SONOMA VALLEY HEALTH CARE DISTRICT

BOARD OF DIRECTORS

AGENDA

THURSDAY, JUNE 4, 2020

REGULAR SESSION 6:00 P.M.

HELD VIA ZOOM VIDEOCONFERENCE ONLY

To participate via Zoom videoconferencing
use the link below:

https://zoom.us/j/93407072804?pwd=S2pZcHVvTFBZdDg2RVZ0R2JiZmFMZz09

and enter the Meeting ID: 934 0707 2804, Password: 312019

To participate via telephone only,
dial: 1-669 900 9128 or 1-669 219 2599
and enter the Meeting ID: 934 0707 2804, Password: 312019

In compliance with the Americans Disabilities Act, if you require special accommodations to participate in a District meeting, please contact District Clerk Vivian Woodall at vwoodall@sonomavalleyhospital.org at least 48 hours prior to the meeting.	**RECOMMENDATION**		
AGENDA ITEM			
MISSION STATEMENT *The mission of SVHCD is to maintain, improve, and restore the health of everyone in our community.*			
1. CALL TO ORDER	*Hirsch*		
2. BOARD CHAIR COMMENT	*Hirsch*		
3. PUBLIC COMMENT *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended that you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Board at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up for Board consideration.*	*Hirsch*		
4. CONSENT CALENDAR 1. Board Minutes 05.07.20 2. Finance Committee Minutes 04.28.20 3. Quality Committee Minutes 04.22.20 4. Governance Committee Minutes 01.22.20 5. SVHCD Bylaws 6. Policies & Procedures 7. Medical Staff Credentialing 8. Medical Staff Allocation of Resources 9. Medical Staff Bylaws	*Hirsch*	Action	Pages 3-5 Pages 6-8 Pages 9-12 Pages 13-14 Pages 15-31 Pages 32-34 Pages 35-139
5. HUMAN RESOURCES ANNUAL REPORT	*McKissock*	Inform	Pages 140-163

6. RESOLUTION NO. 351 ORDERING AN ELECTION FOR OPEN BOARD POSITIONS TO BE HELD AND REQUESTING CONSOLIDATION WITH THE, NOVEMBER 2020 GENERAL DISTRICT ELECTION	*Woodall*	Inform/ Action	Pages 164-167
7. LEGAL CONFLICT WAIVER FOR SVHCD-UCSF CONTRACTS	*Hirsch*	Inform/ Action	Pages 168-171
8. PANDEMIC EMERGENCY UPDATE	*Kidd*	Inform	
9. CMO REPORT	*Kidd*	Inform	Pages 172-173
10. ADMINISTRATIVE REPORT FOR JUNE	*Mather*	Inform	Pages 174-176
11. FINANCIALS FOR THE MONTH ENDED APRIL 30, 2020	*Jensen*	Inform	Pages 177-186
12. BOARD COMMENTS • Letters to State Legislators in Support of Additional Budget Requests for Hospitals • Letters to Federal Legislators Requesting Additional COVID-19 Funding Legislation for Hospitals	*Hirsch*	Inform	Pages 187-190 Pages 191-196
13. ADJOURN	*Hirsch*		

Note: To view this meeting you may visit http://sonomatv.org/ or YouTube.com.

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS' MEETING

MINUTES

THURSDAY, MAY 7, 2020

HELD VIA ZOOM VIDEOCONFERENCE ONLY

	RECOMMENDATION	
MISSION STATEMENT *The mission of SVHCD is to maintain, improve and restore the health of everyone in our community.*		
1. CALL TO ORDER	*Hirsch*	
6:04 p.m.		
2. BOARD CHAIR COMMENT	*Hirsch*	
Ms. Hirsch acknowledged nursing colleagues during national nursing week.		
3. PUBLIC COMMENT	*Hirsch*	
None		
4. REPORT OF SPECIAL CLOSED SESSIONS (HELD APRIL 8, APRIL 23, AND APRIL 30, 2020)	*Hirsch*	
The Board held three recent closed sessions related to trade secrets and expansion of the UCSF-SVH affiliation. No action was taken and no decisions were made. Ms. Hirsch looked forward to sharing further information with the community soon.		
5. CONSENT CALENDAR 1. Board Minutes 04.02.20 2. Finance Committee Minutes 03.24.20 3. Policies & Procedures 4. Medical Staff Credentialing	*Hirsch*	Action
		MOTION: by Boerum to approve, 2nd by Rymer. All in favor.
6. DISCUSSION REGARDING CRITICAL ACCESS HOSPITAL EXPANSION ACT	*Connor*	Inform
Mr. Crozer Connor, Senior Legislative Assistant to Rep. Mike Thompson spoke about legislation introduced last week (HR 6693, Critical Access Hospital Expansion Act of 2020). He discussed the criteria in place for obtaining critical access status. Congress had deleted the authority of the state governors to designate a hospital as critical access; this bill brings that authority back. The bill also means hospitals would get more money from the Federal government when a Medicare patient is treated. Ms. Mather added that the initial estimate is that SVH would net about $3 million more a year. Congress has passed a number of COVID-19 bills recently. Rep. Thompson is going to push for this bill to be included in that package, which should be voted on next week. This is the time we should be providing assistance to small community hospitals; this issue		

transcends partisan politics. We would like a Republican Senator to introduce a similar bill in the Senate and need a base of support in the House, as well as stakeholder support (AHA, CHA, governors, hospitals, etc.). Mr. Connor indicated a lot of support should be found in the House; the Senate may be more work. Rep. Thompson has reached out to a few already, including Sen. Barrasso of Wyoming, Sen. Toomey of Pennsylvania, and Sen. Shelby of Alabama. Obstacles to face include: opposition to the bill, length of process (it may take a couple of years), cost (may cost billions over a 10-year period), and political jockeying (should we spend this on hospitals as opposed to something else). There will also be questions about abuse of authority by governors, which was an issue in the past. A new congress starts January 2021. If the bill is not passed before then, it must be reintroduced. The issue there is the changing players who may sign on, then not be reelected. All are in agreement that while this is a long shot, it is worth pursuing at this time.		
7. PATIENT CARE SERVICES ANNUAL REPORT	*Kobe*	Inform
Mr. Kobe presented the patient care services annual report. In response to questions, he reported that surgical personnel were affected by the low level of surgeries recently, but many staff are being used in other areas. A small percentage of stroke patients come through the ER that can be treated at SVH; many others are transferred to other hospitals.		
8. REVIEW AND APPROVAL OF FY 2021 ROLLING STRATEGIC PLAN	*Mather*	Action
Ms. Mather discussed the Strategic Plan's core strategic initiatives. She indicated that SVH will definitely be UCSF's main regional outpatient center.		**MOTION:** by Mainardi to approve with correction, 2nd by Nevins. All in favor
9. SEISMIC LEGISLATION UPDATE	*Mather*	Inform
If the current outdated 2030 seismic standards are not modified, more than 50% of California hospitals will face significant financial hardship. If SB 758 passes, SVH will be fine to meet the revised 2030 standards.		
10. DISSOLUTION OF JPA – NORTHERN CALIFORNIA HEALTH CARE AUTHORITY	*Boerum*	Action
Mr. Boerum reviewed the history of the JPA. Since the member districts were not able to combine funding or find suitable projects to support, the vote at the last meeting was to dissolve with concurrence by the individual district boards.		MOTION: by Boerum to approve, 2nd by Mainardi. All in favor.
11. CMO REPORT	*Kidd*	Inform
Dr. Kidd gave the CMO report. SVH avoided the COVID-19 surge and is transitioning, while still prepared to activate for a surge at any time. Drive-through testing is being used for pre-op surgery patients. Antibody testing is not being done at this time since it is not yet accurate.		
12. ADMINISTRATIVE REPORT FOR MAY	*Mather*	Inform

Ms. Mather mentioned SVH's 75th anniversary this year. Construction on the Outpatient Diagnostic Center is 23 days behind schedule. Finance Committee is evaluating a no-interest loan from the State with regard to a potential cash flow issue with the ODC project.		
13. FINANCIALS FOR THE MONTH ENDED MARCH 31, 2020	*Jensen*	Inform
Mr. Jensen reviewed the payer mix for March. Cash was ($229,000) short of goal, and April will probably be ($1 million) short of goal. IGT funds of $5.4 million were received in April and $4.4 million of CARES Act stimulus funds in May. These are from the first and second stimulus packages, respectively. Days' cash were 15.6, A/R days were 36.9, A/P were $3.8 million, and A/P days were 53.4. Total gross patient revenue was ($6.5 million) below budget, while total operating revenue was $597,000 better than budget. The operating margin was $1.5 million on a budget of $2.1 million. Net income after all activity was $2.3 million, ($473,000) under budget. EBDA was 25.7% vs. budget of 35%, and year to date 13.6% vs. budget of 9.4%.		
14. BOARD COMMENTS	*Hirsch*	Inform
Mr. Rymer expressed his appreciation to Ms. Mather for her work on the critical access issue, and she in turn thanked Crozer Connor and Mike Thompson.		
15. ADJOURN	*Hirsch*	
Adjourned 7:51 p.m.		

SONOMA VALLEY HEALTH CARE DISTRICT
FINANCE COMMITTEE
MINUTES
TUESDAY, APRIL 28, 2019

HELD VIA ZOOM VIDEOCONFERENCE ONLY

Present		**Staff**	**Public**
Sharon Nevins via Zoom Joshua Rymer via Zoom Dr. Subhash Mishra via Zoom Peter Hohorst via Zoom Art Grandy via Zoom	Bruce Flynn via Zoom Susan Porth via Zoom	Kelly Mather, CEO via Zoom Ken Jensen, CFO, via Zoom Sarah Dungan, Controller, via Telephone Dawn Kuwahara, via Zoom	Luis Sarmiento, Vertran Assoc., via Telephone

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*		
	Called to order at 5:03 pm		
2. PUBLIC COMMENT SECTION	*Nevins*		
	None		
3. CONSENT CALENDAR	*Nevins*		
	The minutes of 3.24.20 were reviewed.	**MOTION:** by Rymer to approve, 2nd by Flynn. All in favor	
4. OUTPATIENT DIAGNOSTIC CENTER UPDATE	*Mather/Sarmiento*		
	Ms. Mather said the CT project was currently 23 days behind schedule due to the COVID-19 situation. She anticipated finishing it by September 4th and to be over budget by $86k, to come out of contingency. Mr. Sarmiento gave an update on the Outpatient Diagnostic Center project as a whole. The timing of some donations has changed due to COVID-19 and		

	economic fluctuations. Ms. Mather indicated the MRI project would probably not be presented to the Board until the CT project was nearly complete so costs could be reviewed.		
5. ADMINISTRATIVE REPORT	*Mather*		
	Ms. Mather reported there had been a complete focus on COVID-19 for the past three weeks. The expected surge did not happen. The Hospital is still exploring ways to work with UCSF and Dr. Carroll may be taking space at SVH by year end. The new primary care physician starts in Sonoma on May 4th A budget discussion will be held with Valley of the Moon Post Acute this week since costs are much higher than the hospital has been charging them.		
6. FINANCIAL REPORT MONTH ENDED MARCH 31, 2020	*Jensen*		
	Mr. Jensen reported that outpatient gross revenue was short by ($4 million) in the last half of March. He briefly discussed the payer mix. Days' cash were 15.6 in March. IGT funds of $5.4 million were received in April, as well as COVID-19 relief funds of $1 million. A/R days were 36.9 in March, A/P days were 53.4 and A/P was $3.8 million (some payables were held back). Additional hospital relief funds were expected that had not yet been disbursed. Gross revenue down by 28% and total operating revenue was below budget by ($598k). IT costs went up in with the purchase of equipment to enable remote working. The operating margin was off by ($608k). After accounting for all items, net income for the month was ($473k) off budget. In response to a question by Ms. Porth, Ms. Mather said staff were being flexed off due to lowered patient census and few surgeries. The last two payrolls had gone down.		
7. REVIEW THIRD QUARTER FY 2020 CAPITAL SPENDING	*Jensen*		
	Ms. Dungan gave a report on third quarter capital spending.		

8. FISCAL YEAR 2021 BUDGET UPDATE	*Jensen*		
	Ms. Dungan gave an update on the budget process, including additions of an ER manager and a 2% salary raise for staff in January 2021.		
9. HELP II LOAN PROGRAM APPLICATION DISCUSSION	*Jensen*		
	Mr. Jensen informed the Committee of an available State loan program which could provide an equipment loan for five years, or a construction loan for 20 years, both at 2% interest. It is an ongoing program so there is no deadline; however, it may take three months to obtain the loan. Ms. Mather expressed a concern that this might go away with the current economic situation. She indicated that cash may be needed for the construction project and suggested going through the application process, but not using the loan unless necessary. Ms. Nevins asked Mr. Jensen to obtain further details and costs and inform the Committee. Then the proposal could be presented for Board approval next month.		
10. APPROVAL OF DELAY OF $1.2 MILLION LINE OF CREDIT PAYMENT FROM APRIL 2021 TO APRIL 2022	*Jensen*		
	Mr. Jensen reported that Union Bank had offered SVH the option to delay payment on the line of credit from April 2021 to April 2022.	**MOTION:** To approve the line of credit payment delay. Vote taken by roll call. All seven Committee members voted aye.	
11. ADJOURN	*Nevins*		
	Meeting adjourned at 6:11 p.m.		

SONOMA VALLEY HEALTH CARE DISTRICT
QUALITY COMMITTEE
MINUTES
April 22, 2020 5:00 PM

HELD VIA ZOOM VIDEOCONFERENCE ONLY

Members Present	Members Present cont.	Excused	Public/Staff
Jane Hirsch via Zoom Susan Idell via Zoom Ingrid Sheets via Zoom Cathy Webber via Zoom Carol Snyder via Zoom	Howard Eisenstark, MD via Zoom Michael Mainardi, MD via Zoom		Sabrina Kidd, MD, CMO Danielle Jones, RN, Chief Quality Officer Mark Kobe, CNO

AGENDA ITEM	DISCUSSION	ACTION
1. CALL TO ORDER/ANNOUNCEMENTS	*Hirsch*	
	5:01 pm	
2. PUBLIC COMMENT	*Hirsch*	
	None	
3. CONSENT CALENDAR		Action
• QC Minutes, 02.26.20		**MOTION:** by Mainardi to approve, 2nd by Idell. All in favor.
4. SVH QUALITY INDICATOR PERFORMANCE AND PLAN	*Jones*	Inform
	Ms. Jones reviewed quality indicator performance for the month of March. CMS has allowed hospitals to delay publicly reporting data until June 2020 (including 2019 Q4 and 2020 Q1) due to COVID-19. Some of the reportable measures were in contradiction to recommended care for COVID-19.	
5. CENTER FOR IMPROVEMENT IN HEALTH-CARE QUALITY CORRECTIVE ACTION PLAN	*Jones*	
	Ms. Jones reviewed citations from the recent CIHQ survey. Those conditions will be relieved by the plan of correction which has been accepted. She indicated there were many	

AGENDA ITEM	DISCUSSION	ACTION
	small plant and facilities citations that were corrected prior to the surveyors leaving the site. Normally those are not cited, but this time they were so the report was lengthy. Ms. Jones will report quality improvement plans quarterly to this Committee.	
8. PROPOSED QUALITY COMMITTEE CHARTER	*Jones*	Inform
	Revisions to the charter were discussed. Further action was delayed until May.	
PATIENT CARE SERVICES DASHBOARD		
	Mr. Kobe reviewed the patient care services dashboard.	
9. POLICIES AND PROCEDURES	*Jones*	Action
	ORGANIZATIONAL **New:** Admits, Transfers, Readmissions PC8610-192 Management of Medical Emergencies in Off-Site Locations PC 8610-192 Pest Management Program CE8610-184 **Revisions:** Hazardous Materials and Waste Management Plan CE8610-140 Medical Waste Management Plan CE8610-158 Storage of Medications MM8610-123 Department Specific Performance Improvement (PI) Plan QA8610-104 Formalin Spill Cleanup LB8610-106 Pathology Specimen Handling LB8610-122 Reporting of Quality Monitoring and Performance QA8610-106 Sara Lite Lift PC8610-165 Reviewed/No Changes: Use of Medication Not Procured by the Facility MM8610-116 AccuChek Inform II Glucose Monitoring system LB8610-102 Patient Safety Evaluation System QA8610-101	**MOTION:** by Eisenstark to approve, 2nd by Sheets pending corrections on a few of the new policies. All in favor.

