net loss for January was ($107,802) on a budget of ($196,231).		
9. ADMINISTRATIVE REPORT FEBRUARY 2017	*Mather*	Inform
Ms. Mather reported that 90% of staff participated in the satisfaction survey, the highest ever. The recent quarterly medical staff meeting was very positive and they were very engaged. Mr. Kobe mentioned that ER patient satisfaction has been very high as well. Discussions are under way regarding the possibility of a cardiac center in Sonoma. A major upgrade to the Electronic Health Record is under way this year. There has been some turnover in surgery and the ER, and a new surgery manager will be in place in March. SVH has a new hospitalist director and new ER Medical Director, and is looking for a new Skilled Nursing Medical Director. The nurse call system has gone down in Skilled Nursing and a replacement is expected to take a year and cost $200,000-300,000.		
10. COMMITTEE REPORTS • Governance Committee Report	*Hohorst*	Inform/Action
SVH is in compliance with AB2040 regarding salary information with a link on the website. Mr. Hohorst reported that the Governance Committee approved a work plan for this year which will be brought to the April Board meeting. The Committee also recommends the medical staff bylaws be approved at the April meeting.		
11. BOARD COMMENTS	*All*	Inform/Discussion
Mr. Boerum attended a conference by the UC Irvine Business School on health care policies under a new presidency. The majority of attendees would prefer some changes to the Affordable Care Act. Mr. Hohorst reminded the public about the parcel tax vote on March 7th.		

The Board thanked Dr. Jared Hubbell for his service as Medical Director of the ER. He will remain as an ER physician.		
12. ADJOURN The meeting adjourned at 7:28 p.m.	*Hirsch*	

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS EMERGENCY SESSION
MINUTES

Wednesday, March 8, 2017, 9:00 AM

Administration Conference Room
Sonoma Valley Hospital
347 Andrieux St, Sonoma CA 95476

CONFERENCE CALL-IN INFORMATION
Call-in number: 1-866 228-9900
Guest Code: 294221#

In compliance with the Americans Disabilities Act, if you require special accommodations to participate in a District meeting, please contact District Clerk, Gigi Betta at (707) 935.5004/5 at least 48 hours prior to the meeting.		
AGENDA ITEM	**RECOMMENDATION**	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER Meeting called to order at 9:04 a.m. and members present were Jane Hirsch, Peter Hohorst, Joshua Rymer, with Sharon Nevins and Bill Boerum by phone.	*Hirsch*	
2. PUBLIC COMMENT	*Hirsch*	
No public comment.		
3. DISCUSSION OF PARCEL TAX VOTE AND RESOLUTION FOR JUNE BALLOT	*Hohorst*	Inform/Action
Ms. Hirsch announced the purpose of this meeting was to share the preliminary results of the March 7, 2017, parcel tax vote, which was 64.8% in favor, 35.2% against, and to discuss next steps. It was recommended and agreed that a special Board meeting be held within 24 hours to consider a resolution for a new ballot measure in June.		
4. ADJOURN Meeting adjourned at 9:40 a.m.	*Hirsch*	

BOARD OF DIRECTORS' SPECIAL MEETING
MINUTES

Thursday, March 9, 2017, 10:00 AM

Administration Conference Room
Sonoma Valley Hospital
347 Andrieux St, Sonoma CA 95476

CONFERENCE CALL-IN INFORMATION
Call-in number: 1-866 228-9900
Guest Code: 294221#

AGENDA ITEM	RECOMMENDATION	
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER Meeting called to order at 10:00 a.m. and members present were Jane Hirsch, Peter Hohorst, Joshua Rymer, and Bill Boerum, with Sharon Nevins by phone. Ms. Hirsch announced a change to the agenda – Item 3 below is Resolution No. 334, not 333.	*Hirsch*	
2. PUBLIC COMMENT	*Hirsch*	
No public comment on items not on the agenda.		
3. REQUEST FOR APPROVAL OF RESOLUTION NO. 334 PARCEL TAX	*Hohorst*	Inform/Action
Ms. Hirsch announced that Measure B, parcel tax, fell just short of the two-thirds vote needed. It is being considered today for the June ballot since it is so critical to the hospital. She asked the Board to consider adding this item to the June 6, 2017, ballot, the amount of the tax, the wording on the ballot, and whether a committee should be formed. Mr. Hohorst read the Board letter for the resolution. Ms. Hirsch asked for public comment on the Board letter; there was none. Mr. Hohorst then read the resolution. Mr. Rymer asked the Board to support the resolution. Ms. Nevins added her support of putting the measure on the ballot and discussed minor edits to the resolution. Those edits were provided to the Clerk. Mr. Boerum discussed his minor edits, which were provided to the Clerk. Mr. Boerum then read his additional language for the resolution. The other Board members did not support the additional language, mentioning they did not see elimination of the parcel tax as an option, as well as objecting to directing hospital operations. The Board members did agree to a revised "whereas" clause, and those edits were provided to the Clerk.		**MOTION:** by Rymer, 2nd by Boerum, to approve Ms. Nevins' edits. All in favor. **MOTION:** by Boerum, 2nd by Rymer, to approve Mr. Boerum's edits. All in favor. **MOTION:** by Rymer, 2nd by Hohorst, to approve the revised "whereas" clause. All in favor.

Ms. Hirsch asked for public comment. Lorrie Hohorst: Mr. Boerum has worked with me many times on past parcel tax measures. The health care districts were set up with a parcel tax possibility in mind in order to be supported by the community. In flush times the parcel tax was removed. The State legislature realized that the parcel tax would be needed. To say to the public that the parcel tax could be eliminated is not in the spirit of the legislation. Gina Cuclis: I am very surprised that this measure failed. I think this was a campaign flaw. My household did not receive any mailers, whereas John Kelly received numerous mailers. Another neighbor did not receive any mailers either. There were no signs, no door-to-door campaign, no phone banks. Most voters are not paying attention; you have to let them know there is an election. Mike Nugent: In December 1992 I attended my first Board meeting. We had the same proofs and tests then. The 1992 Board was no different. You have to bring this to the community because they make the decisions. Some have great reasons to not have the Hospital stay open; I'm not one of them. A bad campaign is not a capital crime; let's go again. Give the people of the community the last word. Ms. Hirsch summarized that the parcel tax measure would be added to the June ballot in the amount of $250 with the wording and edits previously discussed. Mr. Hohorst was concerned about having no "Plan B" if the measure were to fail. He made a motion directing the CEO to make a preliminary projection on when the hospital would run out of cash and a plan to shut down the hospital and discuss this plan at the May Board meeting. Brian Johnson: What is the Board willing to do to ensure the hospital stays here? Ms. Mather replied, What we've been doing for the last seven years, collect as much cash as we can, increase revenues as much as we can. The Hospital was operating like it was in the 1980s. We have had to invest in the Hospital with increased maintenance. One of the biggest expenses is the Electronic Health Record which cost $6 million. We needed the $80 million that was projected 10 years ago in order to survive. I don't think it is realistic to survive without a parcel tax. We have reduced spending already. Mike Nugent: If the parcel tax does not pass in June, the Hospital will not close in July. But there will be reductions in staff and services, and you have to know how you will operate without cash. That's not a scare tactic, that's management. Ms. Mather said there would also be a reduction in quality. We have other services that subsidize the Emergency Department.		**MOTION:** by Hohorst, 2nd by Rymer, to add the measure to the June ballot in the amount and with the wording previously discussed. All in favor.

Ms. Hirsch asked if Hospital management could prepare two budgets – one with and one without the parcel tax. Ms. Nevins thought the issue too broad and suggested the subject go to the Finance Committee before it goes to the Board. Mr. Hohorst withdrew his motion. John Kelly: The District is up against short deadlines. What committee will run this election? I volunteer to work on the committee. There is no substitute for one-on-one personal contact going door to door. Getting a campaign consultant sooner than later is also a great advantage. Mr. Hohorst said a committee plan would be discussed next week. Going forward we will maximize the people involved.		
4. ADJOURN Meeting adjourned at 11:25 a.m.	*Hirsch*	

SVHCD
FINANCE COMMITTEE MEETING
MINUTES
TUESDAY, JANUARY 24, 2017
Schantz Conference Room

Present	Excused	Staff	Public
Sharon Nevins Peter Hohorst Susan Porth Stephen Berezin S. Mishra, MD	Keith Chamberlin	Ken Jensen Sarah Dungan	Sam McCandless

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION & VISION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*			
1. CALL TO ORDER/ANNOUNCEMENTS	*Nevins*		
	Meeting called to order at 5:00 pm. Ms. Nevins announced that Mr. Barclay had passed away in December. The Committee does have a quorum tonight. She also reminded the members that the Committee is green and packets will not normally be provided. She would like to increase the membership to nine.		
2. PUBLIC COMMENT SECTION	*Nevins*		
	No public comment.		
3. CONSENT CALENDAR FC Minutes 10.25.16	*Nevins*	Action	
		MOTION by Hohorst to approve and 2nd by Porth. All in favor	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
4. FINANCE REPORT FOR MONTH ENDING 12.31.16	*Jensen*	Inform/Action	
	Mr. Jensen reported deliveries were low in December and had been over-budgeted. Skilled Nursing days have been down, and new surgeons are ramping up two months later than expected. Thus, gross patient revenue was under budget in December by ($444,646). After accounting for all other activity the December net loss was ($599,524) vs. a budgeted net loss of ($117,622). Days cash stands at 25.2. Accounts Receivable is currently at 50.8 days. There has been a focus on paying down Accounts Payable, which is currently at 49.7 days. Some of the line of credit was paid back as well. The expected pledge of $1 million was received in Jan., not Dec. Inter-Governmental Transfer funds received were only 75% of expected for all hospitals. The remaining 25% (or $354,000) will be received in Feb. SVH also expects receipt of $900,000 of AB915 funds in Feb., a parcel tax payment in April, and another Prime grant payment. It was suggested that future packets include both the current version of the cash forecast as well as a version with the first six months consolidated to make the report more readable.		
5. CAPITAL SPENDING REPORT FOR SECOND QUARTER FY2017	*Dungan/Jensen*	Inform	
	The spent to date column is actually Q1 and Q2 combined. The Foundation has committed to fund the $516,000 plus the overages. Funds for the lobby and fire system upgrades were		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	out of operations. Architect fees were covered by the Foundation. The fluoroscopy equipment was a loan. Many of these items were approved in prior years. Anything over $5,000 must be capitalized. The format of the report will be revised.		
6. PALM DRIVE LAWSUIT	*Jensen*	Inform/Action	
	The Hospital was served with a lawsuit regarding preferential payments from the bankruptcy court for Palm Drive Hospital. Services were provided after the bankruptcy filing. SVH's bankruptcy lawyer was able to reduce our liability to zero, but his costs were $8,000.		
6. FINANCE COMMITTEE ANNUAL WORK PLAN	*Jensen*	Inform/Action	
		MOTION by Porth to approve and 2nd by Berezin. All in favor	
7. ADJOURN	*Nevins*	Inform	
	Meeting adjourned at 6:18 p.m.		

SVHCD
FINANCE COMMITTEE MEETING
MINUTES
TUESDAY, FEBRUARY 28, 2017
Schantz Conference Room

Present	Excused	Staff	Public
Sharon Nevins Peter Hohorst Stephen Berezin Subhash Mishra, MD Susan Porth Keith Chamberlin, MD		Ken Jensen Jeannette Tarver	

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
MISSION & VISION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*			
1. CALL TO ORDER/ANNOUNCEMENTS	*Nevins*		
	Meeting called to order at 5:03 pm.		
2. PUBLIC COMMENT SECTION	*Nevins*		
	No public comment.		
3. CONSENT CALENDAR FC Minutes 01.24.17	*Nevins*	Action	
		MOTION by Hohorst to approve and 2nd by Porth. All in favor	
4. FINANCIAL REPORT FOR MONTH ENDING JANUARY 31, 2017	*Jensen*	Inform/Action	
	Mr. Jensen presented the financial report and discussed the payer mix for January. Although cash collected for January was under goal by $175,000,		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	cash collections for February are over $1 million ahead of goal. Accounts receivable is at 49.7 days and Accounts Payable is at 43.1 days. Days cash stands at 20.2. The AB915 funds of over $900,000 were received. Inpatient revenue was up with increased ICU days. This resulted from longer lengths of stay which negatively impacted contractual allowances. Total operating revenue was $82,490 under budget. The hospital received approval for the 340(b) program allowing it to buy drugs at discount rates; this resulted in a savings of $48,000 in supplies for the month of January. Net loss for January was ($107,802) vs. a budget of ($196,231).		
5. BUDGET ASSUMPTIONS FY2018	*Jensen*	Inform	
	FY2018 budget assumptions were discussed, based on actual for 2017 and on contracts. The budget assumes the parcel tax measure will pass; the Hospital also anticipates a 6% price increase. Expenses will include the 3% salary increase in January and an additional increase for nurses in April.		
6. REVIEW OF CURRENT DEBT	*Jensen*	Inform	
	Mr. Jensen discussed current debt. The Committee requested a total of all yearly payments. Celtic leases were for New Wing equipment. The CEC loans were State loans for energy equipment. The $2 million South Lot loan is due in August 2018. The hospital plans to pay down the line of credit in the event it is needed.		

AGENDA ITEM	DISCUSSION	ACTIONS	FOLLOW-UP
	Ms. Nevins asked for the following items to be together at the March meeting for clarity: cash; days in A/R; days in A/P; capital needs; payment of line of credit. It would also be useful to see benchmarks for hospitals our size. In addition she requested the GO bond portion be removed from the debt report. (The debt report is prepared for Finance Committee members only.)		
6. ADMINISTRATIVE REPORT FEBRUARY 2017	*Mather*	Inform	
	Ms. Mather was not present, but Ms. Nevins asked if there were any questions. Regarding service excellence scores, the thresholds were changed so goals have been harder to attain.		
7. ADJOURN	*Nevins*		
	Meeting adjourned at 6:06 p.m.		

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
January 25, 2017, 5PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Joshua Rymer Susan Idell Ingrid Sheets Howard Eisenstark, MD	Cathy Webber Carol Synder	Jane Hirsch Michael Mainardi Kelsey Woodward Brian Sebastian, MD	Leslie Lovejoy Mark Kobe Peter Hohorst

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Rymer*	
	Meeting called to order at 4:58 p.m.	
2. PUBLIC COMMENT	*Rymer*	
	No public comment.	
3. CONSENT CALENDAR	*Rymer*	Action
• QC Minutes, 12.14.16		**MOTION** by Idell to approve and 2nd by Eisenstark. All in favor
4. POLICY & PROCEDURES	*Lovejoy*	Action
	Ms. Lovejoy explained a new approval process for policies, where patient care policies will go in full to the Medical Staff, with a summary signoff sheet to this Committee. All new policies will still come to the Committee in full. Tonight's policies are all renewals, except for one patient care policy which has already been approved by the Medical Staff.	**MOTION** by Idell to approve and 2nd by Eisenstark. All in favor.
5. REVIEW OF 2017 DRAFT QUALITY COMMITTEE WORK PLAN	*Lovejoy*	Inform/Action
	Ms. Lovejoy announced some scheduling changes.	**MOTION** by Eisenstark to approve ***as amended*** and 2nd by Idell. All in favor.
6. QUALITY REPORT JANUARY 2017	*Lovejoy*	Inform/Action
	Ms. Lovejoy's report included PRIME grant	**MOTION** by Eisenstark to approve

AGENDA ITEM	DISCUSSION	ACTION
	activities, the new health coach program, and the self management of care program for patients. She also plans to work with departments to make quality improvement plans more relevant. SVH is in the window for a survey in March or April. Rescheduling of the November Committee meeting after the holiday was discussed, and Ms. Idell suggested combining the November and December meetings. This will be proposed to Ms. Hirsch.	and 2nd by Idell. All in favor.
7. UPON ADJOURNMENT OF REGULAR SESSION	*Rymer*	
	Regular session adjourned at 5:19 p.m.	
8. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Rymer*	Action
9. REPORT OF CLOSED SESSION	*Rymer*	Inform/Action
	The Medical Staff Credentialing was unanimously approved.	
10. ADJORN	*Rymer*	
	Meeting adjourned at 5:24 p.m.	

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SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
February 22, 2017, 5PM
MINUTES
Schantz Conference Room

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch Howard Eisenstark, MD Susan Idell Kelsey Woodward Carol Snyder Cathy Webber		Joshua Rymer Ingrid Sheets Michael Mainardi Brian Sebastian, MD	Leslie Lovejoy Mark Kobe

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	Meeting called to order at 5:01 p.m.	
2. PUBLIC COMMENT	*Hirsch*	
	No public comment.	
3. CONSENT CALENDAR	*Hirsch*	Action
• QC Minutes, 01.25.17		**MOTION** by Eisenstark to approve and 2nd by Idell. All in favor
4. POLICY & PROCEDURES	*Lovejoy*	Action
	Dr. Eisenstark suggested some language be added to the informed consent policy; Ms. Lovejoy said the standard CHA language is used. . Dr. Eisenstark also mentioned the job shadowing policy was rather vague. Ms. Lovejoy said it is vague on purpose to allow it to cover various types of students and MDs who bring in students. She would check to see if the Med Staff had comments. Ms. Lovejoy will clarify these issues and return the policies for review at the March meeting.	**MOTION** by Idell to approve and 2nd by Eisenstark. All in favor.
5. QUALITY REPORT FEBRUARY 2017	*Lovejoy*	Inform/Action
	A summary discharge plan was created as part of the Prime Grant Transition Record, which will be	

AGENDA ITEM	DISCUSSION	ACTION
	completed by various team members. Follow-up appointments are made for patients for the first 7 days. Advance directive information is recorded, as well as "what matters most" to the patient. The regular discharge instructions are included behind this cover sheet. The self-management plan at the end was adopted as a best practice. This is the transition record we send to the next provider. This material all goes into the patient chart and is scanned on discharge. A personal health care record and magnet is also provided to the patient for home use. Paramedics will look for this file either on the front, or just inside the door, of the refrigerator. The first community health coach was assigned a patient. Next month the quality report will cover infrastructure reporting for the grant. Ms. Lovejoy is currently managing the med staff office.	
6. PATIENT CARE SERVICES DASHBOARD	*Kobe*	
	Mr. Kobe reviewed the 4th quarter results for the patient care services dashboard. Final 4th quarter numbers will come out the first part of March.	
7. QUALITY & RESOURCE MANAGEMENT DEPARTMENT ANNUAL REPORT	*Lovejoy*	
	Ms. Lovejoy presented an annual review on her own Quality and Resource Management department using a format suggested by the QC chair. The department impacts the bottom line through reducing extended stays. She also announced that the hospital credentialing survey is due within the next couple of months.	
8. UPON ADJOURNMENT OF REGULAR SESSION	*Hirsch*	
	Regular session adjourned at 6:00 p.m.	
9. CLOSED SESSION • Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	*Hirsch*	Action

AGENDA ITEM	DISCUSSION	ACTION
10. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	The Medical Staff Credentialing was unanimously approved.	
11. ADJORN	*Hirsch*	
	Meeting adjourned at 6:04 p.m.	

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Brian Sebastian, MD
Chair, P.I./P.T. Committee

3/14/17
Date

Kelly Mather
Chief Executive Officer

3/17/17
Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	2/21/2017	Y	
P.I. Committee	2/23/2017		
Quality Committee	3/22/2017		
Board of Directors	4/06/2017		

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

Policy Submission Summary Sheet

Kathy Mathews, Clinical Quality Coordinator		Leslie Lovejoy, Chief Quality Officer	
Signature: Kathy Mathews	DATE: 2-22-17	Signature: Leslie Lovejoy	DATE: 2-22-17

ORGANIZATIONAL

REVIEWED/NO CHANGES

IC8610-118 Creuzfeldt-Jakob Disease
IC8610-126 Employee Food Refrigerator Temperature Monitoring
IC8610-138 Infection Prevention and Control Training for Healthcare Workers
IC8610-156 Pet Therapy Visitation
IC8610-168 Reporting Infections and Communicable Diseases to Infection Control Procedure
IC8610-174 Scabies Infestation and Outbreak Management
IC8610-176 Toy Cleaning Policy

REVISED

IC8610-122 Droplet Precautions
Reference added

IC8610-134 Hand Hygiene
Artificial nails and nail enhancements are not allowed for anyone providing patient care (rather than just personnel in high risk areas e.g., Surgery)

IC8610-146 Management of Multi-Drug Resistant Organisms Policy
Gloves must be worn when entering the isolation room. A gown must be worn if contact with the patient or his/her environment is anticipated. If the patient needs to ambulate for treatment purposes, the patient needs to bathe/shower, don a clean gown, wash hands prior to leaving the room with a healthcare worker. The healthcare worker accompanies the patient to reduce the risk of contact with other patients or the environment. Incontinent patients cannot ambulate. Isolation is required for pts with current or a history of MDRO. Discontinuing isolation is reviewed on a case by case basis and remains until a physician writes an order to discontinue isolation. This order must follow consultation and approval by the Infection Preventionist and Infectious Disease physician.

IC8610-150 Norovirus Outbreak Management
Updated Contact/Enteric Precautions and use of eye protection

IC8610-152 Neutropenic Precautions, Guidelines for Care of the Immunocompromised Patient
Removed the requirement for no flowers in intensive care. Flowers and plants are restricted from the rooms of immunosuppressed patients

IC8610-154 Outbreak Management
Influenza outbreak has been changed to include two or more laboratory confirmed cases of hospital onset influenza i.e., occurring 48 hours or longer after admission. Also, DPH will be notified of an outbreak.

IC8610-158 Pregnant and Breastfeeding Healthcare Workers
An N95 mask is required for care of patients with novel influenza, Varicella and Measles even if immune. A surgical mask is required for Rubella in accordance with Droplet Precautions. HBV vaccine is recommended at time of hire if appropriate.

IC8610-162 Prevention of Central Line Associated Blood Stream Infections, Prevention
Revised to include CLIP information

IC8610-164 Prevention of Surgical Site Infections
Artificial nails and nail polish are prohibited. SSIs are reported up to 90 days post op. Patients undergoing total joint replacement will follow the S. aureus Decolonization procedure. Timing of pre op antibiotics are withing 60 minutes of cut time and 90 minutes for vancomycin. PPE worn during a surgical case is removed before leaving the Surgery Department.

IC8610-166 Rehabilitation Services with Patients in Contact Isolation, Management
Contact Isolation patients with active diarrhea can't ambulate outside of the room. Patients with MRSA in their sputum who are actively coughing cannot ambulate outside of their room. (Surgical masks cannot prevent aerosolization). Patients in Airborne Isolation should not be out of the room for ambulation e.g., chickenpox. Patients should not be in contact with environmental surfaces. If so, surfaces are disinfected immediately.

IC8610-170 Reporting Positive Culture Results After Transfer to Another Facility Procedure
Removed Joint Commission references

IC8610-177 Table, Transmission Based Precautions for Selected Infections and Conditions
Revised with several changes to anthrax, brochiolitis, diarrhea, norovirus, hepatitis A, polio, and rabies

DEPARTMENTAL – INFECTION CONTROL

REVIEWED/NO CHANGES
IC8750-138 Mandatory Reporting Policy
IC8750-125 Post Discharge SSI Surveillance

REVISED
IC8750-108 Infection Control Committee
Updated to reflect current titles of individuals that comprise the committee

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the following organizational leaders for meeting all of the following criteria. All of these policies and procedures are:

- Consistent with the Mission, Vision and Values of the Sonoma Valley Health Care District
- Consistent with all Board Policy, Hospital Policy and Hospital Procedures
- Meet all applicable law, regulation, and related accreditation standards
- Consistent with prevailing standards of care
- Consistent with evidence-based practice

We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Brian Sebastian, MD
Chair, P.I./P.T. Committee

3/14/17
Date

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/16/17
Date

Kelly Mather
Chief Executive Officer

3/17/17
Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Policy & Procedure Team	1/17/2017	Y	
PI Committee	2/23/2017		
Medical Exec. Committee	3/16/2017		
Quality Committee	3/22/2017		
Board of Directors	4/06/2017		

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Policy Submission Summary Sheet

Kathy Mathews, Clinical Quality Coordinator		Leslie Lovejoy, Chief Quality Officer	
Signature: Kathy Mathews RN	DATE: 2.22.17	Signature: Leslie Lovejoy	DATE: 2/22/17

ORGANIZATIONAL

REVISED
IC8610-171 Staph aureus Decolonization Procedure for Patients Undergoing Total Joint Replacement Surgery
Rephrased for process clarity

Leslie Lovejoy, Chief Quality Officer	
Signature: Leslie Lovejoy	DATE: 2/22/17

ORGANIZATIONAL

REVIEWED / NO CHANGES
UR8610-102 Utilization Review

REVISED
IC8610-172 Standard Precautions
Updated reusable procedure trays and instruments processed according to Manufacturer's instructions and updated patient and visitor hygiene supplies

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Policy and Procedure - Approvals Signature Page

Review and Approval Requirements

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We recommend their acceptance by the Quality Committee and that the Quality Committee forward them to the Sonoma Valley Health Care District Board with a recommendation to approve.

Keith J. Chamberlin, MD MBA
President of Medical Staff

3/15/17
Date

Kelly Mather
Chief Executive Officer

3/17/17
Date

Jane Hirsch
Chair, Board of Directors

Date

Reviewed by:	Date	Approved (Y/N)	Comment
Medical Exec. Committee	3/16/2017		
Quality Committee	3/22/2017		
Board of Directors	4/06/2017		

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Policy Submission Summary Sheet

Mark Kobe, Chief Nursing Officer	
Signature:	DATE:

ORGANIZATIONAL

REVIEWED / NO CHANGES
MS8610-102 Autopsy Policy

MEDICAL STAFF BYLAWS

February 17, 2017

Table of Contents

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
MEDICAL STAFF BYLAWS

Introduction

The Sonoma Valley Hospital Bylaws are designed to comply with California and federal law, and the applicable Center for Improvement in Healthcare Quality (CIHQ) standards. Sonoma Valley Hospital is a division of the Sonoma Valley Health Care District, a political subdivision of the State of California, pursuant to the California District Law Act.

Preamble

These bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the District Board of Sonoma Valley Hospital in protecting the quality of medical care provided in the hospital and assuring the competency of the hospital's Medical Staff. The bylaws provide a framework for self-government, assuring an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the District Board for the effective performance of Medical Staff responsibilities. These bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the District Board, and relations with applicants to and members of the Medical Staff. Should the bylaws, rules, regulations, or policies of the Medical Staff conflict with the bylaws of the District Board, then the bylaws of the District Board shall prevail.

Accordingly, the bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities, including, but not limited to, periodic meetings of the Medical Staff, its committees, and departments and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing Medical Staff officers; and they address the respective rights and responsibilities of the Medical Staff and the District Board.

Finally, notwithstanding the provisions of these bylaws, the Medical Staff acknowledges that the District Board must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital. In adopting these bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these bylaws, the District Board commits to allowing the Medical Staff reasonable independence in conducting the affairs of the Medical Staff. Accordingly, the District Board will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

Definitions

1) **Allied health professional or AHP** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the District Board, the Medical Staff, and applicable State Practice Act, who is qualified to render direct or indirect medical, dental, or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the hospital, and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and District Board, these bylaws and the rules. AHPs are not eligible for Medical Staff membership.

2) **Chief Executive Officer** means the person appointed by the District Board to serve in an administrative capacity or his or her designee.

3) **Chief Medical Officer** means a practitioner to serve as a liaison between the Medical Staff and the administration.

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

5) **Date of receipt** means the date any notice, special notice or other communication was delivered personally; or if such notice, special notice or communication was sent by mail, it shall mean 72 hours after the notice, special notice, or communication was deposited, postage prepaid, in the United States mail.

6) **Days** means calendar days unless otherwise specified.

7) **Distant Site** when used in the context of a discussion regarding Telemedicine providers, means the location at which the Telemedicine equipment is located and from which the Telemedicine provider delivers his/her patient care services via a telecommunication system.

8)

9) **District Board or Governing Body** means the elected members of the Sonoma Valley Health Care District Board of Directors. As appropriate to the context and consistent with the hospital's bylaws, it may also mean any District Board committee or individual authorized to act on behalf of the District Board.

10) **Ex officio** means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.

11) **Hospital** means Sonoma Valley Hospita**l,** and includes all inpatient and outpatient locations and services operated under the auspices of the Hospital's license.

12)

13) **Medical Executive Committee or Executive Committee** means the executive committee of the Medical Staff.

14) **Medical Staff** means the organizational component of the hospital that includes all physicians (M.D. or D.O.), dentists, and podiatrists who have been granted recognition as members pursuant to these bylaws.

15) **Medical Staff year** means the period from July 1 through June 30.

16) **Member** means any practitioner who has been appointed to the Medical Staff.

17) **Notice** means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the hospital.

18) **Originating Site** when used in the context of discussion regarding Telemedicine, means the location at which the patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store-and-forward service originates.

19) **Physician** means an individual with an M.D. or D.O. degree who is currently licensed to practice medicine.

20) **Practitioner** means, unless otherwise expressly limited, any currently licensed physician (M.D. or D.O.), dentist, or podiatrist**.**

21) **Privileges or Clinical Privileges** means the permission granted to a Medical Staff member or AHP to render specific patient services.

22) **Rules** refers to the Medical Staff and/or department rules adopted in accordance with these bylaws unless specified otherwise.

23) **Special notice** means a notice sent by certified or registered mail, return receipt requested.

24) Telemedicine**,** for purposes of these Bylaws**,** is the subset of Telehealth services delivered to hospital patients by practitioners who have been granted privileges by this hospital to provide services via Telehealth modalities ("Telemedicine Providers"). Telehealth is defined by California Business and Professions Code 2290.5 to mean the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the Originating Site and the health care provider is at a Distant Site. Telehealth includes synchronous (a real-time interaction between a patient and a health care provider located at a distant site) and asynchronous (the transmission of a patient's medical information from an Originating Site to the health care provider at a distant site without the presence of a patient) store-and-forward transfers.

    Neither a telephone conversation nor an electronic mail message between a health care practitioner and patient constitutes "telemedicine" for purposes of these Bylaws. The Medical Staff recommends to the District Board which clinical services are appropriately delivered through this medium, according to commonly accepted quality standards.

25) **Telemedicine Provider** means the individual provider who uses the Telemedicine equipment at the Distant Site to render services to patients who are located at the Originating Site. The Telemedicine Provider is a physician who generally contracts with the entity that serves as the Distant Site.

Article 1
NAME AND PURPOSES

1.1 Name

The name of this organization shall be the Medical Staff of Sonoma Valley Hospital.

1.2 Description

1.2-1 The Medical Staff organization is structured as follows: The members of the Medical Staff are assigned to a Staff Category depending on the nature and tenure of practice at the Hospital. All new members are assigned to the Associate Staff. Upon satisfactory completion of a provisional period, the members are assigned to one of the Staff Categories described in Article III.

1.2-2 Members are also assigned to departments, depending on their specialties, as follows: Medicine, Anesthesiology, and Surgery. Each department is organized to perform certain functions on behalf of the department, such as credentials review and peer review. This is accomplished by the department committees, as described in Articles 9 and 10 of these Bylaws.

1.2-3 There are also Medical Staff committees, which perform staff-wide responsibilities, and which oversee related activities being performed by the department committees.

1.2-4 Overseeing all of this is the Medical Executive Committee, comprising the elected officials of the Medical Staff, the department chairpersons and vice-chairpersons, and physician representatives from each of the clinical sections as described in Article 8.3.

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1.3 Purposes and Responsibilities

1.3-1 The Medical Staff's purposes are:

a. To assure that all patients admitted or treated in any of the hospital services, including patients treated via Telemedicine, receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the hospital's means and circumstances.

b. To provide for a level of professional performance that is consistent with generally accepted standards attainable within the hospital's means and circumstances.

c. To organize and support professional education and community health education and support services.

d. To initiate and maintain rules for the Medical Staff to carry out its responsibilities for the professional work performed in the hospital.

e. To provide a means for the Medical Staff, District Board and administration to discuss issues of mutual concern and to implement education and changes intended to continuously improve the quality of patient care.

f. To provide for accountability of the Medical Staff to the District Board.

g. 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 exemption status.

1.3-2 The Medical Staff's responsibilities are:

a. To provide quality patient care;

b. To account to the District Board for the safety and quality of patient care provided by all members authorized to practice in the Hospital through the following measures:

1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

2) An organizational structure and mechanisms that allow on-going monitoring of patient care practices;

3) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;

4) A continuing education program based at least in part on needs demonstrated through the medical care evaluation program;

5) A utilization review program to provide for the appropriate use of all medical services;

c. To recommend to the District Board action with respect to appointments, reappointments, staff category and department assignments, clinical privileges and corrective action;

d. To establish and enforce, subject to the District Board approval, professional standards related to the delivery of health care within the hospital;

e. To account to the District Board for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities;

f. To initiate and pursue corrective action with respect to members where warranted;

g. To provide a framework for cooperation with other community health facilities and/or educational institutions or efforts;

h. To establish, enforce, and amend from time to time as needed Medical Staff bylaws, rules and policies for the effective performance of Medical Staff responsibilities, as further described in these bylaws;

i. To select and remove Medical Staff officers;

j. To assess Medical Staff dues and utilize Medical Staff dues as appropriate for the purposes of the Medical Staff.

Article 2
MEDICAL STAFF MEMBERSHIP

2.1 Nature of Medical Staff Membership

Membership on the Medical Staff and/or privileges may be extended to and maintained by only those professionally competent practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws and the rules. A practitioner, including one who has a contract with the hospital to provide medical-administrative services, may admit or provide services to patients in the hospital only if the practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with these bylaws and the rules. Appointment to the Medical Staff shall confer only such privileges and prerogatives as have been established by the Medical Staff and granted by the District Board in accordance with these bylaws.

2.2 Qualifications for Membership

2.2-1 **General Qualifications**

Membership on the Medical Staff and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the Medical Staff Bylaws and Rules. Medical Staff membership (except honorary Medical Staff) shall be limited to practitioners who are currently licensed or qualified to practice medicine, podiatry, or dentistry in California.

2.2-2 **Basic Qualifications**

A practitioner must demonstrate compliance with all the basic standards set forth in this Section 2.2-2 in order to have an application for Medical Staff membership accepted for review. The practitioner must:

a. Qualify under California law to practice as follows:

1) Physicians must be licensed to practice medicine by the Medical Board of California or the Board of Osteopathic Examiners of the State of California. Dentists must be licensed to practice dentistry by the California Board of Dental Examiners;

2) Podiatrists must be licensed to practice podiatry by the California Board of Podiatric Medicine;

3) Telemedicine providers do not have to reside in California, but must be licensed to practice in California;

b. If practicing clinical medicine, dentistry, or podiatry, have a federal Drug Enforcement Administration (DEA) number.

c. Be certified by or currently qualify to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Board of Podiatric Surgery, the American Board of Orthopedic Podiatric Medicine, or a board or association with equivalent requirements approved by the Medical Board of California in the specialty that the practitioner will practice at the hospital, or have completed a residency approved by the Accreditation Council for Graduate Medical Education that

provided complete training in the specialty or subspecialty that the practitioner will practice at the hospital. This section shall not apply to dentists.

d. Be eligible to receive payments from the federal Medicare and state Medi-Cal programs.

e. Have liability insurance or equivalent coverage meeting the standards specified in the rules (see section 2.7).

f. Have met the requirements for practice experience and volume as specified in the privileges requested for their specialty.

g. Be located close enough (office and residence) to the hospital to be able to provide continuous care to his or her patients. The distance to the hospital may vary depending upon the Medical Staff category and privileges that are involved and the feasibility of arranging alternative coverage, and may be defined in the rules.

h. Pledge to provide continuous care to his or her patients.

i. If requesting privileges only in departments operated under an exclusive contract, must be a member, employee or subcontractor of the group or person that holds the contract.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff membership, and the application shall not be accepted for review, except that applicants for the honorary Medical Staff do not need to comply with any of the basic standards and applicants for the affiliate Medical Staff need not comply with paragraphs (c), (d) and (f), and applicants for the telemedicine affiliate staff need not comply with paragraphs (g) of this Section. If it is determined during the processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these bylaws, but may submit comments and a request for reconsideration of the specific standards which adversely affected such practitioner. Those comments and requests shall be reviewed by the Medical Executive Committee and the District Board, which shall have sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed by Section 2.2-4, Waiver of Qualifications.

2.2-3 **Additional Qualifications for Membership**

In addition to meeting the basic standards, the practitioner must:

a. Document his or her:

1) Adequate experience, education, and training in the requested privileges;

2) Current professional competence;

3) Good judgment; and

4) Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is sufficiently healthy and professionally and ethically competent so that patients can reasonably expect to safely receive the generally recognized professional level of quality of care for this community; and

b. Be determined to:

1) Adhere to the lawful ethics of his or her profession;

2) Be able to work cooperatively with others in the hospital setting so as not to adversely affect patient care or hospital operations; and

3) Be willing to participate in and properly discharge Medical Staff responsibilities.

2.2-4 **Waiver of Qualifications**

Insofar as is consistent with applicable laws, the District Board has the discretion to deem a practitioner to have satisfied a qualification, after consulting with the Medical Executive Committee, if it determines that the practitioner has demonstrated he or she has substantially comparable qualifications and that this waiver is necessary to serve the best interests of the patients and of the hospital. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these bylaws.

2.3 Effect of Other Affiliations

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

2.4 Nondiscrimination

Medical Staff membership or particular privileges shall not be denied on the basis of age, gender, religion, race, creed, color, national origin, sexual orientation, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant complies with the bylaws or rules of the Medical Staff or the hospital.

2.5 Administrative and Contract Practitioners

2.5-1 **Contractors with No Clinical Duties**

A practitioner employed by or contracting with the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the hospital and to the terms of his or her contract or other conditions of employment and need not be a member of the Medical Staff.

2.5-2 **Contractors Who Have Clinical Duties**

a. A practitioner with whom the hospital contracts to provide services which involve clinical duties or privileges must be a member of the Medical Staff, achieving his or her status by the procedures described in these bylaws. Unless a written contract or agreement executed after this provision is adopted specifically provides otherwise, or unless otherwise required by law, those privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing, and appeal procedures of Article 13, Hearings and Appellate Reviews, of these bylaws, upon termination or expiration of such practitioner's contract or agreement with the hospital.

b. Contracts between practitioners and the hospital shall prevail over these bylaws and the rules, except that the contracts may not reduce any hearing rights granted when an action will be taken that must be reported to the Medical Board of California or the federal National Practitioner Data Bank.

2.5-3 **Subcontractors**

Practitioners who subcontract with practitioners or entities who contract with the hospital may lose any privileges granted pursuant to an exclusive or semi-exclusive arrangement (but not their Medical Staff membership) if their relationship with the contracting practitioner or entity is terminated, or the hospital and the contracting practitioner's or entity's agreement or exclusive relationship is terminated. The hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize this right.

2.6 Basic Responsibilities of Medical Staff Membership

Except for honorary members each Medical Staff member and each practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

2.6-1 Provide his or her patients with care of the generally recognized professional level of quality and efficiency;

2.6-2 Abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies and rules of the Medical Staff and the hospital;

2.6-3 Abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of the CIHQ;

2.6-4 Discharge in a responsible and cooperative manner such Medical Staff, department, section, committee and service functions for which he or she is responsible by appointment, election or otherwise;

2.6-5 Abide by all applicable requirements for timely completion and recording of a physical examination and medical history on all patients, in accordance with the clinical guidelines set forth in Section 5.10 as well as Rule 11 of the Rules and Regulations.

2.6-6 Prepare and complete in 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 (EHR) policies and protocols as have been implemented by the hospital;

2.6-7 Abide by the ethical principles of his or her profession;

2.6-8 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral;

2.6-9 Refrain from any unlawful harassment or discrimination against any person (including any patient, hospital employee, hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's age, gender, religion, race, creed, color, national origin, sexual orientation, health status, ability to pay, or source of payment;

2.6-10 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a practitioner or AHP who is not qualified to undertake this responsibility or who is not adequately supervised;

2.6-11 Coordinate individual patients' care, treatment and services with other practitioners and hospital personnel, including, but not limited to, seeking consultation whenever

warranted by the patient's condition or when required by the rules or policies and procedures of the Medical Staff or applicable department;

2.6-12 Actively participate in and regularly cooperate 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, and related monitoring activities required of the Medical Staff, and in discharging such other functions as may be required from time to time;

2.6-13 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of or review of the care of specific patients;

2.6-14 Recognize the importance of communicating with appropriate department officers and/or Medical Staff officers when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the well-being or care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter;

2.6-15 Accept responsibility for participating in Medical Staff proctoring in accordance with the rules and policies and procedures of the Medical Staff;

2.6-16 Complete continuing medical education (CME) that meets all licensing requirements and is appropriate to the practitioner's specialty;

2.6-17 Adhere to the Medical Staff Standards of Conduct (as further described at Section 2.8), so as not to adversely affect patient care or hospital operations;

2.6-18 Participate in emergency service coverage and consultation panels as allowed and as required by the rules;

2.6-19 Cooperate with the Medical Staff in assisting the hospital to meet its uncompensated or partially compensated patient care obligations;

2.6-20 Participate in patient and family education activities, as determined by the department or Medical Staff Rules, or the Medical Executive Committee.

2.6-21 Notify the Medical Staff office in writing promptly, and no later than 14 calendar days, following any action taken regarding the member's license, DEA registration, privileges at other facilities, changes in liability insurance coverage, any report filed with the National Practitioner Data Bank, or any other action that could affect his/her Medical Staff standing and/or clinical privileges at the Hospital.

2.6-22 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in these bylaws. A member may be required to demonstrate continuing satisfaction of any of the requirements of these bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, mandatory health or psychiatric evaluation and mandatory drug or alcohol testing, the results of which shall be reportable to the Medical Executive Committee and/or the Well-Being Committee.

2.6-23 Discharge such other Staff obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

2.7 Professional Liability Insurance

2.7-1 Each Medical Staff member is required as a condition of membership to obtain and maintain professional liability insurance in the minimum amounts of coverage of $1,000,000 per occurrence and $3,000,000 aggregate unless exception is made by the Medical Staff Executive Committee upon written request of the Physician.

2.7-2 Failure to maintain the minimum level of professional liability insurance is deemed voluntary resignation from the Medical Staff. A Physician whose membership is terminated by reason of failure to maintain professional liability insurance will not have the rights of appeal.

2.7-3 The insurance will be with an insurance carrier admitted to market insurance in the State of California, or a Physician mutual cooperative trust, operated in compliance with California law.

2.7-4 The insurance must apply to all patients the Physician treats and to all procedures the Physician has privileges to perform in the hospital.

2.7-5 Proof of insurance will be provided at time of initial appointment and reappointment in the form of current certificates of insurance which will be maintained in the credentials file, and be available upon request from any Medical Staff committee. Proof of active professional liability coverage may be requested at any time by the Medical Staff Services Department.

2.7-6 Each physician will immediately report any reduction, restriction, cancellation or termination of the required professional liability insurance, or any change in insurance carrier as soon as reasonably possible through a written notice to the Medical Staff Services Department. Failure to maintain insurance coverage for any clinical privilege that is held shall result in automatic termination of such privilege until such time as the physician provides evidence of appropriate insurance coverage.

2.8 Standards of Conduct

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

2.8-1 **General**

a. It is the policy of the Medical Staff to require that its members fulfill their Medical Staff obligations in a manner that is within generally accepted bounds of professional interaction and behavior. The Medical Staff is committed to supporting a culture and environment that values integrity, honesty and fair dealing with each other, and to promoting a caring environment for patients, practitioners, employees and visitors.

b. Rude, combative, obstreperous behavior, as well as willful refusal to communicate or comply with reasonable rules of the Medical Staff and the Hospital may be found to be disruptive behavior. It is specifically recognized that patient care and Hospital operations can be adversely affected whenever

any of the foregoing occurs with respect to interactions at any level of the Hospital, in that all personnel play an important part in the ultimate mission of delivering quality patient care.

c. In assessing whether particular circumstances in fact are affecting quality patient care or Hospital operations, the assessment need not be limited to care of specific patients, or to direct impact on patient health. Rather, it is understood that quality patient care embraces—in addition to medical outcome—matters such as timeliness of services, appropriateness of services, timely and thorough communications with patients, their families, and their insurers (or third party payors) as necessary to effect payment for care, and general patient satisfaction with the services rendered and the individuals involved in rendering those services.

2.8-2 **Conduct Guidelines**

a. Upon receiving Medical Staff membership and/or privileges at the hospital, the member enters common goal with all members of the organization to endeavor to maintain the quality of patient care and appropriate professional conduct.

b. Members of the Medical Staff are expected to behave in a professional manner at all times and with all people—patients, professional peers, Hospital staff, visitors, and others in and affiliated with the Hospital.

c. Interactions with all persons shall be conducted with courtesy, respect, civility and dignity. Members of the Medical Staff shall be cooperative and respectful in their dealings with other persons in and affiliated with the Hospital.

d. Complaints and disagreements shall be aired constructively, in a non-demeaning manner, and through official channels.

e. Cooperation and adherence to the reasonable rules of the Hospital and the Medical Staff is required.

f. Members of the Medical Staff shall not engage in conduct that is offensive or disruptive, whether it is written, oral or behavioral.

2.8-3 **Adoption of Rules**

The Medical Executive Committee may promulgate rules further illustrating and implementing the purposes of this Section, including but not limited to, procedures for investigating and addressing incidents of perceived misconduct, and progressive or other remedial measures, including, when necessary, disciplinary action.

Article 3
CATEGORIES OF THE MEDICAL STAFF

3.1 Staff Categories

Each Medical Staff member shall be assigned to a Medical Staff category based on the qualifications defined below. The members of each Medical Staff category shall have the prerogatives and carry out the duties defined in the bylaws and rules. Action may be initiated to change the Medical Staff category or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in the rules. Changes in Medical Staff category shall not be grounds for a hearing unless they adversely affect the member's privileges.

3.1-1 Associate Medical Staff

a. Qualification: Appointees to this staff category must:

i. Meet the general Medical Staff qualifications set for in Article 2.2 of the Bylaws and who immediately prior to their application and appointment were not members in good standing of the Medical Staff.

b. Prerogatives: Appointees to this staff category may:

i. Attend any staff or hospital education programs.

ii. Attend meetings of the Medical Staff, and the departments of which that person is a member in a non-voting capacity.

iii. Serve on committees, but may not be eligible to act as chairperson or hold office.

iv. Admit patients and exercise such clinical privileges are granted pursuant to Article V.

c. Responsibilities: Appointees to this staff category must:

i. Undergo a period of proctoring as described in Section 5.9.

ii. Fulfill the responsibilities of the staff category to which s/he wishes to be transferred after successful completion of the Associate year.

iii. Pay annual dues

3.1-2 Active Medical Staff

a. Qualifications: Appointees to this staff category must:

i. Attend at least fifty percent (50%) of Surgery, Medicine, or Anesthesia Department meetings or Section meetings and at least one (1) general quarterly medical staff meeting per year AND

ii. Have six (6) or more patient encounters (inpatient procedures, admissions, consultations, emergency service visits, or outpatient surgeries) per year.

ii. Be able to assume the functions and responsibilities of membership on the active medical staff.

iv. Have completed at least one (1) year of satisfactory performance on the medical staff (i.e., Associate status).

b. Prerogatives: Appointees to this category may:

i. Vote on all matters presented at general and special meetings of the Medical Staff, of the departments and committees to which s/he is duly appointed, and on changes to Medical Staff Officers and Bylaws.

ii. Hold office and serve as a voting member, or be the chairperson, of any committee to which the member is duly appointed or elected, unless otherwise specified by these Bylaws.

iii. Attend any staff or hospital education programs.

iv. Admit patients and exercise such clinical privileges as are granted pursuant to Article V.

c. Responsibilities: Appointees to this category must:

i. Contribute to the organizational and administrative affairs of the Medical Staff.

ii. Actively participate in recognized functions of the Medical Staff such as monitoring quality improvement, monitoring initial appointees during their provisional period, and in discharging other staff functions as may be required from time to time.

iv. Pay annual dues

3.1-3 Affiliate Medical Staff

a. Qualifications: Appointees to this staff category shall be those who meet the minimum requirements for patient encounters as required for active staff (six (6) or more inpatient procedures, admissions, consultations, emergency service visits, or outpatient surgeries) per year, but do not meet the minimum meeting attendance requirements for Active Staff.

b. Prerogatives: Appointees to this Staff Category may:

i. Attend any staff or hospital education programs.

ii. Attend meetings in a non-voting capacity

iii. Not hold office or be the chairperson of any committee

iv. Admit patients and exercise such clinical privileges as are granted pursuant to Article V.

c. Responsibilities: Appointees to this category must:

i. Have completed at least one (1) year of satisfactory performance on the medical staff (i.e., Associate status).

ii. Pay annual dues

3.1-4 Courtesy Medical Staff

a. Qualifications: Appointees to this staff category shall be those who provide professional services (inpatient procedures, admissions, consultations, emergency service visits, and outpatient surgeries) to no more than six (6) patients each year of the two-year reappointment period in the hospital. There is no meeting requirement. Courtesy Staff members who exceed these limits will be moved to the appropriate staff category at time of reappointment. The Medical Executive Committee may make exceptions to this requirement upon showing of good cause. They must also meet the following requirements:

i. Be members in good standing of the Medical Staff of another California Medicare-participating hospital where each is subject to a patient care audit program and other quality maintenance activities. Exceptions to this requirement may be made by the Medical Executive Committee for good cause.

ii. Have completed at least one (1) year of satisfactory performance on the medical staff (i.e., Associate status).

b. Prerogatives: Appointees to this staff category may:

i. Attend any staff or hospital education programs.

ii. Attend meetings in a non-voting capacity.

iii. Admit patients to the hospital with the limitations of Section 3.1-4a and exercise such clinical privileges as are granted pursuant to Article V.

c. Responsibilities: Appointees to this category must:

i. Pay annual dues

3.1-5 Consulting Medical Staff

a. Qualifications: Appointees to this staff category must:

i. Be interested in the clinical affairs of the hospital and possess unique or special ability and knowledge to provide valuable assistance in difficult cases.

ii. Act only as consultants and not be otherwise eligible to admit patients.

iii. Be members of the Active or Associate Medical Staff of another California Medicare-participating hospital. Exceptions to this requirement may be made by the Medical Executive Committee for good cause.

iv. Have completed at least one (1) year of satisfactory performance on the medical staff (i.e., Associate status).

b. Prerogatives: Appointees to this staff category may:

i. Attend any staff or hospital education programs.

ii. Attend meetings in a non-voting capacity

iii. Not hold office or be the chairperson of any committee

iv. Exercise such clinical privileges as are granted pursuant to Article V.

c. Responsibilities: Appointees to this staff category must:

i. Pay annual dues

3.1-6 Locum Tenens Staff

a. Qualifications: Locum Tenens Staff shall consist of practitioners who only provide coverage for members of the Medical Staff.

b. Prerogatives: They may not hold office or be the chairperson of any committee. They may not vote.

c. Responsibilities: They are not required to pay annual dues.