AGENDA ITEM	DISCUSSION	ACTION
	DEPARTMENTAL **<u>New</u>:** Metabolic and Bariatric Anesthesia Protocol 7430-109 Maggot Therapy 7740-109 Failure of HVAC Systems 8450-15 Failure of Sewer Services 8450-14 **<u>Revisions</u>:** EMTALA COBRA Transfers 7010-07 Cancellation No Show Wound Care 7740-102 Battery Powered Exit Lights 8450-100 Bulk Liquid Oxygen 8450-77 Electrical Failure 8450-63 Emergency Generator Testing 8450-65 Equipment Inventory 8450-48 Fire Alarm Testing 845091 Medical Gases Procurement and Contingency Plan 8450-76 Utilities Failure Phone List 8450-38 Vendor Contact List 8450-31 Linen Management Services 8440-43 Imaging Scope of services 7630-233 Medical Staff QAPI 8710-105 Diet Manual 8340-151 **<u>Reviewed/No Changes</u>:** AccuChek Certification and Recertification 7500-100 AccuChek Meter Replacement 7500-102 Individualized Quality Control Plan 7500-104 **<u>Retire</u>:** Emergency Battery Powered Lights 8450-90	
COVID-19 UPDATE		
	Dr. Kidd reported on the COVID-19 situation at SVH. The Incident Command Center has been open since early March. A core group of 20 staff have been meeting every day and have planned for a surge, increasing beds from 24 to 59, with room for 70+ if needed. SVH has been in close contact with affiliate UCSF to share supplies, protocols, and ask questions. UCSF will be part of the exit strategy as well. The hospital has stabilized from the first wave and is	

AGENDA ITEM	DISCUSSION	ACTION
	starting to focus on what comes next. It has been following County, State, and CDC guidelines throughout. There have been no surgeries other than emergencies since mid-March. The supply chain has not been restored at this point so SVH has to monitor personal protective equipment (PPE) carefully. Starting up surgeries would require a high volume of that equipment. The hospital has prepared an exit strategy with criteria to enact it. Precautions are with us to stay for the near future. Criteria include the need to have adequate PPE (30 days) and 14 days with no new cases. There will need to be a unified plan on opening back up, since many employees are from other counties.	
10. CLOSED SESSION	*Hirsch*	
a. Government Code §54956.9(d)(2): Discussion Regarding Significant Exposure to Litigation **b.** Calif. Health & Safety Code § 32155 Medical Staff Credentialing & Peer Review Report	Called to order at 6:36 pm.	
11. REPORT OF CLOSED SESSION	*Hirsch*	Inform/Action
	Medical Staff credentialing was not reviewed. The Committee had no credentialing report. An unusual occurrence with significant exposure to litigation was discussed.	No action was taken.
12. ADJOURN	*Hirsch*	
	6:45 pm	

SONOMA VALLEY HEALTH CARE DISTRICT
GOVERNANCE COMMITTEE MEETING

MINUTES

Wednesday, January 22, 2020
8:00 AM

SVH ADMINISTRATIVE CONFERENCE ROOM
347 ANDRIEUX STREET, SONOMA, CA 95476

AGENDA ITEM	RECOMMENDATION	
In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District meeting, please contact the District Clerk, Vivian Woodall, at vwoodall@sonomavalleyhospital.org or (707) 935.5005 at least 48 hours prior to the meeting.		
MISSION STATEMENT *The mission of the SVHCD is to maintain, improve, and restore the health of everyone in our community.*		
1. CALL TO ORDER/ANNOUNCEMENTS	*Boerum*	
Called to order at 8:05 am.		
2. PUBLIC COMMENT SECTION *At this time, members of the public may comment on any item not appearing on the agenda. It is recommended you keep your comments to three minutes or less. Under State Law, matters presented under this item cannot be discussed or acted upon by the Committee at this time. For items appearing on the agenda, the public will be invited to make comments at the time the item comes up.*		
No public present		
3. CONSENT CALENDAR Minutes for 11.14.19	*Boerum*	Action
		MOTION: by Rymer to approve 11.14.19 minutes. All in favor. Chair to convene with staff to prepare 07.24.19 minutes.
4. MEDIA COMMUNICATIONS POLICY	*Committee*	Inform/Action
Reviewed and revisions made to the policy in real time.		**MOTION**: by Rymer to approve with corrections. All in favor.
5. SVHCD/SVHF MEMORANDUM OF UNDERSTANDING	*Committee*	Inform/Action
Reviewed the 2016 Memorandum of Understanding and no changes were made. To be placed on consent at next Board meeting.		**MOTION:** by Rymer to approve. All in favor.
6. CEO ANNUAL EVALUATION PROCEDURE AND SCHEDULE POLICY	*Committee*	Inform/Action

Reviewed and revisions made to the policy in real time. The "Overview of Process" attachment will be added both to this policy (Item 6) and the policy in Item 7 below.		**MOTION:** by Rymer to approve Items 6 and 7 with revisions. All in favor.
7. ESTABLISHMENT OF ANNUAL CEO OBJECTIVES POLICY	*Committee*	Inform/Action
See Item 6 above.		Included with Item 6 above.
8. SET CALENDAR FOR 2020	*Boerum*	Inform
Three Committee meetings are planned for 2020.		
9. NEXT MEETING DATE	*Boerum*	Inform
May 27, 2020		
10. ADJOURN	*Boerum*	
8:41 a.m.		

BYLAWS

of the

SONOMA VALLEY HEALTH CARE DISTRICT

Sonoma, California

BYLAWS

of the

SONOMA VALLEY HEALTH CARE DISTRICT

Approved by the Board of Directors June~~anuary~~ 4~~11~~, 2020~~18~~

Jane~~oshua Rymer~~Hirsch, Chair

Kelly Mather, President and Chief Executive Officer – Sonoma Valley Hospital

Orig. Date:	10.31.90
Revised:	02.27.91
	12.02.92
	01.05.94
	07.30.97
	01.08.03
	02.28.03
	02.25.04
	06.29.05
	09.27.06
	12.06.06
	05.30.07
	07.01.09
	11.05.09
	09.02.10
	10.07.10
	02.03.11
	12.01.12
	03.06.14
	08.04.16
	01.11.18

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Bylaws of the Sonoma Valley Health Care District

Article I Preamble

These District Bylaws are adopted by the Sonoma Valley Health Care District (the District) Board of Directors (the Board) pursuant to and consistent with Division 23 of the Health and Safety Code of the State of California, known as "The Local Health Care District Law." These District Bylaws are established to further enable the Board to faithfully exercise its powers and fiduciary duties in accordance with applicable law. The Board-approved Policies shall be used to assist further in implementing the responsibilities of the Board.

Section 1. Mission

The Mission of the Sonoma Valley Health Care District is to maintain, improve, and restore the health of everyone in our community.

This mission is pursued subject to available financial and human resources and leadership consistent with the Local District Health Care Law of California. The District sets forth Core Values as a framework to provide operational guidance for achieving its mission.

The Core Values of the Sonoma Valley Health Care District are that those who live in Sonoma Valley will experience outstanding health care because

1. There will be direct access to appropriate care when needed and overall health will be coordinated in a comprehensive fashion.
2. Care will show respect and honor the dignity of everyone.
3. The available services will (a) match the needs of the community, (b) be fiscally sustainable, and (c) meet or exceed all quality standards.
4. Wise stewardship will be exercised regarding the District's financial resources to ensure stability, agility, and prudent growth.
5. Partnerships with physicians, other healthcare providers, and payers will extend the range of available services and conserve resources.
6. We will feel informed and proud of the quality of health care available in the District.

Section 2. Relationships

The Board recognizes that it is most effective in maintaining, improving, and restoring the health of everyone in our community when it works in collaboration with others. Among our partners are the community, the Hospital, the medical community, other healthcare providers such as the Sonoma Valley Community Health Center and UCSF Health, and the Sonoma Valley Hospital Foundation. Although the responsibilities of the Board are set forth in our public trust as the duties of fiduciary responsibility and care and in state law, it is the intent of the Board to maximize its impact on health by building strong, cooperative relationships.

a. The Community

The Board is publicly elected to represent the collective interests of all people in the District, regardless of whether they may be patients at the Hospital. That trust is exercised by inquiring and listening to the concerns of the entire community regarding health care expectations, community resources that might be available, and matters of good organizational citizenship. It is also the Board's responsibility to ensure that the public is informed about its own health and the operations of the Hospital and other healthcare services. The public is also welcome and encouraged to monitor District operations and policy and participate in the discussion of the public actions of the Board. It is the intent of the Board to honor the full spirit of transparency in its work.

b. The Hospital

The major resource available to the Board for serving the community's health needs is Sonoma Valley Hospital. This is an Acute Care, community hospital providing emergency care, in-patient and ambulatory (inpatient) acute care, post-acute care~~skilled nursing~~, therapy, diagnostics, and related services. It serves the community by providing prompt response to acute health needs and coordination of care and by providing resources to the medical community.

c. The Medical Staff

Physicians are a self-governing community of peers who set standards for quality of care and professional conduct. Some of these professionals are Hospital employees; most are not. The community is best served when an appropriate mix of practitioners is free to reach professional excellence, with the Board providing required oversight and

necessary resources. The physicians accredited at the Hospital are governed by the Medical Staff Bylaws which are reviewed from time to time.

d. Other Healthcare Providers

The District recognizes that maintaining, improving, and restoring the health of everyone in our community involves collaboration with the entire health care community. Individuals who have insurance plans that involve providers outside the Valley who use only the Hospital's emergency or diagnostic and support services are included in our mission. So are those who use the services of other local providers and are referred to Sonoma Valley Hospital for supportive care. Patients of the Hospital can expect that their care will include referral for advanced treatment at Bay Area hospitals that offer specialized services. The District works with local adjunctive services to ensure a supportive community environment.

e. Sonoma Valley Hospital Foundation

Though not a healthcare provider as such, the District recognizes the indispensable role being played by the Sonoma Valley Hospital Foundation as an independent and self-governed entity in funding certain capital requirements and other defined needs of the Hospital as may be determined and coordinated between the two organizations from time to time.

Article II The Board as a Legal Entity

The name of the District shall be the Sonoma Valley Health Care District (the District).

The principal office for transacting business and maintaining records of the Sonoma Valley Health Care District shall be the Sonoma Valley Hospital (the Hospital), located at 347 Andrieux Street, Sonoma, California 95476. The Ddistrict also maintains a Web site at http://www.sonomavalleyhospital.orgvh.com/.

Section 1. Powers

The Board shall have accountability and authority for those powers set forth in the Local Health Care District Law of California [California Health and Safety Code (H&S) 32,000] that are necessary for fulfilling its mission. These shall include, but are not limited to the following abilities to:

a. Form a medical staff to be known as "The Medical Staff of Sonoma Valley Hospital"; such medical staff shall be self-governing, subject to the District Board's final approval of members and their privileges, hospital rules for quality of patient health and safety, indemnification of practice, and Medical Staff Bylaws [California Health and Safety Code (H&S) 32128, 32129].
b. Recruit and manage such volunteers from the community, serving without compensation, as may be needed from time to time to support the Hospital and the District.
c. Hire, direct, evaluate, and terminate if necessary, the President and Chief Executive Officer of the Hospital and any other individuals neither working for the Hospital or reporting directly to the Chief Executive Officer but necessary for meeting the Mission of the District [H&S 32121].
d. Enter into contracts for provision of health care and make certain resources are available to medical staff members who are serving the community [H&S 32121, 32129].
e. Establish and maintain standards for quality of care in facilities under the District's direction [H&S 32125].
f. Create entities or enter into contractual relationships with existing entities useful for promoting the District's Mission [H&S 32121, 32131].
g. Acquire, lease, manage, and dispose of real assets for the purpose of meeting its Mission [H&S 32121, 32123, 32126].
h. Authorize the purchase, lease, management, and disposal of capital and other equipment needed to meet its Mission [California Health and Safety Code 32122, 32132].
i. Place before the public for vote parcel tax and bond measures to finance healthcare services and facilities [H&S 32127].
j. Sue and be sued and exercise related actions as a corporate entity [H&S 32121].
k. Manage its financial assets in a responsible fashion, including authorization for borrowing funds and letting of contracts [H&S 32127, 32130, 32132, 32133, 32136, 32138].
l. Create committees, develop policy, and take other actions necessary to enhance the mission of the District [H&S 32121].
m. Receive input from the public and inform the public regarding matters related to the operation of the district.

The Board exercises its responsibilities through setting goals conducting periodic self-evaluations, assessing the healthcare environment and performance of the hospital, and when appropriate, initiating responsive action. All District powers shall only be exercised pursuant to specific delegation by the Board of Directors.

Section 2. District Bylaws as Basis of Authority

a. Amendment

These District Bylaws shall be reviewed biannually at the beginning of even numbered years. They may be changed by an affirmative vote of at least three Board members at a regularly scheduled board meeting.

b. Relationship to Other Bylaws

The Bylaws of the Sonoma Valley Health Care District Medical Staff (the Medical Staff) are understood to be a subset of the District Bylaws with respect to their relationship with the District. Any action or procedure that is required, allowed, or prohibited in the Medical Staff Bylaws will also be required, allowed, or prohibited in the District Bylaws. The District Board and the Medical Staff shall consult on any proposed changes in either document that may affect both groups. Changes in the Medical Staff Bylaws shall be approved by the District Board; changes in District Bylaws that may affect the Medical Staff require corresponding revision of the Medical Staff Bylaws.
In any case where there is a conflict between the Medical Staff Bylaws and the District Bylaws, the District Bylaws shall be controlling.

Article III Board of Directors

Section 1. Members

a. Selection

The Board shall consist of five members, having permanent residence in the District and elected by the public from registered voters of the District in accordance with California Health and Safety Code Section 32100. Three members shall be elected in years evenly divisible by four and two members shall be elected in alternating even-numbered years. In the event of a Board vacancy, a new Board member shall be appointed to fill the vacated position from applying individuals who meet qualification for election by vote of the remaining Board members in a publicly noticed and open meeting. The appointed Board member shall serve until the next general election returns are certified by the registrar of voters unless the vacancy occurs in the first half of the director's term, but less than 130 days prior to the next general election. In this case the appointed director shall serve the balance of the term. (Section 1780 of the California Government Code)

b. Fiduciary Responsibilities

Board members have fiduciary responsibilities to the District. Those living in the District trust the Board to act on their behalf.

(a.) The duty of care requires that Board members act toward the District with the same watchfulness, attention, caution, and prudence that a reasonable person in the circumstances would. The duty of loyalty requires that Board members not place their personal interests above those of the District.

(b.) Board members shall comply with the District's Conflict of Interest Code as detailed in the Board Policies

(c.) The only actions of the Board are those agreed by a majority of Board members in publicly~~ally~~ noticed meetings that are consistent with state law and regulations. Diversity of informed and well-articulated opinion among Board members is expected while questions are open before the board.

(d). Board members respect privacy of information by not requesting or seeking to obtain information that is not authorized or necessary for conducting the business of the Board. Board members respect confidentiality by not revealing information to others who are not legally authorized to have it or which may be prejudicial to the good of the District. Board members respect information security by requesting and monitoring policies that protect the privacy of individuals served by or doing business with the District.

c. Personal Qualifications

In their service to the District, Board members are expected to

(a.) Actively promote the mission of the District: to maintain, improve, and restore the health of everyone in our community.

(b.) Devote sufficient time to their duties to ensure they are fully knowledgeable regarding matters about which the Board deliberates

(c.) Provide respectful, positive, independent input into the group decision making process

(d.) Seek input from the community and represent the District to the community as ambassadors

(e.) Maintain a high level of personal integrity

Section 2. Officers

The officers of the Board and their duties shall consist of the following:

a. Chair
   1. Serve as the Board's primary liaison with the Chief Executive Officer and with the press and the public
   2. Prepare the Board agenda and request necessary support materials for meetings
   3. Conduct meetings of the Board
   4. Sign documents as authorized by the Board
   5. Appoint members to committees subject to approval by a majority of the Board
   6. Coordinate the Board's performance evaluation of the President and Chief Executive Officer
   7. Coordinate the Board's annual self-evaluation and annual retreat process.

b. First Vice Chair
   1. Serve in the capacity of the chair when necessary or as delegated.
   2. Serve as the permanent Board representative on the Joint Conference Committee of the Medical Executive Committee.

c. Second Vice Chair
   1. Serve as chair or member of the Board Quality Committee
   2. Serve in the capacity of the chair when necessary or as delegated

d. Secretary

   1. Direct that minutes, records, and other support material are prepared and made available in a timely fashion
   2. Serve or cause to be served all notices of the board
   3. Sign, documents as authorized by the Board
   4. Serve as chair or member of the Board Governance Committee

e. Treasurer
   1. Serve as chair or member of the Board Finance Committee

Section 3. Elections

Beginning with the calendar year 2012 officers will be elected at the first regular Board meeting in December of each year for a term of one year. Election is by majority vote of the members of the newly-installed Board in even numbered years and by majority vote of existing members in odd numbered years. Officers may be elected to consecutive terms. In the event that the Board fills a vacant position, it may decide either to confirm the new Board member in the previous Board member's office or conduct a new set of elections.

Section 4. Committees

The Board may create committees in order to facilitate its business and to ensure access to expertise and citizen input. All committees shall be advisory to the Board and have no authority to make decisions or take actions on behalf of the Board unless specifically delegated by the Board. A committee is created or disbanded by majority vote of the Board.

a. Types of Committees

(a.) Standing Committees assist the Board by gathering information, evaluating proposals and policies, and making recommendations regarding key and continuous or regularly recurring functions of the District, and are subject to Ralph M. Brown Act provisions. The Board Standing Committees shall be:
(a) Finance Committee
(b) Quality Committee
(c) Governance Committee
(d) Audit Committee

(b) Advisory Committees ("Ad Hoc") may be established to study and make recommendations to the Board on specific matters. The scope of such committees shall be limited and shall not be of continuous or on-going nature. Upon determination by the Board that the period for advice has passed or upon acceptance of the Advisory Committee's written report by the Board, the Advisory Committee shall be disbanded. Advisory Committees shall be comprised of two Board members and are not subject to Brown Act provisions.

(c) Members of Standing Committees and Advisory Committees shall be full-time residents of the District or practitioners or business owners having their primary activity within the District

b. Types of Meetings

Meetings of the Board and its standing Committees are conducted in accordance with the Ralph M. Brown Act (the Brown Act). A quorum for the Board or for its standing committees shall consist of a majority. Agendas for regular Board and standing committee meetings will be available 72 hours in advance of meetings, and for special meetings 24 hours in advance, giving the date, time and location of meetings. No action will be taken concerning an item not previously noticed on the published agenda. Exceptions exist in the case of an emergency where the majority of the Board determines that an emergency exists (Government Code 54956.5), in which case there is a need to take immediate action. The other exception is if a regular or special meeting is appropriately noticed and the need for urgent action came to the attention of the District subsequent to the agenda being posted. In that case, if two-thirds of the Board members present vote (or there is a unanimous vote if less than two-thirds are present) that there is a need to take immediate action. Public comment will be invited and considered at all open meetings (regular, emergency and special Board meetings and standing committee meetings), and meeting agendas, support materials, and minutes will be available to the public.

(a.) Emergency Board meetings can be called on one hour's notice by the Chair or any Board member. News media that has submitted a prior written request for notification of emergency meetings shall be notified in advance of the meeting.

(b.) Special Board meetings may be called by any two Board members with 24 hours notice and are subject to rules applying to regular meetings. News media that has submitted a prior written request for notification of special meetings shall be notified in advance of the meeting.

(c.) Closed Board meetings may be held for purposes of considering the appointment, employment, evaluation of performance, discipline, dismissal or to hear complaints or charges concerning a Hospital employee or member of the Medical Staff; in consideration of pending litigation; or in matters of negotiations concerning real property, labor contracts, or discussion of trade secrets. Closed meetings shall be announced, conducted, and reported in accordance with the Brown Act, and the public may not participate. Standing committees may hold closed meetings if their charter or Board delegation includes issues allowing closed meetings.

c. Participation of Directors on Standing Committees

No more than two Board members shall be appointed to serve on any Standing Committee at one time. Other Board members may attend standing Committee Meetings as members of the public at any time. In the event of the absence of a regular Board member on a Standing Committee, the Chair of the Board, or in succession, the Chair of the Standing Committee may designate other Directors to serve in the capacity of absent Board committee members. All appointed members of Board committees, including *ex officio* appointments and recognized alternates shall be voting members and shall count toward establishing a quorum. Board members who attend standing committee meetings as members of the public may not participate in the discussions to avoid a possible violation of the Brown Act.

Section 5. Compensation

a. Each member of the Board of Directors shall be allowed his/her necessary traveling and incidental expenses incurred in the performance of official business of the District pursuant to the Board's policy.

Section 6. Indemnification

a. Any person made or threatened to be made a party to any action or proceeding, whether civil or criminal, administrative or investigative, by reason of the fact that he/she, his/her estate, or his/her personal representative is or was a Director, officer or employee, of the District, or an individual (including a medical staff appointee or committee appointee) acting as an agent of the District, or serves or served any other corporation or other entity or organization in any capacity at the request of the District while acting as a Director, officer, employee or agent of the District shall be and hereby is indemnified by the District, as provided in Sections 825 et. seq. of the California Government Code.

b. Indemnification shall be against all judgments, fines, amounts paid in settlement and reasonable expenses, including attorney's fees actually and necessarily incurred, as a result of any such action or proceeding, or any appeal therein, to the fullest extent permitted and in the manner prescribed by the laws of the State of California, as they may be amended from time to time, or such other law or laws as may be applicable to the extent such other law or laws is not inconsistent with the law of California, including Sections 825 et. seq. of the California government Code.

c. Nothing contained herein shall be construed as providing indemnification to any person in any malpractice action or proceeding arising out of or in any way connected with such person's practice of his or her profession

Article IV Delegation of Authority

The Board honors the distinction between governance and management. The Board shall exercise its responsibilities for oversight by operating at the policy level, setting strategic direction and goals, monitoring key outcomes, and taking corrective action where needed.

Section 1. Chief Executive Officer

The District employs or contracts with a President and CEO for the Hospital who acts on behalf of the District within the constraints of the Board Bylaws and Board Policies set by the Board. The Board delegates to the President and CEO the authority to perform the following functions:

a. Manage the District's human, physical, financial, knowledge, and community good will resources in support of the District's Mission to maintain, improve, and restore the health of everyone in our community
b. Manage the activities and resources of the Sonoma Valley Hospital
c. Ensure that the hospital complies with applicable laws, regulations, and standards
d. Provide supporting resources to the Board and its committees as requested
e. Support the operations of the Board by providing reports, general information, staff support, and other resources
f. Annually, create a draft update on the District's rolling Three -Year Strategic Plan and the Budget
g. Promote awareness of the hospital, good will in the community, and philanthropic support
h. Serve as the contact executive in affiliation agreements with other district hospitals, physician foundations, and other healthcare partners
i. Negotiate, sign, monitor, and terminate or renegotiate contracts.
j. Sign checks to meet the District's financial obligations in accordance with Board Policy.
k. Execute and sign borrowing notes as authorized by the Board.
l. Discharge these functions in a positive, legal, and ethical fashion so as to bring respect to the District

m. Carry out directives from the Board

Section 2. Medical Staff

a. Establishment of a Medical Staff

There shall be a Medical Staff for the Hospital established in accordance with the requirements of the Local Healthcare District Law [California Health and Safety Code (H&S) 32,000], whose membership shall be comprised of all physicians, dentists and podiatrists who are duly licensed and privileged to admit or care for patients in the Hospital. The Medical staff shall be an integral part of the Hospital. The District shall appoint the Medical Staff by approving their credentialing. The Medical Staff shall function in accordance with the Medical Staff Bylaws, Rules and Regulations and Policies that have been approved by the Medical Staff and by the District.

The Medical Staff shall be represented as described in Article IV of these Bylaws and shall be afforded full access to the District through the Board's regular meetings and committees as described herein. The Medical Staff, through its officers, department chiefs, and committees, shall be responsible and accountable to the District for the discharge of those duties and responsibilities set forth in the Medical Staff's Bylaws, Rules and Regulations, and Policies and as delegated by the District from time to time.

b. Bylaws, Rules, and Regulations

The Medical Staff is responsible for the development, adoption, and periodic review of the Medical Staff Bylaws and Rules and Regulations, consistent with these District Bylaws, applicable laws, government regulation, and accreditation standards. The Medical Staff Bylaws, Rules and Regulations and all amendments thereto, shall become effective upon approval by the Medical Staff and the District. Whenever there is a reference in the Medical Staff Bylaws, Rules and Regulations, to the "Board of Directors" or "the District," that term shall refer to and be considered as the Sonoma Valley Health Care District as described in Article I of these Bylaws.

c. District Action on Membership and Clinical Privileges

(a.) Medical Staff Responsibilities: The Medical Staff is accountable to the District for the quality of care, treatment and services rendered to patients in the Hospital. The Medical Staff shall be responsible for investigating and evaluating matters relating to Medical Staff membership status, clinical privileges, and corrective action, except as provided in Article 4 of the Medical Staff bylaws. The Medical Staff shall adopt and forward to the

District specific written recommendations, with appropriate supporting documentation, that will allow the District to take informed action. When the District does not concur with a Medical Staff recommendation, the matter shall be processed in accordance with the Medical Staff Bylaws and applicable law before the District renders a final decision. The District shall act on recommendations of the Medical Staff within the period of time specified in the Medical Staff Bylaws or Rules and Regulations, or if no time is specified, then within a reasonable period of time. However, at all times the final authority for appointment to membership on the Medical Staff of the Hospital remains the sole responsibility and authority of the District.

(b.) Criteria for District Action: The process and criteria for acting on matters affecting Medical Staff membership status and clinical privileges shall be as specified in the Medical Staff Bylaws.

(c.) Terms and Conditions of Staff Membership and Clinical Privileges: The terms and conditions of membership status in the Medical Staff, and the scope and exercise of clinical privileges, shall be as specified in the Medical Staff bylaws unless otherwise specified in the notice of individual appointment following a determination in accordance with the Medical Staff Bylaws.

(d.) Initiation of Corrective Action and Suspension: Where in the best interests of patient safety, quality of care, or the Hospital staff, the District may take action subject to the standards and procedures in the Medical Staff Bylaws, Rules and Regulations and applicable law.

The Chief Executive Officer may summarily suspend or restrict clinical privileges of any Medical Staff member subject to the standards and procedures in the Medical Staff Bylaws, Rules and Regulations and applicable law.

(e.) Fair Hearing and Appellate Procedures: The Medical Staff Bylaws shall establish fair hearing and appellate review mechanisms in connection with Staff recommendations for the denial of Staff appointments, as well as denial of reappointments, or the curtailment suspension or revocation of privileges. The hearing and appellate procedures employed by the District upon referral of such matters shall be consistent with the Local Healthcare District Law [California Health and Safety Code (H&S) 32,150~~,~~ and those specified in the Medical Staff Bylaws, Rules and Regulations.

d. Accountability to the District

The Medical Staff shall conduct and be accountable to the District for conducting activities that contribute to the preservation and improvement of quality patient care and safety in the Hospital.

e. Documentation

The District shall receive and act upon the findings and recommendations emanating from the activities required by Article IV, Section 2(d). All such findings and recommendations shall be in writing and supported and accompanied by appropriate documentation upon which the District can take appropriate action.

Section 6. Contractual, Collaborative and Affiliation Relationships

The District may enter into contractual, collaborative and affiliation relationships with other Districts, provider organizations, or consortia in order to share resources and improve access to care to better serve the needs of those in the Valley.

Policy and Procedures – Summary of Changes
Governing Board, June 2020

Review and Approval Requirements

The SVH departmental/organizational policies and/or procedures on the attached list have been reviewed and approved by the P&P Team and 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 Medicine Committee.

ORGANIZATIONAL

NEW: None to report

REVISIONS:

Assessment and Disposition for Psychiatric Patients In the ED
Added psychiatric assessment, screening for potential suicide/self harm risk to be completed by RN. Added environmental risk assessment. Added Consult with SVH Social Worker and consult with Psychiatrist on call.

Clinical Nursing Procedures PC8610-124
Included Respiratory Therapy clinical practices, and update to Dynamic Health from Lippincott. Several Respiratory Therapy policies have been retired as a result of update to Dynamic Health.

REVIEWED/NO CHANGES:

Informed Consent PR8610-134
Advanced Directives PR8610-100

DEPARTMENTAL

NEW:

Physical Therapy
Hazardous Material Handling in the Outpatient rehabilitation Clinic 7770-143

REVISIONS:

Wound Care
Conservative Sharp Debridement 7740-103
Changes include approved by to Chief Ancillary Officer. Removed brand names of antiseptic, reference to resident and hand sanitizer, added use of 2 patient identifiers

Pulse Lavage 7740-140
Changes include approved by to Chief Ancillary Officer. Expanded PPE to Personal Protective Equipment, moved reference to hand sanitizer and resident.

Silver Nitrate, Use of 7740-105

Changes include approved by to Chief Ancillary Officer. Reference to MSDS instructions, removal of brand name calmoseptine. Removal hand sanitizer (redundant), replace doff with remove and added reason for skin barrier.

Physical Therapy
Cold Pack Usage 7770-103
Update to procedure for additional safety and precautions. Reference added. Triennial review.

Department Staffing Plan 7770-109
Changes made to coincide with changes in Rehab care delivery at SVH. Triannual Review.

Discharge Criteria of Rehabilitation Patients 7770-111
Change made to reflect CIHQ standard to notify patients in writing prior to discharge.

Gaits Belts, Use and Cleaning of 7770-117
Change to allow therapist to use Clorox wipe on plastic belt after use.

Iontophoresis 7770-127
Change to use single vials and add reference.

Respiratory Therapy
PB 840 Ventilator 7721-57
Included Dynamic Health as the trusted clinical resource for SVH. Formatting changes.

Phillips V60 BiPap 7721-12
Updated equipment added Patients with Obstructive Sleep Apnea or Central Sleep Apnea.

Scope of Service 7721-66
Updated this scope to reflect Respiratory Therapy services, separate from Cardiopulmonary.

Vapotherm High Flow System 7721-71
Added definitions for Fi02 and liters per minute.

Laboratory
Quarantined Blood Products 7500-102
Updated policy in response to CIHQ survey. Policy Name Change to Compromised Blood Products.

REVIEWED/NO CHANGES:
Physical Therapy
Cancellation Policy 7710-100
Clinical Competency 7770-101
Contested Decision to Discontinue Skilled Rehab Services 7770-105
Collection of Co-Payment 7770-107
Downtime Scheduling Procedure 7770-112
Fluidotherapy Usage 7770-113
Frequently Used Terminology and Abbreviations 7770-115
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MD Notification 7770-129
Paraffin Use 7770-131
Patient Education 7770-133
Phonophoresis 7770-135
Transcutaneous Electrical Nerve Stimulation 7770-137
Ultrasound 7770-139

Retire
Respiratory Therapy
Aerosol Therapy T Piece or Tracheostomy Mist
Alert Patient Protocol for Continuous CPAP
Arterial Blood Gas Sampling Recommended Parameter
Arterial Puncture for Blood Gas Analysis, Technique for Performing
Auto Vent 3000
CPAP Treatment Procedure Alert Patient Protocol, CPAP Mask Procedure
Cuff Leak Assessment
Cuff Pressure Indicator
Education Home Care Use of Compressor and Nebulizer Therapy
Extubation Procedure
Gas Cylinders Protocol
Incentive Spirometry Indications
Incentive Spirometry
Infant Oxyhood
Infection Control
Metered Dose Inhaler Therapy
Nasotracheal Suctioning-Recommended Parameters
Oral Care for the Mechanically Ventilated Patient
Oxygen Administration Per Nasal Cannula
Oxygen Administration Per Venturi Mask Procedure
Oxygen Delivered by Disposable Face Mask
Oxygen Delivery by High Concentration Mask, Non-rebreather Mask
Pulse Oximetry

MEDICAL STAFF BYLAWS

~~February 17, 2017~~June 4, 2020

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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. These bylaws are used in conjunction with the Medical Staff Rules and Regulations in the governance of the general Medical Staff.

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

~~3)~~6) 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)~~ 1.Adhere to the lawful ethics of his or her profession;

~~2)~~ 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)~~ 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~~in a 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~~ 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~~. Be members of the Active or Associate Medical Staff of another California Medicare participating hospital OR have an established local outpatient practice. Additional 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 if they are credentialed at a distant site. Those that are fully credentialed with the hospital shall pay 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 or the Medical Director on 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. The Telemedicine staff credentialed on site will have proctoring done via chart review by the respective department chair.

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**.** For practitioners credentialed on site any performance improvement and/or corrective action will be managed through the peer review process.

iii. Requirement for Contract with Distant Site/Agency: 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/Agency is a contractor of services to the Hospital

2) The Distant Site/Agency 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/Agency 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~~ Medical 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 in conjunction with the Credentialing Verification Organization	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	C~~E~~MO *(See Bylaws Section 5.5-3)*
Chief ~~Executive~~ Medical 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/accredited agency, 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~~ Medical 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

~~3)~~ ii) Denial of his or her request for additional privileges.