3.1-7 Telemedicine Staff

1. Qualifications: Telemedicine Staff shall consist of Telemedicine Providers who provide diagnostic, consulting, or treatment services to hospital patients via Telemedicine devices.

2. Prerogatives: They are not eligible to admit patients. They may serve on committees in a non-voting capacity at the discretion of the Medical Executive Committee.

3. Responsibilities: They are not required to pay annual dues.

4. Additional Provisions Applicable to Telemedicine Staff:

i. Responsibility to Communicate Concerns/Problems:

1) There is a need for clear delineation of reporting responsibilities respecting the Telemedicine providers' performance. At the very least, the Medical Staff officials at this hospital must be informed of any practitioner-specific problems that arise in the delivery of services to this hospital's patients.

2). Additionally, this hospital should communicate to the Medical Staff officials at the Distant Site, through peer review channels, any problems that may arise in the delivery of care by the Telemedicine provider to patients at this hospital.

3). Similarly, when a member of this hospital's Medical Staff is providing telemedicine services to patients at another facility, this hospital's Medical Staff should communicate to the Medical Staff officials at the Originating Site, through peer review channels, any problems that may arise in the delivery of telemedicine services by members of this hospital's Medical Staff.

4). The Chief of Staff may enter into appropriate information sharing agreements and/or develop and implement appropriate protocols to effectuate these provisions.

ii. Responsibility to Review Practitioner-Specific Performance:

1). Special proctoring arrangements may be made for qualified practitioners at the Distant Site to proctor cases performed by new members of the Telemedicine Staff.

2). Primary responsibility to assess what, if any, practitioner-specific performance improvement and/or corrective action may be warranted rests with the Originating Site. If such action gives rise to procedural rights at this hospital, the provisions of Article 13 of the Bylaws will apply. However, this Medical Staff is authorized to develop integrated peer review policies and procedures with other System members, whereby representatives of both the Originating Site's and the Distant Site's Medical Staffs engage in integrated review and recommendation**.**

iii. Requirement for Contract with Distant Site: This Hospital must have a written agreement with each Distant Site from which a Telemedicine Provider delivers telemedicine services that specifies the following:

1) The Distant Site is a contractor of services to the Hospital

2) The Distant Site furnishes services in a manner that permits this hospital to be in compliance with the Medicare Conditions of Participation.

3) This hospital makes certain through the written agreement that all Distant Site Telemedicine Providers' credentialing and privileges meet, at a minimum the Medicare Conditions of Participation at 42 CFR 482.12(a)(1) through (a)(9) and 482.22(a)(1) through (a)(4).

3.1-8 Honorary Staff

a. Qualifications: Honorary Staff shall consist of practitioners the Medical Staff wishes to honor due to their outstanding reputations, noteworthy contributions to the health and medical sciences, or their previous longstanding service to the hospital, and were in good standing when they retired.

b. Prerogatives: They are not eligible to admit patients or exercise clinical privileges. They may not vote or hold office. They may serve on committees in a non-voting capacity at the discretion of the Medical Executive Committee. They may attend any staff or hospital education program.

c. Responsibilities: They are not required to pay annual dues.

3.2 Assignment and Transfer in Staff Category

a. Medical staff members shall be assigned to the category of staff membership based upon the qualifications identified above. Active staff members who fail to achieve the minimum activity for two consecutive years shall be automatically transferred to the appropriate category. Action shall be initiated to evaluate and possibly terminate the privileges and membership of any staff member who has failed to meet the requirements of any category. A Courtesy Member who has exceeded the maximum activity permitted for two consecutive years shall be deemed to have requested transfer to the appropriate category. The Medical Executive Committee shall approve these assignments and transfers, which shall then be evaluated in accordance with the bylaws and these rules. The transfers shall be done at the time of reappointment, or as deemed necessary by the Medical Executive Committee.

b. The District Board (on recommendation of the Medical Executive Committee) may rescind an automatic transfer, but only if the practitioner clearly demonstrates that unusual circumstances unlikely to occur again in his or her practice caused the failure to meet the minimum or maximum requirements.

3.3 General Exceptions to Prerogatives

Regardless of the category of membership in the Medical Staff, podiatrists, dentists, and limited license members:

3.3-1 May not hold any general Medical Staff office.

3.3-2 Shall have the right to vote only on matters within the scope of their licensure. Any disputes over voting rights shall be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee.

3.3-3 Shall exercise privileges only within the scope of their licensure and as limited by the Medical Staff Bylaws and Rules.

Article 4
PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

4.1 General

The Medical Staff shall consider each application for appointment, reappointment and privileges, and each request for modification of Medical Staff category using the procedure and the criteria and standards for membership and clinical privileges set forth in the bylaws and the rules. The Medical Staff shall perform this function also for practitioners who seek temporary privileges and for AHPs. The Medical Staff shall investigate each applicant for appointment or reappointment and make an objective, evidence-based decision based upon assessment of the applicant before recommending action to the District Board, and the District Board shall ultimately be responsible for granting membership and privileges (provided, however, that these functions may be delegated to the Chief of Staff and Chief Executive Officer with respect to requests for temporary privileges). The Medical Staff will verify that the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing a current picture hospital ID card, or a valid picture ID issued by a state or federal agency. By applying to the Medical Staff for appointment or reappointment (or by accepting honorary Medical Staff appointment), the applicant agrees that regardless of whether he or she is appointed or granted the requested privileges, he or she will comply with the responsibilities of Medical Staff membership and with the Medical Staff bylaws and rules as they exist and as they may be modified from time to time.

4.2 Overview of the Process

The following charts summarize the appointment, temporary privileges and reappointment processes. Details of each step are described in Rules 8.2 through 8.9.

APPOINTMENT

Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify application information and perform criminal background check	Department *(See Rule 8.5)*
Department	Review applicant's qualifications vis-à-vis standards of department and requirements of privileges; recommend appointment and privileges	Medical Executive Committee *(See Rule 8.7-1)*
Medical Executive Committee	Review department's recommendation; review applicant's qualifications vis-à-vis medical staff bylaws general standards; recommend appointment and privileges	District Board *(See Rule 8.7-2)*
District Board	Review recommendations of the Medical Executive Committee; make decision	Final Action *(See Rule 8.7-3)*

TEMPORARY PRIVILEGES

Person or Body	*Function*	*Report to*
Medical Staff Coordinator	Verify key information	Chief of Staff *(See Bylaws Section 5.5-2)*
Chief of Staff	Review recommendations of department chair; recommend temporary privileges	CEO *(See Bylaws Section 5.5-3)*
Chief Executive Officer	Make decision	Final action *(See Bylaws Section 5.5-3.)*

REAPPOINTMENT

Person or Body	*Function*	*Report to*
Medical Staff Coordinator	Verify reappointment information	Department *(See Rule 8.9-3)*
Department	Review applicant's performance vis-à-vis standards of department and requirements of privileges; recommend appointment and privileges	Medical Executive Committee *(See Rule 8.9-4)*
Medical Executive Committee	Review department's recommendation; review committee reports; review applicant's performance vis-à-vis medical staff bylaws general standards; recommend appointment and privileges	District Board *(See Rule 8.9-5c)*
District Board	Review recommendations of the Medical Executive Committee; make decision	Final Action *(See Rule 2.9-6)*

4.3 Applicant's Burden

4.3-1 An applicant for appointment, reappointment, advancement, transfer, and/or privileges shall have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. The provision of information containing significant misrepresentations or omissions and/or a failure to sustain the burden of producing information shall be grounds for denying an application or request. This burden may include submission to a physical or mental health examination at the practitioner's expense, if deemed appropriate by the Medical Executive Committee. The applicant may select the examining physician from an outside panel of three physicians chosen by the Medical Executive Committee.

4.3-2 Any committee or individual charged under these bylaws with responsibility of reviewing the appointment or reappointment application and/or request for clinical privileges may request further documentation or clarification. If the practitioner or member fails to respond within 90 days, the application or request shall be deemed withdrawn, and processing of the application or request will be discontinued (See

Rule 8.6). 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 13, Hearings and Appellate Reviews.

4.4 Application for Initial Appointment and Reappointment

4.4-1 **Application Form**

A practitioner for appointment and reappointment shall complete written application forms that request information regarding the applicant and document the applicant's agreement to abide by the Medical Staff Bylaws and Rules (including the standards and procedures for evaluating applicants contained therein) and to release all persons and entities from any liability that might arise from their investigating and/or acting on the application. The information shall be verified and evaluated by the Medical Staff using the procedure and standards set forth in the bylaws and rules. Following its investigation, the Medical Executive Committee shall recommend to the District Board whether to appoint, reappoint and/or grant specific privileges.

4.4-2 **Basis for Appointment**

a. Except as next provided with respect to telemedicine practitioners, recommendations for appointment to the Medical Staff and for granting privileges shall be based upon appraisal of all information provided in the application, (including but not limited to health status and written peer recommendations regarding the practitioner's current proficiency with respect to the privileges requested), the practitioner's training, experience, and professional performance at this hospital, if applicable, and in other settings, whether the practitioner meets the qualifications and can carry out all of the responsibilities specified in these bylaws and the rules, and upon the hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner. Recommendations from peers in the same professional discipline as the practitioner, and who have personal knowledge of the applicant, are to be included in the evaluation of the practitioner's qualifications.

b. The initial appointment of practitioners to the Telemedicine Staff may be based upon

1) The practitioner's full compliance with this hospital's credentialing and privileging standards; or

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

3) By relying entirely on the credentialing and privileging of that other hospital, if the hospital where the practitioner routinely practices is a Medicare-participating hospital and it agrees to provide a comprehensive report of the practitioner's qualifications. This comprehensive report includes at least the following:

i. Confirmation that the practitioner is privileged at that hospital for those services to be provided at this hospital (i.e., list of current privileges)

ii. Evidence of that hospital's internal review of the practitioner's performance of the requested privileges, including information

useful to assist in this hospital's assessment of the practitioner's quality of care, treatment, and services. This must include, at a minimum: all adverse outcomes related to sentinel events that result from the telemedicine services provided and any complaints received at that hospital related to telemedicine services provided at this hospital.

iii. An attestation signed by an authorized representative of that hospital indicating that the packet is complete, accurate, and up-to-date.

4.5 Approval Process for Initial Appointments

4.5-1 **Recommendations and Approvals**

The Department Committee shall review applications, engage in further consideration if appropriate and make a recommendation to the Medical Executive Committee regarding staff appointments and clinical privileges. The Medical Executive Committee shall make a recommendation to the District Board that is either favorable, adverse or defers the recommendation. If the Medical Executive Committee's recommendation to the practitioner is adverse, the Medical Executive Committee shall also assess and determine whether the adverse recommendation is for a "medical disciplinary" cause or reason. A medical disciplinary action is one take 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 a medical and an administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 13, Hearing and Appellate Reviews hearing purposes.

4.5-2 **The District Board's Action**

The District Board shall review any favorable recommendation from the Medical Executive Committee and take action by adopting, rejecting, modifying or sending the recommendation back for further consideration. After notice, the District Board may also take action on its own initiative if the Medical Executive Committee does not give the District Board a recommendation in the required time. The District Board may also receive and take action on a recommendation following procedural rights allowed at Article 13, Hearings and Appellate Reviews.

4.5-3 **Final Action**

If the parties are unable to resolve the dispute, the District Board shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the District Board 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.

4.5-4 **Expedited Review**

a. The District Board may use an expedited process for appointment, reappointment or when granting Privileges following review and approval by the Medical Executive Committee of an applicant for membership and/or privileges. This process entails review/approval by at least 2 members of the Board of Directors. Expedited processing is generally not available if:

1) The practitioner or Member submits an incomplete application;

2) The Medical Executive Committee's final recommendation is adverse in any respect or has any limitations;

3) There is a current challenge or a previously successful challenge to the practitioner's licensure or registration;

4) The practitioner has received an involuntary termination of medical staff membership or some or all privileges at another organization;

5) The hospital determines that there has been either an unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant.

4.5-5 **Notice of Final Decision**

The Chief Executive Officer shall give notice of the District Board's final decision to the Medical Executive Committee and to the applicant, and report any controversial issues regarding their recommendations to the Medical Executive Committee.

4.6 Approval Process for Reappointments

4.6-1 **Basis for Reappointment**

a. Recommendation for reappointment to the Medical Staff and for renewal of privileges shall be based upon a reappraisal of the member's health status, current proficiency with respect to the privileges requested in light of his/her performance at this hospital and in other settings. The reappraisal is to include confirmation of adherence to Medical Staff membership requirements and responsibilities as stated in these Bylaws, the Medical Staff rules and regulations, Medical Staff and Hospital policies, and the applicable department rules. Such reappraisal should also include relevant member-specific information from performance improvement activities and, where appropriate, comparisons to aggregate information about performance, judgment and clinical or technical skills, and reappraisal of the hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner. Where applicable, the results of specific peer review activities shall also be considered. If sufficient review data are unavailable, peer recommendations shall be used, per Section 8.9-2, b of the Rules; or in the case of reappointment of a member of the Telemedicine Staff, reappointment may be based upon information provided by the hospital(s) where the practitioner routinely practices. This information must include, at a minimum: all adverse outcomes related to sentinel events that result from the telemedicine services provided and any complaints received at that hospital related to the telemedicine services provided at this hospital.

4.6-2 **Failure to File Reappointment Application**

Reappointment is required at least every 24 months. There are no extensions allowed for appointments. Completed reappointment applications shall be returned to the medical staff office or CVO at least 90 days prior to the provider's appointment expiration date. Failure to timely file a completed application for reappointment shall result in the automatic termination of the member's admitting and other privileges and prerogatives at the end of the current Medical Staff appointment and he/she will be required to apply for privileges as an initial applicant. Failure to

return the completed application shall result in automatic suspension or resignation as described in Rule 8.9-8. In the event membership terminates for the reasons set forth herein, the practitioner shall not be entitled to any hearing or review.

4.6-3 **Recommendations and Approvals**

The Department Chair shall review applications, engage in further consideration if appropriate, as further described in the Rules, and make a recommendation to the Medical Executive Committee regarding staff reappointment applications. The Medical Executive Committee shall review the Department Committee's recommendations and all other relevant information available to it and shall forward to the District Board its recommendations, whether favorable, unfavorable, or deferred, which are prepared in accordance with Section 4.4-2 above and the Rules. If the Medical Executive Committee's recommendation to the practitioner is adverse, the Medical Executive Committee 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 a medical and an administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 13, Hearing and Appellate Reviews hearing purposes.

4.6-4 **The District Board's Action**

The District Board shall review any favorable recommendation from the Medical Executive Committee and take action by adopting, rejecting, modifying or sending the recommendation back for further consideration. After notice, the District Board may also take action on its own initiative if the Medical Executive Committee does not give the District Board a recommendation in the required time. The District Board may also receive and take action on a recommendation following procedural rights allowed at Article 13, Hearings and Appellate Reviews.

4.6-5 **Final Action**

If the parties are unable to resolve the dispute, the District Board shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the District Board 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.

4.7 Leave of Absence

4.7-1 **Routine Leave of Absence**

Except as next provided with respect to military leave of absence, members may request a leave of absence, which must be approved by the Medical Executive Committee and cannot exceed two years. Reinstatement at the end of the leave must be approved in accordance with the standards and procedures set forth in the rules for reappointment review. The member must provide information regarding his or her professional activities during the leave of absence. During the period of the leave, the member shall not exercise privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue unless waived by the Medical Executive Committee.

4.7-2 **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 section 4.7-1, but may be granted subject to further evaluation or proctoring, as determined by the Medical Executive Committee.

4.8 Waiting Period after Adverse Action

4.8-1 **Who Is Affected**

a. A waiting period shall apply to the following practitioners:

1) An applicant who

i) Has received a final adverse decision regarding appointment; or

ii) Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the District Board.

2) A former member who has

i) Received a final adverse decision resulting in termination of Medical Staff membership and/or privileges; or

ii) Resigned from the Medical Staff or relinquished privileges while an investigation was pending or following the Medical Executive Committee or District Board issuing an adverse recommendation.

3) A member who has received a final adverse decision resulting in

i) Termination or restriction of his or her privileges; or

ii) Denial of his or her request for additional privileges.

b. An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. An action is not considered adverse if it is based upon reasons that do not pertain to medical or ethical conduct, such as actions based on a failure to maintain a practice in the area (which can be cured by a move), to pay dues (which can be cured by paying dues), or to maintain professional liability insurance (which can be cured by obtaining the insurance).

4.8-2 **Duration and Commencement Date of the Waiting Period**

a. Ordinarily the duration of the waiting period shall be the longer of (i) 24 months or (ii) completion of all judicial proceedings pertinent to the action served within two years after the completion of the hospital proceedings. However, for practitioners whose adverse action included a specified period or conditions of retraining or additional experience, the Medical Executive Committee may exercise its discretion to allow earlier reapplication upon completion of the specified conditions. Similarly, the Medical Executive Committee may exercise its discretion, with approval of the District Board, to

waive the 24-month period in other circumstances where, by objective measures, it reasonably appears that changed circumstances warrant earlier consideration of an application.

b. The action is considered final on the latest date on which the application or request was withdrawn, a member's resignation became effective, or upon final District Board action following completion or waiver of all Medical Staff and hospital hearings and appellate reviews.

4.8-3 **Effect of the Waiting Period**

Except as otherwise allowed above, practitioners subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 24 months after the action became final. After the waiting period, the practitioner may reapply. The application will be processed like an initial application or request, plus the practitioner shall document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

4.9 Confidentiality; Impartiality

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

Article 5
PRIVILEGES

5.1 Exercise of Privileges

Except as otherwise provided in these bylaws or the rules, every practitioner or allied health professional (AHP) providing direct clinical services at this hospital shall be entitled to exercise only those setting-specific privileges granted to him or her. Practitioners who wish to participate in the delivery of telemedicine services (whether to patients of this hospital, or to patients of another facility that this hospital is assisting via telemedicine technology) must apply for and be granted setting and procedure-specific telemedicine privileges. (Additionally, practitioners who are not otherwise members of this hospital's Medical Staff who wish to provide services via telemedicine technology must apply for and be granted membership and privileges as part of the telemedicine staff (per Bylaws, Section 3.1-7) in order to provide services to patients of this hospital.)

5.2 Criteria for Privileges

Subject to the approval of the Medical Executive Committee and District Board, each department will be responsible for developing criteria for granting setting-specific privileges (including, but not limited to, identifying and developing criteria for any privileges that may be appropriately performed via telemedicine). These criteria shall 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 or policies.

5.3 Delineation of Privileges in General

5.3-1 **Requests**

Each application for appointment and reappointment to the Medical Staff must contain a request for the specific privileges desired by the applicant. A request for a modification of privileges must be supported by documentation of training and/or experience supportive of the request. The basic steps for processing requests for privileges are described in Bylaws, Section 4.2.

5.3-2 **Basis for Privilege Determinations**

Requests for privileges shall be evaluated on the basis of the applicant's license, education, training, experience, current demonstrated professional competence, judgment and clinical performance, (as confirmed by peers knowledgeable of the applicant's professional performance), current health status, the documented results of patient care and other quality improvement review and monitoring which the medical staff deems appropriate, performance of a sufficient number of procedures each year to develop and maintain the applicant's skills and knowledge, and compliance with any specific criteria applicable to the privileges requested. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where an applicant exercises privileges. When considering a request from a Practitioner who practices Telemedicine, credentialing information from another Medicare-participating hospital may be used, so long as the decision to delineate privileges is made at the Hospital receiving the Telemedicine Services.

5.3-3 **Telemedicine Privileges**

a. The initial appointment of practitioners to the Telemedicine Staff may be based upon a Medical Executive Committee recommendation to the District Board based upon either:

1) The practitioner's full compliance with this hospital's credentialing and privileging standards; or

2) By using this hospital's standards but relying in whole or in part on information provided by the distant-site hospital(s) at which the practitioner routinely practices. This must include, at a minimum: all adverse outcomes related to sentinel events and any complaints received at that hospital ; or

3) By relying entirely on the credentialing and privileging of that other hospital, IF the hospital where the practitioner routinely practices is Medicare-participating AND agrees to provide a comprehensive report of the practitioner's qualifications. This comprehensive report includes at least the following:

i. Confirmation that the practitioner is privileged at that hospital for those services to be provided at this hospital (i.e., list of current privileges)

ii. Evidence of that hospital's internal review of the practitioner's performance of the requested privileges, including information useful to assist in this hospital's assessment of the practitioner's quality of care, treatment, and services. This must include, at a minimum: all adverse outcomes related to sentinel events that result from the telemedicine services provided and any complaints received at that hospital related to the telemedicine services provided at this hospital.

b. Reappointment of a Telemedicine Staff member's privileges may be based upon performance at this hospital, and, if insufficient information is available, upon information from the distant-site hospital(s) where the practitioner routinely practices. This must include, at a minimum: all adverse outcomes related to sentinel events that result from the telemedicine services provided and any complaints received at that hospital related to the telemedicine services provided at this hospital.

5.4 Admissions; Responsibility for Care; History and Physical Requirements; and other General Restrictions on Exercise of Privileges by Limited License Practitioners

5.4-1 **Admitting Privileges**

a. Only Medical Staff members with admitting privileges may independently admit patients to the hospital. The following categories of licensees are eligible to independently admit patients to the hospital:

1. Physicians (MDs or DOs)
2. Dentists
3. Podiatrists

5.4-2 **Responsibility for Care of Patients**

b. All patients admitted to the hospital must be under the care of a member of the Medical Staff.

b. The admitting member of the Medical Staff shall establish, at the time of admission, the patient's condition and provisional diagnosis.

c. Dentist, oral surgeon, and podiatrist members may admit patients only if a physician member assumes responsibility for the care of the patient's medical or psychiatric problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice or clinical privileges.

5.4-3 History and Physicals and Medical Appraisals

a. Members of the Medical Staff, with appropriate privileges, may perform history and physical examinations.

b. When evidence of appropriate training and experience is documented, a limited license practitioner may perform the history or physical on his or her own patient. Otherwise, a physician member with history and physical privileges must document and conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry). All histories and physicals shall be performed in accordance with the clinical guidelines set forth in section 5.9 of these Bylaws.

c. All patients admitted for care in a hospital by a dentist, oral surgeon, or podiatrist shall receive the same basic medical appraisal as patients admitted to other services, and a physician member or a limited license practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate Department Chair.

d. The admitting or referring member of the Medical Staff shall assure the completion of a physical examination and medical history on all patients within 24 hours after admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), or immediately before. This requirement may be satisfied by a complete History and Physical that has been performed within the 30 days prior to admission or registration (the results of which are recorded in the hospital's medical record) so long as an examination for any changes in the patient's condition is completed and documented in the hospital's medical record within 24 hours after admission or registration.

e. Additionally, the history and physical must be updated within 24 hours prior to any surgical procedure or other procedure requiring general anesthesia or moderate or deep sedation. The practitioner responsible for anesthesia may, if granted clinical privileges, perform this updated history and physical.

5.4-4 **Surgery and High Risk Interventions by Limited License Practitioners**

1. Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the chair of the surgery department, or the chair's designee.
2. Additionally, the findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges, prior to major high-risk (as defined by the responsible department) diagnostic or therapeutic interventions.

5.5 Temporary Privileges

5.5-1 There are two circumstances in which temporary privileges may be granted:

1) To fulfill an important patient care, treatment, and/or service need.

2) When a new applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Staff Executive Committee and the District Board.

5.5-2 Each circumstance has different criteria for granting temporary privileges:

a. <u>To Fulfill an Important Care Need</u>
The following criteria must be met in order to grant temporary privileges to meet an important care need:

1) The individual must have a current California license to practice (with primary source verification);

2) The individual must have current malpractice insurance

3) The individual must have current competence to perform the privileges requested. Evidence of current competence can be demonstrated by meeting the following:

a) Graduate of an approved residency program in the area in which privileges are being requested, and evidence of recent relevant (past 2 years) education, training, and experience in the area of privileges being requested.

b) Additional criteria (if any) for the specific privileges requested;

c) In the case of an Urgent Care Need, when Medical Staff Services is unavailable (e.g. nights, weekends, holidays), any member of the Medical Executive Committee may vouch for the clinical competence of a non-Staff physician in order that the physician may be of immediate service to the patient..

4) Results of a National Practitioner Data Bank Query.

5) Current DEA number if the individual prescribes or furnishes medication.

6) In the case of an Urgent Care Need, when Medical Staff Services is unavailable (e.g. nights, weekends, holidays), items 5.5-2a.4) and 5.5-2a.5)

shall be waived until the next opportunity for Medical Staff Services to validate such information.

b. New Applicant Awaiting Review
The following criteria must be met in order to grant temporary privileges to a new applicant awaiting review and approval of the Medical Staff Executive Committee and the District Board:

1) The individual must have a current California license to practice (with primary source verification);

2) The individual must have current malpractice insurance;

3) The individual must show current competence to perform the privileges requested. Evidence of current competence can be demonstrated by meeting the following:

a) Graduate of an approved residency program in the area in which privileges are being requested, and evidence of recent relevant (past 2 years) education, training, and experience in the area of privileges being requested.

b) Additional criteria (if any) for the specific privileges requested;

4) Results of a National Practitioner Data Bank Query;

5) Current DEA number if the individual prescribes or furnishes medication.

6) A complete application;

7) A complete criminal background check;

8) No current or previously successful challenge to licensure or registration;

9) No subjection to involuntary termination of medical staff membership at another organization;

10) No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

11)

c. Temporary members of the Medical Staff who are granted temporary membership for purposes of serving on standing or ad hoc committees for investigation proceedings, are not, by virtue of such membership, granted temporary clinical privileges.

d. There is no right to temporary privileges. Accordingly, temporary privileges should not be granted unless the available information supports, with reasonable certainty, a favorable determination regarding the requesting applicant's or Allied Health Professional's qualifications, ability, and judgment to exercise the privileges requested.

e. If the available information is inconsistent 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.

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.

5.5-3 **General Conditions and Termination**

a. Temporary privileges are granted by the Chief Executive Officer or authorized designee (including the Administrator on-call) based upon the recommendation of the Chief of Staff or authorized designee.

b. Individuals granted temporary privileges may be subject to proctoring requirements as noted in the Bylaws or Rules and Regulations.

c. Temporary privileges shall be granted for a time period not to exceed 120 days.

d. Temporary privileges may be terminated with or without cause at any time by the Chief of Staff, the responsible Department Chair, or the CEO after conferring with the Chief of Staff or responsible Department Chair. A person shall be entitled to the procedural hearing rights afforded by the Bylaws, Article 13, Hearing and Appellate Reviews, ONLY IF a request for temporary privileges is refused based upon, or if all or any portion of temporary privileges are terminated or suspended for a medical disciplinary cause or reason. In all other cases (including a deferral in acting on a request for temporary privileges), the affected practitioner shall not be entitled to any procedural rights based upon any adverse action involving temporary privileges.

e. Whenever temporary privileges are terminated, the appropriate department chair or, in the chair's absence, the Chief of Staff shall assign a member to assume responsibility for the care of the affected practitioner's patient(s). The wishes of the patient and affected practitioner shall be considered in the choice of a replacement member.

f. Temporary privileges shall automatically terminate if the applicant's initial membership application is withdrawn.

g. Temporary privileges shall automatically terminate at the end of the designated period, unless affirmatively renewed as provided at Bylaws, Section 5.5-1, or earlier terminated or suspended as provided in Section 5.5-3d-g.

h. All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules.

5.6 Disaster Privileges

5.6-1 Disaster Privileges may be granted to a licensed independent practitioner (LIP) when the following two criteria have been met:

1) The organization's emergency management plan has been formally activated, and:

2) The organization is unable to meet immediate patient needs.

a. Granting of disaster privileges must be authorized by the Chief of Staff, or the Disaster Medical Director, or authorized designee. In the absence of the Chief of Staff, the Vice-Chief of Staff, and the Department Chairs, the Chief Executive Officer or the CEO's designee may grant disaster privileges consistent with this subsection. Disaster privileges will be granted on a case by case basis.

b. An individual who presents as a volunteer LIP should be directed to the medical staff pool or other area as designated by the emergency management Command Center.

c. A volunteer LIP must present a valid government issued photo identification issued by a state or federal agency (e.g. driver's license or passport). In addition, the volunteer LIP must provide at least one of the following:

1) A current hospital picture identification card that clearly identifies the individual's professional designation;

2) A current license to practice and Primary source verification of licensure;

3) Identification indicating that the individual is a member of a Disaster Medical Assistance Tam (DMAT), Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organization or group(s);

4) Identification indicating that the individual has been granted authority to render patient care, treatment, or services in disaster circumstances (such as authority having been granted by a federal, state, or municipal entity);

5) Identification by a current member of the organization or medical staff who possesses personal knowledge regarding the individual's ability to act as a LIP during a disaster.

d. As soon as the immediate situation is under control, the organization should obtain primary source verification of the volunteer LIP's license. Primary source verification must be completed within 72 hours from the time the volunteer LIP presented to the organization. In extraordinary circumstances (e.g. no means of communication or a lack of resources), verification may exceed 72 hours, but must be completed as soon as possible.

e. Primary source is the entity or agency that has the legal authority to issue the credential in question. If the entity or agency has designated another entity or agency to communicate information about the status of a staff member's credential, then the other entity or agency may be considered the primary source.

f. If the volunteer LIP is <u>not</u> providing care, treatment, or service which required the granting of disaster privileges, then primary source verification is not required.

g. The Medical Staff Office, or other designee, shall be responsible for securing primary source verification on all volunteer practitioners.

h. Volunteer LIP's will be identified by a name badge or tag provided by the organization. The badge/tag will list the name and professional designation of the volunteer (e.g. John Smith, MD) as well as the notation that the individual is a volunteer. The volunteer LIP will be required to wear the badge/tag on his or her person while performing in that role/capacity.

5.6-2 Volunteer LIP's will be assigned to a member of the medical staff who is a peer in the volunteer's area of practice and experience. The medical staff member will serve as a member and resource for the volunteer practitioner. The medical staff member will be responsible for overseeing the professional performance of the volunteer LIP. This may be accomplished by:
1) Direct observation
2) Clinical review of care documented in the patient's medical record.

5.6-3 Volunteer LIP's will cease to providing care, treatment, or service if any one of the following criteria is met:

1) Implementation of the emergency management plan ceases.

2) The capability of the organization's staff becomes adequate to meet patient care needs.

3) A decision is made that the professional practice of the volunteer LIP does not meet professional standards.

5.7 Emergency Privileges

5.7-1 In the case of an emergency involving a particular patient, any member of the Medical Staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges and once the emergency has passed or assistance has been made available, shall defer to the department chair with respect to further care of the patient at the Hospital.

5.7-2 In the event of an emergency under subsection 5.7-1, any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members of the Medical Staff when it becomes reasonably available.

5.7-3 Emergency privileges under subsection 5.7-1 shall not be used to force members to serve on emergency department call panels providing services for which they do not hold delineated clinical privileges.

5.8 Transport and Organ Harvest Teams

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.

5.9 Proctoring

5.9-1 **General Proctoring Requirements**

a. Except as otherwise determined by the Medical Executive Committee and District Board, all initial appointees to the Medical Staff and all members requesting new privileges shall be subject to a period of proctoring in accordance with standards and procedures set forth in the bylaws and rules. In addition, members may be required to be proctored as a condition of renewal of privileges (for example, when a member requests renewal of a privilege that has been performed so infrequently that it is difficult to assess the member's current competence in that area). Proctoring may also be implemented whenever the Medical Executive Committee determines that additional information is needed to assess a practitioner's performance. Proctoring is not viewed as a disciplinary measure, but rather is an information gathering measure. Therefore, it should be imposed only for such period (or number of cases) as is reasonably necessary to enable such assessment. Proctoring does not give rise to the procedural rights described in

Article 13, Hearings and Appellate Reviews, unless the proctoring becomes a restriction of privileges because procedures cannot be done unless a proctor is present and proctors are not available after reasonable attempts to secure a proctor.

b. Whenever proctoring is imposed, the number (or duration) and types of procedures shall be delineated.

c. During the proctoring, the practitioners must demonstrate they are qualified to exercise the privileges that were granted and are carrying out the duties of their Medical Staff category.

d. Proctoring shall be required for certain Allied Health Professionals as set forth in Rule 11.8 of the Rules and Regulations.

e. In cases where there exists a conflict of interest, peer review concern, or lack of a staff member with necessary expertise to serve as proctor, a physician from another facility shall be arranged to provide proctoring. Temporary privileges must be granted for the length of time needed to complete the assignment.

5.9-2 **Completion of Proctoring**

The member shall remain subject to such proctoring until the Medical Executive Committee has been furnished with:

1. 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 member's performance, a statement that the member appears to meet all of the qualifications for unsupervised practice in the Hospital, 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
2. (*where applicable*) A report signed by the chair of the other department(s) in which the member 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 satisfactorily demonstrated the ability to exercise the clinical privileges initially granted in those departments.

5.9-3 **Effect of Failure to Complete Proctoring**

a. Failure to Complete Necessary Volume

Any practitioner or member who fails to complete the required number of proctored cases within the time frame established in the bylaws and rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges), and he or she shall not be afforded the procedural rights provided in Article 13, Hearings and Appellate Reviews. However, the department has the discretion to extend the time for completion of proctoring in appropriate cases subject to ratification by the Medical Executive Committee. The inability to obtain such an extension shall not give rise to procedural rights described in Article 13 Hearings and Appellate Reviews.

b. Failure to Satisfactorily Complete Proctoring

If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, he or she may be terminated (or the relevant privileges may be revoked), and he or she shall be afforded the procedural rights as provided in Article 13, Hearings and Appellate Reviews.

In the event procedural rights are invoked, the practitioner who has not successfully completed proctoring shall be deemed an "applicant" for purposes of Section 13.4-16.

c. Effect on Advancement
The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from Associate Staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated, pursuant to Section 5.9-3(a) or (b) if proctoring is not completed thereafter within a reasonable time.

5.9-4 **Proctor: Scope of Responsibility**

a. All members who act as proctors of new appointees and/or members of the Medical Staff are acting at the direction of and as an agent for the department, the Medical Executive Committee and the District Board. When possible, no business relationship shall exist between proctor and proctoree.

b. The intervention of a proctor shall be governed by the following guidelines:

1) A member who is serving as a proctor does not act as a supervisor of the member or practitioner he or she is observing. His or her role is to observe and record the performance of the member or practitioner being proctored, and report his or her evaluation to the department and/or the Department Chair.

2) A proctor is not mandated to intervene when he or she observes what could be construed as deficient performance on the part of the practitioner or member being proctored.

3) In an emergency situation, a proctor may intervene, even though he or she has no legal obligation to do so, and by intervening in such a circumstance, the proctor acting in good faith should be qualified as a Good Samaritan within the "Good Samaritan" laws of the State of California.

c. The activities of a proctor constitute an integral part of the peer review system of the Medical Staff, and as such, all records, reports, documents, and any other information regarding the proctorship shall be subject to all confidentiality requirements within these bylaws, and the proctors are subject to all immunities accorded Medical Staff peer review activities by these bylaws, and any applicable regulations, statutes or legal decisions.

5.10 History and Physical Requirements

It is the responsibility of the Medical Staff to assure that a medical history and appropriate physical examination (H&P) is performed on patients being admitted for inpatient care, as well as prior to operative and complex invasive procedures in either an inpatient or outpatient setting.

5.10-1 Timing of History and Physicals

A medical history and physical examination must be completed and entered into the medical record for each patient no more than 30 days before or 24 hours after the admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), but prior to surgery or a procedure requiring such anesthesia services.

5.10-2 Updated Exam Timing

When the medical history and physical examination is completed within 30 days before admission or registration, an Updated Exam, including any changes in the patient's condition, must be completed and documented within 24 hours after admission (or registration for a surgery or procedure requiring anesthesia or moderate or deep sedation), but prior to surgery or a procedure requiring such anesthesia services.

5.10-3 Practitioners Permitted to Do History and Physicals

The medical history and physical examination, including any Update notes thereto must be completed and documented by a practitioner granted privileges by the medical staff to do so.

5.10-4 Patients requiring an H&P will receive a full H&P, an abbreviated H&P, or an Updated Exam note. The definition of each of these H&Ps is noted below:

1. Full H&P

A full H&P is defined as an H&P that contains the following data elements:

- A chief complaint
- Details of the present illness
- Past medical and surgical history (including current medications and medication allergies)
- Relevant past psycho-social history (appropriate to the patient's age, social habits, occupation, etc.)
- Family History
- A complete review of systems
- A physical examination inventoried by body systems. Unless relevant to the chief complaint or necessary to establish diagnosis, a pelvic and/or rectal exam need not be performed.
- A statement on the conclusions or impressions drawn from the history and physical examination.

  A statement on the course of action planned for the patient for that episode of care.

2. Abbreviated H&P

An abbreviated H&P may be performed on an inpatient admitted for under 24 hours and without complications and is defined as an H&P that contains the following data elements:

- A chief complaint
- Details of present illness
- Relevant past medical and surgical history pertinent to the operative or invasive procedure being performed.(including current medications and medication allergies)
- Relevant past psycho-social history pertinent to the operative or invasive procedure being performed.
- A relevant physical examination of those body systems pertinent to the operative or invasive procedure performed, but including at a minimum an appropriate assessment of the patients cardio-respiratory status
- A statement on the conclusions or impressions drawn from the history and physical examination.
- A statement on the course of action planned for the patient for that episode of care.

3. Updated Exam Note

For a medical history and physical examination that was completed within 30 days prior to registration or inpatient admission, an updated exam documenting any changes in the patient's condition is completed within 24 hours after registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia services.

An Updated Exam Note is defined as a statement entered into the patient's medical record that the patient has been seen and examined and that a valid full or abbreviated H&P has been reviewed and that:

1) There are no significant changes to the findings contained in the full or abbreviated H&P since the time such H&P was performed, or

2) There are significant changes and such changes are subsequently documented in the patient's medical record.

The updated exam must be completed and documented by a practitioner who has been granted the privileges by the medical staff to perform H&Ps.

While it is recommended that the updated exam note be documented on, or appended to, the H&P, documentation may be entered anywhere in the medical record. For patients undergoing outpatient surgical or complex invasive procedures, the performance of a pre-anesthesia/ sedation assessment that includes a pertinent history and physical examination may be considered an Updated exam note to the H&P, provided the assessment was performed on the day of the surgery or procedure and the practitioner responsible for administering anesthesia has been granted the privileges to perform H&Ps.

5.10-5 Other Requirements

a. Obstetrics

For OB admissions for vaginal deliveries a full H&P, abbreviated H&P, or the patient's prenatal record is required. The H&P must be completed no more than 30 days prior admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an Update note must be entered into the record within 24 hours after admission. If the patient's prenatal record is used in lieu of an H&P, the last entry on the prenatal record must be within 30 days of admission and an Update note must be entered into the record within 24 hours after admission. Otherwise, an H&P must be done.

b. Dentists & Podiatrist

Doctors of dentistry or podiatry are responsible for that part of the patient's history and physical examination that relate, respectively, to dentistry or podiatry whether or not they are granted clinical privileges to take a complete history and perform a complete physical examination. Doctors of dentistry or podiatry may perform a complete H&P if they possess the clinical privileges to do so. If the Dentist or Podiatrist does not possess such privileges, then a qualified Physician must perform the H&P.

c. Licensed Dependent Practitioners

If a licensed dependent practitioner (e.g. physician assistant, nurse practitioner, etc.) is granted privileges to perform part or all of an H&P, the findings and conclusions are confirmed or endorsed by a qualified Physician.

5.11 Dissemination of Privileges List

Documentation of current privileges (granted, modified, or rescinded) shall be disseminated to hospital staff as necessary to maintain an up-to-date listing of privileges for purposes of scheduling and monitoring to assure that practitioners are appropriately privileged to perform all services rendered.

Article 6
ALLIED HEALTH PROFESSIONALS

6.1 Qualifications of Allied Health Professionals

Allied health professionals (AHPs) are not eligible for Medical Staff membership. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of AHPs that the District Board (after securing Medical Executive Committee comments) has identified as eligible to apply for practice privileges, and only if the AHPs are professionally competent and continuously meet the qualifications, standards and requirements set forth in the Medical Staff Bylaws and Rules.

6.2 Categories

The District Board shall determine, based upon comments of the Medical Executive Committee and such other information as it has before it, those categories of AHPs that shall be eligible to exercise privileges in the hospital. Such AHPs shall be subject to the supervision requirements developed in each department and approved by the Interdisciplinary Practice Committee, the Medical Executive Committee, and the District Board.

6.3 Privileges and Department Assignment

6.3-1 AHPs may exercise only those setting-specific privileges granted them by the District Board. The range of privileges for which each AHP may apply and any special limitations or conditions to the exercise of such privileges shall be based on recommendations of the Interdisciplinary Practice Committee, subject to approval by the Medical Executive Committee and the District Board.

6.3-2 An AHP must apply and qualify for practice privileges, and practitioners who desire to supervise or direct AHPs who provide dependent services must apply and qualify for privileges to supervise approved AHPs. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for practitioners, unless otherwise specified in the rules.

6.3-3 Each AHP shall be assigned to the department or departments appropriate to his or her occupational or professional training and, unless otherwise specified in these bylaws or the rules, shall be subject to terms and conditions similar to those specified for practitioners as they may logically be applied to AHPs and appropriately tailored to the particular AHP.

6.4 Prerogatives

The prerogatives which may be extended to an AHP shall be defined in the rules and/or hospital policies. Such prerogatives may include:

6.4-1 Provision of specified patient care services ; which services may be provided independently or under the supervision or direction of a Medical Staff member and consistent with the practice privileges granted to the AHP and within the scope of the AHP’s licensure or certification, as specified in the Rules.

6.4-2 Service on the Medical Staff, department and hospital committees.

6.4-3 Attendance at the meetings of the department to which the AHP is assigned, as permitted by the department rules, and attendance at hospital education programs in the AHP's field of practice.

6.5 Responsibilities

Each AHP shall:

6.5-1 Meet those responsibilities required by the rules and as specified for practitioners in Section 2.6, Basic Responsibilities of Medical Staff Membership, as modified to reflect the more limited practice of the AHP.

6.5-2 Retain appropriate responsibility within the AHP's area of professional competence for the care and supervision of each patient in the hospital for whom the AHP is providing services.

6.5-3 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

6.6 Procedural Rights of Allied Health Professionals

6.6-1 Fair Hearing and Appeal

Denial, revocation, or modification of Allied Health Professionals' Privileges shall be the prerogative of the Interdisciplinary Practices Subcommittee, subject to approval by the Clinical Department, the Medical Executive Committee, and the District Board. The procedural rights described at Article 13, Hearings and Appellate Reviews, shall apply.

6.6-2 Automatic Termination

a. Notwithstanding the provisions of Section 6.6-1, an AHP's privileges shall automatically terminate, without review pursuant to Section 6.6-1 or any other section of the Medical Staff Bylaws, in the event:

1. The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;
2. The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the AHP and the supervising practitioner is otherwise terminated, regardless of the reason therefore; or
3. The AHP's certification or license expires, is revoked, or is suspended.

b. Where the AHP's service authorization is automatically terminated for reasons specified in Sections 6.6-2a 1. or 2., above, the AHP may apply for reinstatement as soon as the AHP has found another supervising practitioner who agrees to supervise the AHP and receives privileges to do so. In this case, the Medical Executive Committee may, in its discretion, expedite the reapplication process.

c. Additionally, AHPs are subject to the automatic action provisions of Section 12.3 of these Bylaws.

6.6-3 Review of Category Decisions

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the District Board, which has the discretion to decline to review the request or to review it using any procedure the District Board deems appropriate.

Article 7
MEDICAL STAFF OFFICERS AND CHIEF MEDICAL OFFICER

7.1 Medical Staff Officers—General Provisions

7.1-1 **Identification**

a. There shall be the following general officers of the Medical Staff:

1) Chief of Staff

2) Vice-Chief of Staff

3) Immediate Past Chief of Staff

b. In addition, the Medical Staff's department and committee chairs shall be deemed Medical Staff officers within the meaning of California law.

7.1-2 **Qualifications**

All Medical Staff officers shall:

a. Understand the purposes and functions of the Medical Staff and demonstrate willingness to assure that patient welfare always takes precedence over other concerns;

b. Understand and be willing to work toward attaining the hospital's lawful and reasonable policies and requirements;

c. Have administrative ability as applicable to the respective office;

d. Be able to work with and motivate others to achieve the objectives of the Medical Staff and hospital;

e. Demonstrate clinical competence in his or her field of practice;

f. Be an active Medical Staff member (and remain in good standing as an active Medical Staff member while in office); and

g. Not have any significant conflict of interest.

1.

7.1-3 **Disclosure of Conflict of Interest**

a. All nominees for election or appointment to Medical Staff offices (including those nominated by petition of the Medical Staff pursuant to Section 7.2-3, Nomination by Petition) 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. Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The

evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. 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.

b. A person nominated from the floor shall be asked to verbally disclose conflicts to those in attendance at the meeting, and the Medical Executive Committee or its representative shall have an opportunity to comment thereon, prior to the vote.

7.2 Method of Selection—General Officers

7.2-1 Succession of Vice-Chief of Staff to Chief of Staff

The Vice-Chief of Staff shall accede to the position of Chief of Staff upon the Chief of Staff's completion of his or her term.

7.2-2 Nominating Committee

An ad hoc nominating committee composed of the Chief of Staff and two staff members elected by the Medical Executive Committee shall develop a slate of candidates meeting the qualifications of office, as described in Section 7.1-2 above. This slate shall be developed at least 45 days prior to the scheduled election. At least one candidate shall be nominated for each of the following positions:

a. Vice-Chief of Staff

7.2-3 Nomination by Petition

The Medical Staff may nominate candidates for office by a petition signed by at least ten members who are eligible to vote and a statement from the candidate signifying willingness to run. Such nominations must be received by the Chief of Staff at least 30 days prior to the scheduled elections.

7.2-4 District Board Review

The slate of candidates (including those nominated by petition), together with the disclosure information provided pursuant to Section 7.1-3, will be presented to the District Board for its review and comment. The District Board may issue written comments about any or all candidates, which comments must be communicated to all voting Medical Staff prior to the election.

7.2-5 Election

The election shall be by mail ballot, and the outcome shall be determined by a majority of the votes cast by mail ballots that are returned to the Medical Staff office within 15 days after the ballots were mailed to the voting Medical Staff members.

7.2-6 Term of Office

a. Officers shall be elected in the spring of odd-numbered years and shall take office the following July.

b. The term of office shall be two years. No officer shall serve consecutive terms in the same position.

7.3 Recall of Officers

A general Medical Staff officer may be recalled from office for any valid cause, including, but not limited to, failure to carry out the duties of his or her office. Except as otherwise provided, recall of a general Medical Staff officer may be initiated by the Medical Executive Committee or by a petition signed by at least 33-1/3 percent of the Medical Staff members eligible to vote for officers; but recall itself shall require a 66-2/3 percent vote of the Medical Executive Committee or 66-2/3 percent vote of the Medical Staff members eligible to vote for general Medical Staff officers.

7.4 Filling Vacancies

Vacancies created by resignation, removal, death, or disability shall be filled as follows:

7.4-1 A vacancy in the office of Chief of Staff shall be filled by the Vice-Chief of Staff.

7.4-2 A vacancy in the office of Vice-Chief of Staff shall be filled by special election held in general accordance with Section 7.2.