~~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.~~i. Physicians (MDs or DOs)

~~2.~~ii. Dentists

~~3.~~iii. 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. To Fulfill an Important Care Need
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~~ Medical 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 C~~E~~MO 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 not 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.~~

a.~~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.

b~~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.

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 email ballot, and the outcome shall be determined by a majority of the votes cast by email 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, Chief Medical 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[s1], 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~~ Medical 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,b- Perioperative Services, and 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~~members, 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)~~1) ~~t~~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)~~2) ~~t~~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
  - Anesthesiology
  - 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~~ Medical 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~~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~~ Medical 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~~ Medical 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 ~~actio~~action n 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, the Chief Medical Officer, 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 Medical Officer and 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.)

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

~~2)~~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)~~3. The burden on the party of producing the requested information; and

~~4)~~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 .~~ 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 E~~R~~D 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.~~ 2. 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~~Michael Brown MD, Chief of Staff MEDICAL EXECUTIVE COMMITTEE	~~2/17/2017~~
___________________________________ ~~Peter Hohorst~~Bill Boerum, Chairman BOARD GOVERNANCE COMMITTEE	
___________________________________ Jane Hirsch, Chairman BOARD OF DIRECTORS	

Sonoma Valley Hospital

Human Resources Department Annual Report - 2019

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

Mission & Vision Statement

Develop, implement and support programs and processes that add value to the Hospital and its employees, leading to improved employee welfare, engagement, growth and retention, while demonstrating our commitment to providing the best patient care with a sense of warmth, friendliness and compassion.

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

2019 Goals

- Performance Evaluation Program
- Corrective Action Plans
- HR Policy Updates
- Employee Handbook

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Additional Accomplishments

- New Job Descriptions
- Applicant Tracking System
- Employee Emergency Notification System
- Employee Apparel Webstore
- Diversity Training
- Employee Engagement Survey

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Engagement Survey Participation Rates

- Total Participation
  - 75% (261/348)
- Participation by Demographic
  - Clinical: 53%
  - Non-Clinical: 47%
  - Day Shift: 82%
  - Night/PM Shift: 18%
  - Years of Service:
    - Less than 1 year: 11%
    - 1 – 5 years: 41%
    - 6 – 10 years: 21%
    - 11 – 20 years: 21%
    - More than 20 years: 6%

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Engagement Survey Results at a Glance

- Overall Score: 4.05
- Average Score by Demographics
  - Clinical: 4.27
  - Non-Clinical: 4.15
  - Day Shift: 4.09
  - Night/PM Shift: 3.82
  - Years of Service
    - Less than 1 year: 4.09
    - 1 – 5 years: 4.00
    - 6 – 10 years: 4.02
    - 11 – 20 years: 4.13
    - More than 20 years: 3.97

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

Engagement Survey
Highest Performing Items

Survey Item	Avg. Score
My work unit strives to exceed the expectations of the people we serve	4.39
The person I report to treats me with respect.	4.32
I respect the abilities of the person to whom I report	4.30

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Engagement Survey
Lowest Performing Items

Survey Item	Avg. Score
My pay is fair for the work I do.	3.52
The benefits I receive meet or exceed my expectations.	3.54
We have excellent systems and processes to support our work.	3.75

SONOMA VALLEY HOSPITAL
SONOMA VALLEY HEALTH CARE DISTRICT
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Engagement Survey Organization Domain

- Highest Performing

Survey Item	Avg. Score
My work unit strives to exceed the expectations of the people we serve.	4.39
This hospital offers exceptional and compassionate care.	4.21
We treat each other with respect throughout the hospital.	4.19

- Lowest Performing

Survey Item	Avg. Score
My pay is fair for the work I do.	3.52
The benefits I receive meet or exceed my expectations.	3.54
We have excellent systems and processes to support our work.	3.75

Engagement Survey
Manager Domain

- Highest Performing

Survey Item	Avg. Score
The person I report to treats me with respect.	4.32
I respect the abilities of the person to whom I report.	4.30
My supervisor is reliable and demonstrates ownership of their responsibilities.	4.18

- Lowest Performing

Survey Item	Avg. Score
I have regular conversations with my direct supervisor about my personal and/or professional development goals.	3.85
I feel supported in my efforts to achieve my highest potential at work.	3.98
I am encouraged to share ideas and suggestions about the services my work unit provides.	4.00

Engagement Survey
Employee Domain

- Highest Performing

Survey Item	Avg. Score
I have a strong sense of purpose and accomplishment in the work I do.	4.28
I feel connected to our hospital's purpose.	4.17
I feel supported in balancing my work life with my personal life.	4.14

- Lowest Performing

Survey Item	Avg. Score
We have excellent systems and processes to support our work.	3.75
I feel supported during times of high stress at work.	3.92
How likely is it that you would recommend this hospital as a place to WORK to a friend or colleague?	4.06

2019 Dashboard

Performance Indicator	2019	2018	2017	2016
Employee Engagement Organizational Score (CY)	4.05	4.17	4.19 61st Percentile	4.24 74th Percentile
Employee Engagement Participation Rate (CY)	75%	53%	81%	90%
Turnover (CY)	15.5%	19%	13.6%	10.3%
Salary Costs / % of Net Revenue (FY)	$23,885,775 / 41.53%	$26,340,903 / 47.05%	$26,169,737 / 47.54%	$25,970,061 / 44.4%
Benefit Costs / % of Net Revenue (FY)	$9,015,532 / 15.67%	$10,200,053 / 18.22%	$10,770,495 / 19.56%	$9,711,167 / 16.6%
Registry/Traveler Costs (FY)	$1,675,354	$1,339,193	$860,071	$993,822
Leave of Absences (CY)	54	62	70	74
Number of Injuries (CY)	20	9	12	6
Number of Open WC Claims (CY)	19	10	10	11
Workers' Comp Costs (CY)	$284,348	$347,342	$156,921	$139,888
Legal costs for Employee Issues (FY)	$51,898	$7,473	$39,772	$36,657
Wellness Program Participation (CY)	131/225 – 58%	147/235 – 63%	216/322 – 67%	182/263 – 69%

Staff Education

- New Hire Skills Assessment
- Skills Lab
- Annual Regulatory/Legally Required Courses
- Advanced Healthcare Directives

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

2020 Goals

- New HRIS System
  - Interface with Applicant Tracking System
  - Streamline Onboarding Requirements
  - Performance Evaluation Module
  - Manager/Employee Access
- Human Experience
  - New Hire Orientation
  - Wellness Program 2.0

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

Questions?

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

Human Resources Department

Annual Report 2019

Prepared by: Lynn McKissock, Chief Human Resources Officer

GOALS & ACCOMPLISHMENTS

It is the mission & vision of Human Resources to develop, implement and support programs and processes that add value to the Hospital and its employees, leading to improved employee welfare, engagement, growth and retention, while demonstrating our commitment to providing the best patient care with a sense of warmth, friendliness and compassion.

With our mission & vision in mind, the goals established for 2019 all reflected the overarching objective to improve employee communication. Well thought-out and effective communication not only demonstrates to employees our commitment to them, but creates an important sense of value and is a known factor of influence on employee engagement and retention. The specific goals/projects targeted for 2019 included the design of a new and improved annual performance evaluation program, a new Employee Corrective Action Plan tool, updates to HR policies aimed at improving clarity and understanding of necessary rules, regulations, and laws, and a long over-due update to our Employee Handbook.

We not only achieved our goals this year, but we managed to throw in a couple of other improvement projects along the way.

Performance Evaluation Program & Corrective Action Plans

Our goal was to design a program that captured a more rounded and holistic picture of employee performance and behavior and that encouraged forward-thinking conversations in terms of problem solving, innovation, and personal development goals. The desired outcome is to have a program that proves to be a meaningful process that both employees and supervisors will value. As this is a program for annual performance reviews, we have yet to fully determine if we achieved our desired outcomes or not (Annual Review Period extended, due to COVID-19, through June). However, feedback to-date is acknowledging that the new process is an improvement over our previous process and has brought "freshness" to the conversation by changing up the format. As with any new program, we have identified elements for improvement as well and will continue to build upon this program and process.

For those performance conversations that need to support "in the moment" coaching and communicating performance expectations along the way, we also designed a new Employee Corrective Action Plan, designed to provide the employee with an improved understanding of how to correct performance behaviors that are not working well now and clearly set expectations moving forward.

HR Policy Updates & New Employee Handbook

Updated a significant number of HR Policies to ensure compliance with laws and regulations (i.e., Meal Breaks & Rest Periods, the eleven different types of Leaves of Absence, Anti-Harassment, etc.), behavior expectations (i.e., Attendance, Dress Code, Drugs & Alcohol, etc.), and Employee Health Services. Most rewarding was the completion of these updates in our Employee Handbook, published in early 2020 (last update was 2013).

New Job Descriptions

The first communication an employee receives from their employer is a description of what they will be doing in their position. This year, we implemented the initiative of re-writing/refreshing all job description documents with a focus on producing a job description that presented a thorough, relevant and current presentation of each position's role and responsibility. This was a significant undertaking by our entire Leadership team and the outcome has resulted in not only an improved document to share with our employees, but proved to be an added feather in the cap for every one of our leaders as they have acquired, or polished, this challenging skill.

Applicant Tracking System (iCIMS)

Implementing a new applicant tracking system presented to us rather unexpectedly when our former system was no longer able to support our needs (or fully functioning). Fortunately, we were able to obtain a new system that not only did not increase our expenses, but actually proved to be a significant improvement to the recruitment process workflow! We can not only electronically share qualified applications with our hiring managers, we now also have capabilities of tracking each application submitted, all through the entire recruitment process, while easily staying in communication with our applicants (semi-automated email functionality). Additionally, we have subsequently added additional functionality by adding an internal job posting board, accessible from our Intranet, with the new capability for current employees to submit an Internal Application form electronically. The next implementation will involve providing all hiring managers with access to the platform to view all of their open position and manage applications/applicants directly – tracking status, keeping notes, utilizing email communications, etc.

Employee Emergency Notification System (One Call Now)

During the North Bay Fires of 2017, we realized we did not have a system in place to contact all hospital staff with important information pertaining to the condition of the hospital and/or staffing needs (similar to the county-wide Nixle system). Simultaneously, we saw an opportunity to improve our appointment reminder process utilizing available technology to remind patients of their appointments via text, email and/or phone call. Working together with Fe Sendaydiego (Chief Information Officer) and Celia Kruse de la Rosa (Marketing & Community Outreach Manager), we configured and implemented the One Call Now notification system and officially launched to all employees in October, 2019. To date, we have more than 120 employees signed up for notifications (which was utilized at the beginning of the COVID-19 pandemic) and our Mammography department has been utilizing the system successfully for appointment reminders. Plans for continued expansion are in progress.

Employee Apparel Webstore

This was a project that we initiated in 2018, but finalized the full hospital-wide launch in 2019. This new webstore (provided to us for free by Mission Linen) gives employees the ability to order their specific color-coded scrubs and uniforms online and have them shipped direct to their homes. Additionally, we are offering fleece jackets & vests with the SVH logo for all employees.

Diversity Training

In response to some public feedback we had received, we partnered with a consultant to lead some training workshops for our Emergency and Registration employees on Unconscious Bias, Diversity and Inclusion. These sessions' were designed to explore and uncover any potential conscious or unconscious biases that affect internal and external harmony and inclusion for all treatment seekers. The participants all responded how surprised they were by these sessions, in terms of the quality of information and insights they feel they gained. We are hoping to offer more workshops in the near future, but in the meantime, to continue the support of these efforts, we have added diversity training as an assignment for all new hires, in our HealthStream Learning Management System.

Employee Engagement Survey

This year we, once again, developed and administered the Employee Engagement Survey internally. This year we also incorporated the Human Experience survey questions to provide feedback to the Quality department on patient experience initiatives, rather than ask employees to complete two different surveys.

The overall engagement score on the Employee Engagement Survey, on a scale of 1 – 5 was 4.05, with a hospital-wide participation rate of 75% - a significant increase over prior year's participation.

The highest performing items on the survey include:

- My work unit strives to exceed the expectations of the people we serve. (4.39)
- The person I report to treats me with respect. (4.32)
- I respect the abilities of the person to whom I report. (4.30)

The lowest performing items on the survey include:

- My pay is fair for the work I do. (3.52)
- The benefits I receive meet or exceed my expectations. (3.54)
- We have excellent systems and processes to support our work. (3.75)

It's pleasing to see positive responses in alignment with our hospital objectives and values in regards to the service we provide to this community while demonstrating respect for one another. Our areas for opportunity have been consistent over the years in regards to pay and benefits. Human Resources continues to evaluate pay scales for all positions on a regular basis to ensure that we remain competitive in this regional area, for our size. Likewise, we are regularly evaluating our benefit program designs and choices and strive to ensure that we are providing the service and access to providers our employees need while maintaining balance with affordability. In regards to systems and processes – this is high on our organizational radar as well with many improvements already in the planning phase.

Some additional results of the Employee Engagement Survey show us opinions based on a "domain." Domains represent questions/responses that are reflective of the Organization, overall, perceptions of Management, and questions that are focused on the Employee experience. Survey results by Domain are as follows:

Organization

The highest performing items in the Organization Domain include:

- My work unit strives to exceed the expectations of the people we serve. (4.39)
- This hospital offers exceptional and compassionate care. (4.21)
- We treat each other with respect throughout the hospital. (4.19)

The lowest performing items in the Organization Domain include:

- My pay is fair for the work I do. (3.52)
- The benefits I receive meet or exceed my expectations. (3.54)
- We have excellent systems and processes to support our work. (3.75)

Manager

The highest performing items in the Manager Domain include:

- The person I report to treats me with respect. (4.32)
- I respect the abilities of the person to whom I report. (4.30)
- My supervisor is reliable and demonstrates ownership of their responsibilities. (4.18)

The lowest performing items in the Manager Doman include:

- I have regular conversations with my direct supervisor about my personal and/or professional development goals. (3.85)
- I feel supported in my efforts to achieve my highest potential at work. (3.98)
- I am encouraged to share ideas and suggestions about the services my work unit provides. (4.00)

Employee

The highest performing items in the Employee Domain include:

- I have a strong sense of purpose and accomplishment in the work I do. (4.28)
- I feel connected to our hospital's purpose. (4.17)
- I feel supported in balancing my work life with my personal life. (4.14)

The lowest performing items in the Employee Domain include:

- We have excellent systems and processes to support our work. (3.75)
- I feel supported during times of high stress at work. (3.92)
- How likely is it that you would recommend this hospital as a place to work to a friend or colleague? (4.06)

Reviewing our survey results at this Domain level gives us a better insight and direction on where we need to concentrate our efforts – or ensure that we maintain what's going well! We use the results from the Manager Domain to guide us on topics and conversations we need to have with our Leadership Team, which we can do through our regularly scheduled Leadership Development Institute. I do think it's important to recognize that this survey was conducted prior to the launch of our newly designed performance evaluation program which, as you know,

was focused on improving feedback and conversations between managers and staff. It will be important to see if this results shifts in next year's survey.

An important note about the Employee Domain responses brings our attention to two important factors a person can experience in the work environment – burn out or engagement. It's pleasing to see the highest performing items represent factors of engagement – sense of purpose/accomplishment, feeling connected to the purpose of the organization, and experiencing a work/life balance. Our areas of opportunity and focus moving forward will start with our continued efforts to continuously improve our systems and processes, and remembering to include the employee in that important decision process to ensure an effective and successful implementation.

2019 DASHBOARD

Performance Indicator	2019	2018	2017	2016
Employee Engagement Organizational Score (CY)	4.05	4.17	4.19 61st Percentile	4.24 74th Percentile
Employee Engagement Survey Participation Rate (CY)	75%	53%	81%	90%
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Wellness Program Participation (CY)	131/225 – 58%	147/235 – 63%	216/322 – 67%	182/263 – 69%

Turnover

We did see our turnover rate come back down a bit this year. We continue to focus on our onboarding process, communication, training and education, and recognition in an effort to continue driving engagement and retention.

Salaries & Benefits

As evidenced in the dashboard above, we saw a significant improvement this year in our cost of

salaries (Note: these expenses are reported for Fiscal Year 2019). This is contributable to our continued efforts and initiatives to either transition services out of the hospital that were causing financial loses (such as Home Care) or close all together (such as Birthplace). This was balanced with providing a 2% increase in salaries to all staff and ensuring that we keep salaries competitive.

Cost of benefits also saw a significant decrease from the previous year as we have been able to successfully negotiate insurance contracts with little or no increases. That being said, we do anticipate cost of benefits increasing this next year as we negotiate a contract that will provide our employees access to the Canopy network.

As always, salaries and benefits are clearly a point of focus in our employee engagement measures and while this expense continues to represent a significant portion of this hospital's overall overhead expense, we will always strive to find and maintain that balance between fiscal responsibility and maintaining our ability to attract and retain top talent.

Workers' Compensation

While we did see a slight increase in our staff injuries this year, they were not large cases. In fact, we see a reduction in our cost of claims from the prior year. We do continue to monitor and track cause of injuries, as well as provide corrective education where applicable. The cause and types of injuries are regularly reviewed by our Safety Committee with a focus on actions we can take to keep our employees free from injury (for example, the purchase of a new patient lift in ICU). The types of injuries that have the highest rate of occurrence are related to patient assistance, with our second highest cause related to repetitive motion.

With regards to the cost of injury claims, as you know we continue to be self-insured and contract with a third party claims administrator that provides us with great claims management service at a relatively nominal annual fee. However, it's important to regularly review our financial status to evaluate whether or not we continue to hold the best financial position possible. That being said, this year we did request a financial analysis of our Workers' Compensation program to compare our current claims experience to a fully insured program. Our conclusion from this analysis is that we continue to be in the best financial position as a self-insured organization.

Wellness Program Revitalization

To ensure that we continue to have a healthy hospital and support and energize our staff to seek and maintain wellness for themselves, we are revitalizing our Wellness Program – starting by engaging a new Wellness Coordinator, Lisa Gallagher. While Lisa has been in Human Resources for more than two years now, and has always managed our Wellness Portal (Virgin Pulse), she is now partnering with Kelly Mather and a Wellness Team to further promote and teach wellness to our staff. In addition to the wellness portal, we have revitalized our employee Gym by adding new equipment, and have added a "playground" area, complete with a ping pong table, hula hoops, and other fun, active games. Additionally we are implementing "Wellness Wednesdays" on a monthly basis with interactive workshops/activities planned and delivered by our Wellness Team.

Education
Our Education Coordinator, Bonnie Bernhardy, continues to demonstrate a high level of value and contribution to this hospital and our staff. Bonnie is passionate and committed to ensuring that staff are well prepared and skilled to deliver quality patient care. Her projects and initiatives this year included:

New Hire Skills Assessment: Required of every nursing and clinical new hire, prior to working on the unit, to assess current skill level and knowledge on topics that are considered high-risk to patient safety. 2019, topics were expanded to include Pacemaker Rhythm Review, Purewick Female External Catheter, Malignant Hyperthermia and CNA Change in Patient Status, for a total of 20 topics (topics vary as appropriate for job classification and department).

Skills Lab: An annual event committed to improving and maintaining the skill level of our staff for those low frequency/high-risk skills. In order to ensure that these high-risk skills meet our high level of standard, the competency verification process includes a hands-on return demonstration. Offered as a two-part session, topics included Paragon training, patient restraints, glucometer, lab specimen collection and handling, pacemaker rhythms, AED/Code Blue response, manual defibrillation, synchronized cardioversion, transcutaneous pacing, change in patient status, Veinlite and 12 Lead ECG lead placement, Safe Patient Handling equipment, Arterial Line and Central Line Waveforms, Capnography Monitoring, Implanted Ports, Constavac Reinfusion, Pleuravac Chest Tube drainage system, IV compounding outside of the Pharmacy, Vertical Evacuation chairs and Malignant Hyperthermia.

Advance Health Care Directives (AHCD): Hospital and community workshops continued to be conducted with the goal of having staff and community members complete AHCD to ensure their wishes are honored during their end of life process.

Additional educational opportunities provided to staff included online training for sensitivity and dignified care of the bariatric patient, bariatric transfer and bariatric post-op complications for staff who care for and interact with bariatric patients, Code Blue drill conducted in surgical services, EBSCO Dynamic Health online procedures implementation, ECHO Bobble Study competency, pacemaker education and a variety of new product in-services.

Our education goals are to continue driving and supporting safe and high-quality patient care. Annual online education modules are assigned to all staff, not only satisfying regulatory requirements, but state and federal requirements as well. We are fortunate to have Bonnie as our Education Coordinator who accomplishes so much within her part-time hours!

HR Goals/Initiatives for 2020
Looking forward, we want to continue building on this new, strong foundation of becoming more efficient and streamlined. We are looking to implement a new HRIS system that will interface with our new Applicant Tracking System that will also provide for a more streamlined

onboarding process. Additionally, this new system will provide a module for managing the employee performance evaluation process electronically, which will improve the flow and usability of this important feedback and communication process. We will also focus on the Human Experience initiative, incorporating the key elements of this program into our New Hire Orientation, Wellness Program and other employee programs, as applicable.

Meeting Date: June 4, 2020

Prepared by: Vivian Woodall, Clerk of the Board of Directors

Agenda Item Title: Resolution No. 351 – Ordering an Election to be Held and Requesting Consolidation with the November 3, 2020, General District Election

---

Recommendation:
That the SVHCD Board approve and adopt Resolution No. 351, as described in the attachment.

Background:
Pursuant to Elections Code Section 10509 (which requires notification prior to the 125th day before the election (July 1, 2020)), the elected office holders of this District whose terms will expire in 2020, and/or their successors, will be required to be elected at the upcoming general election to be held on November 3, 2020. This resolution requests consolidation with the general election.

Consequences of Negative Action/Alternative Actions:
The incumbents interested in running for re-election will not be able to participate in the general election in November 2020.

Financial Impact:
N/A

Selection Process and Contact History:
N/A

Board Committee:
N/A

Attachments:
1. Resolution No. 351;
2. Notice of Offices To Be Filled; and
3. Notice of District Boundaries

SONOMA VALLEY HEALTH CARE DISTRICT
BOARD OF DIRECTORS, COUNTY OF SONOMA, STATE OF CALIFORNIA

RESOLUTION NO. 351

ORDERING AN ELECTION TO BE HELD AND REQUESTING CONSOLIDATION WITH THE NOVEMBER 3, 2020, CONSOLIDATED DISTRICT ELECTION

WHEREAS, an election will be held on November 3, 2020, in the Sonoma Valley Health Care District for the purpose of electing District Directors to fill positions that will expire in 2024;

BE IT RESOLVED THAT, the District Directors of said district hereby request consolidation with any election that may be held on the same day, in the same territory or in territory that is in part the same.

THE FOREGOING RESOLUTION was introduced by Director _____________, who moved its adoption, seconded by Director _____________ and then adopted on roll call by the following vote:

Director Hirsch	Aye	No	Abstain
Director Rymer	Aye	No	Abstain
Director Mainardi	Aye	No	Abstain
Director Nevins	Aye	No	Abstain
Director Boerum	Aye	No	Abstain

AYES: _______ NOES: _______ ABSTAIN:_______ ABSENT:_______

WHEREUPON, the Chair declared the foregoing resolution adopted and **SO ORDERED.**

____
Jane Hirsch, Chair

Dated: 4th of June 2020

Attest:

____
Bill Boerum, Secretary

seal

MEMORANDUM

TO: DEVA MARIE PROTO, COUNTY CLERK & REGISTRAR OF VOTERS

FROM: Sonoma Valley Health Care District

SUBJECT: NOTICE OF OFFICES TO BE FILLED AND STATEMENT OF RESPONSIBILITY FOR STATEMENTS OF QUALIFICATIONS

DATE: June 4, 2020

Notice is hereby given that, pursuant to Elections Code Section 10509 (which requires notification prior to the 125th day before the election (July 1, 2020), the following are the elected office holders of this district whose terms will expire in 2024, and/or their successors will be required to be elected at the upcoming election to be held on November 3, 2020.

DIRECTOR		LENGTH OF NEXT TERM (commencing 12.03.20)
1.	Jane E. Hirsch	Four Years
2.	Sharon B. Nevins	Four Years
3.	William T. Boerum	Four Years

1. The length of Statements of Qualifications shall not exceed **200** words.

2. The costs incurred in the printing of the optional Statements of Qualifications (English and Spanish, if requested by the candidate) in the Voter Information Pamphlet is the responsibility of the **Candidate**.

3. The District opts to **require payment in advance to the District Board Clerk/Secretary**.

Note: It is the responsibility of the District to collect the costs of Statements of Qualifications from the candidates whether payment in advance or payment after the fact is required. **If advance payment is required, candidates must present a receipt from the District at the time of the Statement of Qualifications is filed with the Registrar of Voters Office. Multi-county districts please be advised that the estimated cost reflects only the Sonoma County portion of the cost.**

I HEREBY CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND SUBMIT THIS STATEMENT IN COMPLIANCE WITH ELECTIONS CODE SECTIONS 10509 AND 13307.

SIGNED: ___________________________________ DATE: June 4, 2020
Vivian Woodall, District Board Clerk

seal

MEMORANDUM

TO: DEVA MARIE PROTO, COUNTY CLERK & REGISTRAR OF VOTERS

FROM: Sonoma Valley Health Care District

SUBJECT: NOTICE OF DISTRICT BOUNDARIES/STATEMENT IN LIEU OF MAP

DATE: June 4, 2020

Pursuant to Elections Code Section 10522 (which requires notification prior to the 125th day before the election (July 1, 2020)) regarding district boundaries in the above named district), we are hereby notifying the Registrar of Voters Office that:

> *As of this date, there has been no change in the boundaries of this district since the date of the last election. A map of the district is already on file with your office; therefore this notice is in lieu of providing a duplicate map.*

Submitted by ____________________________________ DATE: 4th of June 2020
Vivian Woodall, District Board Clerk

seal

Granite Bay
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Indian Wells
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Irvine
(949) 263-2600
Los Angeles
(213) 617-8100
Manhattan Beach
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Colin Coffey
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colin.coffey@bbklaw.com

May 20, 2020

Sonoma Valley Healthcare District
Attn: Jane Hirsch, Chair of the Board of Directors
347 Andrieux Street
Sonoma, CA 95476

Re: Conflict Waiver - Representation of the UC Regents

Dear Jane:

Best Best & Krieger ("BBK") represents Sonoma Valley Healthcare District ("SVHD") as its General Council on various matters. Recently, SVHD asked BBK to review and advise on various contracts between SVHD and University of California, San Francisco (the "Contract Matters"). The scope of work involving the University of California, San Francisco ("UCSF") is limited to non-litigation issues.

BBK also represents the Regents of the University of California (the "Regents") in several matters regarding employment and labor matters in the Riverside Campus, Public Records Act in the Los Angeles campus, eminent domain matters in the San Diego Campus, and real estate matters in the San Diego Campus (collectively, the "UC Matters"). BBK does not currently provide any legal services concerning the UCSF campus. Because of BBK's ongoing relationship with the Regents, it is possible the scope of work for the Regents may include other matters in the future.

The Contract Matters and the UC Matters are unrelated. Nonetheless, if BBK represents SVHD on the Contract Matters and the Regents on the UC Matters concurrently, this creates a conflict of interest for BBK. Therefore, we write to advise SVHD of the conflict of interest, the impact of our representation, and to obtain SVHD's informed written consent to proceed.

RULES OF PROFESSIONAL CONDUCT

Rule 1.7 of the California Rules of Professional Conduct provides in pertinent part:

(a) A lawyer shall not, without informed written consent from each client and compliance with paragraph (d), represent a client if the representation is directly adverse to another client in the same or a separate matter.

(b) A lawyer shall not, without informed written consent from each affected client and compliance with paragraph (d), represent a client if there is a significant risk the lawyer's representation of the client will be materially limited by the lawyer's responsibilities to or relationships with another client, a former client or a third person, or by the lawyer's own interests.

. . .

(d) Representation is permitted under this rule only if the lawyer complies with paragraphs (a), (b), . . . and:

(1) the lawyer reasonably believes that the lawyer will be able to provide competent and diligent representation to each affected client;

(2) the representation is not prohibited by law; and

(3) the representation does not involve the assertion of a claim by one client against another client represented by the lawyer in the same litigation or other proceeding before a tribunal.

OUR REPRESENTATION & ETHICAL SCREEN

As part of this consent, you agree that we may represent the Regents on the UC Matters while we concurrently represent SVHD on the Contract Matters as your General Counsel . Our representation of SVHD on the Contract Matters while we represent the Regents in the UC Matters concurrently is not prohibited, but requires SVHD's consent. We do not believe our representation of the Regents will impair our competency, diligence or loyalty to SVHD nor will it otherwise materially limit our representation of SVHD or impair our independent professional judgment in any way. For example, we do not believe we will be tempted to favor the interests of one client over the other, nor do we think the relationship will create any appearance of impropriety. However, these are all things SVHD should consider before signing this conflict waiver.

In the event that circumstances change or we become aware of new information that requires client consent or new notice, each client will be notified of that fact immediately. Continued representation will be subject to that notice and the informed written consent of each client will be obtained as necessary. Should a further conflict of interest develop in the future, or if the relationship should materially limit our representation of either client, we may be required to terminate our representation, which could impact your attorney's fees and costs should you need to hire new counsel at that time.

BEST BEST & KRIEGER LLP
ATTORNEYS AT LAW

As you know, BBK is handling the UC Matters for the Regents, which do not involve SVHD. The attorneys representing SVHD are led by Colin Coffey. SVHD's attorneys are primarily located in our Walnut Creek office. The attorneys representing the Regents on the UC Matters are led by Howard Golds, primarily located in our Riverside office, Ruben Duran, primarily located in our Ontario office, James Gilpin, primarily located in our San Diego Office, and Nancy Park, primarily located in our Sacramento office.

The BBK lawyers who represent SVHD on the Contract Matters will not work on the UC Matters for the Regents, and vice versa. We will establish an ethical screen so that the lawyers and staff representing SVHD on the Contract Matters will not have access to any confidential information, including electronic and physical files, regarding the Regents on the UC Matters and vice versa.

SVHD'S CONSENT

If SVHD agrees to the above, we need a representative of SVHD to sign this consent letter. This consent will not waive any protection that SVHD may have with regard to attorney-client communications with us in its matter. Those communications will remain confidential and will not be disclosed to any third party without SVHD's consent.

Please consider this matter carefully, and do not hesitate to contact us if SVHD has any questions or concerns. You may wish to confer with independent legal counsel regarding this disclosure and your consent, and you should feel free to do so.

SVHD's execution of this consent form will constitute an acknowledgment of full disclosure in compliance with the requirements of Rule 1.7 of the California Rules of Professional Conduct previously quoted in this letter, and SVHD's consent to proceeding with our representation described in this letter.

If you have any questions, please do not hesitate to call.

Sincerely,

Colin Coffey
of BEST BEST & KRIEGER LLP

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CONSENT

By this letter, Best Best & Krieger LLP has explained the existing and/or reasonably foreseeable potential risks and conflict(s) of interest in the above-referenced matter, and has informed SVHD of the possible consequences of this representation and these conflicts. SVHD understands that it has the right to and has been encouraged to consult with independent counsel before signing this consent, and SVHD acknowledges that it has been given sufficient time to do so. Notwithstanding the foregoing, SVHD hereby consents and agrees to be represented by Best Best & Krieger LLP.

By:________________________________ Dated:________________________________

To: SVHCD Board of Directors

From: Sabrina Kidd, MD

Meeting Date: June 4, 2020

Subject: CMO Report

1. May Highlights included:
   a. COVID-19: We continue to maintain preparedness for a future surge, but we are now focusing on recovery and how to safely live with COVID-19 for the near future. Highlights include:
      i. The second floor and old ED remain ready should we experience a future surge.
      ii. We have transitioned our COVID-19 Hotline to a recording and testing is now available with a physician order or through the Health Center.
      iii. PPE (Personal protective equipment)
         1. We continue all re-use protocols and have an adequate supply for patient care.
         2. We continue a universal masking policy for all staff and visitors.
      iv. Testing
         1. We are now running tests through DPH and UCSF labs.
         2. We continue drive through testing by appointment for pre-operative patients and individuals with an order from their community physician.
         3. Other testing methods and types including antigen and serology for immunoglobulins continue to be under investigation.
      v. Services
         1. All services are now available and we have taken many measures to ensure we offer these as safely as possible.
      vi. Increased safety measures include:
         1. Increased spacing in waiting areas.
         2. Increased time between appointments to decrease waiting and allow for cleaning.
         3. More frequent and more thorough cleaning in all patient and non-patient care areas.
         4. Pre-operative testing for all procedures involving airway management.