7.5 Duties of Officers

7.5-1 **Chief of Staff**

The Chief of Staff shall serve as the chief officer of the Medical Staff. The duties of the Chief of Staff shall include, but not be limited to:

- **a.** Enforcing the Medical Staff Bylaws and Rules, promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;
- **b.** Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;
- **c.** Serving as chair of the Medical Executive Committee, and in that capacity shall be deemed the individual responsible for the organization and conduct of the Medical Staff;
- **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.** Appointing, in consultation with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of these committees;
- **f.** Being a spokesperson for the Medical Staff in external professional and public relations;
- **g.** Serving on liaison committees with the District Board and administration, as well as outside licensing or accreditation agencies;
- **h.** Appointing members of the Medical Staff to participate, as a Medical Staff liaison, in the development of hospital policies;
- **i.** Regularly reporting to the District Board on the performance of Medical Staff functions and communicating to the Medical Staff any concerns expressed by the District Board;

j. In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;

k. Interacting with the Chief Executive Officer and District Board in all matters of mutual concern within the hospital;

l. Representing the views and policies of the Medical Staff to the District Board and to the Chief Executive Officer

m. Serving on the Joint Conference Committee;

n. Being accountable to the District Board, in conjunction with the Medical Executive Committee, for the effective performance, by the Medical Staff, of its responsibilities with respect to quality and efficiency of clinical services within the hospital and for the effectiveness of the quality assurance and utilization review programs; and

o. Performing such other functions as may be assigned to him or her by these bylaws, the Medical Staff or the Medical Executive Committee.

7.5-2 **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 and of the Joint Conference Committee, shall serve as the Chair of the Quality Improvement Committee, and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these bylaws or the Medical Executive Committee.

7.5-3 **Immediate Past Chief of Staff**

The immediate past chief of staff shall be a member of the Medical Executive Committee and shall perform such other duties as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

7.6 Chief Medical Officer

7.6-1 Responsibilities

a. The Chief Medical Officer's duties shall be delineated by the District Board in keeping with the general provisions set forth in subparagraph (b) below. The Medical Executive Committee approval shall be required for any Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff.

b. In keeping with the foregoing, the Chief Medical Officer shall:

1) Serve as administrative liaison among hospital administration, the District Board, outside agencies and the Medical Staff;

2) Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the hospital; and

3) In cooperation and close consultation with the Chief of Staff and the Medical Executive Committee, supervise the day-to-day performance of the Medical Staff office and the hospital's quality improvement personnel.

7.6-2 Participation in Medical Staff Committees

The Chief Medical Officer:

a. Shall be an ex officio member—without vote—of all Medical Staff Committees, except the Joint Conference Committee (which the Chief Medical Officer shall attend as a voting member per Section 8.2-1) and any hearing committee.

b. May attend any meeting of any department or section.

Article 8
COMMITTEES

8.1 General

8.1-1 **Designation**

The Medical Executive Committee and the other committees described in these bylaws and the rules shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Medical Executive Committee or a department to perform specified tasks. Any committee—whether Medical Staff-wide or department or other clinical unit, or standing or ad hoc—that is carrying out all or any portion of a function or activity required by these bylaws is deemed a duly appointed and authorized committee of the Medical Staff.

8.1-2 **Appointment of Members**

a. Unless otherwise specified, the chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

b. A Medical Staff Committee created in these bylaws is composed as stated in the description of the committee in these bylaws or the rules. Except as otherwise provided in the bylaws, committees established to perform Medical Staff functions required by these bylaws may include any category of Medical Staff members; allied health professionals; representatives from hospital departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each Medical Staff member who serves on a committee participates with votes unless the statement of committee composition designates the position as nonvoting.

c. The Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.

d. The committee chair, after consulting with the Chief of Staff and Chief Executive Officer, may call on outside consultants or special advisors.

e. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

8.1-3 **Representation on Hospital Committees and Participation in Hospital Deliberations**

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management

and physical plant safety by providing Medical Staff representation on hospital committees established to perform such functions.

8.1-4 **Ex Officio Members**

The Chief of Staff and the Chief Executive Officer, or their respective designees and the Chief Medical Officer are ex officio members of all standing and special committees of the Medical Staff and shall serve with vote unless provided otherwise in the provision or resolution creating the committee.

8.1-5 **Action Through Subcommittees**

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff members, and the Chief Executive Officer regarding hospital staff.

8.1-6 **Terms and Removal of Committee Members**

Unless otherwise specified, a committee member shall be appointed for a term of two years, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Chief of Staff may be removed by a majority vote of the Medical Executive Committee. Any committee member who is appointed by the department chair may be removed by a majority vote of his or her department committee or the Medical Executive Committee. 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 such officer or official.

8.1-7 **Vacancies**

Unless otherwise specified, 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

8.1-8 **Conduct and Records of Meetings**

Committee meetings shall be conducted and documented in the manner specified for such meeting in Article 10, Meetings.

8.1-9 **Attendance of Nonmembers**

Any Medical Staff member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request only if the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all bylaws and rules applicable to that committee.

8.1-10 **Conflict of Interest**

In any instance where a Medical Staff member has or reasonably could be perceived to have a conflict of interest, as defined below, such individual shall not participate in the discussion or voting on the matter, and shall be excused from any meeting during that time. However, the individual with a conflict may be asked, and may answer, any questions concerning the matter before leaving. Any dispute over the existence of a conflict of interest shall be resolved by the chairperson of the committee, or if it cannot be resolved at that level, by the Chief of Staff.

Generally, a conflict of interest arises when there is a divergence between an individual's private interests and his/her professional obligations, such that an independent observer might reasonably question whether the individual's professional actions or decisions are determined by those private interests. A conflict of interest depends on the situation and not on the character of the individual. The fact that an individual practices in the same specialty as a practitioner who is being reviewed does not by itself create a conflict of interest. The evaluation of whether a conflict of interest exists shall be interpreted reasonably by the persons involved, taking into consideration common sense and objective principles of fairness. The fact that a committee member or medical staff leader chooses to refrain from participation, or is excused from participation, shall not be interpreted as a finding of actual conflict.

8.1-11 **Accountability**

All committees shall be accountable to the Medical Executive Committee.

8.2 Joint Conference Committee

8.2-1 **Composition**

The Joint Conference Committee shall be composed of six members: the Chief of Staff, the Vice-Chief of Staff, two members of the hospital's District Board, the Chief Medical Officer, and the Chief Executive Officer. All members are voting members. The person serving as the Joint Conference Committee chair shall alternate annually between the Chief of Staff and one of the District Board representatives.

8.2-2 **Duties and Meeting Frequency**

a. This committee shall serve as a focal point for furthering an understanding of the roles, relationships, and responsibilities of the District Board, administration, and the Medical Staff. It may also serve as a forum for discussing any hospital matters regarding the provision of patient care. It shall meet as often as necessary to fulfill its responsibilities. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee.

b. The committee may also serve as the initial forum for exercise of the meet and confer provisions contemplated by Section 14.6 of these bylaws; provided, however, that upon request of at least three committee members, a neutral mediator, acceptable to both contingents, shall be engaged to assist in dispute resolution.

8.2-3 **Accountability**

The Joint Conference Committee is directly accountable to the Medical Executive Committee and to the District Board.

8.3 Medical Executive Committee

8.3-1 **Composition**

The Medical Executive Committee shall be composed of the Medical Staff officers listed in Article 7, Medical Staff Officers and Chief Medical Officer. It thus includes the Chief of Staff,, Vice-Chief of Staff (Performance Improvement Committee Chair), Immediate Past Chief of Staff, Department Chairs, Department Vice-Chairs, and the Chief Medical Officer. It shall also include the Medical Director, or a physician representative, from each of the following departments and sections: Anesthesiology, Cardiovascular Services, Emergency Medicine, Pediatrics, Hospitalist, ICU, Obstetrics and Gynecology, Pathology, Perioperative Services, Radiology, and the Sonoma Valley Community Health Center. The Chief Executive Officer shall serve as an ex officio member. The Chief of Staff shall chair the Medical Executive Committee. A majority of the committee shall be physicians, but may include other Licensed Independent Practitioners, as appropriate. At their discretion, the Committee may invite others to attend.

8.3-2 **Duties**

The Medical Staff delegates to the Medical Executive Committee the broad authority to oversee the operations of the Medical Staff. With the assistance of the Chief of Staff, and without limiting this broad delegation of authority, the Medical Executive Committee shall perform in good faith the duties listed below.

a. Supervise the performance of all Medical Staff functions, which shall include:

1) Requiring regular reports and recommendations from the departments, committees and officers of the Medical Staff concerning discharge of assigned functions;

2) Issuing such directives as appropriate to assure effective performance of all Medical Staff functions; and

3) Following up to assure implementation of all directives.

b. Coordinate the activities of the committees and departments.

c. Assure that the Medical Staff adopts bylaws and rules establishing the structure of the Medical Staff, the mechanism used to review credentials and to delineate individual privileges, the organization of the quality assessment and improvement activities of the Medical Staff as well as the mechanism used to conduct, evaluate, and revise such activities, the mechanism by which membership on the Medical Staff may be terminated, and the mechanism for hearing procedures.

d. Based on input and reports from the departments, assure that the Medical Staff adopts bylaws, rules or regulations establishing criteria and standards, consistent with California law, for medical staff membership and privileges (including but not limited to any privileges that may be appropriately performed via telemedicine), and for enforcing those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and Staff members.

e. Assure that the Medical Staff adopt bylaws, rules or regulations establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

f. Evaluate the performance of practitioners exercising clinical privileges whenever there is doubt about an applicant's, member's, or AHP's ability to perform requested privileges.

g. Based upon input from the departments, make recommendations regarding all applications for Medical Staff appointment, reappointment and privileges.

h. When indicated, initiate and/or pursue disciplinary or corrective actions affecting Medical Staff members.

i. With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

1. The Medical Staff bylaws, rules, and policies;
2. The Hospital's bylaws, rules, and policies;
3. State and federal laws and regulations; and
4. CIHQ accreditation requirements

j. Oversee the development of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of all such policies.

k. Implement, as it relates to the Medical Staff, the approved policies of the hospital.

l. With the department chairs, set departmental objectives for establishing, maintaining and enforcing professional standards within the hospital and for the continuing improvement of the quality of care rendered in the hospital; assist in developing programs to achieve these objectives.

m. Regularly report to the District Board through the Chief of Staff and the Chief Executive Officer on at least the following:

1)
2) the outcomes of Medical Staff quality improvement programs with sufficient background and detail to assure the District Board that quality of care is consistent with professional standards; and
3) the general status of any Medical Staff disciplinary or corrective actions in progress.

n. Review and make recommendations to the Chief Executive Officer regarding quality of care issues related to exclusive contract arrangements for professional medical services. In addition, the Medical Executive Committee shall assist the hospital in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements or other agreements, in evaluating the levels of safety and quality of services provided via consultation, contractual arrangements, or other agreements, and in providing relevant input to notice-and-comment proceedings or other

mechanisms that may be implemented by hospital administration in making exclusive contracting decisions.

o. Prioritize and assure that hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

p. Establish, as necessary, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the Medical Executive Committee.

q. Establish the date, place, time and program of the regular meetings of the Medical Staff.

r. Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

s. Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and Hospital.

The Authority delegated pursuant to this section 8.3-2 may be removed by amendment of these Bylaws.

8.3-3 **Meetings**

The Medical Executive Committee should be scheduled to meet on a monthly basis and shall meet at least 10 times during the calendar year. A permanent record of its proceedings and actions shall be maintained.

Article 9
DEPARTMENTS AND SECTIONS

9.1 Organization of Clinical Departments

Each department shall be organized as an integral unit of the Medical Staff and shall have a chair and a vice chair who are selected and shall have the authority, duties, and responsibilities specified in the rules. Additionally, each department may appoint a department committee and such other standing or ad hoc committees as it deems appropriate to perform its required functions. The composition and responsibilities of each standing department committee shall be specified in the rules. Departments may also form sections as described below.

9.2 Designation

9.2-1 **Current Designation**

The current departments and their respective sections are:

- ❒ Medicine
  - Cardiovascular Services
  - Emergency Medicine
  - Pediatrics
  - Hospitalist
  - ICU
- ❒ Anesthesiology
- ❒ Surgery
  - Obstetrics and Gynecology
  - Pathology
  - Radiology
- ❒ Interdepartmental Sections
  - OB/Peds/Anesthesia/RN Task Force
  - Perioperative Services

9.2-2 **Future Departments**

The Medical Executive Committee will periodically restudy the designation of the departments and recommend to the District Board what action is desirable in creating, eliminating, or combining departments for better organizational efficiency and improved patient care. Action shall be effective upon approval by the Medical Executive Committee and the District Board.

9.3 Assignment to Departments

Each member shall be assigned membership in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with the practice privileges granted.

9.4 Department Functions

Each department, through its officers and established committees, is responsible for the quality of care within the department, and for the effective performance of the following as it relates to the members and AHPs practicing within the department. Each department or its committees, if any, must meet regularly to carry out its duties.

a. Performance evaluations and monitoring of all members and AHPs exercising privileges in the department and continuous assessment and improvement of the quality of care, treatment and services (including periodic demonstrations of ability), consistent with guidelines developed by the committees responsible for quality improvement, utilization review, education and medical records, and by the Medical Executive Committee.

b. Credentials review, consistent with guidelines developed by the Medical Executive Committee.

c. Recommendation to the Medical Executive Committee of the criteria for the granting of Clinical Privileges, including but not limited to any privileges that may be appropriately performed by AHPs or via telemedicine, and the performance of specified services within the department.

d. Corrective action, when indicated, in accordance with Bylaws Article 12, Performance Improvement and Corrective Action.

e. Planning and budget review consistent with guidelines developed by the Medical Executive Committee. This includes making recommendations regarding space and other resources needed by the department.

f. When the department or any of its committees meets to carry out the duties described below, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by federal and state law for peer review committees.

9.5 Department Chair

9.5-1 Department **Officer Qualifications**

Each department chair and vice-chair shall:

a. If required by California hospital licensure regulations, be board certified or board admissible in his or her appropriate specialty. Where certification/admissibility is not required by law, a person with comparable training and experience shall be eligible to serve.

b. Have demonstrated clinical competence in his or her field of practice sufficient to maintain the respect of the members of his or her department.

c. Have an understanding of the purposes and functions of the staff organization and a demonstrated willingness to promote patient safety over all other concerns.

d. Have an understanding of and willingness to work with the hospital toward attaining its lawful and reasonable goals.

e. Have an ability to work with and motivate others to achieve the objectives of the medical staff organization in the context of the hospital's lawful and reasonable objectives.

f. Be (and remain during tenure in office) an active staff member in good standing.

g. Not have any significant conflict of interest.

9.5-2 Procedures for Selecting Department Officers

a. Each department shall nominate at least one person meeting the qualifications in Rule 10.2 for each of the office of chair. The Anesthesia Department Chair shall be the Medical Director of Anesthesia.

b. In addition, the department members may select candidates for office by a petition signed by at least ten active staff members from the department. Such nominations must be received by the department at least 30 days prior to the scheduled elections.

c. All nominees for election or appointment to department offices (including those nominated by petition of the department members, pursuant to Rule 10.3-2, above) shall, at least 20 days prior to the date of election or appointment, disclose in writing to the department 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 department. The department 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.

d. Should a department officer step down prior to the end of his/her term, the above process (9.5-2) shall be used for selecting a new officer to complete the term.

9.5-3 **Term of Office**

Each department chair and vice-chair shall serve a two-year term, the expiration of which coincides with the Medical Staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their Medical Staff membership or privileges in that department. Department officers are eligible to succeed themselves.

9.5-4 **Removal**

A department officer may be removed for failure to cooperatively and effectively perform the responsibilities of his or her office. Removal may be initiated by the Medical Executive Committee or by written request from 20 percent of the members of the department who are eligible to vote on department matters. Such removal may be

effected by a 66-2/3 percent vote of the Medical Executive Committee members or by a 66-2/3 percent vote of the department members eligible to vote on department matters. The procedures for effecting removal shall be as described in the rules.

9.5-5 **Responsibilities of Department Chairs**

Each department chair shall be responsible for:

a. All department clinically-related activities.

b. All administrative activities of the department not otherwise provided for by the hospital.

c. Integrating the department into the primary functions of the organization.

d. Coordinating and integrating interdepartmental and intradepartmental services.

e. Developing and implementing policies and procedures that guide and support the provision of care, treatment, and services in the department.

f. Recommending a sufficient number of qualified and competent persons to provide care, treatment, and services in the department.

g. Continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department.

h. Recommending the criteria for clinical privileges in the department.

i. Evaluating the qualifications and competence of practitioners and allied health professionals (AHPs) who provide patient care services within the purview of the department.

j. Recommending clinical privileges for each practitioner and AHP desiring to exercise privileges in the department.

k. Maintaining quality control programs, as appropriate and in coordination with the Medical Staff Performance Improvement Committee.

l. Continuously assessing and improving the quality of care, treatment, and services provided in the department.

m. Overseeing the orientation and continuing education of all persons in the department, in coordination with the medical staff committee(s) responsible for continuing medical education.

n. Making recommendations regarding space and other resources needed by the department.

o. Assessing and making recommendations to the relevant hospital authority with respect to off-site sources needed for patient care, treatment, and services not provided by the department or the hospital.

p. Chairing all department meetings.

q. Serving as an ex officio member of all committees of his or her department and attending such committee meetings as deemed necessary for adequate information flow.

r. Assuring that records of performance are maintained and updated for all members of his or her department.

s. Reporting on activities of the medical staff to the District Board when called upon to do so by the Chief of Staff or the Chief Executive Officer.

t. Serving as a member of the Medical Executive Committee.

u. Endeavoring to enforce the Medical Staff Bylaws, Rules and Regulations, and policies within the Department

v. Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Committee or the Chief of Staff.

9.6 Sections

Within each department, the practitioners of the various specialty groups may organize themselves as a clinical section. Each section may develop rules specifying the purpose, responsibilities and method of selecting officers. These rules shall be effective when approved as required by Article 14, General Provisions. While sections may assist departments in performance of departmental functions, responsibility and accountability for performance of departmental functions shall remain at the departmental level.

Article 10
MEETINGS

10.1 Medical Staff Meetings

10.1-1 **Medical Staff Meetings**

There shall be at least one meeting of the Medical Staff during each Medical Staff year. The date, place and time of the meeting(s) shall be determined by the Chief of Staff. The Chief of Staff shall present a report on significant actions taken by the Medical Executive Committee during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

10.1-2 **Special Meetings**

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or District Board, or upon the written request of ten percent of the voting members. The meeting must be called within 30 days after receipt of such request. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.1-3 **Combined or Joint Medical Staff Meetings**

The Medical Staff may participate in combined or joint Medical Staff meetings with staff members from other hospitals, healthcare entities, or the County Medical Society; however, precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

10.2 Department and Committee Meetings

10.2-1 **Regular Meetings**

Departments and committees, by resolution, may provide the time for holding regular meetings and no notice other than such resolution shall then be required. Each department shall meet regularly, at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.

10.2-2 **Special Meetings**

A special meeting of any department or committee may be called by, or at the request of, the chair thereof, the Medical Executive Committee, Chief of Staff, or by 33-1/3 percent of the group's current members, but not fewer than three members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

10.2-3 **Combined or Joint Department or Committee Meetings**

The departments or committees may participate in combined or joint department or committee meetings with staff members from other hospitals, health care entities or the County Medical Society; however, precautions shall be taken to assure that

confidential Medical Staff information is not inappropriately disclosed, and to assure that this Medical Staff (through its authorized representative(s)) maintains access to and approval authority of all minutes prepared in conjunction with any such meetings.

10.3 Notice of Meetings

Written notice stating the place, day and hour of any regular or special Medical Staff meeting or of any regular or special department or committee meeting not held pursuant to resolution shall be delivered either personally or by mail/email to each person entitled to be present not fewer than two working days nor more than 45 days before the date of such meeting. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

10.4 Quorum

10.4-1 **Medical Staff Meetings**

The presence of *25* percent of the voting Medical Staff members at any regular or special meeting shall constitute a quorum.

10.4-2 **Committee Meetings**

The presence of *50* percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of *30* percent of the voting members of a committee but in no event less than three voting committee members.

10.4-3 **Department Meetings**

The presence of *25* percent of the voting Medical Staff members at any regular or special department meeting shall constitute a quorum.

10.5 Manner of Action

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these bylaws. Committee action may be conducted by telephone or internet conference, which shall be deemed to constitute a meeting for the matters discussed in that telephone or internet conference. Valid action may be taken without a meeting if at least 10 days' notice of the proposed action has been given to all members entitled to vote, and it is subsequently approved in writing setting forth the action so taken, which is signed by at least 66-2/3 percent of the members entitled to vote. The meeting chair shall refrain from voting except when necessary to break a tie, except that the Joint Conference Committee chair may vote.

10.6 Minutes

Minutes of all meetings shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer or his or her designee and forwarded to the Medical Executive Committee or other designated committee and District Board as needed. Each committee shall maintain a

permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

10.7 Attendance Requirements

10.7-1 **Regular Attendance Requirements**

Each member of a Medical Staff category required to attend meetings under Bylaw 3.1, shall be required to attend at least one of the general staff meetings annually and 50% of their department or section meetings during the two-year reappointment period. The physicians that do not meet this requirement may be subject to an increase in annual dues and a change in staff category

10.7-2 **Failure to Meet Attendance Requirements**

Medical Staff members will be notified annually if they have not yet met the full attendance requirements. Practitioners who have not met meeting attendance requirements before the end of the appointment/reappointment period (in the absence of extenuating circumstances) will be reviewed at the time of reappointment.

10.7-3 **Special Appearance**

A committee, at its discretion, may require the appearance of a practitioner during a review of the clinical course of treatment regarding a patient. If possible, the chair of the meeting should give the practitioner at least ten days' advance written notice of the time and place of the meeting. In addition, whenever an appearance is requested because of an apparent or suspected deviation from standard clinical practice, special notice shall be given and shall include a statement of the issue involved and that the practitioner's appearance is mandatory. Failure of a practitioner to appear at any meeting with respect to which he or she was given special notice shall (unless excused for a good cause) result in an automatic suspension of the practitioner's privileges for at least two weeks, or such longer period as the Medical Executive Committee deems appropriate. The practitioner shall be entitled to the procedural rights described at Article 13, Hearings and Appellate Reviews.

10.8 Conduct of Meetings

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical failures to follow such rules shall not invalidate action taken at such a meeting.

Article 11
CONFIDENTIALITY, IMMUNITY, RELEASES, AND INDEMNIFICATION

11.1 General

Medical Staff, department, section or committee minutes, files and records—including information regarding any member or applicant to this Medical Staff—shall, to the fullest extent permitted by law, be confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff Committee files and shall not become part of any particular patient's file or of the general hospital records. Dissemination of such information and records shall be made only where expressly required by law or as otherwise provided in these Bylaws.

11.2 Breach of Confidentiality

Inasmuch as effective credentialing, quality improvement, 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, and inasmuch as practitioners and others participate in credentialing, quality improvement, and peer review activities with the reasonable expectations that this confidentiality will be preserved and maintained, any breach of confidentiality of the discussions or deliberations of Medical Staff departments, sections, or committees, except in conjunction with another health facility, professional society or licensing authority peer review activities, 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.

11.3 Access to and Release of Confidential Information

11.3-1 **Access for Official Purposes**

Medical Staff records, including confidential committee records and credentials files, shall be accessible by:

a. Committee members, and their authorized representatives, for the purpose of conducting authorized committee functions.

b. Medical Staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

c. The Chief Executive Officer, the District Board, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities.

d. Upon approval of the Chief Executive Officer and Chief of Staff, the peer review bodies of System Affiliates, as reasonably necessary to facilitate review of an applicant or member of such Affiliate's professional staff.

e. Information which is disclosed to the District Board or its appointed representatives and to peer review bodies of System Affiliates shall be maintained as confidential.

11.3-2 **Member's Access**

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

1) Notice of a request to review the file shall be given by the member to the Chief of Staff (or his or her designee) at least three days before the requested date for review.

1) 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, letter of reference, proctoring reports, complaints, etc., shall be provided to the member, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized.

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

3) In the event a Notice of Charges is filed against a member, access to that member's credentials file shall be governed by Section 13.4-9.

b. A member may be permitted to request correction of information as follows:

1) After review of his or her file, a member may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.

4) The Chief of Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee whether to make the correction as requested, and the Medical Executive Committee shall make the final determination.

5) The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

6) In any case, a member shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any such written statement shall be addressed to the Medical Executive Committee, and shall be placed in the credentials file immediately following review by the Medical Executive Committee.

11.4 Immunity and Releases

11.4-1 **Immunity from Liability for Providing Information or Taking Action**

Each representative of the Medical Staff and hospital and all third parties shall be exempt from liability to an applicant, member or practitioner for damages or other relief by reason of providing information to a representative of the Medical Staff, hospital or any other health-related organization concerning such person who is, or has been, an applicant to or member of the Medical Staff or who did, or does, exercise privileges or provide services at this hospital or by reason of otherwise participating in a Medical Staff or hospital credentialing, quality improvement, or peer review activities.

11.4-2 **Activities and Information Covered**

a. Activities

The 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-related institution's or organization's activities concerning, but not limited to:

1) Applications for appointment, privileges, or specified services;

2) Periodic reappraisals for reappointment, privileges, or specified services;

3) Corrective action;

4) Hearings and appellate reviews;

5) Quality improvement review, including patient care audit;

6) Peer review;

7) Utilization reviews;

8) Morbidity and mortality conferences; and

9) Other hospital, department, section, or committee activities related to monitoring and improving the quality of patient care and appropriate professional conduct.

b. Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics or other matter that might directly or indirectly affect patient care.

11.5 Releases

Each practitioner shall, upon request of the hospital, execute general and specific releases in accordance with the tenor and import of this Article; however, execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

11.6 Cumulative Effect

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

11.7 Indemnification

The hospital shall indemnify, defend, and hold harmless the medical staff and its individual members ("Indemnitee(s)") from and against losses and expenses (including reasonable attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities including, but not limited to:

a. As a member of or witness for a medical staff department, service, committee, or hearing panel;

2. As a member of or witness for the hospital District Board or any hospital task force, group or committee; and

3. As a person providing information to any Medical Staff or hospital group, officer, District Board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant.

The hospital shall retain responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against Indemnitees, including but not limited to selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on Indemnitees' good faith belief that their actions and/or communications are reasonable and warranted and in furtherance of the Medical Staff's peer review, quality assessment or quality improvement responsibilities, in accordance with the purposes of the Medical Staff as set forth in these bylaws. In no event will the hospital indemnify an Indemnitee for acts or omissions taken in bad faith or in pursuit of the Indemnitee's private economic interests.

Article 12
PERFORMANCE IMPROVEMENT AND CORRECTIVE ACTION

12.1 Peer Review Philosophy

12.1-1 **Role of Medical Staff in Organization-Wide Quality Improvement Activities**
The Medical Staff is responsible to oversee the quality of medical care, treatment and services delivered in the hospital. An important component of that responsibility is the oversight of care rendered by members and AHPs practicing in the hospital. The following provisions are designed to achieve quality improvements through collegial peer review and educative measures whenever possible, but with recognition that, when circumstances warrant, the Medical Staff is responsible to embark on informal corrective measures and/or corrective action as necessary to achieve and assure quality of care, treatment and services. Toward these ends:

a. Members of the Medical Staff are expected to actively and cooperatively participate in a variety of peer review activities to measure, assess and improve performance of their peers in the hospital.

b. The initial goals of the peer review processes are to prevent, detect and resolve problems and potential problems through routine collegial monitoring, education and counseling. However, when necessary, corrective measures, including formal investigation and discipline, must be implemented and monitored for effectiveness.

c. Peers in the departments and committees are responsible for carrying out delegated review and quality improvement functions in a manner that is consistent, timely, defensible, balanced, useful and ongoing. The term "peers" generally requires that a majority of the peer reviewers be members holding the same license as the practitioner being reviewed, including, where possible, at least one member practicing the same specialty as the member being reviewed. Notwithstanding the foregoing, D.O.s and M.D.s shall be deemed to hold the "same licensure" for purposes of participating in peer review activities.

d. The departments and committees may be assisted by the Chief Medical Officer

4.

e. Any Medical Staff member, who is involved in an event that is being evaluated and who is requested to attend a specific meeting, is required to attend and participate in good faith.

12.1-2 **Informal Corrective Activities**
The Medical Staff officers, departments and committees may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable

notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the officer, department or committee. Any informal actions, monitoring or counseling shall be documented in the member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. The actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article 13, Hearings and Appellate Reviews.

12.1-3 **Criteria for Initiation of Formal Corrective Action**

A formal corrective action investigation may be initiated whenever reliable information indicates a member may have exhibited acts, demeanor or conduct, either within or outside of the hospital, that is reasonably likely to be:

- **a.** detrimental to patient safety or to the delivery of quality patient care within the hospital;
- **b.** unethical;
- **c.** contrary to the Medical Staff bylaws or rules;
- **d.** below applicable professional standards;
- **e.** disruptive of Medical Staff or hospital operations; or
- **f.** an improper use of hospital resources.

Generally, formal corrective action measures should not be initiated unless reasonable attempts at informal resolution have failed; however, this is not a mandatory condition, and formal corrective action may be initiated whenever circumstances reasonably appear to warrant formal action. Any recommendation of formal corrective action must be based on evaluation of applicant-specific information.

12.1-4 **Initiation**

- **a.** Any person who believes that formal corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff officer, any department chair, any Medical Staff Committee, the chair of any Medical Staff Committee, the District Board or the Chief Executive Officer.
- **b.** If the Chief of Staff, any other Medical Staff officer, any department chair, any Medical Staff Committee, the chair of any Medical Staff Committee, the District Board or the Chief Executive Officer determines that formal corrective action may be warranted under Section 12.1-3, that person, entity, or committee may request the initiation of a formal corrective action investigation or may recommend particular corrective action. Such requests may be conveyed to the Medical Executive Committee orally or in writing.
- **c.** The Chief of Staff shall notify the Chief Executive Officer, or his or her designee in his or her absence, and the Medical Executive Committee and shall continue to keep them fully informed of all action taken. In addition, the Chief of Staff shall immediately forward all necessary information to the committee or person that will conduct any investigation, provided, however, that the Chief of Staff or the Medical Executive Committee may dispense

with further investigation of matters deemed to have been adequately investigated by a committee pursuant to Section 12.1-6 or otherwise.

12.1-5 **Expedited Initial Review**

a. Whenever information suggests that corrective action may be warranted, the Chief of Staff or his or her designee, and/or the Chief Medical Officer may, on behalf of the Medical Executive Committee, immediately investigate and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal corrective action investigation.

b. In cases of complaints of harassment or discrimination involving a patient, etc., an expedited initial review shall be conducted on behalf of the Medical Executive Committee by the Chief of Staff, the Chief of Staff's designee, or the Chief Medical Officer, together with representatives of administration, or by an attorney for the hospital. In cases of complaints of harassment or discrimination where the alleged harasser is a Medical Staff member and the complainant is not a patient, an expedited initial review shall be conducted by the Chief Medical Officer and the hospital's human resources director or their designee, or by an attorney for the hospital, who shall use best efforts to complete the expedited initial review within the timeframe set out at Section 12.1-8. The Chief of Staff shall be kept apprised of the status of the initial review. The information gathered from an expedited initial review shall be referred to the Medical Executive Committee if it is determined that corrective action may be indicated against a Medical Staff member.

12.1-6 **Formal Investigation**

a. If the Medical Executive Committee concludes action is indicated but that no further investigation is necessary, it may proceed to take action without further investigation.

b. If the Medical Executive Committee concludes a further investigation is warranted, it shall direct a formal investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself or may assign the task to an appropriate officer or standing or ad hoc committee to be appointed by the Chief of Staff. The investigating body should not include partners, associates or relatives of the individual being investigated. Additionally, the investigating person or body may, but is not required to, engage the services of one or more outside reviewers as deemed appropriate or helpful in light of the circumstances (e.g., to help assure an unbiased review, to firm up an uncertain or controversial review or to engage specialized expertise). 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, using best efforts to complete the investigation within the timeframe set out at Section 12.1-8, 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.

c. Prior to any adverse action being approved, the Medical Executive Committee shall assure that the member was given an opportunity to provide information in a manner and upon such terms as the Medical Executive Committee, investigating body, or reviewing committee deems appropriate. The investigating body or reviewing body may, but is not obligated to, interview persons involved; however, such an interview shall not constitute a hearing as that term is used in Article 13, Hearings and Appellate Reviews, nor shall the hearings or appeals rules apply.

d. 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 action.

e. The provisions of this Section 12.1-6 (including a determination to dispense with formal investigation and proceed immediately to further action pursuant to 12.1-6(a) shall demark the point at which an "impending investigation" is deemed to have commenced within the meaning of Business and Professions Code Section 805(c).

12.1-7 **Medical Executive Committee Action**

a. As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action including, without limitation:

i. Determining no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the complaint in the first instance, clearly documenting those findings in the member's file;

ii. Deferring action for a reasonable time;

iii. Issuing letters of admonition, censure, reprimand or warning, although nothing herein shall be deemed to preclude department or committee chairs from issuing informal written or oral warnings 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 file;

iv. Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of privileges including, without limitation, requirements for co-admissions, mandatory consultation or monitoring;

v. Recommending reduction, modification, suspension or revocation of privileges. If suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended shall be stated;

vi. Recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

vii. Recommending suspension, revocation or probation of Medical Staff membership. If suspension or probation is recommended, the terms and duration of the suspension or probation and the conditions that must be met before the suspension or probation is ended shall be stated;

viii. Referring the member to the Well-Being Committee for evaluation and follow-up as appropriate; and

ix. Taking other actions deemed appropriate under the circumstances.

b. If the Medical Executive Committee takes any action that would give rise to a hearing pursuant to Bylaws, Section 14.2, it shall also make a determination whether the action is a "medical disciplinary" action or an "administrative disciplinary" action. 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 a medical disciplinary and administrative disciplinary cause or reason, in which case, the matter shall be deemed medical disciplinary for Bylaws, Article 14, Hearings and Appellate Reviews, hearing purposes.

c. And, if the Medical Executive Committee makes a determination that the action is medical disciplinary, it shall also determine whether the action is taken for any of the reasons required to be reported to the Medical Board of California pursuant to California Business & Professions Code Section 805.1.

12.1-8 **Time Frames**

Insofar as feasible under the circumstances, formal and informal investigations should be conducted expeditiously, as follows:

a. Informal investigations should be completed and the results should be reported within 60 days.

b. Expedited initial reviews should be completed and the results should be reported within 30 days.

c. Other formal investigations should be completed and the results should be reported within 90 days.

12.1-9 **Procedural Rights**

a. If, after receipt of a request for formal corrective action pursuant to Section 12.1-4, the Medical Executive Committee determines that no corrective action is required or only a letter of warning, admonition, reprimand or censure should be issued, the decision shall be transmitted to the District Board. The District Board may affirm, reject or modify the action. The District Board shall give great weight to the Medical Executive Committee's decision and initiate further action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the Medical Executive Committee and the Medical Executive Committee still has not acted. The decision shall become final if the District Board affirms it or takes no action on it within 70 days after receiving the notice of decision.

b. If the Medical Executive Committee recommends an action that is a ground for a hearing under Section 13.2, the Chief of Staff shall give the practitioner special notice of the adverse recommendation and of the right to request a hearing. The District Board may be informed of the recommendation, but shall take no action until the member has either waived his or her right to a hearing or completed the hearing.

12.1-10 **Initiation by District Board**

a. The Medical Staff acknowledges that the District Board must act to protect the quality of medical care provided and the competency of its Medical Staff, and to ensure the responsible governance of the hospital in the event that the Medical Staff fails in any of its substantive duties or responsibilities.

b. Accordingly, if the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence, the District Board may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consulting with the Medical Executive Committee. If the Medical Executive Committee fails to act in response to that District Board direction, the District Board may, in furtherance of the District Board's ultimate responsibilities and fiduciary duties, initiate corrective action, but must comply with applicable provisions of Article 12, Peer Review and Corrective Action, and Article 13, Hearings and Appellate Reviews, of these bylaws. The District Board shall inform the Medical Executive Committee in writing of what it has done.

12.2 Summary Restriction or Suspension

12.2-1 **Criteria for Initiation**

a. Whenever a practitioner's conduct is such that a failure to take action may result in an imminent danger to the health of any individual, the Chief of Staff, the Medical Executive Committee, the chair of the department in which the member holds privileges, or the Chief Executive Officer may summarily restrict or suspend the Medical Staff membership or privileges of such member.

b. Unless otherwise stated, such summary restriction or suspension (summary action) shall become effective immediately upon imposition, and the person or body responsible shall promptly give special notice to the member and written notice to the District Board, the Medical Executive Committee, and the Chief Executive Officer. The special notice shall fully comply with the requirements of Section 12.2-1(d), below.

c. The summary action may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary action, 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 and the affected practitioner in the choice of a substitute member.

d. Within one working day of imposition of a summary suspension, the affected Medical Staff member shall be provided with verbal notice of such suspension; followed, within 3 working days of imposition, by written notice of such suspension. This initial written notice shall include a statement of facts demonstrating that the suspension was reasonable and warranted because failure to suspend or restrict the member's privileges summarily could reasonably result in an imminent danger to the health of any 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 section 13.3-1 (which applies in all cases where

the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 13.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

e. The notice of the summary action given to the Medical Executive Committee shall constitute a request to initiate corrective action and the procedures set forth in Section 12.1-4 shall be followed.

12.2-2 **Medical Executive Committee Action**

Within one week after such summary action has been imposed, a meeting of the Medical Executive Committee or a subcommittee appointed by the Chief of Staff shall be convened to review and consider the action. Upon request, the affected practitioner may attend and make a statement concerning the issues under investigation, on such terms as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the affected member, constitute a "hearing" within the meaning of Article 13, Hearings and Appellate Reviews, nor shall any procedural rules apply. The Medical Executive Committee may thereafter continue, modify or terminate the terms of the summary action. It shall give the practitioner special notice of its decision within two working days of the meeting, which shall include the information specified in Section 13.3-1 if the action is adverse.

12.2-3 **Procedural Rights**

Unless the Medical Executive Committee promptly terminates the summary action, and if the summary action constitutes a suspension or restriction of clinical privileges (required to be reported to the Medical Board of California pursuant to Business and Professions Code Section 805), the affected practitioner shall be entitled to the procedural rights afforded by Article 13, Hearings and Appellate Reviews.

12.2-4 **Initiation by District Board**

a. If no one authorized under Section 12.2-1(a) to take a summary action is available to summarily restrict or suspend a member's membership or privileges, the District Board (or its designee) may immediately suspend or restrict a member's privileges if a failure to act immediately may result in imminent danger to the health of any individual, provided that the District Board (or its designee) made reasonable attempts to contact the Chief of Staff and the chair of the department to which the member is assigned before acting.

b. Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

12.3 Automatic Suspension or Limitation

In the following instances, the member's privileges or membership may be suspended or limited as described:

12.3-1 **Licensure**

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

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

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

12.3-2 **Drug Enforcement Administration (DEA) Certificate**

a. Revocation, Suspension, and Expiration: Whenever a member's DEA certificate is revoked, limited, suspended or expired, 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.

12.3-3 **Failure to Satisfy Special Appearance Requirement**

A member who fails without good cause to appear and satisfy the requirements of Section 10.7-3 shall automatically be suspended from exercising all or such portion of privileges as the Medical Executive Committee specifies.

12.3-4 **Medical Records**

Medical Staff members are required to complete medical records within the time prescribed by the Medical Executive Committee. Weekly notifications will be sent to physicians with delinquent records. Failure to timely complete medical records shall result in an automatic suspension after the third notice is given. Such suspension shall apply to the Medical Staff member's right to admit, treat or provide services to new patients in the hospital, but shall not affect the right to continue to care for a patient the Medical Staff member has already admitted or is treating; provided, however, members whose privileges have been suspended for delinquent records may admit and treat new patients in life-threatening situations. The suspension shall continue until the medical records are completed. If after 90 consecutive days of suspension the member remains suspended, the member shall be considered to have voluntarily resigned from the Medical Staff. Exceptions may be made by the Chief of Staff for illness or absence from the community. Nothing in the foregoing shall preclude the implementation, by the Medical Executive Committee, of a monetary fine for delinquent medical records.

12.3-5 **Cancellation of Professional Liability Insurance**

Failure to maintain professional liability insurance as required by these bylaws shall be grounds for automatic suspension of a member's privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A failure to provide evidence of appropriate coverage within six months after the date of automatic suspension shall be deemed a voluntary resignation of the member from the Medical Staff.

12.3-6 **Failure to Pay Dues**

If the member fails to pay required dues within 30 days after written warning of delinquency, a practitioner's Medical Staff membership and privileges shall be automatically suspended and shall remain so suspended until the practitioner pays the delinquent dues. If after 90 consecutive days of suspension the member remains suspended, the member will be considered to have voluntarily resigned from the Medical Staff.

12.3-7 **Failure to Comply with Government and Other Third Party Payor Requirements**

The Medical Executive Committee shall be empowered to determine that compliance with certain specific third party payor, government agency, and professional review organization rules or policies is essential to hospital and/or Medical Staff operations and that compliance with such requirements can be objectively determined. The rules may authorize the automatic suspension of a practitioner who fails to comply with such requirements. The suspension shall be effective until the practitioner complies with such requirements.

12.3-8 **Automatic Termination**

If a practitioner who is not actively involved in judicial review is suspended for more than six months, his or her membership (or the affected privileges, if the suspension is a partial suspension) shall be automatically terminated. Thereafter, reinstatement to the Medical Staff shall require application and compliance with the appointment procedures applicable to applicants.

12.3-9 **Executive Committee Deliberation and Procedural Rights**

a. As soon as practicable after action is taken or warranted as described in Section 12.3-1, Licensure, Section 12.3-2, Drug Enforcement Administration, Certificate, or 12.3-3, Failure to Satisfy Special Appearance, 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 generally set forth commencing at Section 12.1-6, Formal Investigation. The Medical Executive Committee review and any subsequent hearings and reviews shall not address the propriety of the licensure or DEA action, but instead shall address what, if any, additional action should be taken by the hospital. There is no need for the Medical Executive Committee to act on automatic suspensions for failures to complete medical records (Section 12.3-4), maintain professional liability insurance (Section 12.3-5), to pay dues (Section 12.3-6) or comply with government and other third party pay or rules and policies (Section 12.3-7).

b. Practitioners whose privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership shall be entitled to a hearing only if the suspension is reportable to the Medical Board of California or the federal National Practitioner Data Bank.

12.3-10 **Notice of Automatic Suspension or Action**

Special notice of an automatic suspension or action shall be given to the affected individual, and regular notice of the suspension shall be given to the Medical Executive Committee, Chief Executive Officer and District Board, but such notice shall not be required for the suspension to become effective. Patients affected by an automatic suspension shall be assigned to another member by the department chair or Chief of Staff. The wishes of the patient and affected practitioner shall be considered, where feasible, in choosing a substitute member.

12.4 Interview

Interviews shall neither constitute nor be deemed a hearing as described in Article 13, Hearings and Appellate Reviews, shall be preliminary in nature, and shall not be conducted according to the procedural rules applicable with respect to hearings. The Medical Executive Committee shall be required, at the practitioner's request, to grant an interview only when so specified in this Article 12, Performance Improvement and Corrective Action. In the event an interview is granted, the practitioner shall be informed of the general nature of the reasons for the recommendation and may present information relevant thereto. A record of the matters discussed and the findings resulting from an interview shall be made.

12.5 Confidentiality

To maintain confidentiality, participants in the corrective action process shall limit their discussion of the matters involved to the formal avenues provided in these bylaws for peer review and discipline.

Article 13
HEARINGS AND APPELLATE REVIEWS

13.1 General Provisions

13.1-1 **Review Philosophy**

The intent in adopting these hearing and appellate review procedures is to provide for a fair review of decisions that adversely affect practitioners (as defined below), and at the same time to protect the peer review participants from liability. It is further the intent to establish flexible procedures which do not create burdens that will discourage the Medical Staff and District Board from carrying out peer review.

Accordingly, discretion is granted to the Medical Staff and District Board to create a hearing process which provides for the least burdensome level of formality in the process and yet still provides a fair review and to interpret these bylaws in that light. The Medical Staff, the District Board, and their officers, committees and agents hereby constitute themselves as peer review bodies under the federal Health Care Quality Improvement Act of 1986 and the California peer review hearing laws and claim all privileges and immunities afforded by the federal and state laws.

13.1-2 **Exhaustion of Remedies**

If an adverse action as described in Section 13.2 is taken or recommended, the practitioner must exhaust the remedies afforded by these bylaws before resorting to legal action.

13.1-3 **Intra-Organizational Remedies**

The hearing and appeal rights established in the bylaws are strictly adjudicative rather than legislative in structure and function. The hearing committees have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of bylaws, rules or policies. However, the District Board may, in its discretion, entertain challenges to the merits or substantive validity of bylaws, rules or policies and decide those questions. If the only issue in a case is whether a bylaw, rule or policy is lawful or meritorious, the practitioner is not entitled to a hearing or appellate review. In such cases, the practitioner must submit his challenges first to the District Board and only thereafter may he or she seek judicial intervention.

13.1-4 **Joint Hearings and Appeals**

The Medical Staff and District Board are authorized to participate in joint hearings and appeals..

13.1-5 **Definitions**

Except as otherwise provided in these bylaws, the following definitions shall apply under this Article:

a. "Body whose decision prompted the hearing" refers to the Medical Executive Committee in all cases where the Medical Executive Committee or authorized Medical Staff officers, members or committees took the action or rendered

the decision which resulted in a hearing being requested. It refers to the District Board in all cases where the District Board or its authorized officers, directors or committees took the action or rendered the decision which resulted in a hearing being requested.

b. "Practitioner," as used in this Article, refers to the practitioner who has requested a hearing pursuant to Section 13.3-2 of this Article.

13.1-6 **Substantial Compliance**

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

13.2 Grounds for Hearing

Except as otherwise specified in these bylaws (including those Exceptions to Hearing Rights specified in Section 13.9), any one or more of the following actions or recommended actions, if taken for medical disciplinary cause or reason as defined in Business and Professions Code Section 805 or its successor statute, shall be deemed actual or potential adverse action and constitute grounds for a hearing:

13.2-1 Denial of Medical Staff initial applications for membership and/or privileges.

13.2-2 Denial of Medical Staff reappointment and/or renewal of privileges.

13.2-3 Revocation, suspension, restriction, involuntary reduction of Medical Staff membership and/or privileges.

13.2-4 Involuntary imposition of significant consultation or proctoring requirements (excluding proctoring incidental to Associate staff status, or the granting of new privileges, or imposed because of insufficient activity, or proctoring or consultation that does not restrict the practitioner's privileges).

13.2-5 Summary suspension of Medical Staff membership and/or privileges during the pendency of corrective action and hearings and appeals procedures.

13.2-6 Any other "medical disciplinary" action or recommendation that must be reported to the Medical Board of California under the provisions of Section 805 of the California Business and Professions Code or to the National Practitioner Data Bank.

13.3 Notices of Actions and Requests for Hearing

13.3-1 **Notice of Action or Proposed Action, Right to Hearing**

In all cases in which action has been taken or a recommendation made as set forth in Section 13.2, the practitioner shall promptly be given Special Notice of the recommendation or action and of the right to request a hearing pursuant to Section 13.3-2, Request for Hearing. The notice must state:

a. What action or recommendation has been proposed against the practitioner;

b. Whether the action, if adopted, must be reported under Business and Professions Code Section 805 and/or the National Practitioners Data Bank;

c. A brief indication of the reasons for the action or proposed action;

d. That the practitioner may request a hearing;

e. That a hearing must be requested within 30 days after receipt of Special Notice; and

f. That the practitioner has the hearing rights described in the Medical Staff Bylaws, including those specified in Section 13.4, Hearing Procedure.

13.3-2 **Request for Hearing**

a. The practitioner shall have 30 days following receipt of special 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 Chief Executive Officer. If the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. Such final recommendation shall be considered by the District Board within 70 days and shall be given great weight by the District Board, although it is not binding on the District Board.

b. The practitioner shall state, in writing, his or her intentions with respect to attorney representation at the time he or she files the request for a hearing. Notwithstanding the foregoing and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or an appellate review.

13.4 Hearing Procedure

13.4-1 **Hearings Prompted by District Board Action**

If the hearing is based upon an adverse action by the District Board, the chair of the District Board shall fulfill the functions assigned in this section to the Chief of Staff, and the District Board shall assume the role of the Medical Executive Committee. The District Board may, but need not, grant appellate review of decisions resulting from such hearings.

13.4-2 **Time and Place for Hearing**

Upon receipt of a request for hearing, the Chief of Staff shall schedule a hearing and, within 30 days from the date he or she received the request for a hearing, give Special Notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not less than 30 days nor more than 60 days from the date the Chief of Staff received the request for a hearing.

13.4-3 **Notice of Charges**

Together with the special notice stating the place, time and date of the hearing, the Chief of Staff shall state clearly and concisely in writing the reasons for the adverse proposed action taken or recommended, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable. A supplemental notice may be issued at any time, provided the practitioner is given sufficient time to prepare to respond.

13.4-4 **Hearing Committee**

a. When a hearing is requested, the Chief of Staff shall appoint a Hearing Committee which shall be composed of not less than three members 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 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 Hearing Committee. In the event that it is not feasible to appoint a Hearing Committee from the active Medical Staff, the Chief of Staff may appoint members from other Medical Staff categories or practitioners who are not Medical Staff members. Such appointment shall include designation of the chair. When feasible, the Hearing Committee shall include at least one member who has the same healing arts licensure as the practitioner and who practices the same specialty as the practitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Hearing Committee member becomes unavailable.

b. 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 of the duties assigned to the Hearing Officer and to the Hearing Committee.

c. The Hearing Committee, or the arbitrator, if one is used, shall have such powers as are necessary to discharge its or his or her responsibilities.

13.4-5 **The Hearing Officer**

The use of a Hearing Officer to preside at a hearing is mandatory. The appointment of a Hearing Officer shall be by the hospital's Chief Executive Officer, as a representative of the Medical Executive Committee, as follows:

(1) Together with the notice of a hearing, the practitioner shall be provided a list of at least three but no more than five potential Hearing Officers meeting the criteria set forth below.

(2) The practitioner shall have five working days to accept any of the listed potential Hearing Officers, or to propose at least three but no more than five other names of potential Hearing Officers meeting the criteria set forth below.

(3) If the practitioner is represented by counsel, the parties' counsel may meet and confer in an attempt to reach accord in the selection of a Hearing Officer from the two parties' lists.

(4) If the parties are unable to reach an agreement on the selection of a Hearing Officer within five working days of receipt of the practitioner's proposed list, the hospital's Chief Executive Officer shall select an individual from the composite list.

(5) Unless a Hearing Officer is selected pursuant to stipulation of the parties, he/she shall be subject to reasonable voir dire.

The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but an attorney regularly utilized by the hospital, the Medical Staff, or the involved Medical Staff member or applicant for membership, for legal advice regarding its affairs and activities shall not be eligible to serve as hearing officer.

The hearing officer shall gain no direct financial benefit from the outcome (i.e., the hearing officer's remuneration shall not be dependent upon or vary depending upon the outcome

of the hearing). The hearing officer must not act as a prosecuting officer or as an advocate. The hearing officer shall preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed hearing committee members or the hearing officer. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Hearing Committee members or himself or herself serving as the hearing officer. The Hearing Officer's authority shall also include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.

The Hearing Officer may also apprise the Hearing Committee of its right to terminate the hearing due to the member's failure to cooperate with the hearing process, but shall not independently make that determination. Except as provided above, if the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of the examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case.

Upon adjournment of the evidentiary portion of the hearing, the hearing officer shall meet with the members of the Hearing Committee to assist them with the process for their review of the evidence and preparation of the report of their decision. If requested by the Hearing Committee, the hearing officer may participate in the full deliberations of such Committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

In all matters, the hearing officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the hearing officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the hearing officer shall have the authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process review.

13.4-6 **Representation**

1. The practitioner shall have the right, at his or her expense, to attorney representation in any phase of the hearing. If the practitioner elects to have attorney representation, the body whose decision prompted the hearing may also have attorney representation. Conversely, if the practitioner elects not to be represented by an attorney in the hearing, then the body whose decision prompted the hearing shall not be represented by an attorney in the hearing. When attorneys are not allowed, the practitioner and the body whose decision prompted the hearing may 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.
2. Notwithstanding the foregoing, and regardless of whether the practitioner elects to have attorney representation at the hearing, the parties shall have the right to consult with legal counsel to prepare for a hearing or appellate review.
3. Any time attorneys will be allowed to represent the parties at a hearing, the Hearing Officer shall have the discretion to limit the attorneys' role to advising their clients rather than presenting the case.

13.4-7 **Failure to Appear or Proceed**

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

13.4-8 **Postponements and Extensions**

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted upon a showing of good cause, as follows:

a. Until such time as a Hearing Officer has been appointed, by the Hearing Committee or its chair acting upon its behalf; or

b. Once appointed by the Hearing Officer.

13.4-9 **Discovery**

a. Rights of Inspection and Copying:

The practitioner may inspect and copy (at his or her expense) any documentary information relevant to the charges that the Medical Staff has in its possession or under its control. The Medical Executive Committee, or the body whose decision prompted the hearing, may inspect and copy (at its expense) any documentary information relevant to the charges that the practitioner has in his or her possession or under his or her control. The requests for discovery shall be fulfilled as soon as practicable. Failures to comply with reasonable discovery requests at least 30 days prior to the hearing shall be good cause for a continuance of the hearing.

b. Limits on Discovery:

The hearing officer shall rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest

of fairness and equity. Further, the right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners other than the practitioner under review nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

c. Ruling on Discovery Disputes:

In ruling on discovery disputes, the factors that may be considered by the Hearing Officer include:

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

2) Whether the information is exculpatory in that it would dispute or cast doubt upon the charges or inculpatory in that it would prove or help support the charges and/or recommendation;

3) The burden on the party of producing the requested information; and

4) What other discovery requests the party has previously made.

d. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff:

The body whose decision prompted the hearing may object to the introduction of the evidence that was not provided during an appointment, reappointment or privilege application review or during corrective action despite the requests of the peer review body for such information. The information will be barred from the hearing by the hearing officer unless the practitioner can prove he or she previously acted diligently and could not have submitted the information.

13.4-10 **Pre-Hearing Document Exchange**

At the request of either party, the parties must exchange all documents that will be introduced at the hearing. The documents must be exchanged at least ten days prior to the hearing. A failure to comply with this rule is good cause for the hearing officer to grant a continuance. Repeated failures to comply shall be good cause for the hearing officer to limit the introduction of any documents not provided to the other side in a timely manner.

13.4-11 **Witness Lists**

Not less than 15 days prior to the hearing, each party shall furnish to the other a written list of the names and addresses of the individuals, so far as is then reasonably known or anticipated, who are expected to give testimony or evidence in support of that party at the hearing. Nothing in the foregoing shall preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The parties shall notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least ten days prior to the hearing date at which the witness is to appear shall constitute good cause for a continuance.

13.4-12 **Procedural Disputes**

a. It shall be the duty of the parties to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions

concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.

b. The parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the bylaws and to resolve such procedural matters as the hearing officer determines may properly be resolved outside the presence of the full Hearing Committee. Such motions shall be in writing and shall specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party shall deliver a copy of the motion to the opposing party, who shall have five working days to submit a written response to the hearing officer, with a copy to the moving party. The hearing officer shall determine whether to allow oral argument on any such motions. The hearing officer's ruling shall be in writing and shall be provided to the parties promptly upon its rendering. All motions, responses and rulings thereon shall be entered into the hearing record by the hearing officer.

13.4-13 **Record of the Hearing**

A court reporter shall be present to make a record of the hearing proceedings and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The hearing officer 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.

13.4-14 **Rights of the Parties**

Within reasonable limitations, both sides at the hearing may ask the Hearing Committee members and hearing officer questions which are directly related to evaluating their qualifications to serve and for challenging such members or the hearing officer, 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, receive all information made available to the Hearing Committee, and to submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Hearing Officer shall make all necessary rulings on the foregoing. The practitioner may be called by the body whose decision prompted the hearing or the Hearing Committee and examined as if under cross-examination. The Hearing Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

13.4-15 **Rules of Evidence**

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

13.4-16 **Burdens of Presenting Evidence and Proof**

a. At the hearing, the body whose decision prompted the hearing shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner shall be obligated to present evidence in response.

b. An applicant for membership and/or privileges shall bear the burden of persuading the Hearing Committee, by a preponderance of the evidence, that he or she is qualified for membership and/or the denied privileges. The practitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and privileges. An applicant shall not be permitted to introduce information not produced upon the request of the Medical Executive Committee during the Application process, unless the practitioner establishes that the information could not have been produced previously in the exercise of reasonable diligence

c. Except as provided above for applicants for membership and/or privileges, throughout the hearing, the body whose decision prompted the hearing shall bear the burden of persuading the Hearing Committee by a preponderance of the evidence, that its action or recommendation was reasonable and warranted.

13.4-17 **Adjournment and Conclusion**

After consultation with the Chair of the Hearing 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.

13.4-18 **Basis for Decision**

The decision of the Hearing Committee shall be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony.

13.4-19 **Presence of Hearing Committee Members and Vote**

A majority of the Hearing Committee must be present throughout the hearing and deliberations. In unusual circumstances when a Hearing Committee member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she has read the entire transcript of the portion of the hearing from which he or she was absent. The final decision of the Hearing Committee must be sustained by a majority vote of the number of members appointed.

13.4-20 **Decision of the Hearing Committee**

Within 30 days after final adjournment of the hearing, the Hearing Committee shall render a written decision to the Medical Executive Committee. If the practitioner is currently under suspension, however, the time for the decision and report shall be 15 days after final adjournment. Final adjournment shall be when the Hearing Committee has concluded its deliberations. A copy of the decision shall be forwarded to the Chief Executive Officer, the Medical Executive Committee, the District Board, and by Special Notice to the practitioner. The report shall contain the Hearing Committee's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the

practitioner and the body whose decision prompted the hearing shall be provided a written explanation of the procedure for appealing the decision. The decision of the Hearing Committee shall be considered final, subject only to such rights of appeal or District Board review as described in these bylaws.

13.5 Appeal

13.5-1 **Grounds for Appeal**

There are two permissible grounds for appeal:

1) Substantial and material failure to comply with the procedures set forth in the Medical Staff Bylaws for the conduct of the Medical Staff hearing.

2) The decision of the Medical Staff Hearing Committee is not supported by substantial evidence in the record of the hearing.

13.5-2 **Time for Appeal**

Within 40 days after receiving the decision of the Hearing Committee, either the practitioner or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the Chief Executive Officer and the other side in the hearing. If appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the Medical Staff. The District Board shall consider the decision within 70 days, and shall give it great weight.

13.5-3 **Time, Place and Notice**

If an appellate review is to be conducted, the Appeal Board shall, within 30 days after receiving a request for appeal, schedule a review date and cause each side to be given notice (with special notice to the practitioner) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date of such notice provided; however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Appeal Board for good cause.

13.5-4 **Appeal Board**

The District Board may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the District Board. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter. The Appeal Board may select an attorney to assist it in the proceeding. If an attorney is selected, he or she may act as an appellate hearing officer and shall have all of the authority of and carry out all of the duties assigned to a hearing officer as described in this Article 13. That attorney shall not be entitled to vote with respect to the appeal. The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

13.5-5 **Appeal Procedure**

The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record of the hearing before the Hearing 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 in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing; or the Appeal Board may remand the matter to the Hearing 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. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. In addition, each party shall have the right to present a written statement in support of his, her or its position on appeal. The appellate hearing officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

13.5-6 **Decision**

a. Within 30 days after the adjournment of the Appellate Review proceeding, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

b. The Appeal Board may affirm, modify, reverse the decision or remand the matter for further review by the Hearing Committee or any other body designated by the Appeal Board.

c. The Appeal Board shall give great weight to the Hearing Committee recommendation, and shall not act arbitrarily or capriciously. Unless the Appeal Board elects to conduct a de novo review, the Appeal Board shall sustain the factual findings of the Hearing Committee if they are supported by substantial evidence. The Appeal Board may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision is reasonable and warranted in light of the supported findings, and whether any bylaw, rule or policy relied upon by the Hearing Committee is unreasonable or unwarranted. The decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the Hearing Committee.

d. The Appeal Board shall forward copies of the decision to each side involved in the hearing.

e. The Appeal Board may remand the matter to the Hearing Committee or any other body the Appeal Board designates for reconsideration or may refer the matter to the full District Board for review. If the matter is remanded for further review and recommendation, the further review shall be completed within 30 days unless the parties agree otherwise or for good cause as determined by the Appeal Board.

13.6 Administrative Action Hearings

The following modifications to the hearing process apply when the Medical Executive Committee (or District Board) has taken or recommended an action described in Bylaws, Section 13.2 for a non-medical disciplinary cause or reason. Such actions shall be deemed administrative or disciplinary actions.

13.6-1 **Administrative Action Hearing**

The affected practitioner shall be entitled to an administrative action hearing, conducted in accordance with Bylaw, Section 13.4, except as follows:

1. At the election of the body whose decision prompted the hearing, the hearing shall be conducted by an arbitrator. The arbitrator need not be either a health professional or an attorney, and is selected by mutual agreement of the parties, if agreement can be reached within 10 days, failing which the arbitrator shall be selected by the body whose decision prompted the hearing.
2. The arbitrator shall have all of the duties, rights and responsibilities of a Hearing Officer and a Hearing Committee, as described in Bylaws, Section 13.4.
3. At the election of the body whose decision prompted the hearing, both parties shall have the right to be represented by an attorney. The parties shall be notified of this election at the time the practitioner is notified of his/her right to a hearing. If attorney representation is permitted, the parties shall promptly notify each other of their elections regarding attorney representation, together with the name and contact information of their attorneys.

13.6-2 **Non-reportability of Administrative Actions**

Administrative disciplinary actions are not reportable to the Medical Board of California or the National Practitioner Data Bank.

13.6-3 **Nonwaiver of Protections**

Notwithstanding the foregoing, it is understood that circumstances precipitating administrative disciplinary actions may nonetheless involve or affect quality of care in the hospital (e.g., conduct that does or may impair the ability of others to render quality care, or that affects patients' perceptions of the quality of care rendered in the hospital). Processing a matter as an administrative disciplinary action does not waive any protections that may be available under California or federal law for peer review actions taken in furtherance of quality of care or services provided in the hospital.

13.7 Right to One Hearing

No practitioner 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.

13.8 Confidentiality

To maintain confidentiality in the performance of peer review, disciplinary and credentialing functions, participants in any stage of the hearing or appellate review process shall limit their discussion of the matters involved to the formal avenues provided in the Medical Staff bylaws.

All proceedings conducted pursuant to this Article shall be held in private unless otherwise ordered by the District Board pursuant to a request of the practitioner. The practitioner may request a public hearing. Prior to exercising its discretion on any request for a public hearing, the District Board shall seek and consider the comments of the Medical Executive Committee as to the implications and feasibility of conducting such a hearing in public.

13.9 Release

By requesting a hearing or appellate review under these bylaws, a practitioner agrees to be bound by the provisions in the Medical Staff bylaws relating to immunity from liability for the participants in the hearing process.

13.10 District Board Committees

In the event the District Board should delegate some or all of its responsibilities described in this Article 13 to its committees (including a committee serving as an Appeal Board), the District Board shall nonetheless retain ultimate authority to accept, reject, modify or return for further action or hearing the recommendations of its committee.

13.11 Exceptions to Hearing Rights

13.11-1 **Exclusive Use Departments, Hospital Contract Practitioners**

a. Exclusive Use Departments

The procedural rights of Article 13 do not apply to a practitioner whose application for Medical Staff membership and privileges was denied or whose privileges were terminated, suspended, or restricted on the basis that the privileges he or she seeks are granted only pursuant to an exclusive use policy, nor do they apply to a practitioner whose privileges are terminated, suspended, or restricted by, or is no longer affiliated with, the physician or group holding the exclusive contract . Such practitioners shall have the right, however, to request that the District Board review the denial, and the District Board shall have the discretion to determine whether to review such a request and, if it decides to review the request, to determine whether the practitioner may personally appear before and/or submit a statement in support of his or her position to the District Board.

b. Hospital Contract Practitioners

The hearing rights of Article 13 do not apply to practitioners who have contracted with the hospital to provide clinical services. Removal of these practitioners from office and of any exclusive privileges (but not their Medical Staff membership) shall instead be governed by the terms of their individual contracts and agreements with the hospital. The hearing rights of this Article 13 shall apply if an action is taken which must be reported under Business and Professions Code Section 805 and/or the practitioner's Medical Staff membership status or privileges which are independent of the practitioner's contract are removed or suspended.

13.11-2 **Allied Health Professionals**

Allied health professional applicants are not entitled to the hearing rights set forth in this Article unless the action involves a clinical psychologist, marriage and family therapist, or clinical social worker, and must be reported under Business and Professions Code Section 805. However, an AHP whose already-granted privileges are subject to an action that would constitute grounds for a hearing under Section 13.2-2 through 13.2-.6 shall be entitled to the procedural rights set forth in this Article 13 (See Section 6.6-1 for a description of AHP hearing rights.)

13.11-3 **Denial of Applications for Failure to Meet the Minimum Qualifications**

Practitioners shall not be entitled to any hearing or appellate review rights if their membership, privileges, applications or requests are denied because of their failure to have a current California license to practice medicine, dentistry, clinical psychology, or podiatry; to maintain an unrestricted Drug Enforcement Administration certificate (when it is required under these bylaws or the rules); to maintain professional liability insurance as required by the rules; or to meet any of the other basic standards specified in Section 2.2-2 or to file a complete application.

13.11-4 **Automatic Suspension or Limitation of Privileges**

a. No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 12.3-1a, or automatically terminated as set forth in these Bylaws. In other cases described in Sections 12.3-1 and 12.3-2, 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 or the Drug Enforcement Administration was unwarranted, but only whether the member may continue to practice in the hospital with those limitations imposed.

b. Practitioners whose privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to satisfy a special appearance (Section 12.3-3), failing to complete medical records (Section 12.3-4), failing to maintain malpractice insurance (Section 12.3-5), failing to pay dues (Section 12.3-6), or failing to comply with particular government or other third party payor rules or policies (Section 12.3-7) are not entitled under Section 12.3-9 to any hearing or appellate review rights except when a suspension for failure to complete medical records will exceed 30 days in any 12-month period, and it must be reported to the Medical Board of California.

13.11-5 **Failure to Meet Minimum Activity Requirements**

Practitioners shall not be entitled to the hearing and appellate review rights if their membership or privileges are denied, restricted or terminated or their Medical Staff categories are changed or not changed because of a failure to meet any existing minimum activity requirements set forth in the Medical Staff bylaws or rules. In such cases, the only review shall be provided by the Medical Executive Committee through a subcommittee consisting of at least three Medical Executive Committee members. The subcommittee shall give the practitioner notice of the reasons for the intended denial or change in membership, privileges, and/or category and shall schedule an interview with the subcommittee to occur no less than 30 days and no more than 100 days after the date the notice was given. At this interview, the practitioner may present evidence concerning the reasons for the action, and

thereafter the subcommittee shall render a written decision within 45 days after the interview. A copy of the decision shall be sent to the practitioner, Medical Executive Committee and District Board. The subcommittee decision shall be final unless it is reversed or modified by the Medical Executive Committee within 45 days after the decision was rendered, or the District Board within 90 days after the decision was rendered.

Article 14
GENERAL PROVISIONS

14.1 Rules and Policies

14.1-1 **Overview and Relation to Bylaws**

These bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the District Board. Accordingly, the key standards for Medical Staff membership, appointment, reappointment and privileging are set out in these bylaws. Additional provisions, including but not limited to procedures for implementing the Medical Staff standards may be set out in Medical Staff or department rules, or in policies adopted or approved as described below. Upon proper adoption, as described below, all such rules and policies shall be deemed an integral part of the Medical Staff bylaws.

14.1-2 **General Medical Staff Rules**

The Medical Staff shall initiate and adopt such Rules as it may deem necessary and shall periodically review and revise its Rules to comply with current Medical Staff practice. New Rules or changes to the Rules (proposed Rules) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least *50%* of the voting members of the Medical Staff. 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 at Section 14.1-2(d), 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.

b. Medical Executive Committee approval is required, unless the proposed Rule is one generated by petition of at least *50%* 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 14.1-5

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 14.1-2b3, the proposed Rule shall be forwarded to the District Board for action. The Medical Executive Committee may forward comments to the District Board 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 District Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the District Board.

3. With respect to 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 *25%* votes have been cast.

c. Following approval by the Medical Executive Committee or favorable vote of the Medical Staff as described above, a proposed Rule shall be forwarded to the District Board for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following approval of the District Board or automatically within 60 days if no action is taken by the District Board. 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 District Board for approval and immediate implementation, subject to the following. If the Medical Staff did not receive prior notice of the proposed Rule (as described at Section 14.1-2(a)) the Medical Staff shall be notified of the provisionally-adopted and approved Rule, and may, by petition signed by at least *50%* 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 a 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 14.1-2.

14.1-3 **Departmental Rules**

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

14.1-4 **Section Rules**

Subject to the approval of the committee of the department that oversees the section, the Medical Executive Committee and the District Board, each section may formulate its own rules for conducting its affairs and discharge its responsibilities. Additionally, hospital administration may develop and recommend proposed section Rules, and in any case should be consulted as to the impact of any proposed section Rules on hospital operations and feasibility. Such rules shall not be inconsistent with the Medical Staff or District bylaws, rules or other policies.

14.1-5 **Medical Staff Policies**

a. Policies shall be developed as necessary to implement more specifically the general principles found within these bylaws and the Medical Staff rules. New or revised policies (proposed policies) may emanate from any responsible committee, department, medical staff officer, or by petition signed by at least 50% of the voting members of the Medical Staff. Proposed such policies shall not be inconsistent with the Medical Staff or District bylaws, rules or other policies, and upon adoption have the force and effect of medical staff bylaws.

b. Medical Executive Committee approval is required, unless the proposed policy is one generated by petition of at least *50%* of the voting members of the Medical Staff. In this latter circumstance, if the Medical Executive Committee fails to approve the proposed policy, 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 14.1-6.

1. If conflict management is not invoked within *30* days it shall be deemed waived. In this circumstance, the Medical Staff's proposed policy shall be submitted for vote, and if approved by the Medical Staff, the proposed policy shall be forwarded to the District Board for action. The Medical Executive Committee may forward comments to the District Board regarding the reasons it declined to approve the proposed policy.
2. If conflict management is invoked, the proposed policy shall not be voted upon or forwarded to the District Board until the conflict management process has been completed, and the results of the conflict management process shall be communicated to the Medical Staff and the District Board.
3. Approval of the Medical Staff shall require 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 policy, has been given, and at least *25%* votes have been cast.

c. Following approval by the Medical Executive Committee or the voting Medical Staff as described above, a proposed policy shall be forwarded to the District Board for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following approval of the District Board or automatically within *60* days if no action is taken by the District Board.

d. The Medical Staff shall be notified of the approved policy, and may, by petition signed by at least *50%* of the voting members of the Medical Staff require the policy to be submitted for possible recall; provided, however, the approved policy shall remain effective until such time as it is repealed or amended pursuant to any applicable provision of this Section 14.1-5.

14.1-6 Conflict Management

In the event of conflict between the Medical Executive Committee and the Medical Staff (as represented by written petition signed by at least *50%*of the voting members of the Medical Staff) regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the Chief of Staff shall convene a meeting with the petitioners' representative(s). The foregoing petition shall include a designation of up to *3* 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 petitioner's representatives. Unresolved differences shall be submitted to the District Board for its consideration in making its final decision with respect to the proposed Rule, policy, or issue.

14.2 Forms

Application forms and any other prescribed forms required by these bylaws for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by the Medical Executive Committee and the District Board. Upon adoption, they shall be deemed part of the Medical Staff rules. They may be amended by approval of the Medical Executive Committee and the District Board.

14.3 Dues

The Medical Executive Committee shall have the power to establish reasonable annual dues, if any, for each category of Medical Staff membership, 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.

14.4 Medical Screening Exams

14.4-1 All patients who present to the hospital, including the Emergency Department and the Labor and Delivery Unit, and who request examination and treatment for an emergency medical condition or active labor, shall be evaluated for the existence of an emergency medical condition or, where applicable, active labor. This screening may be performed by the following persons:

1. In the Emergency Department: by a registered nurse who has been determined by the ER Nurse Manager to be qualified and experienced in Emergency Nursing and who is required to follow standardized procedures approved by the Medical Staff.

b. In the Labor and Delivery Unit: by a registered nurse who has been determined by the Labor and Delivery Nurse Manager to be qualified and experienced in Obstetrical Nursing and who is required to follow standardized procedures approved by the Medical Staff.

c. In all circumstances: in the event the registered nurse performing the medical screening examination is uncertain about the nature of the patient's condition or the existence of an emergency or active labor, a physician from either the Emergency Department or Labor and Delivery shall be required to examine the patient and make the determination of the existence of an emergency or active labor.

14.4-2 Medical screening examinations and emergency services shall be provided in compliance with all applicable provisions of state and federal law, and hospital policies and procedures respecting Emergency Medical Services.

14.5 Legal Counsel

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

14.6 Authority to Act

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

14.7 Disputes with the District Board

In the event of a dispute between the Medical Staff and the District Board 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 Joint Conference Committee, which shall meet and confer as further described in Section 8.2(b) of the bylaws.

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 District Board. A neutral mediator acceptable to both the District Board 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 District Board; or (b) at least a majority of the District Board 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 District Board shall make its final determination giving great weight to the actions and recommendations of the Medical Executive Committee. Further, the District Board 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.

14.8 Retaliation

Neither the Medical Staff, its members, committees, or department chairs, the District Board, its chief administrative officer, or any other employee or agent of the Hospital or Medical Staff, shall discriminate or retaliate, in any manner, against any patient, hospital employee, member of the medical staff, or any other health care worker of the health facility because that person has done either of the following:

1. Presented a grievance, complaint, or report to the facility, to an entity or agency responsible for accrediting or evaluating the facility, or the medical staff of the facility, or to any other governmental entity.
2. Has initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its medical staff, or governmental entity.

Article 15
ADOPTION AND AMENDMENT OF BYLAWS

15.1 Medical Staff Responsibility and Authority

15.1-1 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 District Board, 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 generally recognized level of quality and efficiency, and maintaining a harmony of purpose and effort with the District Board. 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. Adoption and amendments cannot be delegated by the organized Medical Staff and District Board to another entity.

15.1-2 Proposed amendments shall be submitted to the District Board for comments before they are distributed to the Medical Staff for a vote. The District Board has the right to have its comments regarding the proposed amendments circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

15.1-3 Amendments to these Bylaws shall be submitted for vote upon the request of the Medical Executive Committee or upon receipt of a petition signed by at least *50%* of the voting Medical Staff members. 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 District Board for review and comment as described in Section 15.1-2. The Medical Executive Committee has the right to have its comments regarding the proposed amendments circulated to the District Board when the proposed amendments are submitted to the District Board 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 a vote.

15.2 Methodology

15.2-1 Medical Staff bylaws may be adopted, amended or repealed by the following combined actions:

a. The affirmative vote of a majority of the Medical Staff members voting on the matter by mailed secret ballot, provided at least fourteen days' advance written notice, accompanied by the proposed bylaws and/or alterations, has been given; and

b. The approval of the District Board, which shall not be unreasonably withheld. If approval is withheld, the reasons for doing so shall be specified by the District Board in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and the bylaws committee.

c. Neither the Medical Staff nor the District Board can unilaterally amend or repeal the Medical Staff Bylaws

15.2-2 In recognition of the ultimate legal and fiduciary responsibility of the District Board, the organized Medical Staff acknowledges, in the event the Medical Staff has unreasonably failed to exercise its responsibility and after notice from the District Board to such effect, including a reasonable period of time for response, the District Board may impose conditions on the Medical Staff that are required for continued state licensure, regulatory compliance, or approval by accrediting bodies, or by situations that pose a direct threat to patient safety, or to comply with law or a court order. In such event, Medical Staff recommendations and views shall be carefully considered by the District Board in its actions.

15.3 Technical and Editorial Corrections

The Medical Executive Committee shall have the power to approve technical corrections, such as reorganization or renumbering of the Bylaws, or to correct punctuation, spelling or other errors of grammar expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this Section. Corrections may be effected by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such corrections shall be communicated in writing to the Medical Staff and to the District Board. Such corrections are effective upon adoption by the Medical Executive Committee; provided however, they may be rescinded by vote of the Medical Staff or the District 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% of the voting members of the Medical Staff cast ballots.)

APPROVALS	DATE
_____ Keith Chamberlin MD, Chief of Staff MEDICAL EXECUTIVE COMMITTEE	2/17/2017
_____ Peter Hohorst, Chairman BOARD GOVERNANCE COMMITTEE	
_____ Jane Hirsch, Chairman BOARD OF DIRECTORS	

MEDICAL STAFF RULES & REGULATIONS

January 19, 2017

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PREAMBLE

In accordance with the Medical Staff Bylaws, the Medical Staff has initiated and adopted these General Rules and Regulations. Adherence to these General Rules and Regulations is required of all practitioners holding clinical privileges at SONOMA VALLEY Hospital, including medical staff members, those holding temporary privileges and where applicable allied health professional staff members holding clinical privileges or working under a job description.

RULE 1
ADMISSIONS

1.1 General

1.1-1 The hospital shall accept patients for diagnostic, invasive and therapeutic care. The hospital shall not accept patients who suffer from serious burns, who primarily need psychiatric or substance abuse treatment or, who have virulent infectious diseases for which suitable isolation cannot be maintained.

1.1-2 The appropriate Department Chairpersons, Chief of Staff or Chief Medical Officer shall be consulted whenever questions arise as to whether a patient should be admitted, retained, or transferred, or when disagreements arise between physicians involved in a patient's care. In the case of a disagreement between two Department Chairpersons, the Chief Medical Officer or Chief of Staff shall be consulted to resolve the dispute. Patients whose medical condition warrants a higher level of care than can be provided at Sonoma Valley Hospital shall be transferred to a higher level of care facility in accordance with EMTALA laws.

1.2 Procedure

1.2-1 A patient may be admitted to the hospital only by Medical Staff members who have admitting privileges or by practitioners who have been granted temporary privileges in accordance with the Medical Staff By-Laws. When a patient is admitted to the hospital by a dentist or a podiatrist, a physician Medical Staff member shall assume responsibility for the overall aspect of the patient's medical care.

1.2-2 Patients admitted to the hospital for dental and podiatric care must be given the same basic medical appraisal as patients admitted for other services. The physician Medical Staff member providing medical care shall assume overall responsibility for the patient's medical care throughout the hospital stay, including performance of the history and physical examination except that portion of the examination which relates to dentistry or podiatry.

1.2-3 To improve the accuracy of identification of patients, at the time of admission the patient shall be assigned two patient identifiers: (a) the patient's given name, middle initial, and surname as well as (b) the patient's date of birth.

1.3 Responsibility of the Attending Physician

1.3-1 The patient's attending physician shall be responsible for directing and supervising the patient's overall medical care, for coordinating all consultations, for completing and recording in the medical record a medical history and physical examination within twenty-four (24) hours after admission, for the prompt and accurate completion of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring physician, if any, and to the patient's family. The history and physical examination must be completed and recorded in the medical record prior to any surgery or invasive procedure.

1.3-2 Whenever these primary responsibilities are transferred from the identified attending physician to another Medical Staff member, documentation shall be noted on the order sheet in the medical record. The note shall state to whom care is being transferred and the date and time responsibility is transferred.

1.3-3 Any Medical Staff member who cannot or will not assume all of the responsibilities of the attending physician may admit patients only when another Medical Staff member has assumed such responsibilities and is identified as the attending physician. If the admitting physician is not assuming responsibility as the attending physician then this fact must be clearly stated on the admitting order sheet in the medical record.

1.3-4 Admission laboratory and radiology testing should be tailored to the individual needs of the patient. Specific laboratory testing should be determined by such factors as patient age, clinical status, anticipated blood loss and other clinically relevant information.

1.3-5 All patients admitted to the hospital shall be seen by the attending physician or designee on a daily basis and a daily progress note shall be recorded in the medical record.

1.4 Provisional Diagnosis. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, such statement shall be recorded as soon as possible, no later than twenty-four (24) hours after admission.

1.5 Responsibility of All Physicians Caring for Patients

1.5-1 All physicians caring for patients must comply with the CDC guidelines for hand hygiene.

1.5-2 For verbal or telephone orders or for telephonic reporting of critical test results, verification of the complete order or test result must be carried out by having the person receiving the information record and "read-back" the complete order or test result.

1.6 Psychiatric and Infection Admission Precautions

1.6-1 The attending physician, at the time the patient is admitted, shall inform the admitting staff and nursing staff if he or she suspects that the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending physician shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall note in the patient's medical record the reason for his or her suspicions, and the precautions taken to protect the patient and others.

1.6-2 All patients with infectious disease will be admitted in accordance with the Hospital Infection Control Manual.

1.6-3 In the event the patient or others cannot be appropriately protected in the general acute care service, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed.

1.6-4 The attending physician shall also seek assistance from a psychiatrist for any patient who suffers from an incapacitating emotional illness.

1.7 Emergency Admissions

1.7-1 When a patient requires admission to the hospital for emergency medical treatment, the attending physician shall, whenever possible, contact the Admitting Department and determine whether there is an available bed. Any patient admitted through the Emergency Department shall be seen and evaluated by their attending physician either immediately prior to or within twelve (12) hours of admission except as otherwise required in Section 2.7.

1.7-2 In all cases involving emergency admissions, the attending physician must be able to demonstrate to the Medical Staff Executive Committee and hospital's Chief Executive Officer that the admission was due to a bona fide emergency. The history and physical examination report must clearly justify the emergency admission.

1.7-3 Patients who require emergency admission through the Emergency Department and do not have an attending physician shall be assigned an attending physician in accordance with the Department Call Policy or shall be assigned to the Hospitalist Service .

1.7-4 If a physician on limited suspension due to medical record delinquencies must admit a patient in an emergent situation because the patient could not be admitted or cared for by another physician with appropriate clinical privileges then the physician on suspension must follow the procedures as identified in the current Medical Staff Policy on Medical Record Delinquency and Suspension.

1.8 Admission to the Intensive Care Unit

1.8-1 Questions regarding the discharge or admission of a patient to the Intensive Care Unit shall be resolved by the attending physician consulting with the Intensive Care Unit Director and, when necessary, the Chief of Staff or Chief Medical Officer.

1.8-2 All patients admitted to the Critical Care Unit- shall be seen and evaluated by the attending physician either immediately, prior to or within four (4) hours of admission.

1.8-3 When questions arise regarding the appropriateness of an admission to the ICU, the ICU Director shall, in conjunction with the nursing unit manager or supervisor, assess the appropriateness of the admission.

1. 9 Admission to the SVH Skilled Nursing Facility

1.9-1 Questions regarding the discharge or admission of a patient to the SVH Skilled Nursing Facility shall be resolved by the attending physician consulting with the SVH Skilled Nursing Facility Director and when necessary the Chief of Staff or Chief Medical Officer.

1.9-2 All patients admitted to skilled nursing beds within the SVH Skilled Nursing Facility must have a written report of a physical examination completed within five (5) days prior to admission, or within 72 hours following admission. Further, all SNF skilled nursing patients must be seen within 72 hours of admission and at least monthly thereafter, unless the patient's condition warrants more frequent encounters.

1.9-3 All patients admitted to subacute beds within the SVH Skilled Nursing Facility must have a written report of a physical examination completed within five (5) days prior to admission, or within 72 hours following admission. Further, all SNF subacute patients must be seen within 72 hours of admission and at least twice weekly during the first month after admission and a minimum of at least once weekly thereafter.

1.10 Priority of Admissions and Transfers to the Acute Care

1.10-1 When the hospital's Chief Executive Officer or administrator on call, after consulting with the Chief of Staff, determines that bed space is not available, he or she may limit admissions to emergency cases. In such an event, patients will be admitted using the following order of priority:

A. First Priority - Emergency Admissions. Patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four (4) hours.

B. Second Priority - Urgent Admissions. Patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within twenty-four (24) hours.

C. Third Priority - Preoperative Admissions. Patients who are already scheduled for surgery.

D. Fourth Priority - Routine Admissions. Patients who will be admitted on an elective basis to any service.

1.10-2 Transfer Priorities. Priority shall be given for the transfer of patients in the following order:

A. Emergency Department to an appropriate bed.

B. Critical Care Unit to a telemetry or general care area.

C. Temporary placement in an inappropriate area for that patient to an appropriate area.

1.10-3 The Chief of Staff, or appropriate department or section chairperson, shall be consulted to help prioritize admissions and transfers. In-house transfers and transfers to other facilities will follow the Hospital Transfer Policy.

RULE 2
CONSENTS

2.1 General

2.1-1 Patients have the right to participate actively in decisions regarding their medical care and to decide whether to authorize or refuse procedures recommended by their physicians. Physicians must give patients the information they need to make their decisions. Accordingly, complex diagnostic and therapeutic procedures may be performed only when the patient, or his or her surrogate decision maker, has been given information about the procedure and has given informed consent.

2.1-2 Complex procedures include all operations and invasive procedures, blood transfusions, and other procedures as identified in the CAHSS manual as being complex. Blood draws and IV punctures for venous access are not considered complex procedures.

2.1-3 Informed consent shall be obtained and documented in writing by the attending practitioner or designee for all operations and other complex medical or surgical procedures. Nursing staff may not be designated to obtain Informed Consent.

2.2 Informed Consent Defined

2.2-1 Informed consent is a process whereby the patient, or his or her surrogate decision maker, is given information which will enable him or her to reach a meaningful, informed decision regarding whether to give consent for the complex treatment or procedure which is proposed.

2.2-2 The information that must be provided includes a description of:

A. The nature of the recommended treatment.

B. Its expected benefits or effects.

C. The associated risks and possible complications.

D. Any alternative procedures and their expected benefits or effects and associated risks and possible complications.

E. Any independent economic interests a physician may have which may influence his or her treatment recommendations.

F. Risks of not performing the procedure.

2.3 Who May Give Consent. Informed consent must be secured from patients who have the capacity to give such consent. Any patient adjudicated incompetent by the court or in the physician's opinion lacks capacity by reason of psychiatric or medical condition then consent must be secured from a surrogate decision-maker. A surrogate decision-maker may include parents or guardians of minors who may not consent, conservators, attorneys-in-fact, the patient's closest available relatives, or the court. Persons who may give consent are identified in the CAHHS Consent Manual.

2.4 Responsibility for Securing Informed Consent

2.4-1 The patient's attending physician generally is responsible for giving the patient, or his or her surrogate decision maker, the requisite information and securing informed consent.

2.4-2 Physicians other than the patient's attending physician have a duty to secure consent, when they will provide specialized services involving complex treatments or procedures at the request of or together with the patient's attending physician.

2.5 Verification of Informed Consent for Medical and Surgical Procedures

Hospital personnel shall verify that informed consent has been obtained from the patient by asking the patient to complete the General Authorization for and Consent to Surgery or Special Therapeutic or Diagnostic Procedures form.

2.6 Emergencies

2.6-1 An emergency situation occurs when treatment is immediately necessary to prevent the patient's death, severe impairment or deterioration, or to alleviate severe pain. Consent is implied in an emergency situation if there is insufficient time to obtain consent from the patient or his or her surrogate decision-maker.

2.6-2 The emergency situation exception applies only to the treatment which is immediately necessary and for which consent cannot be secured.

2.6-3 Consent shall be secured for all further, non-emergency treatment that may be necessary.

2.7 Particular Legal Requirements

2.7-1 Special consents must be obtained as required by law. Special consents shall be obtained for blood transfusions, HIV blood tests, elective sterilization procedures, hysterectomies, use of investigational drugs or devices, participation in human experimentation, reuse of hemodialysis filters, treatment for breast and prostate cancer, use of psychotropic medications and involuntary commitment for psychiatric disorders. Special consent must be secured by the attending physician in the manner specified in the law applicable to these particular procedures. When appropriate, hospital personnel shall verify that appropriate consent has been obtained. The laws related to special consents are described in the CAHHS Consent Manual

2.7-2 The attending physician, or designee, shall assure that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

2.7-3 Prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth shall inform the patient about the use of telehealth and obtain verbal or written consent from the patient for the use of telehealth as an acceptable mode of delivering health care services and public health. The consent shall be documented.

2.8 Physician Documentation of Informed Consent

2.8-1 The physicians involved in securing informed consent shall document in the patient's medical record, their discussions regarding the proposed procedure and whether they secured informed consent.

2.8-2 The physician's documentation related to an emergency situation shall be entered in a progress note and must describe:

A. The nature of the emergency.

B. The reasons consent could not be secured from the patient or a surrogate decision maker.

C. The probable result if treatment would have been delayed or not provided.

2.9 Hospital Staff Role in Providing Information

2.9-1 Hospital personnel may not provide patients or surrogate decision-makers with medical information regarding any proposed procedure except as noted in Section 3.8.3 above. If a patient or surrogate decision-maker expresses doubt or confusion about a procedure, the patient's attending physician or the physician who is responsible for securing consent shall be contacted and asked to provide the necessary information.

2.9-2 If the physician responsible for securing consent is not available, hospital personnel shall determine whether the patient's doubt or confusion warrants delaying the procedure until the physician is available to respond to the questions and concerns.

2.9-3 Hospital personnel are responsible for verifying that informed consent and other consents as may be required by law have been obtained. This verification will be done for all operations and other complex procedures for both inpatients and outpatients. Informed consent will be verified by asking the patient if they have given informed consent to their attending physician and asking the patient or surrogate decision maker to sign the hospital's general consent form.

2.10 Consent by Telephone

2.10-1 Consent by telephone may be acceptable in certain situations. The Risk Manager should be contacted if there is a question about using the phone to discuss the case and secure consent.

2.10-2 When the telephone is used to obtain consent from a surrogate decision-maker, the information normally given to secure informed consent must be given. Thus, the condition of the patient and the proposed medical and/or surgical treatment must be explained. Only the physician, or his or her designee, should answer inquiries concerning the procedures.

2.10-3 When consent is obtained by telephone, hospital personnel should join the conversation to listen and act as a witness. All persons joining the call must be informed that hospital personnel would be listening to the discussion.

2.10-4 The physician shall note the exact time, nature and any limitations of the consent in the medical record. The witness shall countersign and date this note or document the event on an appropriate consent form.

2.10-5 The physician should instruct the surrogate decision-maker immediately to send a facsimile, telegram or letter confirming the telephone consent. If possible, a copy of the consent form should be sent and returned (signed) by facsimile. At a minimum, the written documentation should name the person giving the consent, describe his or her relationship to the patient and confirm that consent was given for treatment. The facsimile, telegram or letter should be placed in the medical record.

RULE 3
REFUSAL OF TREATMENT

3.1 A patient or the patient's surrogate decision-maker has the right to refuse treatment. If the patient is a minor who is not legally authorized to consent to treatment and his or her parent or guardian refuses consent, it may be desirable and possible to secure court authorization.

3.2 If a patient or the patient's surrogate decision-maker refuses treatment, the attending physician shall be contacted immediately who shall explain the reason for the treatment and the possible ill effects of refusal. The attending physician shall enter a brief note in the patient's medical record regarding the initial refusal and whether the outcome was consent or continued refusal.

3.3 The Refusal of Treatment form should be presented to the patient or the surrogate decision-maker for signature. If the patient or the surrogate decision-maker refuses to sign, the notation "refuses to sign" shall be made at the place for the signature.

3.4 If treatment is ultimately refused, an Incident Report shall be completed and forwarded to the hospital Risk Manager.

RULE 4
CONSULTATIONS

4.1 Responsibility

4.1-1 The good conduct of medical practice includes proper and timely use of consultation. Judgment as to the seriousness of the illness and the resolution of any doubt regarding the diagnosis or treatment rests with the physician responsible for the care of the patient. The organized Medical Staff, through its Department Chairpersons and the Medical Staff Executive Committee, has oversight responsibility for assuring that consultants are called as needed.

4.1-2 Any qualified physician with clinical privileges in this hospital can be called for consultation within his or her area of expertise and within the limits of clinical privileges that have been granted to him or her.

4.1-3 An attending physician's responsibility for his or her patient does not end with a request for consultation and the attending physician remains in charge of his or her patients care unless a transfer of patient care to a different attending physician has occurred as described in these Rules and Regulations.

4.1-4 The consultation and specific diagnostic and therapeutic procedures will be done at the hospital unless specific diagnostic or therapeutic facilities are not provided within confines of the hospital. Any outside clinical sources used for inpatients must be approved by the Medical Staff and must meet appropriate accreditation standards.

4.2 Request for Consultations. Requests for consultation must be made by direct personal communication from the attending physician to the consulting physician. Hospital nurses or other hospital staff are not to be used as intermediaries. The attending physician must document the consultation request.

4.3 Recommended Consultations. Except in an emergency, consultation is recommended in the following instances:

4.3-1 Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

4.3-2 Where there is doubt as to the choice of therapeutic measures to be used.

4.3-3 In unusually complicated situations where specific skills of other Physicians may be needed.

4.3-4 In instances where the patient exhibits severe psychiatric symptoms.

4.3-5 When pelvic surgery is contemplated in the presence of a confirmed pregnancy.

4.3-6 When requested by the patient or a surrogate decision-maker.

4.4 Required Consultations

4.4-1 A consultation is required when the Department Chairperson, Chief Medical Officer, or Chief of Staff determines that a patient will benefit from such consultation. Such consultation shall be required only after the Department Chairperson or Chief of Staff has discussed the situation with the patient's attending physician.

4.4-2 If a nurse has any reason to doubt or question the care provided any patient or believes that consultation is needed and has not been obtained, he or she may call this matter to their nursing supervisor who may in turn refer the concern to the appropriate Department Chairperson, Chief Medical Officer, or Chief of Staff. If it is deemed appropriate, a consultation may be required after conferring with the patient's attending physician.

4.4-3 A Medical Staff member may be required by the Medical Executive Committee to have consultations on all or some of his or her cases. In such situations, the Medical Staff member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultation.

4.4-4 Surgeons are required to consider contacting a Hospitalist or Internist with admitting privileges for all perioperative patients with an ASA beyond category 2.

4.4-5 Surgeons are required to contact a Hospitalist or Internist with ICU admitting privileges for all patients that are admitted to the ICU.

4.4-6 Surgeons are required to contact a Hospitalist or Internist with admitting privileges for all perioperative patients undergoing total joint replacement.

4.5 Performance of and Reporting of Consultations

4.5-1 A satisfactory consultation includes examination of the patient and the medical record. The attending physician is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation.

4.5-2 The written or dictated consultant reports must contain at least the following elements:

A. Review of history and medical record;

B. Summary of physical findings;

C. Diagnostic impression; and

D. Recommendations for treatment.

4.5-3 A written opinion signed by the consultant must be included in the patient's medical record immediately after the consultation has been performed. A limited statement, such as "I concur", is not sufficient. When operative procedures are involved, consultations performed before surgery shall be reported before the operation, except in emergency cases. Consultation reports shall be prepared in accordance with the Medical Records section of these Rules and Regulations.

RULE 5
COVERAGE

5.1 Each physician shall personally provide or otherwise arrange for continuous care and coverage for each of his or her patients who present to the hospital for clinical care or who are currently hospital inpatients. If a physician is unable to provide care for his or her patients, then the physician must provide coverage through another appropriately credentialed physician. The covering physician must be available and qualified to assume responsibility for the patients during the attending physician's absence and must be aware of the status and condition of any hospital inpatient that he or she is to cover. Failure to arrange appropriate coverage shall be grounds for corrective action.

5.2 In the event the attending physician or the attending physician's alternate is not available to address an issue regarding a hospital inpatient, the Department Chairperson, Chief of Staff, or Chief Medical Officer shall be contacted, and assume responsibility for caring for the patient or appoint an appropriate Medical Staff member who will assume responsibility until the attending physician can be reached.

5.3 If a physician's patient presents to the emergency room for care, it is expected that the physician or designee will be available for consultation and to admit his or her patient to the hospital if clinically indicated. It is not acceptable to refer such patients to the ED backup physician unless the ED backup physician has agreed to assume this responsibility in advance.

5.4 It is expected that a physician on call will respond to pages and on-site requests for medical staff evaluation and/or stabilizing treatment within 30 minutes.

RULE 6

EMERGENCY DEPARTMENT (E.D. CALL PANEL)

6.1 E.D. Call Panel List

6.1-1 The E.D. Call Panel has been established for referring unassigned patients who require ED consultation, hospital admission, or outpatient follow-up.

6.1-2 The Hospital Administration is responsible for working with the Medical Staff and the Medical Director of the Emergency Department to ensure that appropriate E.D. call coverage is available and a written E.D. call panel list is developed.

6.1-3 At the recommendation of the Department Chairperson and with the approval of the Medical Staff Executive Committee members of the Provisional Staff category may be assigned to the E.D. Call Panel.

6.2 Conduct of E.D. Call Panel Member

6.2-1 A panelist who is unable to provide panel coverage during his or her scheduled time must notify the Medical Staff Office at least 24 hours in advance coverage by an appropriately credentialed physician who meets the criteria for panel eligibility.

6.2-2 All E.D. on-call physicians shall comply with all current Medical Staff Emergency Medical Treatment and Active Labor Act (EMTALA) policies and procedures.

RULE 7
CATEGORIES OF MEMBERSHIP

7.1 Categories

The medical staff shall consist of the following categories. The category descriptions and rules applicable to each staff category are set forth in the Bylaws Article 3

Associate Staff

Active Staff

Affiliate Staff

Courtesy Staff

Consulting Staff

Locum Tenens Staff

Telemedicine Staff

Honorary Staff

7.2 Qualifications Generally

Each practitioner who seeks or enjoys staff appointment must continuously satisfy the basic qualifications for membership set forth in the Bylaws and Rules, except those that are specifically waived for a particular category, and the additional qualifications that attach to the staff category to which he or she is assigned. The District Board may, after considering the Medical Executive Committee's recommendations, waive any qualification in accordance with Section 2.2-4 of the Bylaws.

RULE 8
APPOINTMENT AND REAPPOINTMENT

8.1 Overview of Process

The overview of the process for appointment and reappointment may be found in the Bylaws, 4.2.