            5. Entrance screening for all visitors, patients, employees, and physicians.
            6. Universal masking for all visitors, patients, employees, and physicians.
            7. In an effort to reduce traffic and exposures, visitors are not allowed unless critical to the immediate care of a patient.
    b. UCSF Partnership:
        i. We are exploring joint GI services and continue to work on bringing additional UCSF physicians to SVH both via telemedicine and in person.

2. Postponed Events:
    a. Bariatric accreditation site visit is now postponed until 2021 at the earliest due to COVID-19.
3. Quality:
    a. No new concerns or events in May

To: SVHCD Board of Directors
From: Kelly Mather
Date: 5/27/2020
Subject: Administrative Report

Summary
The hospital team has done an outstanding job managing under the pandemic. We had a very nice Hospital Week celebration thanks to many donations from our community. It was appreciated by all! The 75th Anniversary celebration was also featured with staff and banners are up around the plaza. Volumes are slowly picking up, but as you can see from the trending report they were very low these past two months. The CARES support was a life saver.

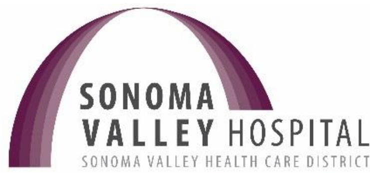
Update from FY 2020 Strategic Plan:

Strategic Priorities	Update
Exceed Community Expectations especially in Emergency Services	➢ As the pandemic continues, our Emergency services are available and we have enough PPE for the staff. ➢ Drive thru testing for anyone in the community is now open Monday – Saturday through the Health Center. The hospital provides the space on weekdays. ➢ COVID 19 communications have been well received and effective. The community updates had a very high engagement level and response. ➢ The Brand Communication Plan will be rolling out in June focusing on being seen as the Compassionate Heart for Sonoma Valley.
Create UCSF Health Outpatient Center	➢ Construction is underway with a plan to complete the CT in the fall. ➢ Our updated strategic plan now demonstrates the position SVH has in the new UCSF affiliate network of hospitals. UCSF is releasing their 2025 strategic plan and it states they "will expand their reach to serve the growing and changing Bay Area by creating a broader network and partnering with more high-quality local providers. Their goal will be to ensure that no Bay Area resident will need to travel more than 20 miles to receive quality care from UCSF Health." ➢ We are making good progress on bringing UCSF physicians through telehealth and already have Neurology and Infectious Disease. Working on GI.
Become a 5 Star Hospital	➢ We are converting to the "Human Experience" model for patients and staff starting this summer. The change will be noticed in how we manage the whole person – physically, cognitively, emotionally and spiritually. ➢ We are re-doing orientation with the new brand and human experience. ➢ Staff Engagement results have been shared and we are gathering feedback for the action plans this month.
Provide Access to Excellent Physicians	➢ Physician clinic visits are increasing again. Many are telehealth visits now. ➢ There are several UCSF specialists that are interested in coming to Sonoma. ➢ Satellite Healthcare (Dialysis company) is working on a new proposal due to enhancements in home based strategies and a change of focus. ➢ We are ready for the accreditation survey for Bariatrics Accreditation.
Healthy Hospital	➢ We are starting Wellness Wednesdays in July with a new Wellness Team. ➢ Physical distancing, limited gatherings to essential meetings only and teleworking will continue during the pandemic. ➢ Performance Evaluations are underway and should be complete by June.

APRIL 2020

Patient Experience	Current Performance	FY 2020 Goal	National Benchmark
Would Recommend Hospital	80%	> 70 percent	50th percentile
Inpatient Overall Rating	75%	>70 percent	50th percentile
Outpatient Services	4.8	4.5	3.8
Emergency Department	4.6	4.5	3.8
Quality & Safety	**YTD Performance**	**FY 2020 Goal**	**Benchmark**
Central Line Infection	0	<1	<.51
Catheter Infection	0	<1	<1.04
Surgery Site Infection – Colon	1	<1	N/A
Surgery Site Infection – Joint	0	<1.5%	N/A
MRSA Bacteremia	0	<.13	<.13
C. Difficile	1	3.5	2.7/10,000 pt days
Patient Safety Indicator	.76	<1	<1
Heart Failure Mortality Rate	11.7%	12%	12.9%
Pneumonia Mortality Rate	17.5%	20%	15.6%
Stroke Mortality Rate	15.1%	15%	13.8%
Sepsis Mortality Rate	7.3%	<18%	25%
30 Day All- Cause Readmissions	14.1%	< 15.3 %	< 15%
Serious Safety Events	1	0	0
Falls	1.5	< 2.3	2.3
Pressure Ulcers	0	<3.7	3.7
Injuries to Staff	10	< 10	17
Adverse Drug Events with Harm	0	0	0
Reportable HIPAA Privacy Events	0	0	0
Case Mix Index	1.8	1.4	1.3
Hospital Star Rating	4	4	3
Staff Satisfaction	**Performance**	**FY 2020 Goal**	**Benchmark**
Staff Pulse Survey	4.05 out of 5	>3.8	75%
Turnover	7.3%/8.76%	< 15%	< 20%
Financial Stability	**YTD Performance**	**FY 2020 Goal**	**Benchmark**
EBDA	11.8%	3%	3%
Paid FTE's	190	<235	n/a
Days Cash on Hand	43.1	20	30
Days in Accounts Receivable	35.5	45	50
Length of Stay	4.0	3.85	4.03
Funds raised by SVHF	$19.2 million	$21 million	$1 million
Strategic Growth		**FY 2020 Goal**	**FY 2019**
Inpatient Discharges	753/903	900	984
Outpatient Visits	41,017/49,220	55,000	54,596
Emergency Visits	8503/10,203	10,000	10,181
Surgeries + Special Procedures	2007/2408	3000	2950
Community Benefit Hours	978/1173	1000	1222

Note: Colors demonstrate comparison to National Benchmark



TRENDED MONTHLY RESULTS

MEASUREMENT	Goal FY 2020	Jul 2019	Aug 2019	Sep 2019	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Mar 2020	Apr 2020	May 2019	Jun 2019
FY YTD Turnover	<15%	1.7	2.6	3.9	3.9	4.8	5.6	5.6	6	7.3	7.3	14.5	17.7
Leave of Absences	<12	14	13	8	11	15	16	13	9	11	13	10	12
EBDA	>3%	56.1	-.4	-1.1	-.3	.4	4.5	16.1	10.5	25.7	-13.9	6.8	6.1
Operating Revenue	>3.5m	3.7	3.7	3.6	3.8	3.7	4.0	5.4	4.1	8.3	2.8	4.8	4.2
Expense Management	<4.5m	4.2	4.2	4.2	4.3	4.2	4.4	5.1	4.4	6.8	3.7	5.0	4.8
Net Income	>50k	2.3m	-93	36	-76	101	180	873	307	2351	-297	248	15.4
Days Cash on Hand	>20	38	36	28	22.5	16.9	17.9	20.4	15.7	15.6	43.1	39	35
Receivable Days	<50	42	42	44	46.2	44	44	38	42.5	36.9	35.5	37	43
Accounts Payable Days	>50	53	40	41	45	43	43	42	42.2	53.4	41.9		
Accounts Payable	<$3m	3.5	2.6	2.7	3.1	2.9	2.9	2.9	3.0	3.7	2.9		
Total Paid FTE's	<235	226	226	235	233	230	230	230	231	236	190	266	255
Inpatient Discharges	>80	72	76	71	90	90	87	79	86	63	39	86	66
Patient Days	>300	269	240	312	351	319	336	321	286	218	156		
Observation Days	<20	11	19	17	21	18	29	12	16	16	13		
Average Daily Census	>10	8.7	7.7	10.4	11.3	10.6	10.8	10.4	9.9	7	5.2		
Outpatient Revenue	>$15m	16.1	15.7	16.4	16.1	15.9	16.3	17.3	16.3	12.3	7.1	16.2	15.1
Surgeries	>150	156	160	143	187	193	152	150	145	80	17	166	157
Special Procedures	>75	85	81	74	74	72	57	58	79	43	1		
Emergency Visits	>900	1001	975	939	973	880	984	953	972	745	529	891	941
MRI	>120	122	127	138	147	145	159	138	146	70	39	149	150
Cardiology (Echos)	>85	115	67	74	107	46	85	83	68	52	35	113	103
Laboratory	>12	11.3	11.3	10.4	11.0	11.3	11.3	11.6	10.9	8.7	5.5	12.3	10.7
Radiology	>900	1005	983	980	1035	888	1033	1113	934	684	420	1044	908
Rehab	>2300	1958	2928	2135	2010	2207	2181	2422	2119	1626	566	2539	1967
CT	>350	413	433	378	406	356	433	429	388	335	263	453	357
Mammography	>200	223	243	222	250	219	216	172	243	243	15	220	224
Ultrasound	>250	281	270	280	244	255	251	234	238	198	110	283	291
Occupational Health	>675	750	737	530	753	535	660	517	572	544	392	804	578
Wound Care	>275	329	316	247	226	237	294	252	233	201	140	311	307

To: SVH Finance Committee
From: Ken Jensen, CFO
Date: May 26, 2020
Subject: Financial Report for the Month Ending April 30, 2020

During the month of April the hospital continued to experience low volumes in response to the Covid-19 pandemic and the extended shelter in place order issued by Sonoma County. The decrease of volume in April has resulted in a loss of net revenue of approximately ($2.2M). April's loss of net revenue was offset by distributions from the CARES Act funding totaling $1,149,084 received. The hospital received another distribution from the CARES Act funding in May for $4,423,886 which will cover the continued loss of net revenue and increased Covid-19 costs.

For the month of April the hospital's actual operating margin of ($958,081) was ($392,176) unfavorable to the budgeted operating margin of ($565,905). After accounting for all other activity; the net loss for April was ($297,569) vs. the budgeted net income of $93,515 with a monthly EBDA of -13.9% vs. a budgeted -0.3%.

Gross patient revenue for April was $10,316,637; ($11,768,361) under budget. Inpatient gross revenue was under budget by ($3,597,671). Inpatient days were under budget by (167) days and inpatient surgeries were under budget by (20) cases. Outpatient gross revenue was under budget by ($6,571,491). Outpatient visits were under budgeted expectations by (3,220) visits, outpatient surgeries were under budget by (126) cases, and special procedures were under budget by (81) cases. The Emergency Room gross revenue was under budget by ($1,599,199) with ER visits under budgeted expectations by (423) visits.

Deductions from revenue were favorable to budgeted expectations by $10,732,675 due to the decreased volumes. The hospital received disbursements of $1,149,084 from the CARES Act funding.

After accounting for all other operating revenue, the **total operating revenue** was unfavorable to budgeted expectations by ($1,030,960).

Operating Expenses of $3,754,694 were favorable to budget by $638,784. Salaries and wages and agency fees were under budget by $392,937 due to flexing both clinical and non-clinical staff due to low volumes and employee benefits were under budget by $5,793. Professional fees are under budget by $60,469 due to clinic physician costs being under budgeted expectations by $28,112 and a decrease in Prima support. Supplies are under budget by $166,524 due to lower volumes. Purchased services were

over budget by ($26,349) primarily due to unbudgeted costs related to Covid-19 ($22,817). Total expenses in the month of April related to Covid-19 is $308,913.

After accounting for all income and expenses, but not including Restricted Contributions and GO bond activity, the net loss for April was ($646,935) vs. a budgeted net loss of ($279,646). The hospital received $186,065 in donations from the Sonoma Valley Hospital Foundation primarily for the Outpatient Diagnostic Center costs. The total net loss for April after all activity was ($297,569) vs. a budgeted net income of $93,515.

EBDA for the month of April was -13.9% vs. the budgeted -0.3%.

Patient Volumes – April

	ACTUAL	BUDGET	VARIANCE	PRIOR YEAR
Acute Discharges	39	85	-46	87
Acute Patient Days	156	323	-167	341
Observation Days	13	0	13	14
OP Gross Revenue	$7,124	$15,295	($8,171)	$15,396
Surgical Cases	17	163	-146	163

Gross Revenue Overall Payer Mix – April

	ACTUAL	BUDGET	VARIANCE	YTD ACTUAL	YTD BUDGET	VARIANCE
Medicare	37.6%	41.6%	-4.0%	40.9%	41.6%	-0.7%
Medicare Mgd Care	19.7%	14.0%	5.7%	14.6%	14.1%	0.5%
Medi-Cal	20.4%	17.6%	2.8%	17.7%	17.6%	0.1%
Self-Pay	1.8%	1.5%	0.3%	1.8%	1.5%	0.3%
Commercial	18.3%	20.9%	-2.6%	21.7%	20.9%	0.8%
Workers Comp	1.2%	2.4%	-1.2%	2.6%	2.3%	0.3%
Capitated	1.0%	2.0%	-1.0%	0.7%	2.0%	-1.3%
Total	100.0%	100.0%		100.0%	100.0%	

Cash Activity for April:

For the month of April the cash collection goal was $3,747,818 and the Hospital collected $2,495,814 or under the goal by ($1,252,004). The year-to-date cash collection goal was $37,108,695 and the Hospital has collected $35,954,893 or under goal by ($1,153,802).

	CURRENT MONTH	PRIOR MONTH	VARIANCE	PRIOR YEAR
Days of Cash on Hand – Avg.	43.1	15.6	27.5	6.2
Accounts Receivable Days	35.5	36.9	-1.4	37.9
Accounts Payable	$2,918,422	$3,775,082	-$856,660	$5,970,513
Accounts Payable Days	41.9	53.4	-11.5	74.4

ATTACHMENTS:

-Attachment A is the Payer Mix Analysis which includes the projected collection percentage by payer.

-Attachment B is the Operating Indicators Report

-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

-Attachment F is the Cash Projection

Sonoma Valley Hospital
Payer Mix for the month of April 30, 2020

ATTACHMENT A

Gross Revenue:	Actual	Budget	Variance	% Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Medicare	3,873,431	9,175,692	-5,302,261	-57.8%	83,746,581	89,163,976	-5,417,395	-6.1%
Medicare Managed Care	2,028,576	3,098,528	-1,069,952	-34.5%	30,019,848	30,088,215	-68,367	-0.2%
Medi-Cal	2,107,751	3,889,857	-1,782,106	-45.8%	36,234,790	37,746,173	-1,511,383	-4.0%
Self Pay	185,675	341,842	-156,167	-45.7%	3,642,640	3,316,180	326,460	9.8%
Commercial & Other Government	1,889,574	4,622,143	-2,732,569	-59.1%	44,573,113	44,774,407	-201,294	-0.4%
Worker's Comp.	123,845	521,090	-397,245	-76.2%	5,340,468	5,012,877	327,591	6.5%
Capitated	107,785	435,846	-328,061	-75.3%	1,526,621	4,208,894	-2,682,273	-63.7%
Total	**10,316,637**	**22,084,998**	**(11,768,361)**		**205,084,061**	**214,310,722**	**(9,226,661)**	

Net Revenue:	Actual	Budget	Variance	% Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Medicare	435,279	1,219,449	-784,170	-64.3%	10,140,619	11,730,328	-1,589,709	-13.6%
Medicare Managed Care	227,607	367,797	-140,190	-38.1%	3,333,674	3,571,472	-237,798	-6.7%
Medi-Cal	232,274	399,488	-167,214	-41.9%	3,698,368	3,876,531	-178,163	-4.6%
Self Pay	76,211	173,382	-97,171	-56.0%	1,832,098	1,681,966	150,132	8.9%
Commercial & Other Government	550,260	1,399,260	-849,000	-60.7%	13,636,168	13,631,221	4,947	0.0%
Worker's Comp.	24,707	109,533	-84,826	-77.4%	1,085,121	1,053,707	31,414	3.0%
Capitated	1,983	7,932	-5,949	-75.0%	31,345	76,601	-45,256	-59.1%
Prior Period Adj/IGT	1,149,084	56,250	1,092,834	1942.8%	8,590,341	5,685,530	2,904,811	51.1%
Total	**2,697,405**	**3,733,091**	**(1,035,686)**	**-27.7%**	**42,347,734**	**41,307,356**	**1,040,378**	**2.5%**

Percent of Net Revenue:	Actual	Budget	Variance	% Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Medicare	16.2%	32.7%	-16.5%	-50.5%	23.9%	28.3%	-4.4%	-15.5%
Medicare Managed Care	8.4%	9.9%	-1.5%	-15.2%	7.9%	8.6%	-0.7%	-8.1%
Medi-Cal	8.6%	10.7%	-2.1%	-19.6%	8.7%	9.4%	-0.7%	-7.4%
Self Pay	2.8%	4.6%	-1.8%	-39.1%	4.3%	4.1%	0.2%	4.9%
Commercial & Other Government	20.4%	37.5%	-17.1%	-45.6%	32.2%	33.0%	-0.8%	-2.4%
Worker's Comp.	0.9%	2.9%	-2.0%	-69.0%	2.6%	2.6%	0.0%	0.0%
Capitated	0.1%	0.2%	-0.1%	-50.0%	0.1%	0.2%	-0.1%	-50.0%
Prior Period Adj/IGT	42.6%	1.5%	41.1%	2740.0%	20.3%	13.8%	6.5%	47.1%
Total	**100.0%**	**100.0%**	**0.0%**	**0.0%**	**100.0%**	**100.0%**	**0.0%**	**0.0%**

Projected Collection Percentage:	Actual	Budget	Variance	% Variance	YTD Actual	YTD Budget	YTD Variance	YTD % Variance
Medicare	11.2%	13.3%	-2.1%	-15.8%	12.1%	13.2%	-1.1%	-8.3%
Medicare Managed Care	11.2%	11.9%	-0.7%	-5.9%	11.1%	11.9%	-0.8%	-6.7%
Medi-Cal	11.0%	10.3%	0.7%	6.8%	10.2%	10.3%	-0.1%	-1.0%
Self Pay	41.0%	50.7%	-9.7%	-19.1%	50.3%	50.7%	-0.4%	-0.8%
Commercial & Other Government	29.1%	30.3%	-1.2%	-4.0%	30.0%	30.4%	-0.4%	-1.3%
Worker's Comp.	19.9%	21.0%	-1.1%	-5.2%	20.3%	21.0%	-0.7%	-3.3%

SONOMA VALLEY HOSPITAL
OPERATING INDICATORS
For the Period Ended April 30, 2020

ATTACHMENT B

	CURRENT MONTH				YEAR-TO-DATE			YTD
	Actual 04/30/20	Budget 04/30/20	Favorable (Unfavorable) Variance		Actual 04/30/20	Budget 04/30/20	Favorable (Unfavorable) Variance	Prior Year 04/30/19
				Inpatient Utilization				
				Discharges				
1	19	72	(53)	Med/Surg	591	712	(121)	751
2	20	13	7	ICU	162	126	36	120
3	39	85	(46)	Total Discharges	753	838	(85)	871
				Patient Days:				
4	65	241	(176)	Med/Surg	1,986	2,375	(389)	2,477
5	91	82	9	ICU	822	810	12	804
6	156	323	(167)	Total Patient Days	2,808	3,185	(377)	3,281
7	13	-	13	**Observation days**	172	-	172	91
				Average Length of Stay:				
8	3.4	3.3	0.1	Med/Surg	3.4	3.3	0.0	3.3
9	4.6	6.3	(1.8)	ICU	5.1	6.4	(1.4)	6.7
10	4.0	3.8	0.2	Avg. Length of Stay	3.7	3.8	(0.1)	3.8
				Average Daily Census:				
11	2.2	8.0	(5.9)	Med/Surg	6.5	7.8	(1.3)	8.1
12	3.0	2.7	0.3	ICU	2.7	2.7	0.0	2.6
13	5.2	10.8	(5.6)	Avg. Daily Census	9.2	10.4	(1.2)	10.8
				Other Utilization Statistics				
				Emergency Room Statistics				
14	529	952	(423)	Total ER Visits	8,503	9,173	(670)	8,349
				Outpatient Statistics:				
15	1,626	4,846	(3,220)	Total Outpatients Visits	41,017	46,573	(5,556)	45,142
16	8	28	(20)	IP Surgeries	210	275	(65)	270
17	9	135	(126)	OP Surgeries	1,173	1,294	(121)	1,354
18	1	82	(81)	Special Procedures	624	792	(168)	802
19	126	361	(235)	Adjusted Discharges	2,789	3,543	(754)	3,130
20	504	1,050	(546)	Adjusted Patient Days	10,373	10,176	197	21,231
21	16.8	35.0	(18.2)	Adj. Avg. Daily Census	34.0	33.4	0.6	69.6
22	1.5272	1.4000	0.127	Case Mix Index -Medicare	1.3813	1.4000	(0.019)	1.5122
23	1.5781	1.4000	0.178	Case Mix Index - All payers	1.5307	1.4000	0.131	1.5428
				Labor Statistics				
24	166	220	54	FTE's - Worked	204	217	12.2	260
25	190	246	57	FTE's - Paid	227	242	14.9	290
26	45.02	43.95	(1.06)	Average Hourly Rate	45.07	43.37	(1.70)	42.77
27	11.28	7.04	(4.24)	FTE / Adj. Pat Day	6.68	7.26	0.58	4.16
28	64.3	40.1	(24.2)	Manhours / Adj. Pat Day	38.1	41.3	3.3	23.7
29	257.2	116.8	(140.4)	Manhours / Adj. Discharge	141.5	118.8	(22.8)	160.8
30	25.4%	22.9%	-2.5%	Benefits % of Salaries	22.9%	23.3%	0.4%	22.8%
				Non-Labor Statistics				
31	23.7%	14.3%	-9.4%	Supply Expense % Net Revenue	15.5%	14.1%	-1.4%	11.7%
32	2,961	1,496	(1,465)	Supply Exp. / Adj. Discharge	1,924	1,508	(416)	1,846
33	30,549	12,477	(18,072)	Total Expense / Adj. Discharge	16,805	13,123	(3,682)	17,048
				Other Indicators				
34	57.0			Days Cash - Operating Funds				
35	35.5	50.0	(14.5)	Days in Net AR	42.0	50.0	(8.0)	43.1
36	66%			Collections % of Net Revenue	97%			101.3%
37	37.7	55.0	(17.3)	Days in Accounts Payable	37.7	55.0	(17.3)	50.5
38	15.2%	17.1%	-1.8%	% Net revenue to Gross revenue	16.9%	17.7%	-0.8%	21.7%
39	16.7%			% Net AR to Gross AR	16.7%			17.3%

ATTACHMENT C

Sonoma Valley Health Care District
Balance Sheet
As of April 30, 2020

		Current Month	Prior Month	Prior Year
	Assets			
	Current Assets:			
1	Cash	$ 2,719,200	$ 2,351,588	$ 1,553,622
2	Cash - Money Market	6,235,214	235,051	1,259
3	Net Patient Receivables	4,841,011	5,785,337	6,023,427
4	Allow Uncollect Accts	(1,299,500)	(1,199,855)	(1,123,964)
5	Net A/R	3,541,511	4,585,482	4,899,463
6	Other Accts/Notes Rec	264,593	305,220	9,020
7	Parcel Tax Receivable	114,617	1,691,803	118,348
8	GO Bond Tax Receivable	1,172,250	1,172,250	1,197,608
9	3rd Party Receivables, Net	573,802	6,986,284	8,166,578
10	Inventory	987,778	976,674	843,684
11	Prepaid Expenses	742,843	738,528	858,237
12	Total Current Assets	$ 16,351,808	$ 19,042,880	$ 17,647,819
13	Property,Plant & Equip, Net	$ 49,287,211	$ 49,309,380	$ 51,206,524
14	Trustee Funds - GO Bonds	4,192,341	4,187,441	3,574,837
15	Other Assets	-	-	-
16	Total Assets	$ 69,831,360	$ 72,539,701	$ 72,429,180
	Liabilities & Fund Balances			
	Current Liabilities:			
17	Accounts Payable	$ 2,918,422	$ 3,775,082	$ 5,970,513
18	Accrued Compensation	3,248,403	3,194,538	3,525,701
19	Interest Payable - GO Bonds	286,278	190,847	302,289
20	Accrued Expenses	1,519,187	1,636,215	1,156,637
21	Advances From 3rd Parties	-	-	105,388
22	Deferred Parcel Tax Revenue	633,322	949,989	1,142,205
23	Deferred GO Bond Tax Revenue	517,469	776,201	-
24	Current Maturities-LTD	347,571	351,797	679,654
25	Line of Credit - Union Bank	5,473,734	5,473,734	6,723,734
26	Other Liabilities	37,836	1,041,036	201,386
27	Total Current Liabilities	$ 14,982,222	$ 17,389,439	$ 19,807,507
28	Long Term Debt, net current portion	$ 28,730,618	$ 28,734,173	$ 32,810,239
29	Fund Balances:			
30	Unrestricted	$ 17,370,898	$ 17,854,532	$ 12,986,042
31	Restricted	8,747,622	8,561,557	6,825,392
32	Total Fund Balances	$ 26,118,520	$ 26,416,089	$ 19,811,434
33	Total Liabilities & Fund Balances	$ 69,831,360	$ 72,539,701	$ 72,429,180

ATTACHMENT D

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended April 30, 2020

	Month					Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual		$	%		Actual	Budget	$	%	Prior Year
					Volume Information					
1	39	85	(46)	-54%	Acute Discharges	753	838	(85)	-10%	871
2	156	323	(167)	-52%	Patient Days	2,808	3,185	(377)	-12%	3,281
3	13	-	13	0%	Observation Days	172	-	172	*	13
4	7,124	15,295	(8,171)	-53%	Gross O/P Revenue (000's)	149,473	147,269	2,203	1%	$ 147,912
					Financial Results					
					Gross Patient Revenue					
5	$ 3,192,413	$ 6,790,084	(3,597,671)	-53%	Inpatient	$ 55,611,561	$ 67,042,094	(11,430,533)	-17%	$ 79,152,178
6	2,530,271	9,101,762	(6,571,491)	-72%	Outpatient	84,594,334	87,473,499	(2,879,165)	-3%	85,617,177
7	4,593,953	6,193,152	(1,599,199)	-26%	Emergency	64,878,166	59,795,129	5,083,037	9%	62,351,140
8	**$ 10,316,637**	**$ 22,084,998**	**(11,768,361)**	**-53%**	**Total Gross Patient Revenue**	**$ 205,084,061**	**$ 214,310,722**	**(9,226,661)**	**-4%**	**$ 227,120,495**
	15.17%				**Deductions from Revenue**					
9	(8,702,043)	(18,234,485)	9,532,442	52%	Contractual Discounts	$ (169,350,202)	$ (176,952,176)	7,601,974	4%	$ (185,352,228)
10	(50,000)	(150,000)	100,000	67%	Bad Debt	(1,880,000)	(1,500,000)	(380,000)	-25%	(1,535,000)
11	(16,273)	(23,672)	7,399	31%	Charity Care Provision	(96,465)	(236,720)	140,255	59%	(253,626)
12	1,149,084	56,250	1,092,834	*	Prior Period Adj/Government Program Revenue	8,590,340	5,685,530	2,904,810	*	8,695,168
13	**$ (7,619,232)**	**$ (18,351,907)**	**10,732,675**	**-58%**	**Total Deductions from Revenue**	**$ (162,736,327)**	**$ (173,003,366)**	**10,267,039**	**-6%**	**$ (178,445,686)**
14	**$ 2,697,405**	**$ 3,733,091**	**(1,035,686)**	**-28%**	**Net Patient Service Revenue**	**$ 42,347,734**	**$ 41,307,356**	**1,040,378**	**3%**	**$ 48,674,809**
15	$ 23,556	$ 35,682	(12,126)	-34%	Risk contract revenue	$ 243,424	$ 356,820	(113,396)	-32%	$ 706,787
16	$ 2,720,961	$ 3,768,773	(1,047,812)	-28%	Net Hospital Revenue	$ 42,591,158	$ 41,664,176	926,982	2%	$ 49,381,596
17	$ 75,652	$ 58,800	16,852	**29%**	Other Op Rev & Electronic Health Records	$ 679,268	$ 588,000	91,268	16%	$ 418,552
18	**$ 2,796,613**	**$ 3,827,573**	**(1,030,960)**	**-27%**	**Total Operating Revenue**	**$ 43,270,426**	**$ 42,252,176**	**1,018,250**	**2%**	**$ 49,800,148**
					Operating Expenses					
19	$ 1,459,137	$ 1,852,074	392,937	21%	Salary and Wages and Agency Fees	$ 17,791,361	$ 18,248,002	456,641	3%	$ 21,532,516
20	660,973	$ 666,766	5,793	1%	Employee Benefits	6,568,427	6,635,376	66,949	1%	7,577,850
21	$ 2,120,110	$ 2,518,840	398,730	16%	Total People Cost	$ 24,359,788	$ 24,883,378	523,590	2%	$ 29,110,366
22	$ 376,449	$ 436,918	60,469	14%	Med and Prof Fees (excld Agency)	$ 4,237,384	$ 4,362,237	124,853	3%	$ 4,723,283
23	373,194	539,718	166,524	31%	Supplies	5,365,237	5,341,729	(23,508)	0%	5,779,749
24	389,638	363,289	(26,349)	-7%	Purchased Services	3,813,177	3,702,840	(110,337)	-3%	3,927,084
25	258,905	266,763	7,858	3%	Depreciation	2,591,484	2,667,630	76,146	3%	2,870,342
26	83,926	92,656	8,730	9%	Utilities	976,750	1,026,724	49,974	5%	986,634
27	37,783	39,582	1,799	5%	Insurance	388,093	395,820	7,727	2%	365,978
28	18,431	40,752	22,321	55%	Interest	307,124	467,377	160,253	34%	524,650
29	96,258	94,960	(1,298)	-1%	Other	995,837	989,164	(6,673)	-1%	1,053,937
30	-	-	-	*	Matching Fees (Government Programs)	2,765,336	1,561,029	(1,204,307)	-77%	2,584,514
31	**$ 3,754,694**	**$ 4,393,478**	**638,784**	**15%**	**Operating expenses**	**$ 45,800,210**	**$ 45,397,928**	**(402,282)**	**-1%**	**$ 51,926,537**
32	**$ (958,081)**	**$ (565,905)**	**$ (392,176)**	**-69%**	**Operating Margin**	**$ (2,529,784)**	**$ (3,145,752)**	**615,968**	**20%**	**$ (2,126,389)**

Sonoma Valley Health Care District
Statement of Revenue and Expenses
Comparative Results
For the Period Ended April 30, 2020

ATTACHMENT D

	Month					Year-To- Date				YTD
	This Year		Variance			This Year		Variance		
	Actual		$	%		Actual	Budget	$	%	Prior Year
					Non Operating Rev and Expense					
33	$ (5,521)	$ (18,367)	12,846	-70%	Miscellaneous Revenue/(Expenses)	$ 1,995,066	$ 1,013,455	981,611	97%	$ (127,487)
34	-	1,375	(1,375)	-100%	Donations	13,461	13,750	(289)	2%	16,613
35	0	(13,416)	13,416	-100%	Physician Practice Support-Prima	(107,328)	(134,160)	26,832	-20%	(423,864)
36	316,667	316,667	-	0%	Parcel Tax Assessment Rev	3,166,670	3,166,670	-	0%	3,165,920
37	0	0	-	0%	Extraordinary Items	(5,444)	0	(5,444)	0%	0
38	**$ 311,146**	**$ 286,259**	**24,887**	**9%**	**Total Non-Operating Rev/Exp**	**$ 5,062,425**	**$ 4,059,715**	**1,008,154**	**25%**	**$ 2,631,182**
39	**$ (646,935)**	**$ (279,646)**	**(367,289)**	**131%**	**Net Income / (Loss) prior to Restricted Contributions**	**$ 2,532,641**	**$ 913,963**	**1,624,122**	**178%**	**$ 504,793**
40	$ -	$ -	-	0%	Capital Campaign Contribution	$ -	$ -	-	0%	$ 30,447
41	$ 186,065	$ 209,860	(23,795)	0%	Restricted Foundation Contributions	$ 1,878,920	$ 2,098,600	(219,680)	100%	$ 1,903,689
42	**$ (460,870)**	**$ (69,786)**	**(391,084)**	**560%**	**Net Income / (Loss) w/ Restricted Contributions**	**$ 4,411,561**	**$ 3,012,563**	**1,398,998**	**46%**	**$ 2,438,929**
43	163,301	163,301	-	0%	GO Bond Activity, Net	1,627,673	1,627,673	-	0%	1,531,672
44	**$ (297,569)**	**$ 93,515**	**(391,084)**	**-418%**	**Net Income/(Loss) w GO Bond Activity**	**$ 6,039,234**	**$ 4,640,236**	**1,398,998**	**30%**	**$ 3,970,601**
	$ (388,030)	$ (12,883)	(375,147)		**EBDA - Not including Restricted Contributions**	$ 5,124,125	$ 3,581,593	1,542,532		$ 3,375,135
	-13.9%	-0.3%				11.8%	8.5%			6.8%