8.2 Application

8.2-1 Each practitioner who expresses formal interest in a recognized and appropriate category of membership and privileges shall be provided an application form for medical staff membership. Upon completion by the practitioner, the form shall be returned to the medical staff office together with the nonrefundable application fee required by the rules.

8.2-2 The application form shall be approved by the Medical Executive Committee and the District Board and, once approved, shall be considered part of these rules. The application shall include an agreement to abide by the medical staff and hospital bylaws, rules and applicable policies. The application shall request information pertinent to the applicant's qualifications, such as (but not limited to) information regarding the applicant's education, specialty training, professional affiliations, proffered references, relevant health status, as well as information regarding possible involvement in professional liability actions (including but not limited to all final judgments or settlements involving the applicant); previously completed or currently pending challenges involving professional licensure, certification or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification or registration; voluntary or involuntary termination, limitation, reduction or loss of medical staff or medical group membership and/or clinical privileges at any other hospital or health facility or entity; any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and information detailing any prior or pending government agency or third party payor investigation, proceeding or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including but not limited to Medicare or Medi-Cal fraud and abuse proceedings or convictions. The application shall also release all persons and entities from any liability that might arise from their investigating and/or acting on the application. Additionally, the practitioner shall provide the names and addresses of professional peers who are able to attest to the practitioner's relevant qualifications.

8.3 Physical and Mental Capabilities

8.3-1 Obtaining Information

a. The application shall request information pertaining to the condition of the applicant's via attestation physical and mental health.

b. When the medical staff office verifies information and obtains references, it shall ask for any information concerning physical or mental disabilities to be reported.

c. The Medical Executive Committee shall be responsible for verifying the mental or physical condition of any practitioner who has or may have a physical or mental disability that might affect the practitioner's ability to exercise his or her requested privileges in a manner that meets the hospital and medical staff's quality of care standards. This may include one or all of the following:

1) **Medical Examination:** To ascertain whether the practitioner has a physical or mental disability that might interfere with his or her ability to provide care which meets the hospital and medical staff's quality of care standards.

2) **Interview:** To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.

d. Any practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Medical Executive Committee and Well-Being Committee. Any such disclosure will be treated with the high degree of confidentiality that attaches to the medical staff's peer review activities.

8.3-2 Review and Reasonable Accommodations

a. Any practitioner who discloses or manifests a qualified physical or mental disability will have his or her application processed in the usual manner..

b. The Well-Being Committee shall not disclose any information regarding any practitioner's qualified physical or mental disability until the Medical Executive Committee (or, in the case of temporary privileges, the medical staff representatives who review temporary privilege requests) have determined that the practitioner is otherwise qualified for membership and/or to exercise the privileges requested. Once the determination is made that the practitioner is otherwise qualified, the Well-Being Committee shall disclose information it has regarding any physical or mental disabilities and the effect of those on the practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Committee to evaluate: i what, if any, accommodations may be necessary and feasible and ii any concerns the committee has regarding the potential for the practitioner to render unsafe treatment. The Well-Being Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

c. As required by law, the medical staff and hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities, if the practitioner is otherwise qualified and can perform the essential functions of the staff appointment and privileges in a manner which meets the hospital and medical staff quality of care standards. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in Article 13, Hearings and Appellate Reviews, of the Bylaws.

8.4 Effect of Application

By applying for or by accepting appointment or reappointment to the medical staff, the applicant:

8.4-1 Signifies his or her willingness to appear for interviews in regard to his or her application for appointment.

8.4-2 Authorizes medical staff and hospital representatives to consult with other hospitals, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

8.4-3 Consents to the inspection and copying, by hospital representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

8.4-4 Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Department Committee, Medical Executive Committee, and the chief executive officer.

8.4-5 Releases from any and all liability the medical staff and the hospital and its representatives for their acts performed in connection with evaluating the applicant.

8.4-6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to hospital representatives.

8.4-7 Authorizes and consents to hospital representatives providing other hospitals, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the hospital may have concerning him or her, and releases the hospital and hospital representatives from liability for so doing.

8.4-8 Consents to undergo and to release the results of a physical or mental health examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

8.4-9 Signifies his or her willingness to abide by all the conditions of membership, as stated on the appointment application form, on the reappointment application form, and in the bylaws and these rules.

8.4-10 For purposes of this Rule 8.3, the term "hospital representative" includes the District Board, its individual Directors/Trustees and committee members; the chief executive officer, all medical staff, department and section officers and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

8.4-11 Signifies his or her willingness to comply with all administrative and medical staff initiatives to continuously improve the quality and safety of health care including,

but not limited to, The CIHQ Core Measures, CMS mandated quality outcomes measures, and other payer or regulator sponsored initiatives.

8.5 Verification of Information

d. The applicant shall fill out and deliver an application form to the medical staff office, which shall seek to verify the information submitted. The application will be deemed complete when all necessary verifications have been obtained, including current license (verified by primary source, the Medical Board of California), licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank query results, Drug Enforcement Administration certificate, if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance, applicant's attestation of mental and physical capability to exercise all privileges requested, and favorable peer reference letters. Additionally, the Medical Staff office may seek information from other relevant sources, such as the American Medical Association's Physician Masterfile (for verification of a physician's medical school graduation and residency completion), the American Board of Medical Specialties (for verification of a physician's board certification), the Educational Commission for Foreign Medical Graduates (for verification of a physician's graduation from a foreign medical school), the American Osteopathic Association Physician Database (for pre- and post-doctoral education), and the Federation of State Medical Boards Physician Disciplinary Data Bank (for all actions against a physician's medical license). Background checks will be performed on all initial applicants. The Medical Staff office shall then transmit the application and all supporting materials to the chair of each department in which the applicant seeks privileges.

8.6 Incomplete Application

8.6-1 If the Medical Staff office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise significantly incomplete, the medical staff office may delay further processing of the application, or may begin processing the application based only on the available information with a decision that further information may be considered upon receipt.

8.6-2 If the processing of the application is delayed for more than 60 days and if the missing information is reasonably deemed significant to a fair determination of the applicant's qualifications, the affected practitioner shall be so informed. He or she shall then be given the opportunity to withdraw his or her application, or to request the continued processing of his or her application. If the applicant does not respond within 30 days, he or she shall be deemed to have voluntarily withdrawn his or her application. If the applicant requests further processing, but then fails to provide or arrange for the provision within 45 days or any other date mutually agreed to when the extension was granted (whichever is later) of the necessary information that the practitioner could obtain using reasonable diligence, the practitioner shall be deemed to have voluntarily withdrawn his or her application.

8.6-3 Any application deemed incomplete and withdrawn under this rule may, thereafter, be reconsidered only if all requested information is submitted, and all other information has been updated.

8.7 Action on the Application

8.7-1 Department Action

Upon receipt, the Department Chair shall review the application and supporting documentation with consideration of the applicant's qualifications for Medical Staff membership and the clinical privileges requested. If deemed appropriate, he/she may select additional members of the department to review and/or have the file reviewed at the department meeting. At the discretion of the Chair, designated members of the department may personally interview the applicant. Recommendations as to staff appointment and clinical privileges shall be transmitted to the Medical Executive Committee.

8.7-2 Medical Executive Committee Action

a. At its next regular meeting the Medical Executive Committee shall consider all relevant information available to it, including the department recommendations. The Medical Executive Committee shall then formulate a recommendation. The Medical Executive Committee shall forward their recommendations to the District Board, as follows:

1) **Favorable Recommendation:** Favorable recommendations shall be promptly forwarded to the District Board.

2) **Adverse Recommendation:** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the practitioner by special notice, and he or she shall be entitled to such procedural rights as may be provided in Bylaws Article 13, Hearings and Appellate Reviews. The District Board shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse recommendation until the applicant has

exhausted or waived his or her procedural rights.

(For the purposes of this section, an adverse recommendation by the Medical Executive Committee is as defined in Bylaws Section 13.2.)

3) **Deferral:** The Department or Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and privileges, or for rejection for staff membership.

8.7-3 District Board Action

a. **On Favorable Medical Executive Committee Recommendation:** The District Board shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the District Board's action is a ground for a hearing under the Bylaws, Section 13.2, the chief executive officer shall promptly inform the applicant by special notice, and he or she shall be entitled to the procedural rights as provided in the Bylaws Article 13, Hearings and Appellate Reviews.

b. **Without Benefit of Medical Executive Committee Recommendation:** If the District Board does not receive a Medical Executive Committee recommendation within the time specified in Rule 8.7-5 below, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the District Board. If the recommendation is a ground for a hearing under the Bylaws, Section 13.2, the chief executive officer shall give the applicant special notice of the tentative adverse recommendation and of the applicant's right to request a hearing. The applicant shall be entitled to the Bylaws Article 13, Hearings and Appellate Reviews, procedural rights before any final adverse action is taken.

c. **After Procedural Rights:** In the case of an adverse Medical Executive Committee recommendation pursuant to Rule 8.7-2a or an adverse District Board decision pursuant to Rule 8.7-3a and 8.7-3b., the District Board shall take final action in the matter only after the applicant has exhausted or has waived his or her Bylaws Article 13, Hearings and Appellate Reviews, procedural rights. Action thus taken shall be the conclusive decision of the District Board, except that the District Board may defer final determination by referring the matter back for reconsideration. Any such referral shall state the reasons therefore, shall set a reasonable time limit within which reply to the District Board shall be made, and may include a directive that additional hearings be conducted to clarify issues which are in doubt. After receiving the new recommendation and any new evidence, the District Board shall make a final decision.

d. **Expedited Review:** The District Board may use an expedited process for appointment, reappointment or when granting Privileges when criteria for that process are met, as further described in the Bylaws, 4.5-4. If the available information is inconsistent or casts any reasonable doubts on the applicant's qualifications, the expedited review process may not be used.

8.7-4 Notice of Final Decision

A decision and notice to appoint shall include:

a. The staff category to which the applicant is appointed;

b. The department and section, if any, to which the practitioner is assigned;

c. The clinical privileges the practitioner may exercise; and

d. Any special conditions attached to the appointment.

If the decision is adverse, the notice to the applicant shall be by special notice, as further described at Section 13.-3-1 of the Bylaws.

8.7-5 Guidelines for Time of Processing

All individuals and groups shall act on applications in a timely and good faith manner. Except when additional information must be secured, or for other good cause, each application should be processed within the following time guidelines:

REVIEWER	TIME FRAMES FOR REVIEW
Medical Staff Office	45 DAYS after all necessary documentation is received
Department Chair	45 DAYS after receiving application from medical staff office
Medical Executive Committee	45 DAYS after receiving application from the Department
District Board	45 DAYS after receiving application from the Medical Executive Committee, except when the hearing and appeal rights of Bylaws Article 13, Hearings and Appellate Reviews, apply

These time periods are guidelines and are not directives which create any rights for a practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Chief Executive Officer.

8.8 Duration of Appointment

8.8-1 All new staff members shall be appointed to the Associate staff and subjected to a period of formal observation and review, except for those appointed to the Locum Tenens Affiliate or Consulting Staff. Provisional appointments are for not more than twelve months.

8.8-2 Reappointments to any staff category other than Associate shall be for a maximum period of two years, and shall be staggered throughout the year so as to enable thorough review of each member. Changes in staff category may be requested at any time during the reappointment period after requirements of provisional status are met.

8.9 Reappointment Process

8.9-1 Schedule for Reappointment

At least 120 days prior to the expiration date of each staff member's term of appointment, the medical staff office (or by way of CVO) shall provide the member with a reappointment application. Completed reappointment applications shall be returned to the medical staff office or CVO at least 90 days prior to the provider's appointment expiration date. Failure to return the completed application shall result in automatic suspension or resignation as described in Rule 8.9-8.

8.9-2 Content of Reappointment Application

a. The reappointment application form shall be approved by the Medical Executive Committee and the District Board and, once approved, shall be considered part of these rules. The form shall seek information concerning the changes in the member's qualifications since his or her last review. Specifically, the form shall request an update of all of the information and certifications requested in the appointment application form, as described in Rule 8.2-2, with the exception of that information which cannot change over time, such as information regarding the member's premedical and medical education, date of birth, and so forth. The form shall also require information as to whether the member requests any change in his or her staff status and/or in his or her clinical privileges, including any reduction, deletion or additional privileges. Requests for additional privileges must be supported by the type and nature of evidence which would be necessary for such privileges to be granted in an initial application.

b. If the staff member's level of clinical activity at this hospital is not sufficient to permit the staff and board to evaluate his or her competence to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the staff may require and the Medical Staff Office shall obtain at least two (2) peer references which shall be made part of the provider's reapplication and evaluated by the medical staff

8.9-3 Verification and Collection of Information

The medical staff shall, in timely fashion, seek to verify all of the information made available on each reappointment application (as per Rule 8.5), and to collect any other materials or information deemed pertinent by the Medical Executive Committee or Department. The information shall address, without limitation:

a. Reasonable evidence of current ability to perform privileges that may be requested, including but not limited to consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

b. Participation in relevant continuing education activities.

c. Level/amount of clinical activity (patient care contacts) at the hospital.

d. Sanctions imposed or pending, including but not limited to previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

e. Health status including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected practitioner and staff, when requested by the department chair or Medical Executive Committee and subject to the standards set forth in Rule 8.3 pertaining to physical and mental capabilities.

f. Attendance at required medical staff, department and committee meetings.

g. Participation as a staff officer and committee member/chair.

h. Timely and accurate completion and preparation of medical records.

i. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel and patients.

j. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

k. Compliance with all applicable medical staff and district bylaws, rules, and policies.

l. Compliance with all applicable medical staff quality performance measurements (ie: TB compliance, Core Measures, UR, Medication Errors).

m. Payment of current medical staff dues.

n. Any other pertinent information including the staff member's activities at other hospitals and his or her medical practice outside the hospital.

o. Information concerning the member from the state licensing board and the federal National Practitioner Data Bank.

p. Information from other relevant sources, such as but not limited to the Federation of State Medical Boards Physician Disciplinary Data Bank.

q. Areas of general competency: Patient Care, Medical / Clinical Knowledge, Practice Based Learning and Improvement, Interpersonal and Communication Skills, Professionalism, and Systems-Based Practice. These competencies are addressed at reappointment by the Department Chair or his/her designee.

8.9-4 Department Action

The department chair shall review the application and all other relevant available information. The chair may confer with the department committee or the whole department, if there is no department committee. He or she shall transmit to the Medical Executive Committee his or her recommendations.

8.9-5 Medical Executive Committee Action

a. The Medical Executive Committee shall review the department chair's recommendations and all other relevant information available to it and shall forward to the District Board its favorable recommendations, which are prepared in accordance with Rule 8.7-2.

b. When the Medical Executive Committee recommends adverse action, as defined in the Bylaws, Section 13.2, either with respect to reappointment or clinical privileges, the Chief of Staff shall give the member special notice of the adverse recommendation and of the member's right to request a hearing in the manner specified in Section 13.3. The member shall be entitled to the Article 13, Hearings and Appellate Reviews, procedural rights. The District Board shall be informed of, but not take action on, the pending recommendation until the member has exhausted or waived his or her procedural rights.

c. Thereafter, the procedures specified for members in Rule 8.7-3 (District Board action), Rule 8.7-4 (Notice of Final Decision) and in the Bylaws, Section 4.7 (Waiting Period After Adverse Action), shall be followed. The committee may also defer action; however, any deferral must be followed up within 70 days with a recommendation.

8.9-6 Reappointment Recommendations

Reappointment recommendations shall specify whether the member's appointment should be renewed; renewed with modified membership category, department affiliation and/or clinical privileges; or terminated. The reason for any adverse recommendation shall be described. The medical staff may require additional proctoring of any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

8.9-7 No Extension of Appointment

There are no extensions of appointments. Reappointment is required for each practitioner at least every 24 months.

8.9-8 Failure to File Reappointment Application

If an application for reappointment is not submitted in a timely manner and cannot be completed as required before the appointment expires, the member shall be deemed to have resigned his or her membership in the medical staff, effective the date his or her appointment expires. Members who automatically resign under this rule will be processed as new applicants should they wish to reapply.

8.9-9 Relinquishment of Privileges

A staff member who wishes to relinquish or limit particular privileges (other than privileges necessary to fulfill Emergency Room call responsibilities) shall send written notice to the Chief of Staff and the appropriate department chair identifying the particular privileges to be relinquished or limited. A copy of this notice shall be forwarded to the medical staff office for inclusion in the member's credentials file.

RULE 9
COMMITTEES

9.1 Committees

The medical staff hereby establishes the following committees. The rules applicable to each committee are set forth in the corresponding appendix.

Committee	Appendix
Medicine Department Committee	9A
Surgery Department Committee	9B
Anesthesia Department Committee	9C
Performance Improvement Committee	9D
Bioethics Committee	9E
Bylaws Committee	9F
Institutional Review Board	9G
Peer Review Committee	9H
Interdisciplinary Practice Committee	9I
Well-Being Committee	9J

Appendix 9A
MEDICINE DEPARTMENT COMMITTEE

1. Composition

   The Medicine department shall have a committee consisting of at least three active staff members.

2. Duties

   The Medicine department committee shall assist the department chair to carry out the responsibilities assigned to the department chair, including the duties to recommend professional criteria for clinical privileges within the department, review applicants for appointment, reappointment, and clinical privileges, and to fulfill the responsibility for peer review. The Medicine department committee shall also fulfill the medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, monitoring of departures from established clinical patterns, patients' and families' education, coordination of care, and medical records and functions otherwise assigned to the Performance Improvement Committee.

3. Meetings

   The Medicine department committee shall meet as often as necessary, but at least quarterly.

Appendix 9B
SURGERY DEPARTMENT COMMITTEE

1. Composition

   The Surgery department shall have a committee consisting of at least three active staff members.

2. Duties

   The Surgery department committee shall assist the department chair to carry out the responsibilities assigned to the department chair, including the duties to recommend professional criteria for clinical privileges within the department, review applicants for appointment, reappointment, and clinical privileges, and to fulfill the responsibility for peer review. The Surgery department committee shall also fulfill the medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, monitoring of departures from established clinical patterns, patients' and families' education, coordination of care, and medical records and functions otherwise assigned to the Performance Improvement Committee.

3. Meetings

   The Surgery department committee shall meet as often as necessary, but at least quarterly.

Appendix 9C
ANESTHESIA DEPARTMENT COMMITTEE

1. Composition

   The Anesthesia department shall have a committee consisting of at least three active staff members.

2. Duties

   The Anesthesia department committee shall assist the department chair to carry out the responsibilities assigned to the department chair, including the duties to recommend professional criteria for clinical privileges within the department, review applicants for appointment, reappointment, and clinical privileges, and to fulfill the responsibility for peer review. The Anesthesia department committee shall also fulfill the medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, monitoring of departures from established clinical patterns, patients' and families' education, coordination of care, and medical records and functions otherwise assigned to the Performance Improvement Committee.

3. Meetings

   The Anesthesia department committee shall meet as often as necessary, but at least quarterly.

Appendix 9D
PERFORMANCE IMPROVEMENT COMMITTEE

1. Composition

The Performance Improvement Committee shall consist of the Vice-Chief of Staff, department chairs (or designees), Chief Medical Officer, Administrative Representative, Infection Control Coordinator, Utilization Review, Laboratory Director, Pharmacy Director, QA Director, Radiology Representative, Nursing Representative, Home Health Manager, Medical Records Manager, Risk Manager, and additional members of the medical staff as deemed necessary. The chair shall be the Vice-Chief of Staff. The Chief Medical Officer will be an ex-officio member.

2. Duties

The Performance Improvement Committee shall be responsible to provide leadership in measuring, assessing and improving: medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, monitoring of significant departures from established clinical patterns, patients' and families' education, coordination of care with other practitioners and hospital personnel, and the accurate, timely, and legible completion of patients' medical records. Subcommittees that report to the Performance Improvement Committee may be appointed, using the procedure described in the Medical Staff Bylaws, when necessary to carry out these functions.

a. Quality Improvement

1) Develop, review annually and revise as needed, a quality improvement plan that is appropriate for the hospital and Medical Staff and that meets The CIHQ and regulatory requirements. This shall specifically include, but is not limited to, providing leadership in measuring, assessing and improving: medical assessment and treatment, use of medications, use of blood and blood components, operative and use of information about adverse privileging decisions for any practitioner privileged through the Medical Staff process, other procedures, appropriateness of clinical practice patterns, significant departures from established clinical pattern, and the use of developed criteria for autopsies. The quality improvement plan may also include mechanisms for:

i) Establishing objective criteria;

ii) Measuring actual practice against the criteria;

iii) Analyzing practice variations from criteria by peers;

iv) Taking appropriate action to correct identified problems;

v) Following up on action taken; and

vi) Reporting the findings and results of the audit activity to the Medical Staff, the Chief Executive Officer and the District Board.

2) Utilize at least sentinel event data and patient safety data in measuring and assessing performance improvement.

3) Review and act upon, on a regular basis, factors affecting the quality, appropriateness and efficiency of patient care provided in the hospital, including review of surgical and other invasive procedures, mortality, use of medications, including antibiotics, blood and blood components usage, admissions and continued hospitalization, and fulfillment of consultation requirements.

4) Coordinate the findings and results of department committee, and staff patient care review activities, utilization review activities, continuing education activities, reviews of medical record completeness, timeliness, and clinical pertinence; and other staff activities designed to monitor patient care practices.

5) Submit monthly reports to the Medical Executive Committee on the overall quality, appropriateness and efficiency of medical care provided in the hospital, and on the department, committee, and staff patient care review, utilization review and other quality review, evaluation and monitoring activities.

6) On at least an annual basis, evaluate the coordination of patient care and formulate policy recommendations for dietary services, equipment standardization, home health, physical therapy and social services.

7) At least once a year, evaluate and revise as needed the hospital-wide quality improvement program to assess the effectiveness of the monitoring and evaluation activities and to recommend improvement.

b. Operative/Invasive Procedures

Regularly review the surgery department's review of surgical cases, including those in which a tissue specimen was not removed. Surgical cases must be reviewed except that when surgical case review consistently supports the justification and appropriateness of surgical procedures performed by individual practitioners, an adequate sample of cases may be reviewed. The review should address: (i) selecting appropriate procedures; (ii) preparing the patient for the procedure; (iii) performing the procedure and monitoring the patient; and (iv) providing post-procedure care.

c. Death and Tissue Review

Review all deaths and review all removed tissue when the tissue is found to be normal or not consistent with the clinical diagnosis, and develop and implement measures to correct any problems discovered.

d. Medication Administration and Usage Duties

Develop, implement and monitor professional policies regarding evaluation, selection and procurement of drugs comprising the hospital formulary; preparing and dispensing medications; distribution, administration, safety, and effect (including reactions and interactions) of drug usage; patient education; and other matters pertinent to drug use in the hospital.

e. Blood and Blood Components Usage Review Duties

1) Provide for at least a quarterly review of blood usage. This includes evaluating all or a sample of cases involving transfusion; all confirmed transfusion reactions; the adequacy of transfusion services in meeting patient needs; ordering practices; distributing, handling and dispensing, and administration of blood and blood components.

2) Provide for review of policies governing blood usage.

f. Medical Records Function

1) Provide for regularly and/or needed review of medical records for clinical pertinence and timely completion.

2) Review summary reports concerning timely completion of medical records.

3) Approve a standardized medical record format, forms used in the record and electronic data processing and storage systems.

4) Recommend solutions for problems identified during review and monitor effectiveness of these interventions.

g. Infection Control

The PI Committee will provide resources to develop an infection control surveillance program and to review:

1) Effective measures to prevent, identify, and control hospital-associated infections and community-acquired infections. Recommend corrective action based on reports of infections and infection potentials among patients and personnel. The Committee may institute control procedures or studies if there is reasonable certainty of danger to patients or personnel.

2) Develop and/or approve hospital department and Medical Staff policy related to infection surveillance, control and prevention in the patient population and the inanimate environment.

h. Pharmacy & Therapeutics

The PI Committee is responsible for oversight of:

1) The development and surveillance of drug utilization policies and practices within the hospital, including evaluation, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs, biologicals, and parenteral solutions in the hospital

2) Serve as a resource and provide oversight and review as needed to the following functions:

   a) Hospital formulary

   b) Evaluation of new drugs requested for use in the hospital

   c) Medication stocked in various nursing units and other services

   d) Control and research associated with use of investigational drugs

e) Review information on medication errors, drug interactions and adverse drug events.

i. Patient Safety

The PI Committee is responsible for oversight of:

1). Develop, implement, and evaluate a patient safety program. This program is committed to reducing medical errors and reducing patient harm, therefore improving patient safety and suffering.

2). Provide for at least quarterly, receive and renew reports of patient safety events.

3). Monitor implementation of corrective actions for patient safety events.

4). Make recommendations to eliminate future patient safety events.

5). Review and revise patient safety plans, annually or more often, if necessary.

3. Sub-Committee Functions

The following sub-committees will function under the Performance Improvement Committee as needed:

a. Bioethics
b. Bylaws
c. Infection Control
d. Institutional Review
e. Interdisciplinary Practice
f. Utilization Review
g. Patient Safety

4. Meetings

The committee shall meet at least quarterly, and more often as necessary.

Appendix 9E
BIOETHICS COMMITTEE

1. Composition

The Bioethics Committee shall be composed of at least the following voting members, when possible: three practitioners, one of whom should be a psychiatrist; one registered nurse; one clergy; one medical social worker (or a comparable discipline); one member of hospital administration; one non-hospital local community member at large; and one ethicist (if one is available). Additional members may be appointed by the Chief of Staff.

2. Duties

The Bioethics Committee shall strive to contribute to the quality of health care provided by the hospital by:

a. Providing assistance and resources for decisions which have bioethical implications. The Bioethics Committee shall not, however, be a decision-maker in any case.

b. Educating members within the hospital community concerning bioethical issues and dilemmas.

c. Facilitating communication about ethical issues and dilemmas among members of the hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

d. Retrospectively reviewing cases to evaluate bioethical implications, and providing policy and education guidance relating to such matters.

3. Meetings

The Bioethics Committee shall meet annually, or more often as needed.

Appendix 9F
BYLAWS COMMITTEE

1. Composition

The Bylaws Committee shall include at least five active staff members, including the Chief Medical Officer, who serves as an ex-officio member.

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 forms promulgated by the Medical Staff and its departments;

b. Receiving and evaluating suggestions for modification of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its departments;

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

d. Assuring that the Bylaws and Rules adequately and accurately describe the structure of the Medical Staff, including but not limited to:

1) Establishing and enforcing criteria and standards for Medical Staff membership and clinical privileges, as well as the mechanisms for doing so;

2) Establishing and enforcing clinical criteria and standards to oversee and manage quality improvement and assessment, utilization review, and other Medical Staff activities, including procedures for meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records; as well as procedures for evaluating and revising such activities;

3) The mechanism for terminating Medical Staff membership;

4) The fair hearing and appeal procedures;

5) Provisions for assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff and in a manner that is consistent with the Hospital's nonprofit tax-exempt purposes;

6) Provisions respecting the Medical Staff's ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and

7) Provisions requiring a physical examination and medical history to be completed within the time frames established by state hospital licensing regulations and federal Medicare law.

3. Meetings

The committee will meet as requested by the Bylaws Committee chair or Chief of Staff

Appendix 9G
INSTITUTIONAL REVIEW BOARD

1. Composition

a. Each IRB shall have at least five members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the entity. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members, including consideration of race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to possessing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall therefore include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, such as children, prisoners, pregnant women, or handicapped or mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects.

b. Every nondiscriminatory effort will be made to ensure that no IRB consists entirely of men or entirely of women, including the institution's consideration of qualified persons of both sexes, so long as no selection is made to the IRB on the basis of gender. No IRB may consist entirely of members of one profession.

c. Each IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

d. Each IRB shall include at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

e. No IRB may have a member participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

f. An IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

2. Duties

a. The IRB must adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, including procedures for:

1) Conducting its initial and continuing review of approving research and for reporting its findings and actions to the investigator and to the institution.

2) Determining which projects require review more often than annually and which projects need verification from sources other than the investigators that no material changes have occurred since previous IRB review.

3) Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval was already given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.

4) Assuring prompt reporting to the IRB and institutional officials of unanticipated problems involving risks to subjects or others.

5) For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.

6) Assuring timely reporting to the appropriate institutional officials of: (i) any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB and (ii) any suspension or termination of IRB approval. For research subject to the HHS and FDA regulations, these reports must also be made to HHS, or to the FDA, as appropriate.

7) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth in Paragraph 2.b. below. In order for the research to be approved, it must meet the criteria set forth in federal regulations and it must receive the approval of a majority of those members present at the meeting. Research which is approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the institution, but such review is not required. However, those officials may not approve any research subject to the federal regulations if it has not been approved by an IRB.

b. The Institutional Review Board shall:

1) Review and have authority to approve, require modifications in (to secure approval) or disapprove all research activities covered by HHS, FDA or state law and regulations.

2) Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The IRB may require that information, in addition to that specifically mentioned in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.

3) Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.

4) Notify the investigator and the institution in writing of its decision to approve or disapprove a proposed research activity, or of modifications

required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.

5) Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and have authority to observe or have a third party observe the consent process and the research.

6) Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all the reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials and appropriate regulatory authorities.

3. Meetings

The IRB shall meet annually, or more often as needed.

Appendix 9H
PEER REVIEW COMMITTEE

1. Composition

The Peer Review Committee shall be composed of at least the following members: Medicine and Surgery Department Chairs and Vice-Chairs, and the Chief Medical Officer. Additional members of the Medical Staff are encouraged to participate. Committee Chair and Vice-Chair will be nominated by the Committee.

2. Duties

The Committee shall provide a documented, ongoing medical staff mechanism to measure and assess the quality of patient care at Sonoma Valley Hospital so that identified problems can be addressed and improvement opportunities can be pursued, by:

- Providing for review of the clinical care, both inpatient and outpatient, regardless of location to evaluate practitioner compliance with safe, correct and appropriate care
- Tracking and trending department and practitioner-specific quality data recognizing best practices and any opportunities for improvement
- Providing practitioner education through the review of processes and outcomes
- Identifying processes and systems that may require review and improvement to enhance physician practices and patient outcomes
- Providing valid quality data for physician credentialing and reappointment

1. Meetings

The Peer Review Committee shall meet monthly, or more often as necessary.

Appendix 9I
INTERDISCIPLINARY PRACTICE COMMITTEE

1. Composition

The Interdisciplinary Practice Committee (IPC) shall have an equal number of medical staff members and nursing staff members. It shall include a representative from the nursing administration. In addition, representatives of the categories of allied health professionals (AHPs) granted privileges in the hospital should serve as consultants on an as-needed basis and shall participate, when available, in the committee proceedings when a member of the same specialty is applying for privileges.

2. Duties

a. Standardized Procedures

1) The IPC shall develop and review standardized procedures that apply to nurses or AHPs; identify functions that are appropriate for standardized procedures and initiate such procedures; and review and approve standardized procedures.

2) Standardized procedures can be approved only after consultation with the medical staff department involved and by affirmative vote of the administrative representatives, a majority of physician members, and a majority of nurse members.

b. Credentialing Allied Health Professionals

1) The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning and directing the patients' diagnostic and therapeutic care.

2) The IPC shall review AHPs' applications and requests for privileges and forward its recommendations and the applications on to the appropriate clinical department.

3) The IPC shall participate in AHP peer review and quality improvement. It may initiate corrective action when indicated against AHPs in accordance with the Medical Staff Bylaws, these Rules or guidelines governing AHPs.

4) The IPC shall serve as liaison between AHPs and the medical staff.

c. Education - The IPC shall assure that appropriate ongoing educational programs are developed and implemented addressing issues of interest to the AHP staff.

3. Meetings

The IPC shall meet as often as needed, but at least quarterly.

Appendix 9J
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 should 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 Performance 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:

1) Educating the medical staff and hospital staff about illness and impairment recognition issues specific to practitioners.

2) Self-referral by a practitioner, and referral by other medical staff and hospital staff including maintaining practitioner and informant confidentiality

3) 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.

4) Evaluating the credibility of a complaint, allegation or concern, including such review as reasonably deemed necessary.

5) Monitoring the affected practitioner and the safety of patients until the rehabilitation or any corrective action process is complete.

6) Should 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.

7) Initiating appropriate actions when a practitioner fails to complete the required rehabilitation process.

b. In accordance with the Rule 2.3 (Physical and Mental Capabilities), 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, Reporting and Minutes

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

RULE 10
ALLIED HEALTH PROFESSIONALS

10.1 Overview

10.1-1 The credentialing process for allied health professionals (AHPs) is similar to that for credentialing medical staff members. However, the Interdisciplinary Practices Committee (IPC) is responsible for overseeing the credentialing of AHPs. The credentialing process for AHPs is summarized at Rule 11.3, below.

10.1-2 Rule 11.4 reflects the basic requirements that all AHPs must meet, and Appendices 11A through 11D set forth requirements that specific types of AHPs must meet in addition to the basic requirements.

10.1-3 Also, the clinical department in which the AHP will exercise privileges has a role in establishing criteria for the exercise of specific privileges in that department, and in evaluating whether the particular applicant meets the established criteria. The departments also have the responsibility for generally supervising AHPs in their department, through their proctoring and peer review mechanisms.

10.1-4 Until the AHP has been granted privileges and assigned to a department, an AHP should not be practicing within the hospital.

10.1-5 This Rule 11 applies to AHPs who practice independently, as well as AHPs who are employees or independent contractors of a medical staff member. It does *not* apply to hospital-employed AHPs, except physician assistants and advanced practice nurses (CRNA's, RNFA's and NP's) who are employees of the hospital.

10.2 Categories of AHPs Eligible to Apply for Practice Privileges

10.2-1 The types of AHPs allowed to practice in the hospital will be ultimately determined by the District Board, based upon the comments of the Medical Executive Committee and such other information as may be available to the District Board.

10.2-2 The types of AHPs currently eligible to apply for practice privileges are:

- ❒ nurse practitioners
- ❒ physician's assistants
- ❒ registered nurse first assistants
- ❒ certified registered nurse anesthetists

10.2-3 When an AHP in a category that has not been approved as eligible to apply for clinical privileges under Article VI of the Bylaws requests privileges, the IPC may begin to process an application at the same time the request for recognition of the profession is processed; however, no right to practice in the hospital is thereby created or implied.

10.3 Processing the Application

10.3-1 Applications shall be submitted and processed in a manner parallel to that specified for medical staff applicants in Rule 8, Appointment and Reappointment, except that the applications shall be submitted to the IPC rather than the Department Committee.

10.3-2 Once the application is determined to be complete, it will be forwarded to the IPC for consideration. The IPC may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The IPC shall evaluate the AHP based upon the standards set forth in Rules 8 and 11.4. The IPC will also ascertain that appropriate monitoring mechanisms are in place (in the department or through the Performance Improvement Committee). Whenever possible, the IPC shall include practitioners in the same AHP category when conducting its evaluation. The IPC shall forward its recommendations to the department to which the AHP would be assigned.

10.3-3 Upon receipt of an AHP application from the IPC, the department chair or Department Committee (in the discretion of the department) shall evaluate the AHP based upon the standards set forth in Rules 8 and 11.4. The department chair or his or her designee or Department Committee may meet with the AHP as well as the sponsoring or supervising practitioner (if applicable) to further investigate the AHP's request for privileges. The Department Committee will make a recommendation to the Medical Executive Committee regarding the applicant's qualifications to exercise the requested privileges.

10.3-4 Thereafter, the application shall be processed by the Medical Executive Committee and District Board in accordance with the procedures set forth in Rule 8.7-3 through 8.7-6.

10.4 Credentialing Criteria

10.4-1 Basic Requirements

a. The applicant must belong to an AHP category approved for practice in the hospital by the District Board.

b. If required by law, the applicant must hold a current, unrestricted state license or certificate.

c. In addition, hospital independent contractors shall meet all conditions of their contract with the hospital.

d. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the hospital, and that he or she is qualified to exercise clinical privileges within the hospital.

e. The applicant must maintain in force professional liability insurance or its equivalent for the privileges exercised in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.

f. The applicant must submit a minimum of two references from either licensed physicians or adequately trained professionals in the appropriate field and who are familiar with his or her professional work and have demonstrated competency.

g. The applicant must have actively practiced for an average of at least 20 hours per week in his or her field for eighteen of the previous 24 months. If applicant is working in an independent setting, he or she must have completed one year of clinical practice outside of his or her training program.

h. The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the medical staff.

10.4-2 Specific Requirements

In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his or her category of AHP, as set forth in the applicable appendix:

❒ nurse practitioners	11A
❒ physician's assistants	11B
❒ registered nurse first assistants	11C
❒ certified registered nurse anesthetists	11D

10.4-3 Supervising Practitioner Responsibilities

a. Any supervising practitioner or group which employs or contracts with the AHP agrees that the AHP is solely his, her or its employee or agent and not the hospital's employee or agent. The supervising practitioner or group has full and sole responsibility for paying the AHP, and for complying with all relevant laws, including federal and state income tax withholding laws, overtime laws and workers' compensation insurance coverage laws.

b. A supervising practitioner or group which employs or contracts with the AHP agrees to indemnify the hospital against any expense, loss or adverse judgment it may incur as a result of allowing an AHP to practice at the hospital or as a result of denying or terminating the AHP's privileges.

10.5 Provisional Status

All AHPs initially shall be appointed to a provisional status for at least twelve months. Advancement from the provisional status will be based upon whether the professional's performance is satisfactory, as determined by the department in which the AHP is assigned, IPC (when its review is necessary for the privileges), the Medical Executive Committee and the District Board.

10.6 Duration of Appointment and Reappointment

10.6-1 AHPs shall be granted practice privileges for no more than 24 months. Reappointments to the AHP staff shall be processed every other year, in a parallel manner to that specified in the Rule 8 for medical staff members.

10.6-2 Applications for renewal of the AHP's privilege and the supervising practitioner's approval must be completed by the AHP and supervising practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Rules.

10.8 Observation

10.8-1 Each department shall be responsible to establish observation programs appropriate to each category of AHP granted privileges within that department. The department shall determine the appropriate frequency and methods of initial evaluation, which

may include concurrent or retrospective chart review or consultations. AHPs exercising surgery or anesthesia practice privileges shall be observed during surgery, following the proctorship guidelines in Article 5.8 of the bylaws.

10.8-2 The evaluator should be a member in good standing of the medical staff who exercises appropriate clinical privileges; however, in appropriate circumstances, the department chair may assign an appropriately credentialed AHP to serve as the evaluator. Whenever possible, the evaluator should not be the sponsoring or supervising practitioner of the AHP being observed.

10.8-3 The District Board may approve alternative observation procedures for employee or Contract AHPs.

10.9 General

10.9-1 Duties

Upon appointment, each AHP shall be expected to:

a. Be consistent with the privileges granted to him or her, exercise independent judgment within his or her areas of competence and, if applicable, within the limits of an approved standardized procedure, provided that a medical staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

b. Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable standardized procedures, and by the privileges granted by the District Board.

c. Write orders to the extent established by any applicable medical staff or department policies, rules or standardized procedures and consistent with privileges granted to him or her.

d. Record reports and progress notes on patient charts to the extent determined by the appropriate department, and in accordance with any applicable standardized procedures.

e. Assure that records are countersigned as follows: (i) the supervising practitioner, if any, shall countersign all entries except routine progress notes; (ii) unless otherwise specified in the rules or specific supervision protocols, all chart entries that require countersignatures must be countersigned within fourteen days after the entry is made.

f. Consistent with the privileges granted to him or her, perform consultations as requested by a medical staff member.

g. Comply with all medical staff and hospital bylaws, rules and policies.

10.9-2 Prerogatives and Status

AHPs are not members of the medical staff, and hence shall not be entitled to vote on medical staff or department matters. AHPs shall not be required to pay dues. They are expected to attend and actively participate in the clinical meetings of their respective departments, to the extent consistent with department rules.

10.10 Standardized Procedures

10.10-1 Definition

Standardized procedures means the written policies and protocols for the performance of standardized procedure functions, and which have been developed in accordance with the requirements of state law.

10.10-2 Functions Requiring Standardized Procedures

Standardized procedures are required whenever any registered nurse (including, but not by way of limitation, nurse anesthetists, Nurse Practitioners and nurse midwives) practices beyond the scope of practice taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

10.10-3 Development of Standardized Procedures

a. Standardized procedures may be initiated by the appropriate department, the affected AHPs, or sponsoring or supervising practitioners.

b. The IPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Representatives of the category of AHPs that will be practicing pursuant to the standardized procedures shall be involved in developing the standardized procedures.

c. Each standardized procedure shall:

1) Be in writing and show the date or dates of approval by the IPC.

2) Specify which standardized procedure functions registered nurses may perform and under what circumstances.

3) State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

4) Specify any experience, training and/or education requirements for performance of standardized procedure functions.

5) Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

6) Provide for a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

7) Specify the nature and scope of review and/or supervision required for performance of standardized procedure functions; for example, whether the functions must be performed under the immediate supervision of a physician.

8) Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

9) State the limitations on settings or departments, if any, in which standardized procedure functions may be performed.

10) Specify patient recordkeeping requirements.

11) Provide for a method of periodic review of the standardized procedures.

d. Standardized procedures shall be reviewed by the department, and then must be approved by the IPC, the Medical Executive Committee and the District Board.

Appendix 10A
NURSE PRACTITIONERS

1. Licensure and Certification

Nurse Practitioners shall be currently licensed as a Registered Nurse in California and currently certified as a Nurse Practitioner by the California Board of Registered Nursing.

2. Scope of Practice

Nurse Practitioners may receive privileges to perform the following professional services at the hospital:

a. Perform tasks or functions which fall within the customary scope of nursing practice; and

b. Furnish or order drugs or devices (other than controlled substances) to patients under the following conditions:

1) The drug or device is furnished or ordered incidentally to the provision of family planning services, routine health or prenatal care, or when rendered to essentially healthy persons within the hospital;

2) The drug or device is furnished or ordered pursuant to a standardized procedure or protocol which is promulgated by the hospital in accordance with legal requirements;

3) The drug or device is furnished or ordered under the supervision of the attending physician, who:

i) Collaborated in the development of the standardized procedure;

ii) Approved the standardized procedure;

iii) Is available by telephone at the time of patient examination by the Nurse Practitioner; and

iv) Supervises no more than four Nurse Practitioners at one time.

4) The drug or device may include Schedule III through Schedule V controlled substances, and shall be further limited to those drugs agreed upon by the Nurse Practitioner and the supervising physician and specified in the standardized procedure. When Schedule III controlled substances are furnished by a Nurse Practitioner, they shall be furnished in accordance with a patient-specific protocol approved by the treating or supervising physician;

5) The drug or device is furnished or ordered pursuant to certification from the Board of Registered Nursing that the nurse-midwife has completed:

i) At least six months' physician-supervised experience in the furnishing of drugs or devices; and

ii) A course in pharmacology covering the drugs and devices to be furnished

6) The drug or device is furnished or ordered under a number issued by the Board of Registered Nursing to the Nurse Practitioner, to be included on all transmittals of orders for drugs or devices.

7) The term "furnish" shall include

i) Ordering a drug or device in accordance with the standardized procedure; and

ii) Transmitting an order of a supervising physician

c. Perform tasks or functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in standardized procedures, promulgated by the hospital in accordance with Rule 6.9.

Appendix 10B
PHYSICIAN ASSISTANTS

1. Requirements

Physician's Assistants shall be currently licensed by the Physicians' Assistants Examining Committee of the Medical Board of California. Orthopedic Physician Assistants shall be currently licensed by the National Board for Certification of Orthopedic Physician Assistants (NBCOPA).

Physician's Assistants shall perform all services at the hospital under the direction of a qualified supervising physician.

2. Scope of Practice

a. Physician's Assistants may receive privileges to perform the following professional services at the hospital:

1) Take a history, perform a physical examination, assess the patient, make a diagnosis, and record the pertinent data in a manner meaningful to the supervising physician;

2) Order, transmit an order for and perform or assist in performing laboratory screening and therapeutic procedures delegated by the supervising physician, provided that the procedures are consistent with the supervising physician's practice and with the patient's condition;

3) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy and nursing services;

4) Recognize and evaluate situations which call for the immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient;

5) Administer or provide medication to patient or transmit orally or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication to the patient, subject to the following conditions:

i) Any prescription transmitted by the physician assistant shall be based either on a patient-specific order by the supervising physician or on written protocol approved by the supervising physician which specifies all criteria for the use of a specific drug or device and any contraindications for the selection;

ii) The supervising physician must countersign and date within seven days the medical record of any patient cared for by the physician assistant for whom the supervising physician's prescription has been issued, transmitted or carried out;

iii) Physician's Assistants may not administer, provide or issue a prescription for controlled substances listed in Schedules II

through V inclusive without a patient-specific order by the supervising physician.

6) Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as medications, diets, social habits, family planning, normal growth and development, aging and understanding and managing their diseases;

7) Assist the supervising physician by arranging admissions, making appropriate entries in the patient's medical record, reviewing and revising treatment and therapy plans, ordering, transmitting orders for, performing, or assisting the performance of radiology services, therapeutic diets, physical therapy treatment, ordering occupational therapy treatment, ordering respiratory care services, acting as first or second assistant in surgery under the direct supervision of the supervising physician and providing continuing care to patients following discharge;

8) Facilitate the supervising physician's referral of patients to the appropriate health facilities, agencies and resources of the community; and

9) Perform, outside the personal presence of the supervising physician, surgical procedures which are customarily performed under local anesthesia, which the supervising physician has determined the physician assistant has training to perform, and for which the physician assistant has privileges to perform;

10) Act as a first or second assistant in surgery under the supervision of the supervising physician.

b. Physician's Assistants shall not:

1) Perform any task or function that requires the particular skill, training, or experience of a physician, dentist or dental hygienist;

2) Determine eye refractions or fit glasses or contact lenses; or

3) Prescribe or use any optical device for eye exercises, visual training or orthoptics (this does not, however, preclude administering routine visual screening tests).

3. Supervision

a. Physician's Assistants shall perform all services at the hospital under the direction of a supervising physician who:

1) Is currently licensed by the State of California;

2) Is a current member in good standing of the medical staff and practices actively at the hospital; and

3) Meets the requirements set forth in this Appendix 11B.

b. Before the Physician Assistant is permitted to perform services at the hospital, the supervising physician shall submit a signed, written request which describes the tasks and functions that the physician assistant would be performing. Those tasks and functions shall be consistent with the supervising physician's

specialty, with the supervising physician's usual and customary practice, and with the patient's health and condition.

c. The supervising physician shall establish the following in writing, together with any necessary documentation:

1) That the supervising physician accepts full legal and ethical responsibility for the performance of all professional activities of the Physician Assistant;

2) Those specific duties and acts, including histories and physical examinations, that the Physician Assistant would be permitted to perform outside of the supervising physician's immediate supervision and control;

3) That the supervising physician is covered by professional liability insurance with limits as determined by the governing board, for acts or omissions arising from supervision of the Physician Assistant (the supervising physician shall verify such coverage in a form acceptable to the Medical Staff Executive Committee).

d. No supervising physician shall have a supervisory relationship with more than two Physician Assistants at any one time. (Notwithstanding the foregoing, an emergency physician may have a supervisory relationship with more than two emergency care Physician Assistants at any one time, provided that the emergency physician does not oversee the work of more than two such Physician Assistants while on duty at any one time.)

e. The supervision of the Physician Assistant by the supervising physician shall include all of the following:

1) Availability of the supervising physician in person or by electronic communication when the Physician Assistant is caring for patients;

2) Observation or review of the Physician Assistant's performance of all tasks and procedures that the supervising physician will delegate to the Physician Assistant until the supervising physician is assured of competency;

3) Establishment of written transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the Physician Assistant's scope of practice for such times when the supervising physician is not on the premises;

4) Establishment of written guidelines for the adequate supervision of the Physician Assistant, which shall include one or more of the following:

i) Examination of the patient by the supervising physician the same day as care is given by the Physician Assistant;

ii) Countersignature and dating of all medical records written by the Physician Assistant within 24 hours, or, in the case of emergency admissions or circumstances requiring transfer of a patient to a higher level of care, within eight hours of when the care was given by the Physician Assistant;

iii) Adoption of protocols by the supervising physician to govern the performance of a Physician Assistant for some or all tasks.

The minimum content for any such protocol governing diagnosis and management shall include the presence or absence of symptoms, signs and other data necessary to establish a diagnosis or assessment, any appropriate test or studies to order, drugs to recommend to the patient and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the supervising physician, adopted from, or referred to, texts or other sources. Protocols shall be signed and dated by the supervising physician and the Physician Assistant. the supervising physician shall review, countersign, and date a minimum sample of ten percent of medical records of patients treated by the Physician Assistant functioning under these protocols within 24 hours. The supervising physician shall select or review those cases which by diagnosis, problem, treatment or procedure represent, in his or her judgment, the most significant risk to the patient;

5) On-site supervision by the supervising physician of any surgery requiring anesthesia other than local anesthesia; and

6) Responsibility on the part of the supervising physician to follow the progress of the patient and to make certain that the Physician Assistant does not function autonomously.

Appendix 10C
REGISTERED NURSE FIRST ASSISTANTS

1. Qualifications

An applicant for Registered Nurse First Assistant privileges shall:

a. Be currently licensed as a Registered Nurse in California; and

b. Either:

1) Be currently certified as a "Registered Nurse First Assistant" by the National Certification Board: Perioperative Nursing; or

2) Be a graduate of a Registered Nurse First Assistant program accredited by the National Certification Board: Perioperative Nursing, who is obtaining the necessary clinical experience before taking the certification examination of the National Certification Board: Perioperative Nursing to become a "Registered Nurse First Assistant.