*** Operating Margin without Depreciation expense:**

				Description				
$ (958,081)	**$ (565,905)**	**$ (392,176)**	**-69%**	**Operating Margin**	**$ (2,529,784)**	**$ (3,145,752)**	**$ 615,968**	**20%**
258,905	266,763	7,858	3%	Add back Depreciation	2,591,484	2,667,630	76,146	3%
$ (699,176)	**$ (299,142)**	**$ (384,318)**	**-134%**	**Operating Margin without Depreciation expense**	**$ 61,700**	**$ (478,122)**	**$ 692,114**	**113%**

Sonoma Valley Health Care District
Variance Analysis
For the Period Ended April 30, 2020

ATTACHMENT E

Operating Expenses	**YTD Variance**	**Month Variance**	
Salary and Wages and Agency Fees	456,641	392,937	Salaries and wages are under budget by $353,536 and agency fees are under budget by $39,401.
Employee Benefits	66,949	5,793	
Total People Cost	**523,590**	**398,730**	
Med and Prof Fees (excld Agency)	124,853	60,469	Physician and professional fees are under budget primarily due to clinic physician costs being under budget by $28,112.
Supplies	(23,508)	166,524	Supplies are under budget by due to lower volumes.
Purchased Services	(110,337)	(26,349)	Unbudgeted purchased services due to Covid-19 of ($22,817).
Depreciation	76,146	7,858	
Utilities	49,974	8,730	
Insurance	7,727	1,799	
Interest	160,253	22,321	
Other	(6,673)	(1,298)	
Matching Fees (Government Programs)	(1,204,307)	-	
Operating expenses	**(402,282)**	**638,784**	

Sonoma Valley Hospital
Cash Forecast
FY 2020

ATTACHMENT F

#		Actual July	Actual Aug	Actual Sept	Actual Oct	Actual Nov	Actual Dec	Actual Jan	Actual Feb	Actual Mar	Actual Apr	Forecast May	Forecast Jun	TOTAL
	Hospital Operating Sources													
1	Patient Payments Collected	4,267,579	3,747,119	3,783,981	3,724,440	3,674,833	4,402,798	4,285,824	3,729,401	4,098,798	2,787,408	2,045,762	2,612,725	43,160,667
2	Capitation Revenue	26,337	24,434	24,943	24,298	25,643	26,005	24,819	19,835	23,554	23,556	22,735	22,735	288,894
3	Napa State	2,565	983	6,153	17,109	18,240	49,465	14,872	-	142	2,063	11,231	11,231	134,055
4	Other Operating Revenue	27,168	113,630	31,381	162,702	77,470	51,209	86,697	148,851	96,064	83,650	58,800	58,800	996,421
5	Other Non-Operating Revenue	38,832	43,824	24,455	35,838	13,448	22,627	20,495	10,126	22,181	9,463	25,795	25,785	292,870
6	Unrestricted Contributions	12,593		755	3,263	6,219	2,765	10,214	1,550	545	24,128	1,375	1,375	64,782
7	Line of Credit													-
	Sub-Total Hospital Sources	**4,375,074**	**3,929,990**	**3,871,668**	**3,967,650**	**3,815,852**	**4,554,869**	**4,442,921**	**3,909,763**	**4,241,285**	**2,930,267**	**2,165,698**	**2,732,651**	**44,937,689**
	Hospital Uses of Cash													
8	Operating Expenses	4,751,297	5,353,928	4,260,382	4,307,504	4,160,854	4,479,501	5,664,106	4,235,166	3,575,640	4,678,063	4,129,598	4,085,675	53,681,713
9	Add Capital Lease Payments	111,366	185,165	32,638	390,032	112,524	33,887	71,986	7,732	7,757	7,757	7,150	74,150	1,042,144
10	Additional Liabilities/LOC		625,000				625,000							1,250,000
11	Capital Expenditures	435,215	73,951	160,473	54,243	187,550	59,628	447,224	146,675	304,401	161,937	209,860	209,859	2,451,017
	Total Hospital Uses	**5,297,879**	**6,238,044**	**4,453,493**	**4,751,778**	**4,460,928**	**5,198,016**	**6,183,316**	**4,389,573**	**3,887,797**	**4,847,757**	**4,346,608**	**4,369,684**	**58,424,874**
	Net Hospital Sources/Uses of Cash	**(922,805)**	**(2,308,055)**	**(581,825)**	**(784,129)**	**(645,076)**	**(643,147)**	**(1,740,395)**	**(479,810)**	**353,488**	**(1,917,490)**	**(2,180,910)**	**(1,637,033)**	**(13,487,185)**
	Non-Hospital Sources													
12	Restricted Cash/Money Market	(1,056,509)	725,000	1,500,000			(500,000)	200,000		1,100,000	(6,000,000)	(4,000,000)	1,200,000	(6,831,509)
13	Restricted Capital Donations	342,251	5,000	160,473	36,918	187,550	59,628	447,224	146,675	304,401	161,937	209,860	209,859	2,271,776
14	Parcel Tax Revenue	100,099					2,108,197			1,000,000	574,501			3,782,796
15	Other Payments - South Lot/Ins. Claims/HHS	956,411		51,682							1,149,084	4,423,886		6,581,062
16	Other:									35,656				35,656
17	IGT									1,408,802	5,481,012			6,889,814
18	IGT - AB915					31,705					1,033,318	294,488	113,200	1,472,711
19	PRIME						135,000						229,500	364,500
	Sub-Total Non-Hospital Sources	**342,251**	**730,000**	**1,712,154**	**36,918**	**219,255**	**1,802,825**	**647,224**	**146,675**	**3,848,859**	**2,399,851**	**928,234**	**1,752,559**	**14,566,807**
	Non-Hospital Uses of Cash													
20	Matching Fees					67,500		451,221		2,314,115	114,750	62,198		3,009,784
	Sub-Total Non-Hospital Uses of Cash	-	-	-	-	67,500	-	451,221	-	2,314,115	114,750	62,198	-	3,009,784
	Net Non-Hospital Sources/Uses of Cash	**342,251**	**730,000**	**1,712,154**	**36,918**	**151,755**	**1,802,825**	**196,003**	**146,675**	**1,534,744**	**2,285,101**	**866,036**	**1,752,559**	**11,557,023**
	Net Sources/Uses	**(580,553)**	**(1,578,055)**	**1,130,329**	**(747,211)**	**(493,321)**	**1,159,679**	**(1,544,392)**	**(333,135)**	**1,888,232**	**367,612**	**(1,314,874)**	**115,526**	
	Operating Cash at beginning of period	3,450,014	2,869,461	1,291,406	2,421,736	1,674,525	1,181,204	2,340,883	796,491	463,356	2,351,588	2,719,200	1,404,326	
	Operating Cash at End of Period	**2,869,461**	**1,291,406**	**2,421,736**	**1,674,525**	**1,181,204**	**2,340,883**	**796,491**	**463,356**	**2,351,588**	**2,719,200**	**1,404,326**	**1,519,852**	
	Money Market Account Balance	3,258,551	2,533,925	1,034,199	1,034,330	1,035,454	1,534,600	1,334,793	1,334,946	235,051	6,235,214	10,235,214	9,035,214	
	Total Cash at End of Period	**6,128,012**	**3,825,331**	**3,455,935**	**2,708,855**	**2,216,658**	**3,875,483**	**2,131,284**	**1,798,302**	**2,586,639**	**8,954,414**	**11,639,540**	**10,555,066**	
	Average Days of Cash on Hand	**38.82**	**36.60**	**28.00**	**22.51**	**16.89**	**17.85**	**20.38**	**15.67**	**15.61**	**43.09**	**68.42**	**62.04**	

May 13, 2020

The Honorable Bill Dodd
State Capitol
Sacramento, CA 95814

SUBJECT: Budget Request for California Hospitals

Dear Senator Dodd:

On behalf of Sonoma Valley Hospital and all hospitals in California, I'm requesting your support for an immediate $1 billion in state funds for hospitals to help defer some of the costs incurred as we quickly responded to COVID-19.

In early March, our hospital was asked to free up space and increase bed capacity first by 40%, and then by 50%. We immediately went to work on doing just that. We continue to maintain that bed capacity and will need to do so for the foreseeable future. At the same time, we canceled non-emergency procedures and surgeries, also in response to COVID-19. We also purchased personal protective equipment, more ventilators, and trained additional staff — all at great expense.

These were all measures necessary to make way for the COVID-19 patients we would care for, many of whom would need intensive care services. As a result, in the last six to seven weeks, our hospital has seen its revenue decline by approximately 51%, while our expenses have increased dramatically. We now must resume care to more of our patients while at the same time caring and preparing for more COVID-19 patients.

Since the shelter in place order in mid-March, the hospital has seen a decline in emergency room visits by 50%. As we resume some of our non-emergency procedures, we will see our revenues improve, but we don't expect them to reach prior levels for an extended period of time. We need financial help immediately in order to continue to serve our community. Although we have received some funds from the federal CARES Act, they do not come close to making up for the losses we have sustained and will continue to experience.

To address these losses and stabilize hospitals, we are asking the Governor and legislature to immediately provide $1 billion to hospitals in the current budget year, as well as $3.1 billion in state funds for an 1115 emergency disaster waiver to be submitted to the federal government. The $1 billion would be made available to hospitals immediately, while the waiver dollars — if approved — would not be available for several months.

I urge you to support our budget request of the Governor by talking with your budget leaders and the Administration about the need to provide hospitals with immediate financial assistance. California cannot reopen safely without its hospitals being stable and fully prepared to serve the needs of all patients, whether those needs are COVID-19-related or not.

Please feel free to contact me if you have any questions or would like to discuss this request. Thank you.

Sincerely,

Kelly Mather
President and Chief Executive Officer
kmather@sonomavalleyhospital.org

May 13, 2020

The Honorable Marc Levine
State Capitol
Sacramento, CA 95814

SUBJECT: Budget Request for California Hospitals

Dear Mr. Levine:

On behalf of Sonoma Valley Hospital and all hospitals in California, I'm requesting your support for an immediate $1 billion in state funds for hospitals to help defer some of the costs incurred as we quickly responded to COVID-19.

In early March, our hospital was asked to free up space and increase bed capacity first by 40%, and then by 50%. We immediately went to work on doing just that. We continue to maintain that bed capacity and will need to do so for the foreseeable future. At the same time, we canceled non-emergency procedures and surgeries, also in response to COVID-19. We also purchased personal protective equipment, more ventilators, and trained additional staff — all at great expense.

These were all measures necessary to make way for the COVID-19 patients we would care for, many of whom would need intensive care services. As a result, in the last six to seven weeks, our hospital has seen its revenue decline by approximately 51%, while our expenses have increased dramatically. We now must resume care to more of our patients while at the same time caring and preparing for more COVID-19 patients.

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I urge you to support our budget request of the Governor by talking with your budget leaders and the Administration about the need to provide hospitals with immediate financial assistance. California cannot reopen safely without its hospitals being stable and fully prepared to serve the needs of all patients, whether those needs are COVID-19-related or not.

Please feel free to contact me if you have any questions or would like to discuss this request. Thank you.

Sincerely,

Kelly Mather
President and Chief Executive Officer
kmather@sonomavalleyhospital.org

May 13, 2020

Transmitted Electronically

The Honorable Dianne Feinstein
331 Hart Senate Office Building
Washington, DC 20510

Dear Senator Feinstein:

On behalf of our 355 employees, our patients, and our community, Sonoma Valley Hospital appreciates the hard work you have done to help protect Californians during this pandemic. This unprecedented public health emergency requires unprecedented actions, and we write with both gratitude and a request for additional assistance.

At Sonoma Valley Hospital, like others around the nation, we have worked tirelessly to prepare and adapt to care for COVID-19 patients. As we work to support our nurses, doctors, and other health care heroes, we have purchased supplies, retrained employees, and reorganized our facility to ensure we are ready to serve our community. Many of these supplies are hard to find and, when we do find them, they command as much as 10 times the normal price and shipping costs. We have built surge space, tracked down testing kits, worked to secure medications and other supplies to care for the critically ill. The investments we have made are extraordinary, including:

- Purchased 21 additional beds, curtains, IV poles, and supplies to create COVID-19 patient surge rooms, bringing total inpatient capacity to 59
- Set up and stocked an additional Emergency Room for overflow patients
- Set up and staffed drive-through testing seven days a week for symptomatic community members
- Created a health platform website providing COVID-19 information, protocols, and training for employees
- Purchased additional laptops and IT equipment to enable administrative team managers to work remotely
- Purchased additional personal protective equipment (PPE) and supplies
- Payroll for administrative team, manager, nursing, and staff hours devoted solely to COVID-19 liaison with other facilities and State and local agencies, surge plans, protocols, preparation of additional patient rooms, stocking additional supplies, recovery plans, etc.

In addition to our efforts and expense to prepare, we stopped performing any non-essential surgical and outpatient diagnostic services. Furthermore, Sonoma County issued a shelter in place order on March 17th (which has yet to be lifted), and since that time the hospital has seen a decline in emergency room visits by 50%. These services are a significant portion of our normal revenue, and we are now in a financial as well as a health crisis. Moreover, our payer mix for reimbursement is over 76% government (Medicare, Medicare Managed Care, and Medi-Cal). We do not expect the lost revenue to return: a knee replacement scheduled for March could be rescheduled for October, but it will only displace another procedure. As we maintain proper health and safety protocols of distancing and sanitizing, as well as surge capacity, we simply will not be able to increase our schedule to recoup the losses we have incurred.

Congress has acted swiftly to establish and fund the Public Health and Social Services Emergency Fund, and we are grateful. However, the first few distributions have been based on formulas that do not offer appropriate recognition of the investments we have made or the lost revenue we have incurred. In fact, we have received $5,572,969 and estimate our investment and lost revenue to be more than $5,947,589 to date, and we expect this latter figure to continue to rise. California health care providers rank 46th in the nation for per capita allocation of the funds distributed so far.

As you work on additional relief for our country, please keep in mind that successful reopening of the economy will depend on the security of the health care safety net provided by hospitals like Sonoma Valley Hospital. Hospitals around the state and nation are suffering dramatic financial losses that threaten our hospital, the health care infrastructure, and access to care; they must be prioritized in the distribution of funds to ensure their services remain available.

Thank you again for your commitment to Sonoma Valley Hospital and our patients.

Sincerely,

Kelly Mather
President and Chief Executive Officer
kmather@sonomavalleyhospital.org

May 13, 2020

Transmitted Electronically

The Honorable Kamala D. Harris
United States Senate
331 Hart Senate Office Building
Washington, DC 20510

Dear Senator Harris:

On behalf of our 355 employees, our patients, and our community, Sonoma Valley Hospital appreciates the hard work you have done to help protect Californians during this pandemic. This unprecedented public health emergency requires unprecedented actions, and we write with both gratitude and a request for additional assistance.

At Sonoma Valley Hospital, like others around the nation, we have worked tirelessly to prepare and adapt to care for COVID-19 patients. As we work to support our nurses, doctors, and other health care heroes, we have purchased supplies, retrained employees, and reorganized our facility to ensure we are ready to serve our community. Many of these supplies are hard to find and, when we do find them, they command as much as 10 times the normal price and shipping costs. We have built surge space, tracked down testing kits, worked to secure medications and other supplies to care for the critically ill. The investments we have made are extraordinary, including:

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Thank you again for your commitment to Sonoma Valley Hospital and our patients.

Sincerely,

Kelly Mather
President and Chief Executive Officer
kmather@sonomavalleyhospital.org

May 13, 2020

Transmitted Electronically

The Honorable Mike Thompson
U.S. House of Representatives
406 Cannon Office Building
Washington, DC 20515

Dear Mr. Thompson:

On behalf of our 355 employees, our patients, and our community, Sonoma Valley Hospital appreciates the hard work you have done to help protect Californians during this pandemic. This unprecedented public health emergency requires unprecedented actions, and we write with both gratitude and a request for additional assistance.

At Sonoma Valley Hospital, like others around the nation, we have worked tirelessly to prepare and adapt to care for COVID-19 patients. As we work to support our nurses, doctors, and other health care heroes, we have purchased supplies, retrained employees, and reorganized our facility to ensure we are ready to serve our community. Many of these supplies are hard to find and, when we do find them, they command as much as 10 times the normal price and shipping costs. We have built surge space, tracked down testing kits, worked to secure medications and other supplies to care for the critically ill. The investments we have made are extraordinary, including:

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kmather@sonomavalleyhospital.org