3) Demonstrate sufficient training and experience to ensure the ability to act as a Registered Nurse First Assistant at a level that will ensure that patients receive care of the proper quality.

2. Scope of Practice

a. Registered Nurse First Assistants may receive privileges to perform the following professional services at the hospital under the direct supervision of a physician on the medical staff:

1) Perform the following preoperative services:

i) Conduct patient interviews;

ii) Perform patient assessments;

iii) Perform patient teaching;

iv) Obtain patient histories; and

v) Perform physical examinations.

2) Perform the following intraoperative services:

i) Assist with positioning, preparing and draping the patient;

ii) Provide retraction for adequate exposure;

iii) Use surgical instruments;

iv) Perform dissection;

v) Apply pressure;

vi) Suction the wound area;

vii) Pack sponges or laparotomy pads into body cavities to hold tissues or organs out of the operating field;

viii) Grasp or fixate tissue with screws, staples or other devices;

ix) Suture tissue;

x) Perform knot tying;

xi) Provide hemostasis by clamping bleeding vessels, suturing or tying clamped vessels or cauterizing vessels;

xii) Cauterize tissues;

xiii) Apply bovie power to instrumentation held by the surgeon when the surgeon is unable to do so;

xiv) Inject medications;

xv) Provide closure of the surgical wound by suturing fascia, subcuticular tissue and skin; and

xvi) Affix and stabilize drains, clean the wound and apply the dressing, and assist in applying casts.

3) Perform the following postoperative services:

i) Remove dressings, sutures, skin staples, drains, chest tubes, and casts;

ii) Perform postoperative assessments;

iii) Perform postoperative teaching; and

iv) Conduct discharge planning.

4) Perform other functions according to standardized procedures adopted by the hospital.

b. Registered Nurse First Assistants shall not function concurrently as a scrub nurse or a circulating nurse.

Appendix 10D
CERTIFIED REGISTERED NURSE ANESTHETISTS

1. Standard

The CRNA is a licensed independent practitioner (LIP) rendering direct patient care as defined by the American Association of Nurse Anesthetists, and collaborating with the operating surgeon to provide a safe surgical procedure with optimal outcomes for the patient. The responsibility of the CRNA is based on documented knowledge and skills acquired through graduation from a nationally accredited nurse anesthesia educational program, successfully passing a national certification examination following graduation, advanced practice certification, and practice experience.

2. Qualifications

An applicant for Certified Registered Nurse Anesthetist privileges shall possess all of the following:

a) Current Licensure as a Registered Nurse in California with no pending disciplinary actions.

b) A current Nurse Anesthetist (NA) advanced practice nursing certificate issued by the state of California.

c) Current recertification as a CRNA by the Council on Recertification of Nurse Anesthetists (COA) of the National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA).

d) Current certifications:

1) Neonatal Resuscitation Program (NRP)

2) Advanced Cardiac Life Support (ACLS)

3) Basic Life Support (BLS)

e) Education and Experience:

1) Bachelor of Science in Nursing or other appropriate baccalaureate degree.

2) Graduation from a program of nurse anesthesia education accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs (COA). These nationally accredited programs offer a graduate degree and include clinical training in university-based or large community hospitals.

3) Experience in an acute care setting practicing obstetric and non-obstetric anesthesia to include patient care activities within the past two-year period. Documentation of anesthesia cases for the previous 12 month period is required at minimum.

f) Other Requirements:

1) References from the following:

i) Board Certified Anesthesiologist (initial appointment only).

ii) Board Certified Surgeon (initial appointment and reappointment).

iii) CRNA (initial appointment and reappointment).

2) Current Professional Liability Insurance ($1,000,000 per occurrence/$3,000,000 aggregate)

III. Scope of Practice

a. The CRNA may perform the following professional services at the hospital

1) PREANESTHESIA EVALUATION AND PREPARATION:

i) Perform the preanesthetic evaluation and record the evaluation, anesthetic plan and risk assigned on the chart.

ii) Order or perform those pre-anesthetic examinations, tests or therapies necessary for the evaluation of patients for anesthesia.

iii) Order those medications necessary for the preparation of patients prior to anesthesia.

iv) Plan and implement anesthetic management, including selecting the anesthetic agent or agents and the anesthetic technique.

2) ADMINISTRATION OF GENERAL ANESTHESIA:

i) Intravenous agents

ii) Inhalational agents

iii) Intramuscular agents

3). ADMINISTRATION OF CONDUCTION ANESTHESIA:

i. Epidural Block

ii). Spinal Block

iii) Blood Patch for CSF fistula

4). ADMINISTRATION OF MONITORED ANESTHESIA CARE (MAC) and light through deep sedation.

5) ADMINISTRATION OF REGIONAL ANESTHETIC BLOCKS, including, but not limited to:

i) Upper extremity blocks
ii) Lower extremity blocks

v) IV regional blocks
vi) Transtracheal blocks

6) PERIOPERATIVE PROCEDURES:

i) Administer emergency/ancillary drugs and fluids to maintain physiological homeostasis and prevent or treat emergencies during the perianesthesia period.

iii) Perianesthetic monitoring, and insertion of invasive monitoring modalities.

iv) Tracheal intubation, extubation and airway management.

v) Mechanical ventilation/oxygen therapy.

v) Administration of intravenous fluids and electrolytes.

vi) Administration of blood, blood products, plasma expanders.

7) POST-ANESTHESIA CARE:

i) Order pertinent post-anesthetic medications, tests, or therapies in the Post Anesthesia Care Unit (PACU).

ii) Discharge the patient from the PACU.

iii) Perform and record post-anesthetic evaluation.

iv) Postoperative Pain Management.

v) Epidural and/or spinal placement and administration of neuroaxial narcotics.

8) PERFORM OTHER FUNCTIONS ACCORDING TO STANDARDIZED PROCEDURES ADOPTED BY THE HOSPITAL.

IV. Proctorship

All CRNAs shall undergo proctoring performed by a board certified Anesthesiologist or Certified Registered Anesthetist pursuant to the Medical Staff Rules and Regulations.

V. Reappointment and Performance Review

a) Reappointment by the Sonoma Valley Hospital Board of Directors is required every two years and is dependent upon the following:

1) Current California RN Licensure and NA advanced practice certificate.
2) Current recertification by the Council on Recertification of Nurse Anesthetists (COA) of the National Board on Certification and Recertification of Nurse Anesthetists (NBCRNA).
3) A written review of performance shall be completed at least every 2 years, or at the time of reappointment by those surgeons utilizing the services of the CRNA.
4) Shall be subject to the peer review process.

RULE 11
MEDICAL RECORDS

11.1 General

11.1-1 The patient's hospital medical record serves a multitude of purposes, including those relating to primary patient care, continuity of patient care, quality management, medical research, and business documentation. Although the primary purpose of the medical record is to serve the interests of the individual patient, it also serves as the basis for quality management and utilization review activities. In addition, it may be used in connection with lawsuits, and thus serves a medico-legal function.

11.1-2 Medical records must be maintained for all patients who receive treatment at Sonoma Valley Hospital, including inpatients, outpatients, emergency patients and patients admitted for special procedures. All medical records are property of the hospital.

11.1-3 All entries in the medical record must be timed, dated, authenticated, and legible (illegible entries shall be deemed as non-documentation).

11.2 Responsibility for the Medical Record. Attending physicians, and each consulting physician involved in the care of any patient shall be responsible for their respective complete and legible medical records.

11.3 Timely Completion of the Medical Record

11.3-1Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care.

11.3-2 A medical record lacking any required element or required authentication is considered incomplete.

11.3-3 Medical record entries must be completed promptly and authenticated or signed by the author within fourteen (14) days following the patient's discharge. Medical records, which are incomplete for any reason 14 days after discharge, are considered to be delinquent.

11.3-4 Upon the patient's discharge the Health Information Management Department shall assemble the medical record and assign deficiencies within the medical record to the responsible physician(s). Any physician having incomplete records after the patient's discharge will receive a notice of the incomplete records pursuant to the current Medical Staff Delinquency and Suspension Policy.

11.3-5 If the physician fails to complete his or her medical records within fourteen (14) days of discharge, actions including suspension of admitting privileges as well as a monetary fine will be initiated pursuant to the current Medical Staff Delinquency and Suspension Policy.

11.3-6 When a physician accumulates over thirty (30) days of suspension in the any consecutive twelve (12) months, the Director of Health Information Services shall notify the Chief Executive Officer and the Medical Staff Executive Committee of the number of suspension days and the nature of the deficiencies which have occurred. Further action related to the physician will then be determined by the Medical Staff Executive Committee.

11.3-7 A medical record shall not be permanently filed until it is completed by the responsible attending physician or is ordered to be filed by the Information and Healthcare Resources Committee. The Committee Chairperson may authorize the Manager of Health Information Services to retire medical records under the following circumstances: when the physician is deceased, has moved from the area, has resigned from the Medical Staff, or is on an extended leave of absence. The Committee Chairperson must sign and date a cover letter for the medical record, stating the reason for retirement.

11.4 Use of Electronic Signature

11.4-1 The Medical Staff permits the use of electronic signature, per approved Health Information Management Policy and Procedure.

11.5 Use of Electronic Medical Records

11.5-1 The Medical Staff recognizes that the successful utilization of any component of the Electronic Medical Record depends on its universal use by all members of the Medical Staff. Therefore, if appropriate training has been offered by the Hospital on a component of the Electronic Medical Record and ongoing technical support is available, it is expected that the Medical Staff will use the component.

11.6 Use of Symbols and Abbreviations

11.6-1 No symbols or abbreviations may be used on the face sheet.

11.6-2 A list of symbols and abbreviations which may be used in the medical record shall be approved by the Medical Staff Executive Committee and distributed to the Medical Staff. Specific prohibited abbreviations include:

Do Not Use	**Use Instead**
U (unit)	Write "unit"
IU (International Unit)	Write "International Unit"
Q.D., QD, q.d., qd (daily)	Write "daily"
Q.O.D., QOD, q.o.d, qod	Write "every other day"
Trailing zero (X.0 mg)	Write X mg
Lack of leading zero (.X mg)	Write leading zero (0.X mg)

MS, MSO_4 and $MgSO_4$	Write "morphine sulfate" OR "magnesium sulfate"

11.7 Correction of the Medical Record. In the event it is necessary to correct an entry in a medical record, the authorized person shall line out the incorrect data with a single line in ink, leaving the original writing legible. The person shall note the reason for the change, the date of striking, and sign the note. Appropriate cross-referencing shall be placed in the medical record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating physician at the time the report is authenticated. Any cross-outs with or without re-entries in the report should be noted as error, dated, and initialed. No medical record entry shall be removed from the medical record.

11.8 Authentication, Dating, and Timing of Entries. Each entry that is made in the medical record shall be signed by the person making the entry, dated and timed. The date and time shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

11.9 Contents

11.9-1 General. Each medical record shall contain sufficient detail and be organized in a manner that will enable a subsequent treating Physician or other health care provider to understand the patient's history and to provide effective care. All entries in the medical record must be legible.

11.9-2 Inpatient Medical Records. The inpatient medical record shall include the following elements:

A. Identification Data. The identification sheet (face sheet) shall include the patient's name, address, identification number, age, sex, marital status, religion, date of admission, date of discharge, name, address and telephone number of a person responsible for the patient, and initial diagnostic impression.

B. Admitting Note. An admitting note must be written in the progress notes on admission. (The only exceptions are A.M. surgeries, when the physician already has a dictated history and physical examination report on the medical record.) The admitting note shall include a summary of the patient's chief complaint and presenting symptoms, a summary of pertinent physical findings, a provisional diagnostic impression and a statement on the course of action planned for the patient.

C. History and Physical Examination Report. A comprehensive and complete general history and physical examination is required on all hospital patients. The history and physical shall be dictated or legibly handwritten. The scope and content of the examination must be relevant to the patient's medical history and the clinical findings.

1) The History must include at least the following elements: Chief Complaint; History of Present Illness; Relevant Past Medical History; Social, Family and Allergy Histories; and a review of body systems.

2) The Physical Examination must include at least the following: Statement of general condition and an examination of at least the following: HEENT; neck; cardiovascular; respiratory; abdominal; extremities; vascular; neurologic status; mental status; detailed dental when patient is undergoing dental procedures; detail podiatric when patient undergoing podiatric procedures; a female pelvic, breast and/or rectal examination or a male genital and/or rectal examination is required as part of the history and physical whenever it is clinically indicated.

3) A history and physical also must contain a statement regarding the conclusion or impressions drawn from the admission history and physical.

4) A complete history and physical must be performed and at least a pertinent summary of the history and physical findings recorded in the medical record within twenty-four (24) hours of admission by a Medical Staff member with appropriate privileges. All patients must have a history and physical completed prior to surgery or major invasive procedure. The written history and physical summary note should include all pertinent findings. If the history and physical is performed more than twenty-four (24) hours prior to admission, any subsequent changes in the patient's status must be reflected in an interval history and physical note recorded in the medical record within twenty-four (24) hours of admission.

5) If a complete history and physical was performed within thirty (30) calendar days prior to the patient's admission to the hospital for elective surgery, a reasonably durable, legible copy of the report may be used in the patient's medical record in lieu of the admission history and physical, provided the report was completed by a Medical Staff member or validated and authenticated by a Medical Staff member and the medical record contains an interval noted completed on admission which up-dates the original history and physical relevant to the patient's current clinical status.

6) If the patient is readmitted to the hospital within thirty (30) days of a previous discharge for the same or a related condition, an interval admission note within twenty-four (24) hours stating the reason for re-admission and any changes in the history and physical report may be written in lieu of a complete history and physical report. A copy of the original history and physical report shall be placed in the patient's medical record.

7) The history and physical report shall be prepared by the patient's attending physician, unless delegated to another Physician..

D. Consultation Reports. Consultation requests must be documented in the medical record. Consultation reports must provide a written opinion, signed by the consultant, including findings on physical examination of the patient or other data and information. (See also the Consultations section). In the case of consultation

prior to surgery, completed consultation notes are required ("cleared" notes are not acceptable).

E. Order Sheets. Medications, treatment, and diet orders shall be entered on the order sheet. (See also the Drug/Medication and Treatment Orders section). All entries shall be dated and timed.

F. Progress Notes. Progress notes shall be entered at least daily and more often when warranted by the patient's condition. The progress notes shall give a chronological picture of the patient's progress, and be sufficient to permit continuity of care and transferability. The progress note shall delineate the course and results of treatment. All progress notes shall be dated and timed.

G. Pre-anesthetic Assessment. The required content of the pre-anesthetic assessment include significant past medical history, previous anesthesia experience, any unusual family history relating to anesthesia, allergy history, current medications, documented physical status assessment including ASA classification, relevant physical examination (specifically airway status), review of relevant diagnostic studies, anesthetic plan,, and documented informed consent for the anesthesia

H. Operative Reports. A postoperative note must be entered into the medical record immediately after surgery and include pertinent information that is necessary for any care provider who will be attending the patient. The postoperative note must include at least the following elements:

1) Pre and post-op diagnosis.

2) Surgeon and assistant surgeon.

3) Technical procedure performed.

4) Surgical findings.

5) Complications.

6) Estimated blood loss.

7) Condition of patient postoperatively.

8) Anesthetic type utilized

9) Name of anesthesia provider

A dictated operative report must be completed within forty-eight (48) hours of each surgery and shall contain at least the information described above. Failure to complete operative reports within 48 hours will result in immediate suspension of privileges.

I. Nursing and Ancillary Documentation. Documentation and reports from the nursing, ancillary and support staff and services involved in the patient's care shall include:

1) Nursing documentation, providing a Medical Record of the nursing care that is rendered, pertinent observations regarding the patient, including psycho-social and physical manifestations, and of the administration of medications.

2) Dietitian documentation.

3) Vital signs.

4) Reports of any diagnostic and therapeutic procedures; pathology/laboratory clinical laboratory examinations; radiology and nuclear medicine.

5) Record of donation and receipt of transplants or implants.

6) Autopsy report, when performed.

7) Relevant vital signs and pain status

8) Consciousness

9) Psycho-social status

J. Consent Forms/Informed Consent. Documentation involved in the patient's care shall include, but are not limited to:

1) Authorization for and Consent to Surgery or Complex Therapeutic or Diagnostic Procedures.

2) Forms provided in the Consent Manual prepared by the California Association of Hospitals and Health Systems located in the Health Information/Medical Records Department.

K. Discharge Instructions. Discharge instructions shall be recorded and discussed with the patient and, if appropriate, family members or other care providers. Written discharge instructions shall be given to the patient, family members or other care providers and shall include the following:

1) Activities and any activity restrictions.

2) A list of medications which are to be continued post discharge ("resume" orders are unacceptable).

3) Diet.

4) Follow-up instructions.

L. Discharge Summary. The discharge summary shall be dictated by the responsible physician within fourteen (14) days after discharge. The discharge summary shall briefly recapitulate the significant findings and events of the patient's hospitalization including the reason for hospitalization, significant findings and conclusions at the termination of hospitalization, procedures performed and treatments rendered, the condition on discharge relevant to the patients presenting symptoms or complaint and all final diagnoses. If the patient was hospitalized for less than forty-eight (48) hours for a minor ailment, a written clinical resume note may be used in place of a dictated discharge summary.

11.10 Availability and Removal of Medical Records

11.10-1 All records are the property of the hospital and shall not be taken from the hospital premises.

11.10-2. Medical records, or copies, may be removed from the hospital's jurisdiction and safekeeping in accordance with court order, subpoena or state statute.

11.10-3 In cases of readmission of a patient, all previous records shall be made available for the use of the attending physician, whether the patient be attended by the same physician or by another physician.

11.10-4 All record management shall confirm to relevant HIPPA compliance, and other relevant regulations.

11.11 Access to Medical Records. Former members of the Medical Staff shall be permitted access to information from medical records of their patients covering all periods during which they attended such patients in the hospital.

RULE 12

SURGERY AND INVASIVE PROCEDURE REQUIREMENTS

12.1 All surgery or invasive procedures performed shall require informed consent of the patient or his legal representative except in emergency which shall be defined as a condition in which delay may endanger the patient's life and health. Consents shall be obtained in compliance with these Rules and Regulations.

12.2 All material removed from the patient by operative procedure shall become the property of the hospital and shall remain in the hospital laboratory for a sufficient time to allow the pathologist to make a permanent record.

12.3 If a procedure requires a history and physical, then prior to commencing the procedure, the history and physical examination report must be contained in the medical record. If a history and physical examination has been dictated, but not yet present on the medical record the physician must hand write a relevant and pertinent history and physical examination in the progress notes. In an emergency, the physician shall record a pre-operative note regarding the patient's condition and reason for emergency surgery prior to the surgical procedure commencing.

12.3-1 When a history and physical examination is not on the medical record in dictated or written form prior to surgery or invasive procedure requiring anesthesia, including moderate sedation, the procedure shall be postponed until the history and physical examination has been recorded. The operating room staff must verify that the history and physical examination is on the medical record before admitting the patient to the operating room suite.

12.4 A pre-anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.

12. 5 Minimum preoperative testing shall be determined by the operating physician and the anesthesiologist based on the procedure to be performed and the clinical status of the patient.

12.5-1 Preadmission and preoperative laboratory work from outside laboratories will be accepted from a laboratory run by a licensed technologist and require proficiency testing acceptable to Medicare and Medi-Cal. Such tests must be made available for review, if necessary.

12.5-2 Outside chest films may be accepted for patients undergoing surgical procedures provided there is a radiologist interpretation. A hospital radiologist will review outside films if requested and notify the physician of any problems identified. Pertinent outside films accompanied by a radiologist interpretation would be reviewed by the hospital's radiologist without charge if such a request is made by

the attending physician. Such request for film review must be submitted to the Radiology Department twenty-four (24) hours prior to the scheduled surgical procedure.

12.6 Outpatient surgery is designed to accommodate all patients for whom an outpatient procedure is safe and appropriate

12.7 Surgeons must be in the operating room and ready to begin the operation at the time scheduled. In no case should the operating room be held longer than fifteen (15) minutes.

12.8 Medication containers (syringes, medicine cups, basins), or containers with other solutions (on and off the sterile field) must be labeled. The label must include the drug name, strength, amount (if not apparent from the container), expiration date when not used within 24 hours, and expiration time when expiration occurs in less than 24 hours.

12.9 Immediately prior to commencement of a procedure, all members of the operative team should engage in a pre-procedure "time out" to clearly verify the patient's identity using two identifiers, the planned procedure and its inclusion in the informed consent, the operative site of the procedure, and any special diagnostic studies or special equipment required for the procedure.

12.10 Immediately prior to the administration of moderate or deep sedation or anesthesia, the patient is to be reevaluated.

12.11 All previous orders are canceled when patients undergo operative procedures

12.12 A post anesthesia evaluation shall be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. When a post-anesthetic visit and record entry is not feasible because of early release from the hospital, the physician who discharges the patient from the hospital must assume this responsibility.

12.13 Patients may be discharged from the recovery area to an inpatient bed following examination by a licensed independent practitioner or by using pre-established discharge criteria. A patient may be discharged from the hospital from a surgical area only following examination by a licensed independent practitioner or by a registered nurse using a standardized procedure-.

12.14 Assistant Surgeons

Surgical cases that may require an assistant surgeon include:

DENTAL SURGERY

Major Orthognathic surgery

ENT

Rhinology – front sinus obliteration

Head and Neck

- Parotidectomy
- Laryngectomy, partial and total
- Neck dissections
- Temporal bone resections
- Major myocutaneous flaps

GENERAL SURGERY

Major intra-abdominal procedures, except simple tube gastrostomy

Major vascular and thoracic procedures

OB/GYN

Major abdominal and vaginal procedures, except umbilical herniorrhaphy, mini lap/tubal ligation

Laparoscopy procedures as follows:

- Laparoscopically assisted vaginal hysterectomy
- Other laparoscopic procedures at the discretion of the surgeon

ORTHOPEDIC SURGERY

Major joint revisions

Major spine procedures

UROLOGIC SURGERY

All intra-abdominal procedures, except:

- Simple suprapubic cystostomy

RULE 13
DEATHS

13.1 Pronouncement of Deaths. a patient arrives at the hospital dead or dies in the hospital, physician shall pronounce the patient dead within a reasonable time. The patient's remains may not be released until the physician has made an authenticated entry of the pronouncement of death in the patient's medical record. Nurses may pronounce death pursuant to standardized procedures.

13.2 Autopsies

13.2-1 It shall be the duty of all Medical Staff members to attempt to secure meaningful autopsies in all cases of unusual deaths and of medical, legal, and/or educational interest, and in all deaths that meet the following criteria, as identified by the College of American Pathologists as follows:

a. Patient death in which an autopsy may help explain unknown and unanticipated medical complications
b. Deaths in which the cause is not known with certainty on clinical grounds
c. All obstetric, perinatal, neonatal and pediatric deaths (except for stillborn infants of less than twenty (20) weeks gestation, per California Health & Safety Code 102950)
d. Patient deaths at any age in which it is thought that autopsy would reveal the known or suspected illness which may have bearing on survivors or recipients of transplant organs
e. Deaths suspected or known to have resulted from environmental or occupational hazards
f. Deaths resulting from high-risk infections and contagious diseases
g. Sudden unexpected or unexplained deaths in the facility which appear natural and are not subject to forensic medical jurisdiction
h. Sudden unexpected or unexplained deaths that have occurred during or after any dental, medical or surgical procedures and/or therapeutic procedures
i. Deaths that are waived by forensic medical jurisdiction, (DOAs, patients deaths occurring within 24 hours of admission to the facility)

13.2-2 An autopsy may be performed only with a written consent, signed in accordance with State law. The persons who may consent to autopsies are identified in Chapter 10 of the California Association of Hospitals and Health Systems (CAHHS) Consent Manual. This consent must be documented in the medical record.

13.2-3 Except in coroner's cases, the hospital will provide referrals to a pathologist for a private autopsy. Communication between the attending physician and the pathologist prior to performance of an autopsy is essential and it is the responsibility of the pathologist to notify the attending physician when an autopsy will be performed and when indicated, a "limited" autopsy should be considered to focus efforts on organ system questions. Autopsies of suspected infectious etiology will be performed at the discretion of the pathologist in consultation with the attending physician. Provisional anatomic diagnoses shall be medically recorded on the medical record by the pathologist within forty-eight (48) hours after completion of the autopsy and the complete report should be made a permanent part of the medical record within sixty (60) days.

13.2-4 When a private physician's patient has an autopsy, that physician will be notified of the performance of the autopsy and of its results.

13.3 Coroner's Cases.

13.3-1 California Coroner's Statutes, as described in the Health and Safety Code 102850, and Government Code 27491, decrees that all certain deaths require the notification of the Medical Examiner Coroner. Physicians shall immediately notify the Coroner when he/she has knowledge of his/her patient's death if any of the below circumstances pertain:

a. Unknown or doubtful cause of death
b. Violent, sudden or unusual deaths
c. Death within 24 hours after admission to hospital
d. When deceased had not been seen by physician in 20 days
e. Physician unable to state cause of death
f. Known or suspected homicide
g. Involving any known or suspected criminal action
h. Related to or following known or suspected self-induced or criminal abortion
i. Associated with known or alleged rape or crime against nature
j. Following an accident or injury
k. Drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, acute alcoholism, drug addiction, strangulation or aspiration
l. Accidental poisonings
m. While in prison or under sentence (covers County jails)
n. Suspected sudden infant death syndrome (SIDS)
o. Deaths known or suspected as due to contagious disease and constituting public hazard
p. Deaths from occupational diseases or hazards
q. Deaths in state hospitals (SDC)

r. Death after which a request is made to remove remains from county absent a physician's consent to sign death certificate (coroner policy)

s. Death occurred without medical attendance

13.3-2 The Coroner's Report will be filed and become a permanent part of the patient's medical record.

13.4 Notifying Next of Kin. The Attending Physician, or his or her representative, is responsible for notifying the next of kin in all cases of death.

13.5 Disposition of Remains and Contributions of Anatomical Gifts

13.5-1 The patient's remains shall be disposed of in accordance with the instructions of the patient, the patient's legal representative, or his or her next of kin. The order in which the next of kin shall be consulted is set forth in the CAHHS Consent Manual.

13.5-2 If the patient or his or her family indicates that the patient has or will contribute anatomical gifts, consent shall be secured in accordance with the relevant law, which is described in the CAHHS Consent Manual. The patient's physician shall comply with hospital protocol for identifying potential organ and tissue donors, and, whenever possible, confer with the patient or family about donations.

13.6 Death Certificate**.** The attending physician or other physician last in attendance is responsible for signing the death certificate or ensuring its completion.

RULE 14
DISCHARGE OF PATIENTS

14.1 General

14.1-1 Patients shall be discharged only on the written order of the attending physician or his or her designee. The attending physician shall see that the record is complete, state the final diagnosis and sign the medical record. Appropriate discharge instructions for care will be given to the patient or family using current hospital format and a copy is to be retained in the medical record.

14.1-2 Minors shall be discharged only to their parents or legal guardians or a person designated in writing by the parent or legal guardian, unless such parent or legal guardian shall direct otherwise in writing. This shall not preclude minors legally capable of contracting for medical care from assuming responsibility for himself/herself upon discharge. The Health Facility Minor Release Report of the CAHHS Consent Manual, must be completed whenever a minor is discharged to anyone except a parent, relative by blood or marriage, or legal guardian.

14.1-3 The attending physician should inform the Nursing Service of possible discharges as early as possible and enlist the aid of the Discharge Planning Coordinator when appropriate.

14.2 Leaving Against Medical Advice

14.2-1 If a patient indicated that he or she will leave the hospital without a discharge order from the attending physician, the nursing staff shall attempt to arrange for the patient to discuss his or her plan with the attending physician before the patient leaves.

14.2-2 Whenever possible, the attending physician shall discuss with the patient the implications of leaving the hospital against medical advice.

14.2-3 The patient who insists on leaving against medical advice shall be asked to sign the form entitled “Leaving Against Medical Advice”. If the patient cannot be located or refuses to sign the form, the nursing staff shall document in the patient’s medical record the facts surrounding the patient’s departure and an Incident Report shall be submitted to the hospital Risk Manager.

14.3 Refusal to Leave. Administration shall be contacted for assistance whenever a patient refuses to leave the hospital.

RULE15

DISCONTINUING LIFE-SUSTAINING TREATMENT:

WITHHOLDING AND WITHDRAWING MEDICAL CARE: ISSUING NO CPR CODE ORDERS

15.1 General. Decisions to withhold or withdraw medical care are to be made by the patient or his or her surrogate decision-maker after discussions with the patient's attending physician. The attending physician is responsible for providing advice regarding when medical care should be withheld or withdrawn.

15.2 No CPR Orders and Partial No CPR Orders

15.3-1 A No Cardiopulmonary Resuscitation Orders (NO-CPR) means to stop the otherwise automatic initiation of cardiopulmonary resuscitation (CPR). Such an order may be proper when the patient has an underlying incurable medical condition, does not have any reasonably conceivable possibility of recovering or long-term survival, and there is no medical justification or purpose which would be achieved by applying CPR should the natural course of a patient's medical condition cause vital functions to fail.

15.3-2 CPR will be initiated when cardiac or respiratory arrest is recognized, unless a NO-CPR Order is given. No resuscitative measures will be taken if the Physician writes "NO-CPR", "No Code" or "Do Not Resuscitate".

15.3-3 A partial NO-CPR or partial do not resuscitate order may be warranted in limited situations, such as when aggressive medical intervention is not indicated when a patient cannot survive the basic intervention. If a partial NO-CPR order is issued, the Physician must specify precisely which modalities shall be used and which shall not.

15.3 Issuing the Order. All orders to withhold or withdraw life-sustaining treatment must be written and signed by a physician on the physician order sheet in the patient's medical record. Orders not to resuscitate should be reviewed whenever there is a significant change in the patient's clinical condition to assure the orders remain constant with the patient's condition and desire.

RULE 16

DRUG/MEDICATION, TREATMENT, AND DIAGNOSTIC TESTING ORDERS

16.1 General

16.1-1 All orders for drugs/medications, treatment and diagnostic testing orders shall be in writing on the patient's order sheet and signed and dated by the Physician.

16.1-2 Drugs/medications, treatment, and diagnostic testing orders may only be accepted from a licensed practitioner and the order the licensed practitioner gives must be within the licensed practitioner's scope of practice as defined by state law and within the scope of the practitioner's clinical privileges.

16.1-3 Drug orders may be given only by a person lawfully authorized and credentialed to prescribe the particular drug being ordered.

16.1-4 All drugs/medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia National Formulary, American Hospital Formulary Service or the American Medical Association Drug Evaluations or newly approved medications that are approved medications that are not listed but have been approved by the appropriate Medical Staff Committee.

16.1-5 Drugs for bona fide clinical investigations are exceptions. All uses must be in compliance with the federal Protection of Human Subjects regulations, which are described in the CAHHS Consent Manual. Investigational drugs must be dispensed by the Hospital pharmacy according to established procedure for handling investigational drugs.

16.1-6 Orders for medications must include the name of the drug, the dosage and frequency of administration, the route of administration, if other than oral, and the date, time and signature of the prescriber or furnisher. If medications are to be given on an "as needed basis", the order must be specific why the medication is to be administered. If the order is for a broad dosage range, more than one (1) drug for the same indication, and/or for more than one (1) route of administration, there must be additional information on how to administer the medication.

16.1-7 No drugs shall be administered except by licensed personnel authorized to administer drugs and upon the order of a person lawfully authorized to prescribe. This shall not preclude the administration of aerosol drugs by respiratory therapists.

16.2 Review of Drug Orders

16.2-1 Each physician is expected to review all medications for all patients regularly to ensure discontinuation of all orders that are no longer needed.

16.2-2 Automatic stop order policies shall be effected as follows:

A. Antibiotics: 7 days

B. Narcotics: 7 days

C. All Other Medications: 32 days

The pharmacist shall notify the attending or ordering physician whenever an automatic stop note has been ordered by placing a notice in the medical record approximately two days prior to the automatic stop.

16.2-3 An automatic stop order does not apply when the prescriber specifies the number of doses or an exact and reasonable period of time.

16.2-4 Orders for drugs will automatically stop and any new or continuing drugs must be rewritten when:

A. A patient goes to surgery.

B. Patient's level of care is changed.

16.3 Procurement of Drugs

18.3-1 All drugs shall be procured from the hospital pharmacy except as specified in this Section.

18.3-2 All drugs and medications brought to the hospital by patients will be turned over for safekeeping to the nurses in charge of the patient's care and may be administered to the patient only if the medication is clearly identified by the hospital's pharmacist and specifically ordered by the patient's attending physician

16.4 Substitution of Generic Drugs. Generic drugs may be dispensed unless ordered otherwise.

16.5 Verbal Orders

Orders dictated to a licensed person by a person lawfully authorized to prescribe are known as verbal orders. Verbal orders can be given in emergency situations or situations when the person lawfully authorized to prescribe is physically unable to write the orders.

16.5-1 Verbal/telephone orders for the administration of medications shall be received and recorded only by those health care professionals whose scope of licensure authorizes them to receive orders for medications. Verbal / telephone orders must be verified by having the person receiving the information record and "read-back" the complete order.

16.5-2 Verbal/telephone orders for treatments and diagnostic testing may be given to other licensed care professionals (i.e. respiratory therapist, radiology technologist,

medical technologist, physical therapist, and dietitian) as related to their scope of practice.

16.5-3 Verbal/telephone orders must be countersigned by the physician within forty-eight (48) hours. Verbal orders for restraints must be countersigned within twenty-four (24) hours.

16.6 Standing Orders

16.6-1 Standing orders for drugs may be used for specified patients when authorized by a person licensed to prescribe. Copy of standing orders for a specific patient must be promptly signed, dated and timed by the prescriber, and included in the patient's medical record. These standing orders must:

A. Specify the circumstances under which the drug is to be administered;

B. Specify the types of the medical conditions to which the standing orders are intended to apply;

C. Be initially approved and reviewed annually by the appropriate Medical Staff Committee.

D. Be specific as to the drug, dosage route and frequency of administration.

16.6-2 Standing orders for other forms of treatment may be used for specified patients when authorized by a person licensed and given privileges to issue the orders. A copy of standing orders for specific patient must be dated, promptly signed by the physician, and included in the patient's medical record. These standing orders must:

A. Specify the circumstances under which the orders are to be carried out;

B. Specify the medical conditions to which the standing orders are intended to apply;

C. Be specific as to the orders that are to be carried out, including all of the relevant information that usually is given in the order;

D. Be initially approved and reviewed annually by the appropriate Medical Staff Committee.

16.7 Legibility. The physician's orders must be written clearly, legibly, and completely. Orders that are unclear, illegible or incomplete will not be carried out until rewritten or understood by the nurses.

RULE 17

DUES AND APPLICATION FEES

17.1 ***Dues.*** *The annual dues for Medical Staff Members shall be determined by th*e Medical Executive Committee on an annual basis. Note, Allied Health Professionals do not pay dues as they are not staff members.

17.2 Application Fees

17.2-1 Each applicant for Medical Staff membership shall be required to pay a non-refundable application fee.

17.2-2 Allied health professional applicants shall be required to pay a non-refundable application fee. This fee may be waived at the discretion of the Medical Executive Committee

RULE 18

DISASTER PLAN

It shall be the responsibility of the Emergency Management Committee to prepare and keep updated plans for disasters within and outside of the hospital. In the event of such a disaster or preparatory drill, all Medical Staff members shall report to their assigned stations. None shall perform any duties other than those assigned. The Chief of Staff and the Hospital's Chief Executive Officer will work as a team to coordinate activities and directors. In cases of evacuation from hospital premises, the Chief of Staff will authorize the movement of patients. All policies concerning patient care will be joint responsibility of the Chief of Staff and the Hospital's Chief Executive Officer. In their absence, the Vice Chief of Staff and the Hospital's Chief Executive Officer's designee are next in line of authority, respectively. All Medical Staff Members specifically agree to relinquish direction of the professional care of their patients to the Chief of Staff in cases of emergencies.

RULE19

ADOPTION AND AMENDMENT TO RULES AND REGULATIONS

19.1 The Medical Executive Committee shall adopt such General Rules and Regulations as may be necessary for the proper conduct of its work as outlined in the Medical Staff Bylaws. Amendments to the Medical Staff General Rules and Regulations shall be made by the Medical Staff Executive Committee and shall become effective after approval by the Board of Trustees.

19.2 The General Rules and Regulations shall be reviewed and revised, if necessary, at least annually, and more often as required, to reflect the actual practices of the Medical Staff.

APPROVALS	**DATE:**
_____ Keith Chamberlin, MD, Chief of Staff MEDICAL EXECUTIVE COMMITTEE	February 17, 2017
_____ Peter Hohorst, Chair BOARD GOVERNANCE COMMITTEE	
_____ Jane Hirsch, Chair BOARD OF DIRECTORS	

6.

STRYKER SYSTEM PRESENTATION

STRYKER SYSTEM
The Next Level in Surgical Visualization

Sonoma Valley Health Care District
Board of Directors Meeting
April 6, 2017

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

- http://www.stryker.com/en-us/Solutions/AIMPlatform/index.htm?general-surgery-content

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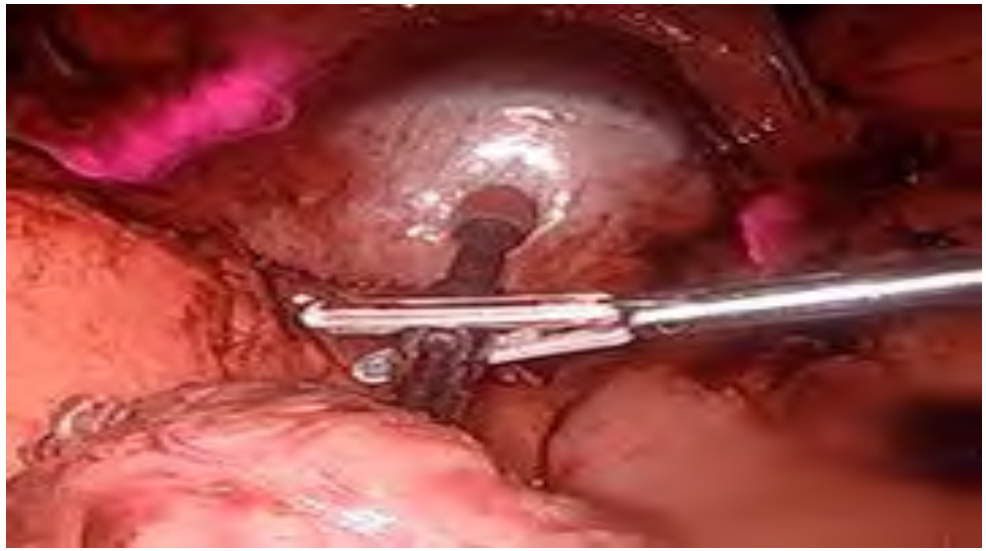
The 1588 AIM Platform for General Surgery:

1. IRIS: Infrared Illumination System

IRIS is a visualization technology designed to reduce the risk of ureteral damage. When IRIS mode is activated on the light source,
lighted pre-placed stents transilluminate the ureters so that the surgeon can avoid damaging them.
Useful in Colorectal surgeries (Dr. Kidd)



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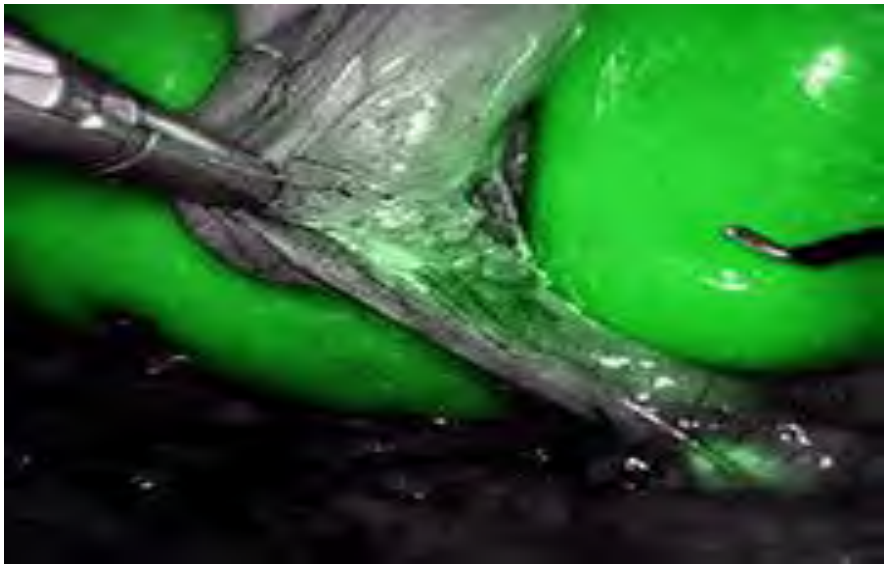
The 1588 AIM Platform for General Surgery:

2.ENV: Endoscopic Near-Infrared Visualization

ENV enhances visualization of anatomy in real-time during minimally invasive surgery. When ENV mode is activated, it provides visual assessment of blood flow, tissue perfusion, and biliary ducts by using fluorescent light. ENV is used with a fluorescent indocyanine green (ICG) dye. Additional Scopes are needed to engage this technique. Vendor is bringing in for trial.



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The 1588 AIM Platform for General Surgery:

3. Clarity

A real-time video enhancement device designed to amplify visualization by improving clarity, contrast and detail. This military grade technology helps you see through smoke and sub optimal conditions by improving image quality up to 48%. There are 6 levels of visual enhancement available.

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Room Setup before Stryker

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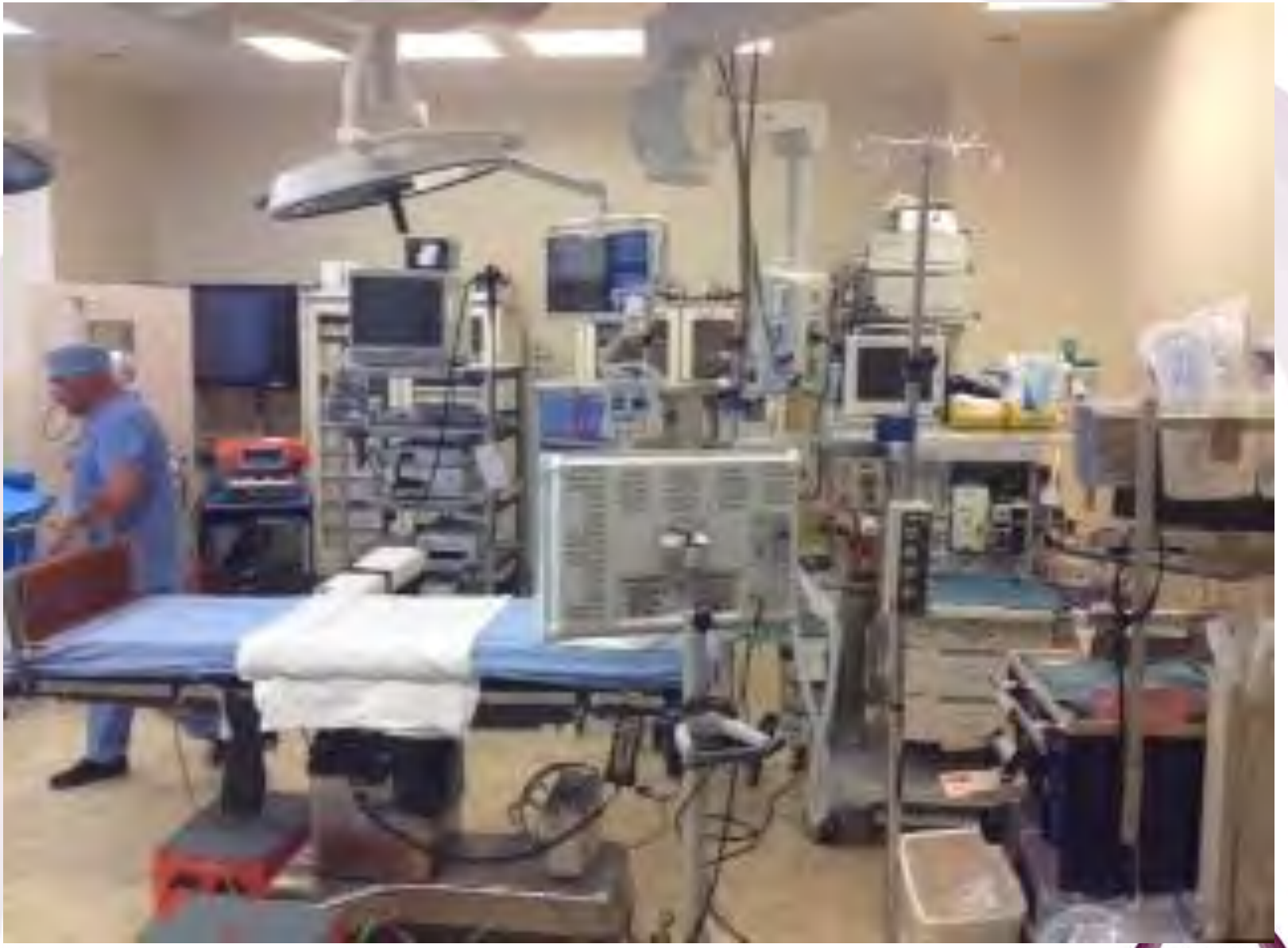

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Room Setup after Stryker

VALLEY HOSPITAL
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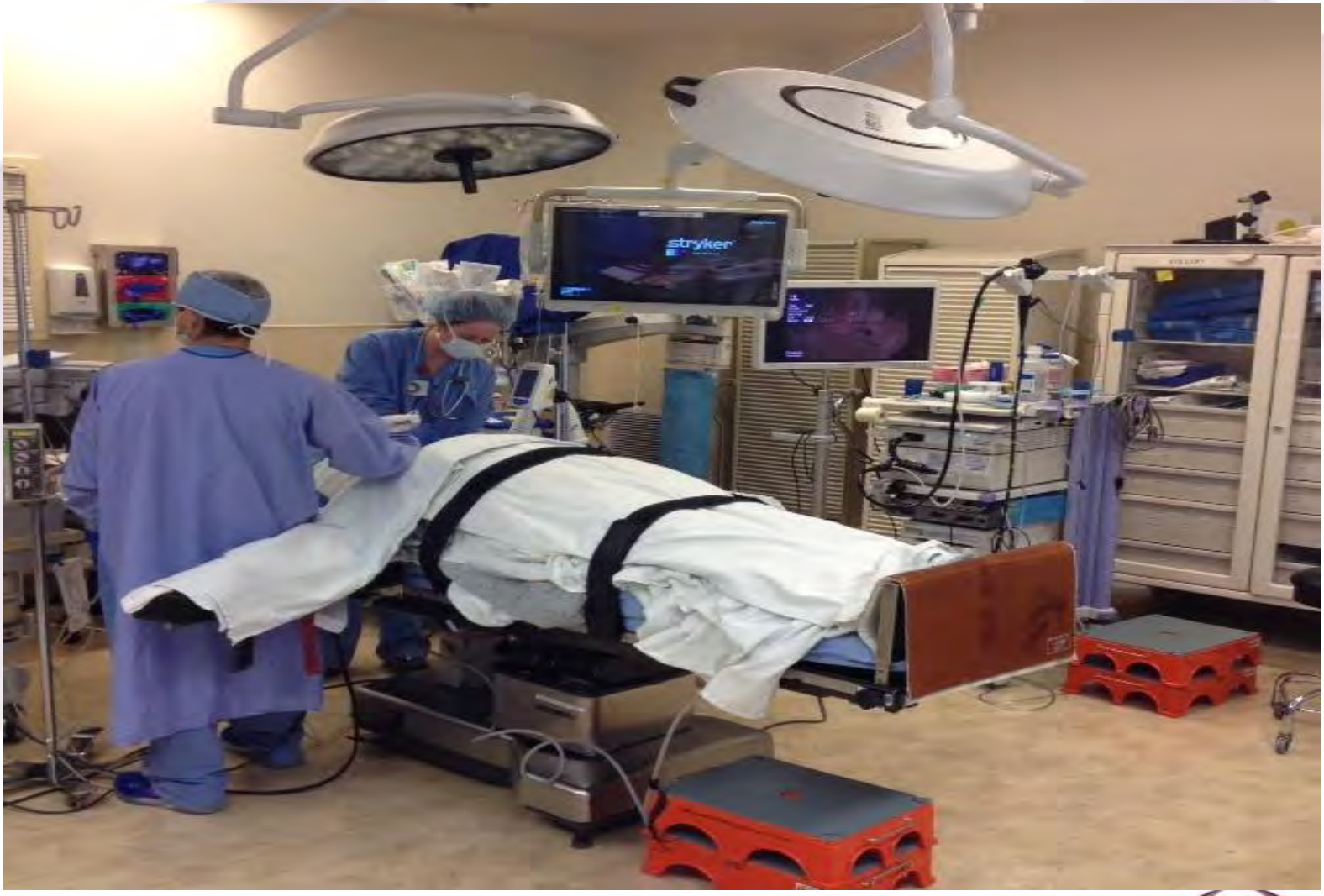

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Enhanced visualization for the surgeons.

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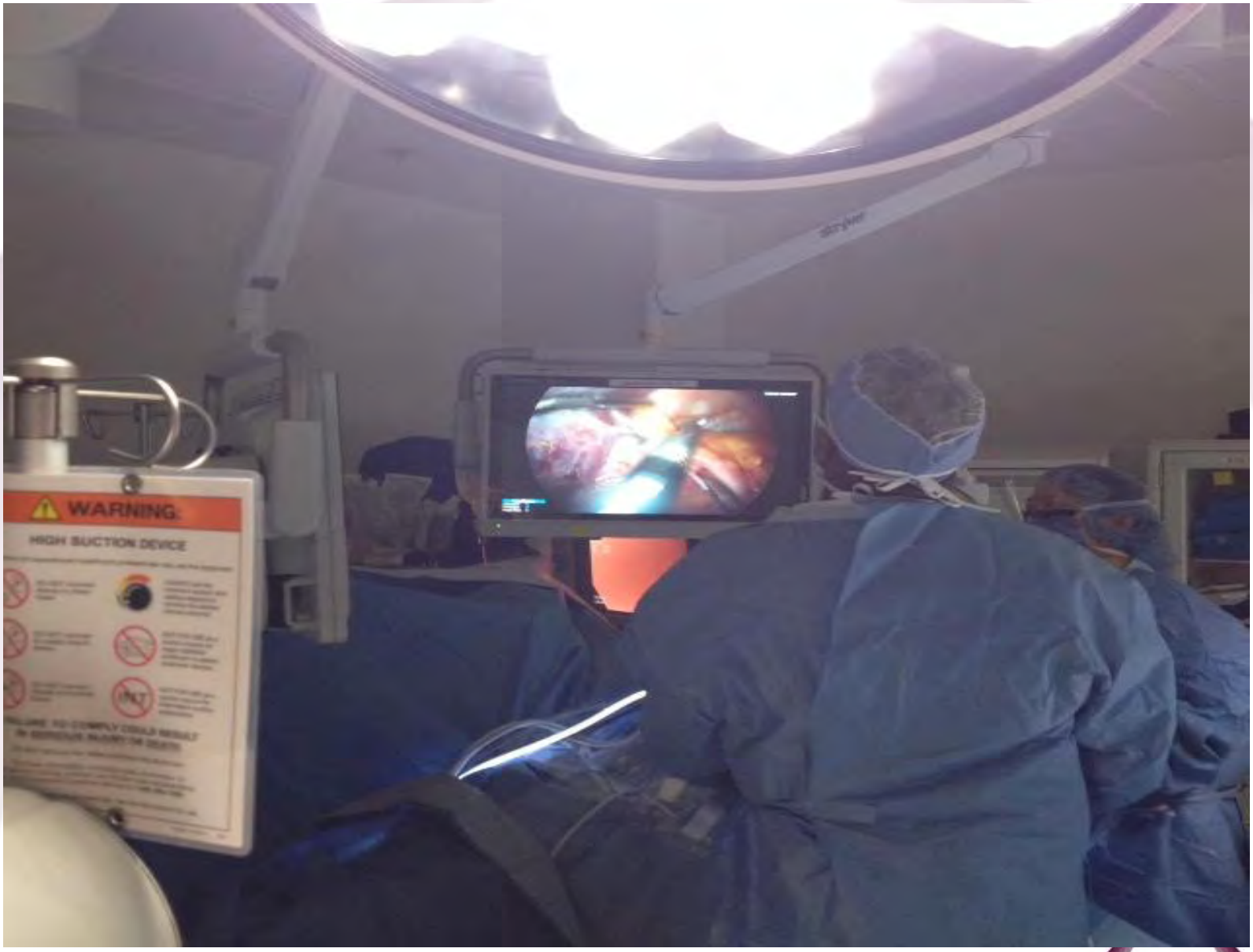

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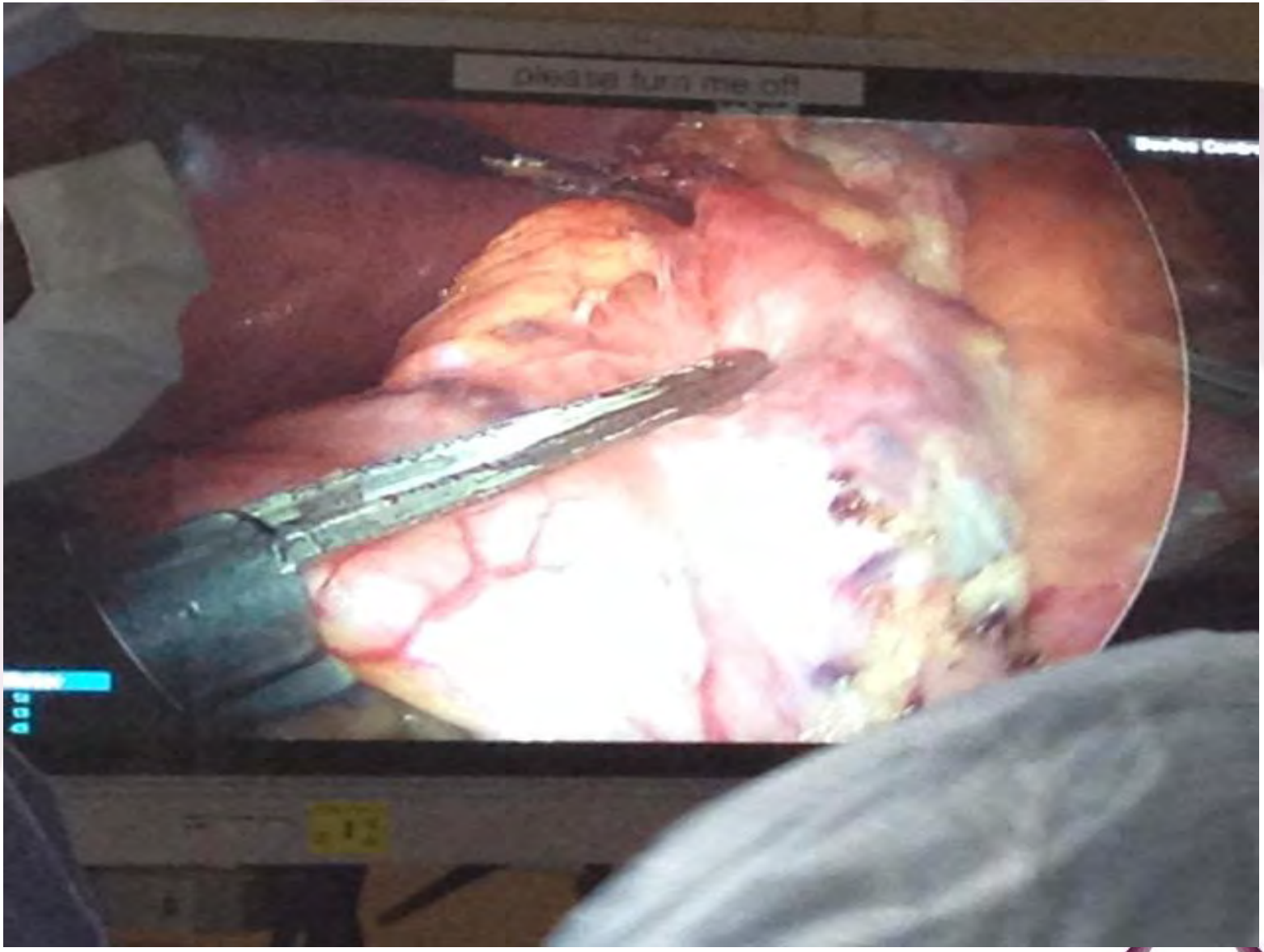

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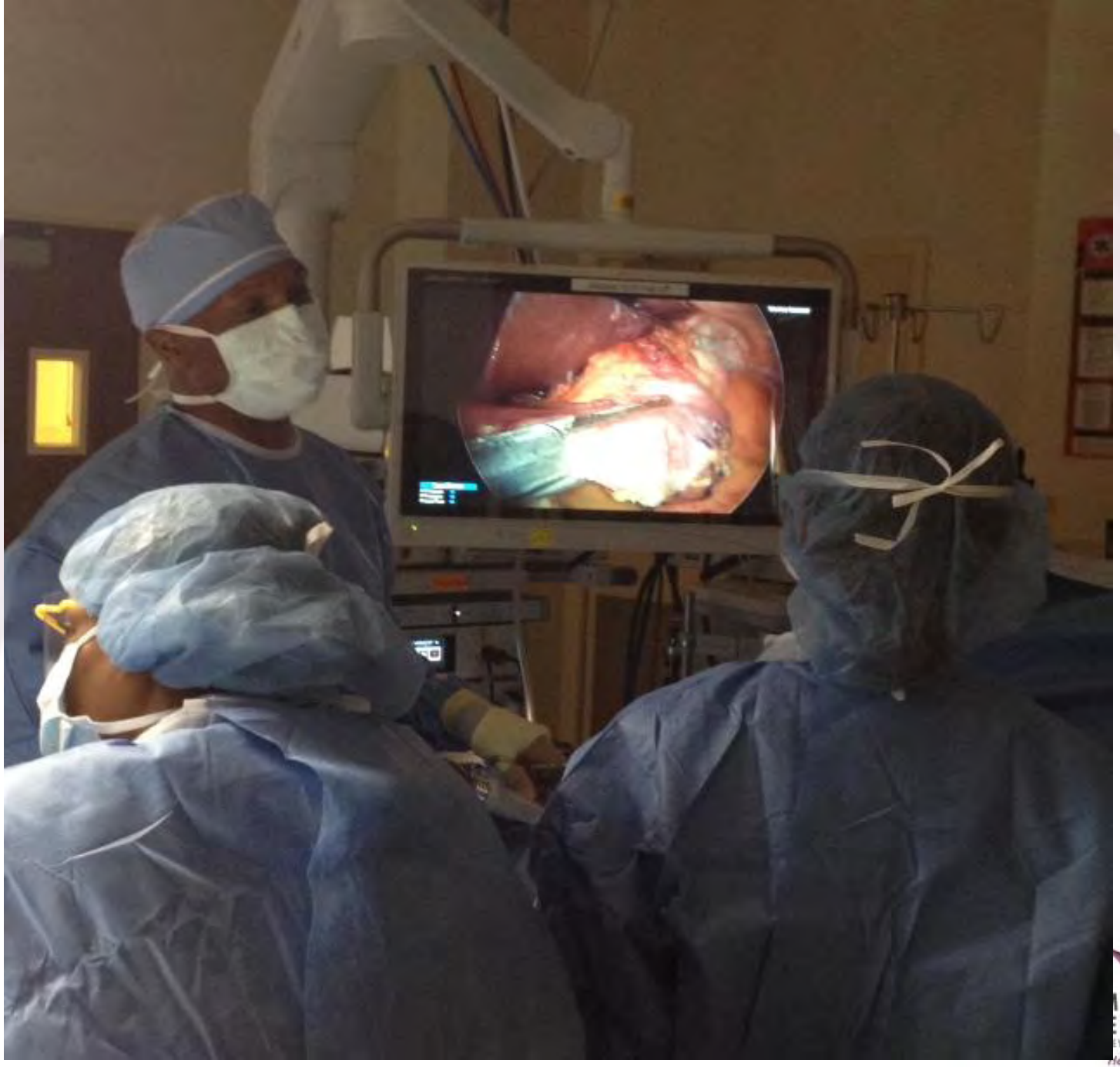
Healing Here at Home



SVH Surgeons' Comments on Stryker System (March 2017)

"One of the things that makes Sonoma Valley Hospital unique is that I can honestly say that we are able to deliver true state-of-the-art care in an intimate community hospital setting. In my own practice, I am able to perform advanced arthroscopic procedures and techniques for a variety of injuries to the shoulder, elbow, wrist, hand knee foot and ankle. However, to be able to continue to deliver this high level of care in our own hospital requires a continual investment from our community. Thanks to our Foundation, we are now using a fantastic new arthroscopy system that will allow us to go even further in advancing arthroscopic or minimally invasive surgery. There are truly very few reasons for an Orthopedic patient to leave Sonoma Valley."

Noah D. Weiss, MD

Orthopedic Surgery

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"The new Stryker OR equipment provides state-of-the-art video guidance for advanced laparoscopic surgery and colonoscopies. This is essential technology that allows me to provide minimally invasive abdominal surgery to patients with improved visualization and accuracy which ultimately improves outcomes, decreases surgical time and thus cost as well. It also improves the flow and safety in the OR via its ceiling installation. This system is a great long-term investment for Sonoma Valley Hospital and one of the many reasons I find working there to be so enjoyable."

Sabrina Kidd, MD, FACS, FASCRS
Colorectal & General Surgery

"The new towers keep cords off the floor and allow easier/safer access around the patient while doing laparoscopy. There are cases where you need circumferential access, and that was difficult with the old rolling towers."

Russell W. Sawyer, MD, PC
General Surgery

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7.

FY 2018 ROLLING STRATEGIC PLAN

FY 2018 ROLLING THREE-YEAR STRATEGIC PLAN

Strategic Priorities FY 2018 –2020

- **Achieve the highest levels of health care safety, quality and value**
- **Be the preferred hospital for patients, physicians, employers and health plans**
- **Implement new and enhanced revenue strategies**
- **Continue to improve financial stability**
- **Lead progress toward being a healthier community**

Achieve the highest levels of health care safety, quality and value as measured by Patient Satisfaction and National Quality Benchmarks

A) Continue to implement cutting edge practices for Emergency Care
B) Develop goals and standards for becoming a "Highly Reliable Organization" and begin implementation
C) Implement more Evidence-based medicine tools such as Choose Wisely and National Registries
D) Improve inpatient satisfaction by adding "What Matters to You" program
E) Remain in the top quartile for staff engagement and satisfaction
F) Continue the "Culture of Safety" initiatives and monitoring
G) Use the departmental Quality Assurance/Performance Improvement plans to create an organization-wide quality goal

Be the preferred hospital for patients, physicians, employers and health plans as measured by volume and referrals

A) Begin the construction of an Outpatient Diagnostic Center with state-of-the-art equipment
B) Add a patient engagement tool such as "Rate My Hospital" to obtain immediate feedback from outpatients
C) Increase physician and office staff outreach to ensure we are meeting their needs
D) Implement a transparency tool for patients to show financial obligations up front
E) Market our value (high quality/lower cost) to employers and health plans
F) Track and increase physician loyalty in referrals to all services and measure their satisfaction

Implement new and enhanced revenue strategies as measured by increased direct margins in each service area

A) Continue to increase volumes by drawing patients from outside of the District
B) Implement the Chronic Pain Network using alternative therapies such as medical cannabis addressing addiction such as opioids
C) Create awareness of our high quality and value General Surgery service line from bariatrics to colorectal services
D) Open a Rural Health Center with local primary care physicians
E) Evaluate opening an Urgent Care center after hours in Occupational Health
F) Continue to expand marketing of Occupational Health to regional employers
G) Evaluate a mobile wound care clinic to increase access and patient convenience
H) Work with other hospitals to increase outside referrals to the Skilled Nursing Facility
I) Evaluate the feasibility of an Acute Detox Unit
J) Evaluate offering Chemotherapy locally with possible connection to larger name-brand hospital in the upgraded Pharmacy
K) Work with the Cardiology Associates of Marin to open a new office and Cardiology Center
L) Implement a Bariatric Institute
M) Work with current physicians on staff to expand Urology and OB/GYN
N) Expand the Birthplace into a Women's Center with new procedures and a breast surgeon
O) Continue to expand Orthopedic services through state contracts
P) Increase SNF admissions and recruit a dedicated physician
Q) Work with Employer Direct to become a destination hospital

Continue to improve financial stability as measured by operating margin

A) Use the cost accounting system to maximize Outpatient services margins
B) Negotiate with larger hospitals to keep patients local
C) Work with Meritage Medical Network to increase our Western Health Advantage revenue
D) Implement a sustainable solution for energy to decrease costs and waste
E) Determine the best purpose of the South Lot while retaining the parking lot
F) Develop a plan to improve Healing at Home margin
G) Evaluate the revenue cycle and identify opportunities to improve stability
H) Ensure the 1206b clinics are financially stable

Lead progress toward being a healthier community as measured by community benefit and reduced readmissions

A) Utilize Community Health Coaches for care transitions and to reduce readmissions
B) Continue to offer Wellness University and increase the number of ambassadors
C) Increase Outpatient Nutrition counseling services for Diabetes such as "Sweet Success"
D) Collaborate with the Integrative Health Network to enhance team-approach to healing

E) Work closely with the Community Health Center to ensure patients have access to primary care and speciality services
F) Continue health education and outreach through Girltalk, Active Aging Series and other programs
G) Increase the number of "Clinical Healers" as the foundation for the Healing Hospital ™
H) Assist SVHF to meet their annual giving goals and in leading a capital campaign
I) Use the Health Needs Assessment by La Luz to improve outreach to the Latino population

ENVIRONMENT ASSESSMENT: TRENDS IN HOSPITAL HEALTH CARE

SVH continues to navigate a disruptive period in health care that shows no signs of abating. Like most hospitals, we have adapted to changes brought about by the Affordable Care Act but now face a new period of uncertainty because it is unclear what changes to the Act may follow and how they will affect hospital revenues. Small community hospitals like ours are more at risk during this period because of our narrow patient base and already tight margins. Our hospital is at particular risk because of the outsized role that government insurance plays in our financials.

In addition, there are a number of industry trends that continue to affect our operations:

- Continued declines in reimbursement for services by both government and commercial payers.
- Continued mandates to reduce hospital inpatient care utilization.
- The challenge of managing operations with greater efficiency while simultaneously meeting ever-higher quality of care standards.
- Increased competition among regional hospitals that necessitates even small hospitals expand core services, especially for outpatient services.
- The critical importance of maintaining a convenient and well-managed Emergency Department with the attendant high-value services this requires.
- Continued integration of various providers and payers linked to an overall patient management regime, one that increasingly extends beyond the hospital and into the home.

In response to these and other challenges, hospitals have by necessity become more creative in addressing patient needs. This includes increased emphasis on outpatient services; employing a team approach that coordinates inpatient and outpatient care for defined populations; forging new relationships with physicians; and monitoring quality of care outcomes even outside of the hospital. There also is growing awareness of the need for strategic partnerships among hospitals to efficiently provide certain critical services.

The future role of a primary care hospital in smaller communities like ours continues to emerge. However, as health care trends take shape, we have taken steps in a number of areas with positive results.

Payer Reimbursement

We continue to see declines in reimbursement, driven by government payer programs, which impact all types of insurance and place increased pressure on margins. This requires hospitals to become more efficient while searching for new revenue. For small hospitals in California, the dominance of government as the main reimbursement source underscores the need for greater efficiency, especially as the level of that reimbursement is low. With over 70% of our patients depending on Medicare or Medi-Cal programs, SVH has made considerable progress in managing costs and improving margins, even while increasing quality.

Emergency Care

Emergency care remains our number one priority. Our modern Emergency Department, which opened in 2014, continues to provide advantages in operating efficiency and patient satisfaction. Since opening the new wing, we have seen patient visits to the Emergency Department increase by 20 percent while maintaining wait times shorter than the industry average and high levels of patient satisfaction.

Outpatient Services

It's clear that access and efficiency for outpatient services is the key to a sustainable hospital. Following industry trends, we continue to grow those outpatient services important for our future while strategically adding new services by recruiting physician specialists. As part of this effort, we have opened two physician timeshare offices near the hospital to make it easier for specialists to see patients here. We also have increased revenues by marketing certain specialized services, such as bariatric and orthopedic surgery, outside of our immediate market.

Services Integration

Moving ahead, tighter integration of physicians, providers and hospital networks is needed to deliver comprehensive and coordinated care, including wellness/prevention, episodic care, and management of chronic conditions. Effective integration management can ensure sustainable delivery systems, especially as reimbursement moves toward bundled payments and capitation arrangements based on the wellness, outcomes and the health status of individuals. SVH is well positioned for this because we offer services across the entire continuum of care including Skilled Nursing, Home Health Care and Outpatient Rehabilitation. In addition, we are aligned with Prima Medical Foundation and are expanding our 1206b physician clinics.

Quality of Care

Finally, we will always place a very strong emphasis on quality, patient safety and outcomes, as well as advances in information technology, electronic health records, and telemedicine. While positive and necessary, these contribute to rising health care expenditures and must be managed appropriately.

SVH SITUATION ANALYSIS

The Community Served

SVH serves a small community, running from Glen Ellen through the City of Sonoma, including Boyes Hot Springs, El Verano, Fetters Hot Springs and Agua Caliente, and also Temelec, Shellville, Eldridge and Vineburg. The two main zip codes served are 95476 and 95442, which identifies the primary service area. The population of the district is approximately 42,000.

Age of Residents and Growth Rate of Seniors

SVH's service area has a disproportionate share of 50+ residents and is under-represented in younger age categories. In 2016, residents aged 65 and older made up 23.2% of the total population and this segment of the population is growing the fastest. There are significantly more young people living in the Springs area compared to the rest of Sonoma Valley.

Growth of Latino Population

Over the past three years, Sonoma Valley's Latino population has increased to 28% and is projected to grow to 30% within the next several years. The Springs area has a significantly larger proportion of Latino residents at over 50%. In the Sonoma Valley overall, 35% of Latinos are uninsured. SVH continues to support the Hispanic population with increased access to health care services as well as bilingual health education and communication.

Payer Mix Trends

The hospital continues to address the effects of the changing payer mix. Medicare volumes are stable and continue to represent over half of our payer mix. Medi-Cal has increased significantly over the years and now represents 17% of the payer mix while the percentage of patients with commercial insurance is less than 20%. The dominance of government as the main reimbursement source underscores the need for additional sources of revenue and community support.

Patient Experience

SVH has above-average patient satisfaction and continues to improve. The Centers for Medicare and Medicaid Services (CMS) measures satisfaction in 9 domains, and each domain is compared to a national percentile rank. SVH is consistently above the 60th percentile in almost every domain. This means that SVH has higher inpatient satisfaction than 60 percent of all hospitals in the country. The Emergency satisfaction is in the top quartile.

Quality Outcomes

SVH is in the top 25 percent of hospitals in the nation based on quality of patient outcomes. We are also rated by CMS as a 4-star hospital. There are very few 4-star hospitals in the Bay Area, we are one of five in the entire North Bay. In addition to the CMS outcome measures, safety and quality indicators are regularly monitored and

reported to the board Quality Committee and all exceed national benchmarks. SVH staff and our physicians strive to provide excellent care for all of our patients.

Inpatient and Skilled Nursing Care

Inpatient admissions have increased over the prior year after declining rapidly for many years. Patient days were 11% above the prior year. Inpatient admissions were up 5% in FY 2017 from FY 2016. Skilled Nursing Facility patient days have decreased this past year due to shorter lengths of stay, but admissions have increased. Obstetrics is down 23% from 174 births in FY 2016 to a projected 141 births in FY 2017. This corresponds to trend of lower number of births in the Valley.

Emergency Care

SVH's market share for our Emergency Department is over 70%. The volume continues to increase each year from approximately 9,500 visits before the new department opened to almost 11, 000 visits per year currently. Patient satisfaction is very high and in the top quartile as compared to national benchmarks.

Outpatient Services

Outpatient services overall continue to grow by over 3% per year. MRI volumes increased over prior year. Mammography and Nuclear Medicine continue to decline due to technological advances. SVH has high market share in Diagnostics, Occupational Health, Wound Care and Physical Therapy. There is an opportunity to increase Echocardiograms with the addition of another Cardiologist in the community. The new 3D Mammography will also increase volumes.

Surgical Services

While it took a couple of years to increase surgeries, SVH has enjoyed great success in FY 2017 with surgical procedures growing by 10% over the prior year. Bariatrics has experienced a significant increase and this service line now attracts patients from outside the district. General Surgery, Orthopedics, Surgical Pain Management and Endoscopy have all increased. There is still opportunity to increase Opthalmology and Urology.

Managing Service Line Profitability

SVH continues to show improvement in direct operating margins in 8 of its 10 service units. The cost accounting system allows SVH to complete initiatives such as the consolidation of services and payor contract negotiation leverage. With this system, SVH has a more detailed level of analysis, to continuously improve and adjust to reductions in reimbursements without compromising safety and quality.

Financial Stability

Over the past three years, SVH has decreased all non staff and physician expenses. The cash on hand has improved in FY 2017. In addition, the amount of trade payables is now in line with cash. Much of the deferred maintenance from the past 30 years has been addressed but there is still major physical plant and equipment upgrades needed. Some of the long term debt has been paid off except for the line of credit.

Primary Care

The shortage of Primary Care coverage is becoming more of a challenge for Sonoma Valley. In a recent survey, 70% of our PCPs report they are not accepting new patients. This situation recently has been improved with the addition of two new primary care providers and a concierge physician.

Charity Care

The hospital serves all patients who require it, regardless of the ability to pay. As such, SVH provides substantial amounts of uncompensated care. When this care is provided to patients who lack the financial resources, it is classified as Charity Care. In FY 2016, the hospital provided $294,762 in Charity Care.

Community Benefit

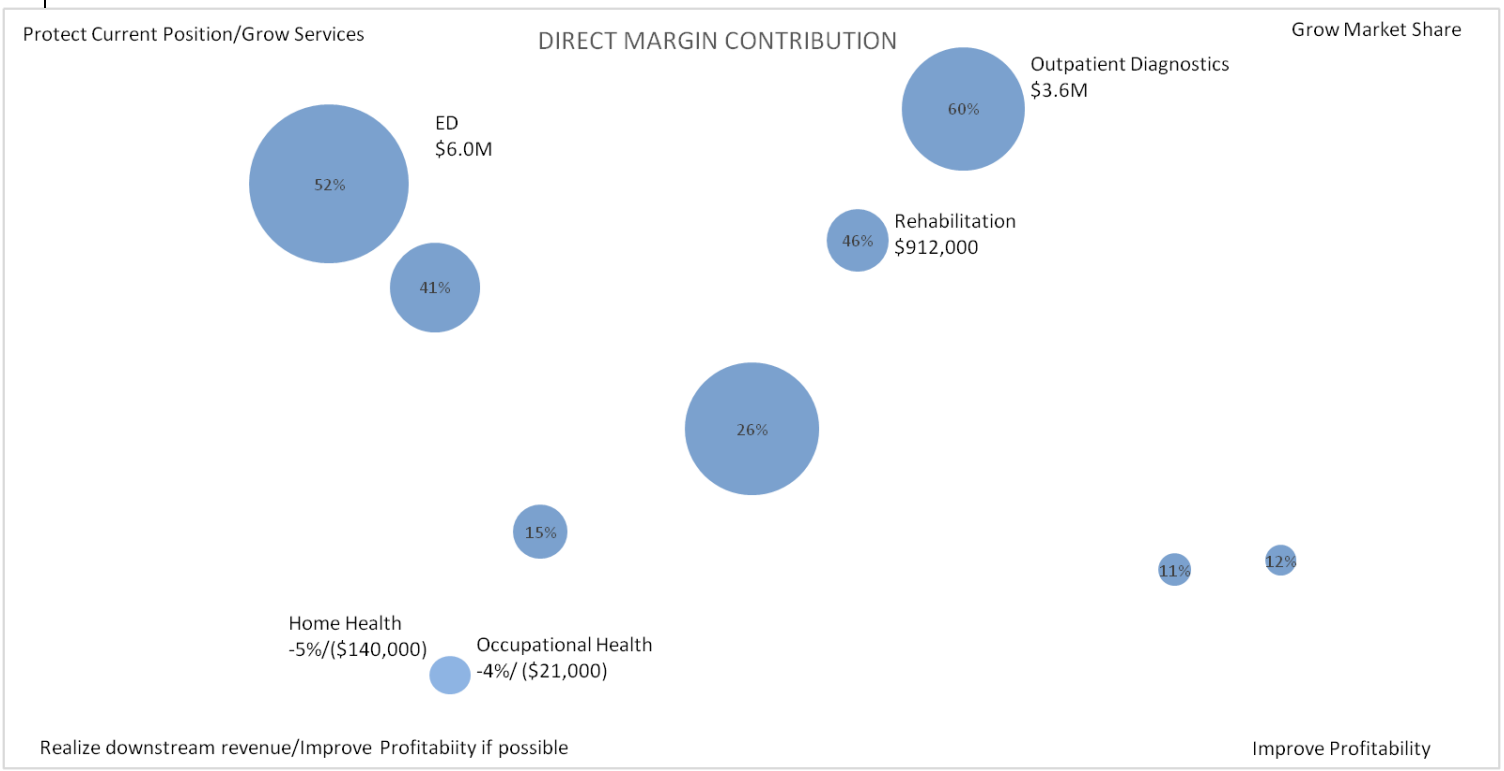
The hospital leadership provides many innovative health improvement programs to the community. We participate in many community activities such as health fairs and educational events. Many of our programs are collaborative with organizations such as Vintage House, the Sonoma Valley Health Center and Integrative Health Practitioners.

COMPETITIVE ASSESSMENT

As the only hospital in a relatively isolated Valley, SVH has a very distinct market with over 80% of our patients coming from the District. The closest hospital is 14 miles away (Petaluma Valley Hospital). While Kaiser, Sutter and St. Joseph's continue to have some inpatient market share in our primary market area, SVH has experienced a slight growth in our own inpatient market share. Emergency market share also continues to increase each year. Outpatient services has increased or maintained market share. Skilled Nursing and Home Care have very high market share.

INSERT MAP of Hospitals in surrounding area with beds and mileage

Sonoma Valley Hospital has made a concerted effort in recent years to reduce the migration of patients to competitors outside of our market, mainly by adding specialist services in our community. As a result, local referrals have increased 10% in the past year. Santa Rosa Memorial Hospital continues to be the largest competitor for inpatient and outpatient migration outside of our market. Most inpatient admissions that are not provided by SVH are for services that a primary care hospital should not provide.



8.

FINANCIAL REPORT
MONTH ENDING
FEBRUARY 28, 2017

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: **SVH Finance Committee**
From: **Ken Jensen, CFO**
Date: **March 28, 2017**
Subject: **Financial Report for the Month Ending February 28, 2017**

The actual loss of ($514,286) from operations for February was ($156,039) unfavorable to the budgeted loss of ($358,247). The year-to date actual loss from operations is ($3,520,214) compared to the expected loss of ($3,247,325). After accounting for all other activity, the February net income was $307,753 vs. the budgeted net loss of ($8,761) with a monthly EBIDA of 0.5% vs. a budgeted 3.5%. Year-to-date the total net income is $456,879 favorable to budget with a year to date EBIDA of 2.0% vs. the budgeted 2.6%.

Gross patient revenue for February was $20,320,692, ($344,757) less than expected. Inpatient gross revenue was under budget by ($106,114). Inpatient days were over budgeted expectations by 36 days but inpatient surgeries were under budget by (15) cases. Outpatient revenue was under budget by ($969,339). Outpatient visits were under budgeted expectations by (539) visits and outpatient surgeries were under budget by (16) cases. The Emergency Room gross revenue is over budget by $663,778; ER visits are under budget by (13) visits but had higher charges per patient due to higher acuity patients. SNF gross charges were over budgeted expectations by $98,671 and SNF patient days were at budget at 607 days. Home Health was under budget by ($31,753) with visits under budget by (114) visits.

Deductions from revenue were favorable to budgeted expectations by $100,892. The favorable variance is due to February's accrual of the Prime Grant of $125,000. Without the accrual of the Prime grant and cost report adjustment the revenue deductions would be unfavorable to budget by ($31,649). This is primarily due to the unfavorable variance in IP and OP surgeries and the length of stay in the ICU was 12.6 days on a budgeted expectation of 5.9 days contributing to the increase in revenue deductions.

After accounting for all other operating revenue, the **total operating revenue** was unfavorable to budget by ($272,455).

Operating Expenses of $4,802,557 were favorable to budget by $116,416. Salaries and wages were under budget by $29,115 and employee benefits are over budget by ($21,264) due to PTO being over budget by ($8,025) and employee benefits (FICA) being over budgeted expectations by ($13,239). Supplies are under budget in February due to the cost of surgical implants being under budgeted expectations by $28,219 and the pharmacy's participation of the 340b drug pricing program; the pharmacy's drug costs were better than budget by $38,046. Purchase services were under budget by

$33,258 due to budgeted services not used in the month of February. Interest expense is over budget in February due to the unbudgeted interest expense related to the south lot loan and the fluoroscopy project.

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for February was ($310,398) vs. a budgeted net loss of ($166,102). The total net income for February after all activity was $307,753 vs. a budgeted net loss of ($8,761).

EBIDA for the month of February was 0.5% vs. the budgeted 3.5%.

Patient Volumes – February

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	**97**	**98**	**-1**	**101**
Newborn Discharges	**12**	**11**	**1**	**9**
Acute Patient Days	**415**	**379**	**36**	**417**
SNF Patient Days	**607**	**607**	**0**	**671**
Home Care Visits	**922**	**1,036**	**-114**	**889**
OP/ER/HHA Gross Rev.	**$12,189**	**$12,524**	**($335)**	**$12,049**
Surgical Cases	**127**	**158**	**-31**	**127**

Gross Revenue Overall Payer Mix – February

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	**45.2%**	**47.2%**	**-2.0%**	**45.8%**	**47.2%**	**-1.4%**
Medicare Mgd Care	**13.4%**	**7.1%**	**6.3%**	**10.5%**	**7.1%**	**3.4%**
Medi-Cal	**16.1%**	**18.8%**	**-2.7%**	**17.2%**	**19.0%**	**-1.8%**
Self Pay	**0.5%**	**1.1%**	**-0.6%**	**1.4%**	**1.2%**	**0.2%**
Commercial	**19.7%**	**20.0%**	**-0.3%**	**20.5%**	**20.0%**	**0.5%**
Workers Comp	**2.8%**	**3.1%**	**-0.3%**	**2.6%**	**2.8%**	**-0.2%**
Capitated	**2.3%**	**2.7%**	**-0.4%**	**2.0%**	**2.7%**	**-0.7%**
Total	**100.0%**	**100.0%**		**100.0%**	**100.0%**	

Cash Activity for February:

For the month of February the cash collection goal was $2,990,696 and the Hospital collected $4,023,651 or over the goal by $1,032,955. The year-to-date cash collection goal was $27,900,333 and the hospital has collected $29,972,477, or over goal by $2,072,144. Days of cash on hand are 27.0 days at February 28, 2017. Accounts Receivable decreased from January, from 49.7 days to 45.7 days in February. Accounts Payable decreased by $288,789 from January and Accounts Payable days are at 38.9.

ATTACHMENTS:

-Attachment A is the Payer Mix Analysis which includes the projected collection percentage by payer.

-Attachment C is the Balance Sheet

-Attachment D (two pages) is the Statement of Revenue and Expense. The first page breaks out the hospital operations and page two includes all other activity.

-Attachment E is the Variance Analysis. The line number tie to the Statement of Revenue and Expense line numbers and explains any significant variances.

Sonoma Valley Hospital
Payer Mix for the month of February, 2017

ATTACHMENT A

	February-17				YTD			
Gross Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	9,192,976	9,714,750	-521,774	-5.4%	78,544,090	78,347,267	196,823	0.3%
Medicare Managed Care	2,730,527	1,460,497	1,270,030	87.0%	18,095,297	12,010,252	6,085,045	50.7%
Medi-Cal	3,272,736	3,876,391	-603,655	-15.6%	29,336,818	31,597,247	-2,260,429	-7.2%
Self Pay	95,338	231,531	-136,193	-58.8%	2,559,510	1,949,590	609,920	31.3%
Commercial & Other Government	4,006,519	4,188,665	-182,146	-4.3%	35,339,533	33,505,941	1,833,592	5.5%
Worker's Comp.	561,365	634,243	-72,878	-11.5%	4,494,518	4,597,641	-103,123	-2.2%
Capitated	461,231	559,372	-98,141	-17.5%	3,484,081	4,411,309	-927,228	-21.0%
Total	**20,320,692**	**20,665,449**	**(344,757)**		**171,853,847**	**166,419,247**	**5,434,600**	

Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	1,554,130	1,687,744	-133,614	-7.9%	12,512,244	13,418,888	-906,644	-6.8%
Medicare Managed Care	385,806	237,528	148,278	62.4%	2,471,904	1,836,265	635,639	34.6%
Medi-Cal	424,801	527,964	-103,163	-19.5%	3,983,982	4,728,412	-744,430	-15.7%
Self Pay	42,387	92,612	-50,225	-54.2%	956,755	767,189	189,566	24.7%
Commercial & Other Government	1,451,640	1,656,221	-204,581	-12.4%	12,102,761	13,316,680	-1,213,919	-9.1%
Worker's Comp.	139,230	160,411	-21,181	-13.2%	1,022,941	1,042,224	-19,283	-1.9%
Capitated	13,745	18,124	-4,379	-24.2%	107,060	153,425	-46,365	-30.2%
Prior Period Adj/IGT	125,000	-	125,000	*	2,094,626	-	2,094,626	*
Total	**4,136,739**	**4,380,604**	**(243,865)**	**-5.6%**	**35,252,273**	**35,263,083**	**(10,810)**	**0.0%**

Percent of Net Revenue:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	37.6%	38.5%	-0.9%	-2.3%	35.6%	38.0%	-2.5%	-6.6%
Medicare Managed Care	9.3%	5.4%	3.9%	72.2%	7.0%	5.2%	1.8%	34.6%
Medi-Cal	10.3%	12.1%	-1.8%	-14.9%	11.3%	13.4%	-2.1%	-15.7%
Self Pay	1.0%	2.1%	-1.1%	-52.4%	2.7%	2.2%	0.5%	22.7%
Commercial & Other Government	35.1%	37.8%	-2.7%	-7.1%	34.3%	37.8%	-3.5%	-9.3%
Worker's Comp.	3.4%	3.7%	-0.3%	-8.1%	2.9%	3.0%	-0.1%	-3.3%
Capitated	0.3%	0.4%	-0.1%	-25.0%	0.3%	0.4%	-0.1%	-25.0%
Prior Period Adj/IGT	3.0%	0.0%	3.0%	*	5.9%	0.0%	6.0%	*
Total	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**

Projected Collection Percentage:	**Actual**	**Budget**	**Variance**	**% Variance**	**Actual**	**Budget**	**Variance**	**% Variance**
Medicare	16.9%	17.4%	-0.5%	-2.9%	15.9%	17.1%	-1.2%	-7.0%
Medicare Managed Care	14.1%	16.3%	-2.2%	-13.5%	13.6%	15.3%	-1.7%	-11.1%
Medi-Cal	13.0%	13.6%	-0.6%	-4.4%	13.6%	15.0%	-1.4%	-9.3%
Self Pay	44.5%	40.0%	4.5%	11.3%	37.4%	39.4%	-2.0%	-5.1%
Commercial & Other Government	36.2%	39.5%	-3.3%	-8.4%	34.2%	39.7%	-5.5%	-13.9%
Worker's Comp.	24.8%	25.3%	-0.5%	-2.0%	22.8%	22.7%	0.1%	0.4%
Capitated	3.0%	3.2%	-0.2%	-6.3%	3.1%	3.5%	-0.4%	-11.4%
Prior Period Adj/IGT	0.6%	0.0%	0.6%	*	1.2%	0.0%	1.2%	*

ATTACHMENT C

Sonoma Valley Health Care District
Balance Sheet
As of February 28, 2017

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 4,331,056	$ 3,224,109	$ 1,842,966
2	Trustee Funds	2,699,211	1,691,454	2,970,872
3	Net Patient Receivables	7,543,693	8,118,058	8,556,938
4	Allow Uncollect Accts	(1,179,316)	(1,202,373)	(632,008)
5	Net A/R	6,364,377	6,915,685	7,924,930
6	Other Accts/Notes Rec	2,515,774	4,687,699	4,509,697
7	3rd Party Receivables, Net	961,331	1,750,015	727,100
8	Inventory	834,899	821,117	908,797
9	Prepaid Expenses	793,790	839,826	732,717
10	Total Current Assets	$ 18,500,438	$ 19,929,905	$ 19,617,079
12	Property,Plant & Equip, Net	$ 53,830,783	$ 53,542,041	$ 52,897,846
13	Specific Funds	259,348	326,047	439,163
14	Other Assets	-	-	143,691
15	Total Assets	$ 72,590,569	$ 73,797,993	$ 73,097,779
	Liabilities & Fund Balances			
	Current Liabilities:			
16	Accounts Payable	$ 2,841,397	$ 3,130,186	$ 3,346,012
17	Accrued Compensation	4,572,173	4,559,155	4,565,618
18	Interest Payable	110,266	661,595	799,793
19	Accrued Expenses	1,428,041	1,404,470	1,334,648
20	Advances From 3rd Parties	100,376	142,811	867,474
21	Deferred Tax Revenue	1,987,635	2,484,543	1,971,110
22	Current Maturities-LTD	1,709,727	1,708,979	1,709,727
23	Line of Credit - Union Bank	6,973,734	6,973,734	5,923,734
24	Other Liabilities	1,386	1,386	145,077
25	Total Current Liabilities	$ 19,724,735	$ 21,066,859	$ 20,663,193
26	Long Term Debt, net current portion	$ 37,185,596	$ 37,358,649	$ 36,623,727
27	Fund Balances:			
28	Unrestricted	$ 11,904,381	$ 12,078,136	$ 12,698,717
29	Restricted	3,775,858	3,294,350	3,112,142
30	Total Fund Balances	$ 15,680,238	$ 15,372,485	$ 15,810,859
31	Total Liabilities & Fund Balances	$ 72,590,569	$ 73,797,993	$ 73,097,779

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended February 28, 2017

	Month					Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Volume Information					
1	97	98	(1)	-1%	Acute Discharges	813	789	24	3%	792
2	607	607	-	0%	SNF Days	4,452	5,035	(583)	-12%	5,099
3	922	1,036	(114)	-11%	Home Care Visits	7,428	7,324	104	1%	7,619
4	12,189	12,524	(335)	-3%	Gross O/P Revenue (000's)	$ 104,572	$ 102,491	2,081	2%	$ 99,735
					Financial Results					
					Gross Patient Revenue					
5	$ 6,030,469	$ 6,136,583	(106,114)	-2%	Inpatient	$ 51,648,447	$ 46,408,324	5,240,123	11%	$ 43,298,551
6	6,540,610	7,509,949	(969,339)	-13%	Outpatient	54,160,326	59,423,278	(5,262,952)	-9%	56,862,903
7	5,326,194	4,662,416	663,778	14%	Emergency	48,010,544	40,575,854	7,434,690	18%	40,618,325
8	2,103,699	2,005,028	98,671	5%	SNF	15,429,940	17,519,938	(2,089,998)	-12%	17,410,196
9	319,720	351,473	(31,753)	-9%	Home Care	2,604,590	2,491,853	112,737	5%	2,504,126
10	**$ 20,320,692**	**$ 20,665,449**	**(344,757)**	**-2%**	**Total Gross Patient Revenue**	**$ 171,853,847**	**$ 166,419,247**	**5,434,600**	**3%**	**$ 160,694,101**
					Deductions from Revenue					
11	$ (16,163,294)	$ (16,182,626)	19,332	0%	Contractual Discounts	$ (137,530,448)	$ (130,338,412)	(7,192,036)	-6%	$ (126,487,975)
12	(100,000)	(66,250)	(33,750)	-51%	Bad Debt	(940,000)	(530,000)	(410,000)	-77%	(590,000)
13	(53,200)	(35,969)	(17,231)	-48%	Charity Care Provision	(233,293)	(287,752)	54,459	19%	(215,366)
14	132,541	-	132,541	*	Prior Period Adj/Government Program Revenue	2,102,167	-	2,102,167	*	1,802,827
15	**$ (16,183,953)**	**$ (16,284,845)**	**100,892**	**-1%**	**Total Deductions from Revenue**	**$ (136,601,574)**	**$ (131,156,164)**	**(5,445,410)**	**4%**	**$ (125,490,514)**
16	**$ 4,136,739**	**$ 4,380,604**	**(243,865)**	**-6%**	**Net Patient Service Revenue**	**$ 35,252,273**	**$ 35,263,083**	**(10,810)**	**0%**	**$ 35,203,587**
17	$ 128,777	$ 155,771	(26,994)	-17%	Risk contract revenue	$ 1,039,566	$ 1,246,168	(206,602)	-17%	$ 1,179,794
18	$ 4,265,516	$ 4,536,375	(270,859)	-6%	Net Hospital Revenue	$ 36,291,839	$ 36,509,251	(217,412)	-1%	$ 36,383,381
19	$ 22,755	$ 24,351	(1,596)	**-7%**	Other Op Rev & Electronic Health Records	$ 277,359	$ 194,808	82,551	42%	$ 193,779
20	**$ 4,288,271**	**$ 4,560,726**	**(272,455)**	**-6%**	**Total Operating Revenue**	**$ 36,569,198**	**$ 36,704,059**	**(134,861)**	**0%**	**$ 36,577,160**
					Operating Expenses					
21	$ 2,185,721	$ 2,214,836	29,115	1%	Salary and Wages and Agency Fees	$ 17,667,629	$ 18,048,022	380,393	2%	$ 17,548,453
22	851,589	$ 830,325	(21,264)	-3%	Employee Benefits	7,020,662	6,808,485	(212,177)	-3%	6,725,983
23	$ 3,037,310	$ 3,045,161	7,851	0%	Total People Cost	$ 24,688,291	$ 24,856,507	168,216	1%	$ 24,274,436
24	$ 390,982	$ 396,757	5,775	1%	Med and Prof Fees (excld Agency)	$ 3,095,864	$ 3,137,063	41,199	1%	$ 2,813,124
25	480,535	533,105	52,570	10%	Supplies	4,407,770	4,197,911	(209,859)	-5%	4,124,523
26	288,077	321,335	33,258	10%	Purchased Services	2,455,920	2,754,568	298,648	11%	2,252,268
27	285,005	293,214	8,209	3%	Depreciation	2,244,109	2,345,712	101,603	4%	2,321,158
28	91,935	100,684	8,749	9%	Utilities	798,342	798,491	149	0%	758,547
29	32,235	33,417	1,182	4%	Insurance	237,279	267,083	29,804	11%	202,006
30	47,144	34,560	(12,584)	-36%	Interest	326,854	279,349	(47,505)	-17%	426,990
31	149,334	160,740	11,406	7%	Other	1,087,622	1,314,700	227,078	17%	1,314,490
32	-	-	-	*	Matching Fees (Government Programs)	747,361	-	(747,361)	*	368,026
33	**$ 4,802,557**	**$ 4,918,973**	**116,416**	**2%**	**Operating expenses**	**$ 40,089,412**	**$ 39,951,384**	**(138,028)**	**0%**	**$ 38,855,568**
34	**$ (514,286)**	**$ (358,247)**	**(156,039)**	**-44%**	**Operating Margin**	**$ (3,520,214)**	**$ (3,247,325)**	**(272,889)**	**-8%**	**$ (2,278,408)**

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended February 28, 2017

	Month						Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual	Budget	$	%		Actual	Budget	$	%	Prior Year
					Non Operating Rev and Expense					
35	$ (13,924)	$ (20,355)	6,431	-32%	Miscellaneous Revenue/(Expenses)	$ (92,917)	$ (150,704)	57,787	*	$ 18,946
36	5,312	-	5,312	0%	Donations	76,167	-	76,167	0%	0
37	(37,500)	(37,500)	-	0%	Physician Practice Support-Prima	(300,000)	(300,000)	-	0%	(300,000)
38	250,000	250,000	-	0%	Parcel Tax Assessment Rev	2,000,378	2,000,000	378	0%	2,001,954
39	**$ 203,888**	**$ 192,145**	**11,743**	**6%**	**Total Non-Operating Rev/Exp**	**$ 1,683,628**	**$ 1,549,296**	**134,332**	**9%**	**$ 1,720,900**
40	**$ (310,398)**	**$ (166,102)**	**(144,296)**	**87%**	**Net Income / (Loss) prior to Restricted Contributions**	**$ (1,836,586)**	**$ (1,698,029)**	**(138,557)**	**8%**	**$ (557,508)**
41	$ 78,417	$ 20,698	57,719	279%	Capital Campaign Contribution	$ 178,095	$ 165,584	12,511	8%	$ 611,767
42	$ 403,091	$ -	403,091	0%	Restricted Foundation Contributions	$ 582,924	$ -	582,924	100%	$ -
43	**$ 171,110**	**$ (145,404)**	**316,514**	**-218%**	**Net Income / (Loss) w/ Restricted Contributions**	**$ (1,075,567)**	**$ (1,532,445)**	**456,878**	**-30%**	**$ 54,259**
44	246,909	246,909	-	0%	GO Bond Tax Assessment Rev	1,975,272	1,975,272	-	0%	1,942,216
45	(110,266)	(110,266)	-	0%	GO Bond Interest	(897,771)	(897,772)	1	0%	(917,721)
46	**$ 307,753**	**$ (8,761)**	**316,514**	**-3613%**	**Net Income/(Loss) w GO Bond Activity**	**$ 1,934**	**$ (454,945)**	**456,879**	**-100%**	**$ 1,078,754**
	$ 21,751	$ 161,672			**EBIDA - Not including Restricted Contributions**	$ 734,377	$ 927,032			$ 2,190,640
	0.5%	3.5%				2.0%	2.6%			6.0%
	$ (25,393)	$ 127,112			**EBDA - Not including Restricted Contributions**	$ 407,523	$ 647,683			
	-0.6%	2.8%				1.1%	1.8%			

Sonoma Valley Health Care District **ATTACHMENT E**

Statement of Revenue and Expenses Variance Analysis

For the Period Ended February 28, 2017

		YTD	MONTH	
	Description	**Variance**	**Variance**	
	Volume Information			
1	Acute Discharges	24	(1)	
2	SNF Days	(583)	-	
3	Home Care Visits	104	(114)	
4	Gross O/P Revenue (000's)	2,081	(335)	
	Financial Results			
	Gross Patient Revenue			
5	Inpatient	5,240,123	(106,114)	Inpatient surgeries are 26 vs. budgeted expectations of 41.
6	Outpatient	(5,262,952)	(969,339)	Outpatient visits are 4,077 vs. budgeted expectations of 4,616 visits and outpatient surgeries are 101 vs. budgeted expectations 117.
7	Emergency	7,434,690	663,778	ER visits are 851 vs. budgeted visits of 864. The ER visits in February had a higher acuity than previous months.
8	SNF	(2,089,998)	98,671	SNF patient days are 607 vs. budgeted expected days of 607.
9	Home Care	112,737	(31,753)	HHA visits are 922 vs. budgeted expectations of 1,036.
10	**Total Gross Patient Revenue**	**5,434,600**	**(344,757)**	
	Deductions from Revenue			
11	Contractual Discounts	(7,192,036)	19,332	
12	Bad Debt	(410,000)	(33,750)	
13	Charity Care Provision	54,459	(17,231)	
14	Prior Period Adj/Government Program Revenue	2,102,167	132,541	Prime grant accrual for February and an adjustment to the Medicare 2016 filed cost report.
15	**Total Deductions from Revenue**	**(5,445,410)**	**100,892**	
16	**Net Patient Service Revenue**	**(10,810)**	**(243,865)**	
17	Risk contract revenue	(206,602)	(26,994)	Blue Shield capitation received was under budget.
18	Net Hospital Revenue	**(217,412)**	**(270,859)**	
19	Other Op Rev & Electronic Health Records	82,551	(1,596)	
20	**Total Operating Revenue**	**(134,861)**	**(272,455)**	
	Operating Expenses			
21	Salary and Wages and Agency Fees	380,393	29,115	
22	Employee Benefits	(212,177)	(21,264)	Employee benefits are over budgeted expectations due to PTO ($8,025) and employee benefit costs ($13,239) .
23	Total People Cost	**168,216**	**7,851**	
24	Med and Prof Fees (excld Agency)	41,199	5,775	
25	Supplies	(209,859)	52,570	Supplies are under budget primarily due to surgical implants being under budgeted expectations by $28,219 and the pharmacy's participation in the 340b drug pricing program, $38,046 better than budget.
26	Purchased Services	298,648	33,258	Budgeted purchased services not used in February.
27	Depreciation	101,603	8,209	
28	Utilities	149	8,749	
29	Insurance	29,804	1,182	
30	Interest	(47,505)	(12,584)	Interest on the South lot loan ($11,872) and the flouroscopy project ($4,031) were unbudgeted for FY 2017.
31	Other	227,078	11,406	Budgeted other costs not used in February.
32	Matching Fees (Government Programs)	(747,361)	-	
33	**Operating expenses**	**(138,028)**	**116,416**	
34	**Operating Margin**	**(272,889)**	**(156,039)**	
	Non Operating Rev and Expense			
35	Miscellaneous Revenue	57,787	6,431	
36	Donations	76,167	5,312	Foundation grants received for employee education and training and for OP diagnostic center architect fees.
37	Physician Practice Support-Prima	-	-	
38	Parcel Tax Assessment Rev	378	-	
39	**Total Non-Operating Rev/Exp**	**134,332**	**11,743**	
			-	
40	**Net Income / (Loss) prior to Restricted Contributions**	**(138,557)**	**(144,296)**	

Sonoma Valley Health Care District **ATTACHMENT E**
Statement of Revenue and Expenses Variance Analysis
For the Period Ended February 28, 2017

	Description	YTD Variance	MONTH Variance	
			-	
41	Capital Campaign Contribution	12,511	57,719	Capital campaign donations received from the Foundation are over budgeted expectations for February.
42	Restricted Foundation Contributions	582,924	403,091	Foundation grants received for fetal monitors ($24,518) and the surgical tower ($378,573).
43	**Net Income / (Loss) w/ Restricted Contributions**	**456,878**	**316,514**	
44	GO Bond Tax Assessment Rev	-	-	
45	GO Bond Interest	**1**	-	
46	**Net Income/(Loss) w GO Bond Activity**	**456,879**	**316,514**	

9.

ADMINISTRATIVE REPORT APRIL 2017

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

To: **SVHCD Board of Directors**
From: **Kelly Mather**
Date: **3/30/17**
Subject: **Administrative Report**

Summary
The three-year accreditation survey went very well. The final report will be here next week, but there were no "conditional recommendations" – which is very positive and reflective of our excellent quality. The new strategic plan is ready for review by the Board this month. We have a number of great revenue improvement strategies. We have been working with many physicians to increase access to health care services here at home. Finally, the parcel tax vote was very disappointing as we did not get the 66.7% needed to pass and final results from the March election were at 66% favorable. Hopefully it will pass in June as this is necessary to continue services at SVH.

Dashboard and Trended Results

The patient satisfaction results are exceptional in the Emergency department and we have now met goal. We continue to focus on improving inpatient satisfaction to be in the top quartile even though we are currently above average. The organization wide staff satisfaction came in at 4.22/5 with 90% participation. The individual department results will be shared next week at the Leadership Development Institute and at the staff forums in April. We are very excited to see the participation is much higher from nursing this year. We are a bit behind in meeting our budget for FY 2017 but hope to meet the goal by the end of the fiscal year. Leaders are doing a great job managing expenses, but revenues are lower than expected due to reduced reimbursement and lower ancillary services with insurances not authorizing as many treatments as in the past. Surgery volume is still up 11% over the prior year but this includes special procedures.

Strategic Update from FY 2017 Strategic Plan:

Strategic Priorities	Update
Satisfaction	We are looking at using "Rate Your Hospital" text messaging for outpatients to capture their satisfaction and do more timely service recovery this summer.
Quality & Safety	We are developing a new performance score card for next year. I am meeting with all of the leaders this month to gather the quality measures and create a new quality/safety goal.
Physician Alignment	The new Ophthalmologist is on staff and we hope to see the return of those surgeries to SVH. We also have two new pain management physicians.
Regional Services	Bariatrics, Wound Care, Skilled Nursing, Colorectal Surgery and Occupational Health are all serving patients regionally.
Technology Upgrades	The remote hosting to upgrade the Electronic Health Record is underway. This will take a few months. We will start the outpatient rehab EHR after.
Financial Stability	Cash on hand is much better at 27 days and accounts payable is down because of the parcel tax payment.
Community Health	Many education and outreach activities are happening this spring with several weekend events in May and June.

FEBRUARY 2017

PILLAR	PERFORMANCE GOAL	METRIC	ACTUAL RESULT	GOAL LEVEL
Service Excellence	Highly satisfied Inpatients	Rolling 12 month average of at least 5 out of 9 HCAHPS domain results above the 70th percentile	1 out of 9 through January	>7 = 5 (stretch) 6 = 4 5 = 3 (Goal) 4 = 2 <4=1
Service Excellence	Highly satisfied Emergency Patients	Rolling 12 month average of at least 4 out of 7 ERCAPS domain results above the 70th percentile	2 out of 7 through January	6 = 5 (stretch) 5 = 4 4 = 3 (Goal) 3 = 2 2 = 1
Quality	Excellent Clinical Outcomes	Value Based Purchasing Safety Score at 75% or higher	77%	>85 = 5 (stretch) >80 =4 >75 =3 (Goal) >70=2 <70 =1
People	Highly Engaged and Satisfied Staff	Press Ganey percentile ranking of 75th percentile or higher	4.22/5 or the 81st percentile	>80th = 5 (stretch) >77th=4 >75th=3 (Goal) >72nd=2 <70th =1
Finance	Financial Viability	YTD EBIDA	2%	>4% (stretch) >3.5%=4 >3.0% (Goal) >2.5%=2 <2.5%=1
	Efficiency and Financial Management	Meet FY 2017 Budgeted Expenses (excluding IGT)	$39,342,051 (actual) $39,951,384 (budget)	<2% =5 (stretch) <1% = 4 <Budget=3 (Goal) >1% =2 >2% = 1
Growth	Surgical Cases	Increase surgeries by 2% over prior year	1566 YTD FY2017 1391 YTD FY2016	>2% = 5 >1% = 3 < 1% = 2
	Outpatient & Emergency Volumes	2% increase (gross outpatient revenue over prior year)	$104.8 mm YTD $99.9 mm prior year	>5% = 5 (stretch) >3% = 4 >2% = 3 (Goal) <2% = 2
Community	Community Benefit Hours	Hours of time spent on community benefit activities per year	919 hours for 8 months	>1500 = 5 >1200 = 4 >1000 = 3 >750 = 2 >500 = 1

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

FY 2017 TRENDED RESULTS

MEASUREMENT	Goal FY 2017	Jul 2016	Aug 2016	Sep 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	Mar 2016	Apr 2016	May 2016	Jun 2016
Inpatient Satisfaction	5/9	0	0	1	2	3	3						
Emergency Satisfaction	4/7	1	1	1	1	2	3						
VBP Safety score	>75	77.5	77.5	67	67	67	67	77					
Staff Satisfaction	>75th	84	84	84	84	84	84	84	81	84	84	84	84
FY YTD Turnover	<10%	.9	1.5	1.8	3.6	4.2	4.8	5.6	6.3	6.7	7.9	8.8	10
YTD EBIDA	>4%	4.5	3.8	4.2	5.2	4.4	1.5	2.2	2	5.6	5.2	4.7	4.4
Operating Revenue	>5m	5.1	5.0	4.5	4.7	4.5	3.7	4.5	4.3	4.5	4.3	4.6	4.9
Expense Management	<5m	4.9	5.1	4.8	4.9	5.0	4.7	5.0	4.8	4.9	5.1	5.2	5.4
Net Income	>50k	59	-23	94	336	-270	-599	-107	307	-131	-99	-403	-132
Days Cash on Hand	>20	11	15	6	11	10	25	20	27	12	13	9	9
A/R Days	<50	55	50	50	50	53	51	50	46	50	50	55	57
Total FTE's	<315	320	321	319	316	319	309	316	322	326	324	332	324
FTEs/AOB	<4.0	4.28	3.86	3.54	4.11	4.35	4.03	3.74	3.54	3.5	3.7	4.16	4.08
Inpatient Discharges	>100	103	105	95	99	95	100	119	97	99	97	85	95
Outpatient Revenue	>$13m	12.6	13.3	13.5	13.3	13.1	12.9	13.5	12.2	14.2	12.5	13.8	13.5
Surgeries	>130	116	124	118	126	161	126	148	127	141	118	123	124
Home Health	>950	960	890	1042	880	938	919	877	922	879	999	844	942
Births	>15	14	17	14	9	8	9	11	12	17	17	13	14
SNF days	>600	563	608	624	512	446	500	592	607	580	578	529	526
MRI	>120	105	97	104	140	118	130	115	107	127	105	122	120
Cardiology (Echos)	>50	41	53	66	60	51	51	55	69	67	61	52	68
Laboratory	>12	11.2	12.2	11.4	12.6	12.1	12.0	12.5	11.5	12.4	12.0	11.9	11.8
Radiology	>850	902	944	1001	898	870	934	1012	981	1010	963	926	1000
Rehab	>2700	2618	3008	3136	2575	2286	2117	2530	2161	2979	2780	2782	2948
CT	>300	365	327	412	367	306	340	341	323	398	333	373	348
ER	>900	940	918	897	852	850	942	1000	851	945	912	940	907
Mammography	>425	400	475	421	434	435	399	171	215	432	384	457	420
Ultrasound	>300	281	310	288	288	290	271	253	284	317	325	285	255
Occupational Health	>650	602	724	741	797	636	601	484	568	757	663	679	651
Wound Care	>200	221	312	253	226	199	225	228	238	222	276	235	264

10.

CHANGE BYLAWS OF NORTHERN CALIF. HEALTH CARE AUTHORITY

Meeting Date: April 6, 2017

Prepared by: Bill Boerum, Board Member & Secretary (JPA Chairman)

Agenda Item Title: Change Bylaws of Northern California Health Care Authority (JPA)

Recommendation: Amend the "Joint Powers Agreement" (Bylaws) of the Northern California Health Care Authority to Enable Non-Member Conduit Issuer Transactions.

Background and Reasoning: Three years ago the JPA was considering changing its Bylaws to enable it to provide certain financial services (as will be described) to non-JPA members. All five JPA Members were needed to change the Bylaws. Sonoma Valley and Healdsburg (The North Sonoma County Healthcare District) approved the requested text changes to the Bylaws. The Southern Humboldt Community Healthcare District voted not to approve. The Palm Drive Healthcare District and the Mendocino Coast Healthcare District did not consider the matter being pre-occupied with other issues.

The issue of changing the Bylaws is being brought back to the districts for two reasons: first, in December the JPA acted as the conduit issuer for the Healdsburg District becoming once more, knowledgeable about its role in and the risk dimensions of such transactions; and secondly, the JPA has an actual opportunity to consider acting as a conduit issuer for a non-member, a Federally Qualified Healthcare Center.

Four years ago in 2013 following extensive interviews with the various stakeholders of the Northern California Health Care Authority (JPA), it was decided to continue to maintain the existence of the Authority which, though it had had limited accomplishments, continued to hold the promise of potential future collaboration for the five district members. Further, it was decided to scale back operations to fewer meetings and a generally minimalist mode, and await opportunities which might arise. Additionally, in view of the fact that there were no immediate activities requiring action or funding, contributions by the members would not be required for the foreseeable future. Nonetheless, it was recognized that given several regulatory requirements (e.g. annual audits and state agency filings) as well as internal requirements (e.g. basic administrative work and D&O insurance) that existing financial resources would be utilized and likely exhausted after a few years.

Three years ago it came to the attention of the JPA board of directors, through financial advisors known to us, that there was a business opportunity in the domain of our knowledge and mission and which could generate monies to extend the Authority's financial resources into the future and perhaps prompt undertakings which we might otherwise be unable to support. The business opportunity then and now is serving as the "conduit issuer of debt obligations" for non-member agencies and institutions.

Three years ago following discussions by the JPA board as well as consideration of a business plan (informed by the financial advisors), it was decided to accept the then 2014 Business Plan. It was recognized that the JPA "Agreement" would have to be amended to allow the plan to go forward. Changes to the "Agreement" (as suggested by the financial advisors) were considered and recommended by the Board with review and recommendation of counsel. All our member districts are needed to approve an amended Agreement.

Attached for consideration by the Sonoma Valley Health Care District Board is an updated Business Plan and the same "Amended Joint Powers Agreement" provision tracking the changes to the Agreement.

Consequences of Negative Action/Alternative Actions: Without Sonoma's approval the JPA Bylaws cannot be amended even if all the other Districts approve, and therefore such non-member "conduit issuer transactions" cannot go forward. No revenues would be generated and the JPA likely would have to be terminated in the fiscal 2018-2019 year.

Financial Impact: No impact to the Sonoma Valley Health Care District. Our District does not need to commit or advance any funds. However whatever potential benefits – financial or otherwise – which might be realized for our District will not be possible without new revenue to sustain the JPA.

As reported by Treasurer Peter Hohorst at the most recent JPA Board meeting, the ending cash balance of the Authority at February 28 was $12,105.50. This amount reflected the fee of $7,500 from acting as the conduit issuer for the Healdsburg debt financing in December. Without the fee, the cash balance would have been only $4,500. It was expected that this past December, the Authority would have received a bankruptcy court settlement (from the Palm Drive District bankruptcy proceedings – unpaid dues) of approximately $4,800. This has not been received and there is no indication when it will be received. Approximately $12,000 is needed annually to administratively support the Authority at a bare minimum level.

Board Committee: Sonoma District Board JPA Representatives Boerum and Hohorst.

Attachments: 2017 Business Plan (Updated), and Amendment Text for the JPA

Northern California Health Care Authority

Business Plan (updated): **The Authority as a Conduit Issuer of Debt Obligations**

March 31, 2017

Background

Through conversations with financial professionals with whom three of our five member districts have had experience, Bond Counsel Brian Quint and Financial Advisor, Gary Hicks it had come to our attention that there was a business opportunity for the Authority to provide a financial intermediary service. The Authority, through its foundational Agreement and Bylaws already has been an issuer of Certificates of Participation (COP) for the Palm Drive and Northern Sonoma County Districts.

The proposed business opportunity is that the Authority extend its charter capabilities as a joint powers agency to selected borrowing entities which are not our members that is, to other governmental (district) entities and to non-profits, 501 (c) (3) public benefit corporations. By state law such borrowing entities must have a quasi-municipal entity such as a joint powers or state authority acting as a conduit.

The Business Opportunity

The purpose of the business is to generate revenues from non-member client fees to make the Authority largely self-sustaining (not requiring member district contributions) and thereby funding the organization's collaboration, communications, educational (including public health conferences) and administrative activities (such as applying for grants).

As a broad definition, the business activity would be as a "Conduit Issuer of Tax Exempt Obligations." The Authority's charter enables it to act as a public agency intermediary for selected borrowers in order to secure tax-exempt status for their debt obligations. This role provides lower financing costs for the borrower and improved access to a diverse market for the investor(s).

There are different types of transactions for which a conduit can facilitate through competitive sales or negotiated sales (e.g. private or direct placements) for new debt financings such as general obligation bonds, revenue bonds, certificates of participation and other debt forms.

The latest transaction for which the Authority acted as a conduit issuer was in December 2016 for the debt of the Northern Sonoma County Healthcare District (Healdsburg Hospital). The debt issued was a refinancing and new money totaling $12,400,000 for as previously issued Certificates of Participation supported by parcel tax revenues to fund capital expenditures. Net of legal fees of $2,500, the JPA realized $7,500.

Currently, there is an immediate opportunity to act as a conduit issuer for a small Federally Qualified Healthcare Center (FQHC). The total debt amount is approximately $7,800,000. We are being referred to the transaction by Opus Bank as investor, who is the investor in the Healdsburg COPs. The Financial Advisor (not disclosed at this time for competitive reasons) is known to Gary Hicks who was the Financial Advisor for two Healdsburg transactions, for the Palm Drive debt, and for our General Obligation Bond as well as the refinancing of the first tranche of our debt. Certain other financial service providers who acted in the Healdsburg transaction will participate in the proposed FQHC transaction. The issuance team is still being assembled. Preliminarily, a conduit issuer fee of $10,000, $7,500 net to the JPA has been quoted to the Financial Advisor and the issuer.

Revenue Generation - Fees

There are several potential fees incident to such debt issuance. We believe that application and transaction fees would average between $5,000 and $15,000 per debt issue for public entities and between $5,000 and $30,000 for non-profit entities. Financial advisory fees and administrative fees can be negotiated. There can be recurring fees of $1,000 to $3,000 annually for on-going administration in behalf of the issuer. Non-profit healthcare entities such as clinics, senior housing, assisted living, skilled nursing facilities or hospitals may be the most frequent users of conduit issuers. We do not believe our fees would need material discounts to attract business.

Fees for conduit transactions (just the issuance itself) range from $5,000 to $30,000 and average around $10,000 per debt issuance. These fees usually are based on the size of the debt issued, the perceived value brought to the transaction by the conduit issuer and the type of borrower involved. The three transactions for which the Authority served as a conduit for our members resulted in fees of $10,000 each, net $7,500.

Generally, the administrative and legal fees associated with the conduit transaction are included in the debt instrument or bond indenture and paid by the borrower in addition to the above-referenced issuance fees. Fees are paid at the time of closing. However, as our business starts up we may experience administrative and communications expenses depending on the due diligence involved. These activities might involve engaging or contracting with experienced, retired district trustees or hospital chief financial officers. We should not staff up for this business, but address the expenses per transaction.

Market Opportunity

According to Messrs. Hicks and Quint there definitely is a variety of conduit opportunities. Issuance size ranges from $5,000,000 to in excess of $50,000,000. There are 30 to 50 issues annually in California. (There are well over 1,000 special districts in the state). Attracting at least three transactions the first year (at about a $10,000 fee per issuance), gross fee income of $20,000 to $25,000 would seem achievable.

Obviously, clients would not be limited to health care districts. However, starting in this domain which has more than 60 districts would be the first step in a word-of-mouth and networking campaign, including a web page, emails to investment bankers and financial advisors and presence at selected conferences. Additionally, there are the related domains of FQHCs, nonprofit health care owners and operators. Non-profits are required by federal law to use a conduit. According to Hicks a website and monthly email distributions would be essential for visibility for the business. The website would be a ready source of information for both borrowers/issuers and purchasers/investors. It would add credibility for the Authority itself.

It may be that Hicks and Quint as well as Opus Bank could be immediate sources of transactions since they know ready borrowers and the competitive landscape and could come to us with transactions which fit our legal authority and desired applicants. There is no quid pro quo. We understand that currently there is good interest on the part of selected commercial banks (for example Opus Bank) as investors in the types of transactions for which the Authority could serve as a conduit.

Competition

There are several major conduit issuers active in the business which primarily service their members and constituencies. These include:

- The California Statewide Communities Development Authority (CSCDA) primarily assists the financing of county and city housing and energy projects but works with all types of borrowers;
- The Association of Bay Area Governments (ABAG) primarily sponsors financings of its municipal government members but also works with all types of borrowers;
- The California Municipal Finance Authority (CMFA) primarily sponsors underwritings to finance large educational projects and large hospitals but also works with all types of borrowers; and,
- The California Infrastructure and Economic Development Bank (successor to the Economic Development Financing Authority) supports public infrastructure projects in communities with broad statutory powers but also works with all types of borrowers to issue revenue bonds, make loans and provide credit enhancements.

In addition, cities and counties can act as conduit issuers as can the California Health Facilities Financing Authority (CHFFA) that only sponsors healthcare borrowers as a conduit issuer.

Meeting the competition would involve competitive (lower) fees, not charging an annual service fee and/or the willingness to do smaller size transactions. The latter could be a distinct competitive advantage. To the extent that bundling two or more small issues (commonly referred to as a pooled or composite issue) could be feasible, a future opportunity may lie there as well.

Liability

We had been told by our insurance provider (the California Special District Risk Management Authority) that our existing "D&O" coverage would include risks associated with this new activity under the "errors and omissions" provisions. It would be ideal to obtain some form of acknowledgement to this effect in order to determine if in fact any risk management augmentation is needed which might require an additional premium expense.

The debt instrument documents and bond indentures incident to these financings routinely indemnify and hold harmless the conduit issuer from liability. We would insist upon such indemnification in the documentation of each transaction. Bond Counsel Quint characterizes the risk in conduit transactions as minimal. This does not mean that there is no risk. Any and all parties associated with a transaction that results in a claim of liability for a loss could be sued. Additionally, it should be recognized that the constituent districts of the Authority theoretically may be held responsible for the Authority's actions. Neither Messrs. Hicks or Quint, or we are aware of any such contentions ever having been filed.

Financial Resources of the Authority

As reported by Treasurer Peter Hohorst at the most recent JPA Board meeting, the ending cash balance of the Authority at February 28 was $12,105.50. This amount reflected the fee of $7,500 from acting as the conduit issuer for the Healdsburg debt financing in December. Without the fee, the cash balance would have been only $4,500. It was expected that this past December, the Authority would have received a bankruptcy court settlement (from the Palm Drive District bankruptcy proceedings – unpaid dues of $12,000) of approximately $4,800. This has not been received and there is no indication when it will be received. Approximately $12,000 to $16,000 is needed annually to administratively support the Authority at a bare minimum level.

Without a revenue stream, such as proposed, the Authority cannot continue to operate.

Next Steps

- If the business concept is re-approved by the Board of Directors of the Authority, changes to the Joint Powers Authority Agreement and to the Bylaws must be approved not only by
- the Authority's Board but also by each of the Boards of the constituent member districts;

- If the changes are approved by the Authority's Board and the District Boards, the Authority's Board needs to develop screening criteria and due diligence procedures as well as policies and operating procedures (including perhaps some form of approving committee, if not the full Board itself) stipulating among other things the fee structure to be negotiated;
- A budget for the business for the year 2017-2018 (to include development of a website) within the Authority's annual 2017-2018 budget to be considered by the full Board; and,
- All deliberate speed and actions need to be taken to participate in the proposed transaction which has been offered.

Northern California Health Care Authority

Reaching out in Collaboration

AMENDED AND RESTATED JOINT POWERS AGREEMENT ESTABLISHING A COORDINATED SYSTEM FOR HEALTH CARE SERVICES

This JOINT POWERS AGREEMENT ESTABLISHING A COORDINATED SYSTEM FOR HEALTH CARE SERVICES (hereinafter, the "Agreement") is entered into by and between the undersigned parties ("Parties" or "Districts" or "Agencies") as of ~~July 1, 2007~~the date of the last execution hereof by all Parties, pursuant to the provisions of Title I, Division 7, Chapter 5, Article I (Sections 6500, et seq.) of the California Government Code (hereinafter, the "Act") relating to joint exercise of powers by public agencies.

Recitals

A. The Parties are all local health care districts organized pursuant to the Local Health Care District Law (California Health and Safety Code §§ 32000 *et seq.* hereinafter the "District Law") of the State of California (the "State"). The Districts own or operate licensed hospitals and/or other health care facilities and services in Northern California.

B. The Parties wish to form a joint powers authority entity (hereinafter, "JPA") pursuant to the Act to assist in pursuing the joint mission of providing health care services in their respective communities and to provide financing vehicle for the Districts, for other local health care districts organized pursuant to the District law ("Other Districts") and for nonprofit, public benefit corporations organized and existing under the laws of the State ("Nonprofits"). All of the Parties desire to establish a cooperative relationship for the following purposes:

i. To foster the development of, and expand, a system to deliver high quality health care services to the residents served by the Districts.

ii. To ensure a sufficient foundation of local support and financial stability to maintain a locally-owned health care delivery system.

iii. To create more efficient health care services by eliminating unnecessary duplication of services and resources.

iv. To establish a formal structure for business discussions and decisions ~~making~~ made leading to collaborative activities.

v. To establish a formal structure for the involvement of each District's Board of Directors.

vi. To develop and implement strategies and programs for meeting the needs of indigent residents in the areas served by the Districts.

vii. To undertake the financing and/or refinancing of projects of any nature, including, but not limited to, capital or working capital projects, insurance, liability or retirement programs or facilitating the Districts', Other Districts' and Nonprofits' use of existing or new financial instruments and mechanisms.

viii. To issue and execute bonds, notes, commercial paper or any other evidences of indebtedness, including leases or installment sale agreements or certificates of participation therein (herein "Bonds"), and to otherwise undertake financing programs under the Act or other applicable provisions of the laws of the State to accomplish its public purposes.

NOW, THEREFORE, THE PARTIES HEREBY AGREE TO THE TERMS AND CONDITIONS SET FORTH BELOW.

Agreement

1. **Recitals**. The Recitals set forth above are true and correct.

2. **General Purpose of Agreement**. The purpose of this Agreement is to establish a cooperative relationship by and among the Districts through the creation of a joint powers agency that efficiently and effectively provides opportunities to collaborate in the delivery of health care and financing services. The Parties intend that additional public agencies that provide health care services in Northern California, not presently executing this Agreement, may join the JPA in the future subject to the applicable terms and conditions stated in this Agreement. The Parties also intend to utilize flexible, cost effective, and efficient methods of providing coordinated health care and financing services. The methods used in future years to provide these services may differ from those initially established under this Agreement. Any such changes shall be determined by the Board of Directors of the JPA.

3. **Joint Powers Authority Created**. Pursuant to Section 6506 of the Act, the Parties create a public entity, separate and apart from the Parties to this Agreement, to be known as the Northern California Health Care Authority (hereinafter, the "Authority"). The debts, liabilities and obligations of the Authority shall not constitute debts, liabilities and/or obligations of any of the Parties.

4. **Joint Activities**.

A. **Joint Program Proposals**. The Districts shall collaborate in establishing joint program proposals which may be submitted to the Authority and shall, if approved by its Board of Directors, serve as a framework for the scope, operation and administration of that program by the Authority. The form of proposals for the financing and/or refinancing of projects as stated above shall be determined by the JPA to allow for an adequate assessment and evaluation of said proposals to the JPA. Only programs that receive approval by the Board shall be operated under the terms of this Agreement.

B. **Potential Projects**. The partied have identified the following specific projects as potential areas of joint activity under this Agreement:

i. Consolidated home care and ambulance services
ii. Emergency medical services;
iii. Joint warehousing;
iv. Joint benefits planning (employment and other);
v. Community benefits program;
vi. Provider sponsored network;
vii. Joint purchase or leasing of medical equipment and supplies;
viii. Physician recruitment and call services;
ix. Pooled financing, issuance of bonds and other funding vehicles (revenue, general obligation and other short term and long term);
x. Joint fundraising, philanthropy and sharing of gifts;
xi. Joint contracting negotiations with various third party and government payers inclusive of Medi-Cal managed care, commercial PPO, HMO, existing medical groups and JPA's;
xii. Such other projects as may be added in the future by agreement among the Parties;

xiii. Joint venture activities relating to inpatient and outpatient services;
xiv. Management activities;
xv. Development and implementation of insurance provider networks; and
xvi. Sharing and cross over of managed care contractual rates.

C. **Contents of Project Proposals**. Project proposals shall include the following elements:

i. A statement of the purpose of the joint program with a brief description.
ii. Contributions to be made by each District in cash or in kind (if permitted), including a statement as to the manner in which any surplus funds or assets on hand after the completion of its purpose shall be returned to the District.
iii. Any agreements or any obligations anticipated as part of the joint project, including the nature, anticipated scope and purpose of those agreements and obligations.
iv. Compensation, if any, to be paid to any party or parties implementing or administering the joint project.
v. Designation of a person or entity responsible for day-to-day administration of the joint project. In addition, the bonding requirements, if any, of any such person or entity as required by section 6505.1 of the Act shall be stated.
vi. Provisions, if appropriate, for the delegation of authority to independent contractors, consultants or committees.
vii. Disposition, division or distribution of any property acquired as a result of the joint exercise of power.
viii. Commencement and termination provisions.

5. **Powers and Duties**.

A. **Authority**. The Authority shall have the powers common to the Parties to this Agreement, to wit: the powers set forth in the District Law including, but not limited to, the powers set forth in section 32121 *et seq.* of the District Law. Such powers shall be exercised in the manner provided in the Act subject only to the restrictions set forth in this Agreement and those imposed upon the Parties in the exercise of similar power. The Authority is authorized in its own name to perform all acts necessary for the exercise of common powers, including, but not limited to, the powers to:

i. Engage in joint planning for health care services;
ii. Allocate health care services among the different facilities operated by the Parties;
iii. Engage in joint purchasing, joint development, and joint ownership of health care delivery and financing programs;
iv. Consolidate or eliminate duplicative administrative, managerial, clinical, and/or medical services;
v. Incur debts, liabilities or obligations, but no debt, liability or obligation of the Authority shall be a debt, liability or obligation of any of the Parties, except as otherwise provided herein;
vi. Receive gifts, contributions and donations of property and funds, services and other forms of financial assistance, from persons, firms and corporations and any governmental entity;
vii. Engage in joint contracting and negotiations with health plans;
viii. Take cooperative actions in order to provide for the health care needs of the residents of the communities they serve; and
ix. Make and enter contracts for goods and services, employ agents and employees, acquire, construct, manage, maintain or operate any building, works or

improvements, acquire, hold or dispose of property, incur debts, liabilities or obligations, and sue in its own name.

B. **Assessments**. Pursuant to Section 6504 to the Act, the Authority is empowered, and by this Agreement required, to assess the Parties to finance the entire operation of the Authority in the manner set forth in this Agreement.

C.**Bonds**. Without limiting the generality of the foregoing, the Authority may issue or cause to be issued Bonds, and pledge any property or revenues as security to the extent permitted under the Act, or any other applicable provision of law; provided, however, the Authority shall not issue Bonds with respect to any project unless the governing body of the District, Other District or Nonprofit, or its duly authorized representative, shall approve, conditionally or unconditionally, the project, including the issuance of Bonds therefor. Such approval may be evidenced by resolution, certificate, order, report or such other means of written approval of such project as may be selected by the District, Other District or Nonprofit, (or its authorized representative) whose approval is required.

The Bonds, together with the interest and premium, if any, thereon, shall not be deemed to constitute a debt of any District or pledge of the faith and credit of the Districts or the Authority. The Bonds shall be only special obligations of the Authority, and the Authority shall under no circumstances be obligated to pay the Bonds except from revenues and other funds pledged therefor. Neither the Districts nor the Authority shall be obligated to pay the principal of, premium, if any, or interest on the Bonds, or other costs incidental thereto, except from the revenues and funds pledged therefor, and neither the faith and credit nor the taxing power of the Districts nor the faith and credit of the Authority shall be pledged to the payment of the principal of, premium, if any, or interest on the Bonds nor shall the Districts or the Authority in any manner be obligated to make any appropriation for such payment.

No covenant or agreement contained in any Bond or related document shall be deemed to be a covenant or agreement of any Director, or any officer, employee or agent of the Authority in his or her individual capacity and neither the Board of the Authority nor any Director or officer thereof executing the Bonds shall be liable personally on any Bond or be subject to any personal liability or accountability by reason of the issuance of any Bonds.

6. **Governance**.

A. **Board of Directors**. The Authority shall be governed by a Board of Directors ("Board"). The Board of Directors, as the governing and administrative body of the Authority, shall formulate and set policy, and shall exercise the powers set forth in this Agreement to accomplish its purpose. Unless otherwise specified herein, each Party shall appoint one member of the Board ("Director"). Each Director shall be an elected or appointed official of the appointing Party.

B. **Normal Term of Office of Directors**. Each Director shall serve a two (2) year term of office. All Directors shall serve at the will and pleasure of their respective Agencies and may be replaced at any time and without cause by the member Agency that initially appointed the Director. Any replacement Director shall serve out the balance of the term of the Director being replaced.

C. **Alternates**. Any Director may, from time to time, appoint an alternate to serve in the Director's place at any meeting. Any such alternate shall be a government employee or official from the same District as the Director.

7. **Meetings of the Board of Directors**.

A. **Conducting Meetings**. The Board shall hold regular meetings at least quarterly and shall adopt bylaws for conducting their meetings and other business. All meetings of the Board, including without limitation regular, adjourned regular and special meetings, shall be called, noticed and conducted, in accordance with the provisions of the Ralph M. Brown Act (commencing with Section 54950 of the California Government Code).

B. **Quorum and Decision Making Methods**. A majority of voting members of the Board shall constitute a quorum. Each Director, or alternate, shall be entitled to one vote. Decisions shall be made by supermajority votes of at least 75% of the voting members present, except where otherwise required by law or established by Board bylaws or other provisions of this Agreement.

C. **Board Officers**. The Board shall have a Chair to preside at and conduct all meetings and a Vice Chair who shall succeed the Chair and preside in the absence of the Chair. The offices of Chair and Vice Chair shall rotate through each of the seats on the Board annually in a manner to be determined by the bylaws.

8. **Limitation on Powers**. Nothing in this Agreement shall authorize activities that corporations and other artificial legal entities are prohibited from conducting by Section 2400 of the California Business and Professions Code.

9. **Appointed Officers**. Pursuant to section 6505.6 of the Act, the Board of Directors shall appoint an Auditor and a Treasurer for the Authority to perform the duties required by law as well as providing any other services that may be desired by the Authority. Should the County Auditor and County Treasurer be willing to serve, they may serve the Authority as Auditor and Treasurer, or the Authority may select another eligible Auditor and Treasurer to perform such duties. Such officers shall receive no compensation for holding the appointed office but shall be compensated for the cost of providing services as per written agreement with the Authority.

10. **Fiscal Year and Annual Budget/Financing**.

A. **Fiscal Year**. The Authority's fiscal year shall be the twelve (12) month period commencing each July 1, except if the effective date of this Agreement is other than July 1, the first fiscal year shall be the short year commencing the effective date and ending the following June 30.

B. **Annual Budget**. The Authority shall operate only under an approved fiscal year budget. The Authority may not operate at a deficit. The Parties shall pay for the entire operation of the Authority, with the annual expenditure budget determining the total amount of assessment required. Once adopted annually for each fiscal year, the total annual expenditure budget may only be increased by unanimous vote of the Board of Directors. The Authority will adopt a preliminary annual budget no later than March 15 for the following fiscal year and will adopt a final budget prior to July 1.

C. **Budget Elements**. The Board of Directors, in adopting an annual budget, thereby fixes the assessment against the Parties which is binding thereon. The budget policy shall include, but is not limited to, the following components:

i. Operation and Maintenance Expenses. The costs of operating and maintaining a facility and the equipment housed therein shall include, but is not limited to, personnel salaries and benefits, office and computer supplies and other

consumables, payments to lease a facility, and replacement parts necessary to repair facility equipment due to normal wear and tear from ordinary usage; and

ii. Capital Expenditures. Capital expenditures shall include the costs of original purchase of equipment, hardware, software and other fixed asset type items typically having a useful life of more than one (1) year, including equipment improvements and additions, as opposed to replacement parts for ordinary maintenance during the useful life of the capital items. All costs · associated with such purchase, such as installation, shall be capitalized.

Replacement of equipment at the end of its useful life shall be a capital item. Capital expenditures shall be shared by the Parties in conformance with the cost formula established by this Agreement, except capital expenditures which are incurred for and are unique to a minority of the Parties, in which case such minorities shall share the expense equally.

D. **Assessments**. Upon adoption of the fiscal year budget by the Board of. Directors, and the forwarding thereof to the governing bodies of the Parties by the Board Secretary, unless otherwise specified by the order of the Board of Directors, the assessments fixed therein are automatically due and payable without further notice as follows:

July 15: 35% of total assessment
October 15: 25% of total assessment
January 15: 25% of total assessment
April 15: 15% of total assessment

The Board of Directors may set a different payment schedule to provide for adequate cash flow for operations and maintenance expenses and/or capital purchases, as needed. A five (5) percent late charge shall be imposed upon assessment payments not received by the Authority within thirty (30) calendar days following the scheduled dates for payment. An additional five (5) percent shall be imposed if payment is not made within an additional thirty (30) calendar days. If an assessment, including late charges, is not paid in full within seventy five (75) calendar days following any scheduled due date, the Party shall be in default and subject to immediate and automatic termination in accordance with this Agreement . .

E. **Annual Notification**. The Authority shall notify each participating Agency of its share of the Authority's annual cost for the following fiscal year no later than April 1.

F.**Fees Relating to the Issuance of Bonds**. The Board of Directors of the Authority shall, from time to time, establish a fee schedule for the issuance of Bonds, which schedule may vary if the Bonds are issued for District, Other Districts or Nonprofits.

11. **Funding and Cost Allocation**. The Authority's annual budget shall include a reasonable provision for contingencies as well as financing for the maintenance, upgrade, or ultimate replacement of key fixed assets and structures. The Authority shall endeavor to provide its services in the most cost effective manner available without compromising quality standards. The Authority shall endeavor to allocate all costs fairly and equitably to all participating agencies and approved providers. The Authority shall consider all available funding options to finance its costs. These shall include but are not limited to: charges to member Parties for baseline services, charges to member Parties, approved providers, and others to cover the costs of any enhanced, additional or contract services, taxes, bonds, and federal, state or private grants. The percentage allocations may also be revised at any time by the Board of Directors to accommodate the addition, if any, of new providers and any annexations or consolidations between members.

12. **Appeals to the Board of Directors**. Any member agency shall have the right to appeal any implemented or recommended policy or procedure to the Authority's Board of Directors for final determination should, in the opinion of the member agency, such policy or procedure pose a significant adverse impact on the member agency. In such cases, a unanimous vote of the Authority's Board of Directors (excluding the Director from the appealing agency) shall be required to approve the policy or recommendation.

13. **Term of Agreement and Termination Provisions**. This Agreement shall be deemed to go into effect on ~~July 1, 2007~~the date of approval by the last of the Districts (the "Effective Date"), and shall continue in full force and effect until rescinded or terminated, as set forth below.

A. **Termination of Individual Membership**. Any member may terminate its participation in this Agreement by giving written notice to the Board of Directors not less than one year before the start of the fiscal year, which termination shall be effective only on the beginning of the next fiscal year.

i. If a member terminates its participation in this Agreement, it shall pay its portion of the costs for which it is responsible up to the effective date of the termination. In addition, a terminating member shall be required to pay its proportionate share of remaining unpaid costs/debts related to any and all tangible and intangible property (including, but not limited to, costs of equipment, leases, facilities, improvements, etc.), as well as the actual costs associated with its membership termination (including, but not limited to, staff time). Any payments due under this section shall be paid within ninety (90) days after the effective date of termination.

ii. Termination of this Agreement by any Party shall not be construed as a completion of the purpose of this Agreement, and shall not require the repayment or return to the remaining Parties of all or any part of any contributions, payments, or advances made by the parties until this Agreement is rescinded or terminated as to all Parties. Further, the Board of Directors of the Authority has the discretion and authority to determine how to address any claims of ownership and/or possession of any property by a terminating party.

B. **Rescission of Agreement by All Parties**. At any time, this Agreement may be rescinded and terminated, and the Authority may be dissolved, by a unanimous vote of all Parties. In that event, the remaining assets and liabilities shall be apportioned among all Parties according to the relative assessments paid by those Parties, exclusive of late charges, from the inception of the JPA, up to the point of termination.

14. **Consolidations, Divisions and Annexations of Parties**. Consolidations of Parties with other Parties or with non-member agencies, divisions of Parties into two or more entities, and annexations of portions of Parties shall have no adverse effect on the cost assessments of uninvolved Parties. In the event that involved Parties cannot come to an agreement regarding adjustments to cost assessments between themselves, the Board of Directors shall resolve the matter after considering and hearing from the affected Parties.

15. **Membership**. Membership in the Authority shall be open to all cities, independent districts, and other public agencies which have an interest in providing health care services in Northern California.

A. **Admission of New Members**. The Board of Directors has the authority to admit new members to the Authority, after notice to existing members and an opportunity for them to be heard at a public meeting. The Board shall set the terms and conditions for admitting new members (either individually or generally) that it deems appropriate.

B. **Cost of Admitting New Members**. The Board of Directors shall determine the cost of admitting any new members to the Authority, including any buy-in costs, on? going assessments or charges that new members will be required to pay to the Authority. It shall have the discretion to charge new members less than the actual cost of admission as an initial incentive; however, ultimately the Board is responsible for assessing costs to new members based on the actual costs incurred and in the manner assessed to other member agencies.

C. **New Member Obligations**. Each agency accepted as a new member shall be required to pay all costs established by the Board of Directors, and sign a copy of this Agreement, or an acknowledgement that it is bound to all the terms and conditions herein (at the discretion of the Authority).

D. **Removal of Member**. The Board of Directors may remove any member from the Authority for good cause, including, but not limited to, failure to pay required costs or compromising the function or integrity of the Authority. Such removal can be effectuated only upon a 2/3 vote of the Board of Directors after providing the affected member (and all other members) with at least 30 days written notice of the intended removal and an opportunity to be heard. A member removed from the Authority pursuant to the provisions of this section will be deemed to have terminated its membership, and shall be required to comply with the payment provisions of section 13(A)(i) above, as well as all other applicable requirements.

16. **Amendments to Agreement**. This Agreement may be amended or modified only by a unanimous vote of the Member Agencies that are Parties to this Agreement. Any amendments to this Agreement shall be in writing and signed by all members.

17. **Severability**. Should any part, term, portion or provision of this Agreement, or the application thereof to any person or circumstances, be in conflict with any State or Federal law, or otherwise be rendered unenforceable or ineffectual, the validity of the remaining parts, terms, portions, or provisions, or the application thereof to other persons or circumstances, shall be deemed severable and shall not be affected thereby, provided such remaining portions or provisions can be construed in substance to continue to constitute the Agreement that the Parties intended to enter into in the first instance.

18. **Insurance**. The Authority shall be required to obtain insurance, or join a self insurance program in which one or more of the Parties participate, appropriate for its operations. Any and all insurance coverages provided by the Authority, and/or any self? insurance programs joined by the Authority, shall name each and every Party to this agreement as an additional insured for all liability arising out of or in connection with the operations by or on behalf of the named insured in the performance of this Agreement. Minimum levels of the insurance or self-insurance program shall be set by the Authority in its ordinary course of business. The Authority shall also require all of its contractors and subcontractors to have insurance appropriate for their operations.

19. **Indemnity**. The Authority shall indemnify, defend and hold harmless the Parties their officers, agents, servants, employees and volunteers from any and all claims, losses, costs or liability resulting to any person, firm or corporation or any other public or private entity for damages of any kind, including, but not limited to, injury, harm, sickness or death to persons and/or property from any cause whatsoever arising from or in any way connected with the performance of its operations and exercise of its powers, except from any such claim arising

solely out of acts or omissions attributable to the member Party or its officers, employees, volunteers or agents.

20. **Successors**. This Agreement shall be binding upon and shall inure to the benefit of the successors of the Parties hereto.

21. **Notice of Creation**. A notice of the creation of the Authority by this Agreement shall be filed by the Authority with the Secretary of State, pursuant to Section 6503.5 of the Act.

22. **Other Notices**. Notices to the Authority required or permitted to be given under this Agreement shall be in writing. Delivery of such notices shall be conclusively taken and sufficiently given forty-eight (48) hours after deposit in the United States Mail, return receipt requested, with the postage thereon fully prepaid, addressed to the Authority as follows:

[Insert address of principal place of business]

Notices to the Parties shall be provided in the same manner as above, addressed as set forth in the signature page hereto. The Authority may change its address above for notices by giving written notice as described above to all Parties. Any Party may change its address for notices by giving written notice as described above to the Authority.

23. **Counterparts**. This Agreement may be executed in any number counterparts, each of which shall be deemed an original, but all such counterparts together shall constitute but one and the same instrument.

24. **Entire Agreement**. This Agreement contains the final and entire agreement between the parties and supersedes all other agreements, written or oral, heretofore made by the parties. The parties shall not be bound by any terms, conditions, statements, or representations, oral or written, not contained herein.

IN WITNESS WHEREOF, the Parties hereto have caused this Agreement to be executed and attested by their proper officers thereunto duly authorized, as of the day and year first above written.·

NORTH SONOMA COUNTY HOSPITAL DISTRICT

Name _____
Title _____
Date of Execution _____

PALM DRIVE HEALTH CARE DISTRICT

Name _____
Title _____
Date of Execution _____

SONOMA VALLEY HEALTH CARE DISTRICT

Name _____
Title _____
Date of Execution _____

MENDOCINO COAST HEALTH CARE DISTRICT

Name _____
Title _____
Date of Execution _____

SOUTHERN HUMBOLDT COMMUNITY HEALTHCARE DISTRICT

Name _____
Title _____
Date of Execution _____

11.

SVH OPPOSE
LETTER RE: AB 387

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
Healing Here at Home

March 16, 2017

The Honorable Tony Thurmond
Chair, Assembly Labor and Employment Committee
State Capitol, Room 4005
Sacramento, CA 95814

SUBJECT: AB 387 (Thurmond) – OPPOSE

Dear Assemblymember Thurmond:

Sonoma Valley Hospital is writing today in opposition of AB 387 (Thurmond, D-Richmond), which would require health care entities to pay allied health students minimum wage for time spent in clinical or experiential training that is required for state licensure. AB 387 fails to recognize that for patient care-related training programs, myriad state and federal laws prohibit students from providing unsupervised care. Because they are in training, these students are not lawfully permitted to deliver care except within strict supervision requirements. They are not employees, and the cost of treating them as such will have the adverse consequence of reducing students' opportunities to benefit from hospital-provided training and clinical experience and exacerbating workforce shortages.

Many allied health professions require students to participate in clinical or experiential training at a hospital to obtain a degree and/or qualify for the licensure or certification exam. These occupations include radiologic technologists, clinical laboratory scientists, respiratory therapists, physical therapists, occupational therapists and speech therapists, among others — all of which are in high demand and pay good wages. Hospitals are critical partners in the education and training of health professionals as they are uniquely poised to provide clinical experience.

Sonoma Valley Hospital currently partners with several local colleges and universities to provide experiences in a clinical setting. We continuously host students, up to as many as 10 per quarter, in various Hospital departments – including student nurses, speech and physical therapies, and social work, as well as medical students in our emergency department. Hospital leadership accomplishes supervision of these students in addition to their regular duties. Hospital training programs are funded exclusively by hospitals — costs are not reimbursed by Medi-Cal, private insurance or other sources.

Sonoma Valley Hospital opposes AB 387 because it would result in a significant decrease in our ability to partner with local colleges to train the allied health workforce needed to provide care for California's patients now and in the future. The effects of this significant decrease in capacity within the current training system would exacerbate existing allied health care workforce shortages and put the development of a strong and diverse pipeline of future caregivers in jeopardy.

For the above reasons, Sonoma Valley Hospital respectfully asks for your "NO" vote on AB 387.

Sincerely,

Kelly Mather
President and Chief Executive Officer

cc: The Honorable Members of Assembly Labor and Employment Committee