AGENDA

CONTRA COSTA COUNTY Medical Services (CCRMC) Joint Conference Committee and Professional Affairs Committee

Monday, November 24, 2025 **1:00 PM** **Location: Building 1 Conference Room, Contra Costa Regional Medical Center - 2500 Alhambra Ave., Martinez | Zoom: https://cchealth.zoom.us/j/96075398286 | Call in:+16465189805,,96075398286# OR Office of Supervisor Gioia or Supervisor Carlson**

Building 1 Conference Room, CCRMC - 2500 Alhambra Ave., Martinez;
Office of Supervisor Gioia, 11780 San Pablo Ave., Suite D, El Cerrito;
Office of Supervisor Carlson, 2255 Contra Costa Blvd., Suite 202, Pleasant Hill

Agenda Items: Items may be taken out of order based on the business of the day and preference of the Committee

1. Roll Call and Introductions

Members: Voting Board of supervisors: Chair Supervisor John Gioia, Vice Chair Supervisor Ken Carlson; Medical executive committee members: Dr Tarun Bhandari, Dr Dayana Carcamo-Molina;

Non-voting: CCRMC Medical Staff President Dr. Sarah Mcneil; CCRMC past medical staff president Dr. Kristin Moeller; Contra Costa Director Health Services Dr. Grant Colfax; Chief Financial Officer Brian Buchanan; CCRMC Chief Executive Officer David Culberson; CCRMC Chief Medical Officer Dr. Sergio Urcuyo; CCRMC Chief Nursing Officer Harmandeep Madra, RN; CCRMC Interim Chief Operations Officer Shannon Abella, MPH

2. APPROVAL OF MINUTES **25-4948**

Attachments: JCC Minutes 09.22.25_Draft

Meeting Chair: Supervisor Gioia

3. Public comment on any item under the jurisdiction of the Committee and not on this agenda (speakers may be limited to two minutes).

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 two 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.

4. Administrative Update **25-4949**

Attachments: A. Hospital & HC Op Updates 112425
A1. CMS TEAM Notice 102025
B. Finance Report 11.24.25
C. Operational Policy Agenda 11-24-25

David Culberson, Chief Executive Officer, Contra Costa Regional Medical Center and Health Clinics; Brian Buchanan, Interim Chief Financial Officer; Leah Carlon, MPH, CPHRM, Health Care Risk Manager

5. Medical Staff Update **25-4950**

Attachments: A. CCRMC JCC Exp Privileges Subcommittee Minutes (Sep, Oct 2025)
B. JCC Patient Care Agenda & Policies 11.24.25

Sarah McNeil, MD, Medical Staff President

6. Adjourn

1. Call to Order Professional Affair Committee (PAC)

2. 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 two 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.

3. Adjourn to Professional Affairs Committee Closed Session

4. Professional Affairs Committee (PAC) Closed Session

A) Hospital MEDICAL AUDIT AND/OR QUALITY ASSURANCE COMMITTEE REPORT (Health and Safety Code section 1461)

B) STAFF PRIVILEGES (Health and Safety Code section 1461)

5. Adjourn Professional Affairs Committee Meeting

6. The next meeting of the Joint Conference Committee and Professional Affairs Committee is to be determined.

The Joint Conference Committee and Professional Affairs Committee observes Ralph M. Brown Act open meeting law procedures. Reasonable accommodations will be provided for persons with disabilities planning to attend. Contact the staff person listed below at least 72 hours before the meeting. Any disclosable public records related to an open session item on a regular meeting agenda and distributed by the County to a majority of members of the Joint Conference Committee and Professional Affairs Committee prior to that meeting are available for public inspection at 2500 Alhambra Avenue during normal business hours. Public comment may also be submitted via electronic mail at least one full workday prior to the published meeting time. For information contact Corticha Flucus Corticha.Flucus@cchealth.org

For Additional Information Contact: Corticha Flucus Corticha.Flucus@cchealth.org

File #: 25-4948 **Agenda Date:** 11/24/2025 **Agenda #:** 2.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee and Professional Affairs Committee
Subject: Approval of Minutes - September 22, 2025
Presenter: Meeting Chair, Supervisor Gioia

Information: Approval of Minutes - September 22, 2025

Recommendation(s)/Next Step(s):

Minutes for September 22, 2025, JCC meeting (action: approve) - review and approve minutes

CONTRA COSTA HEALTH

JOINT CONFERENCE COMMITTEE

MINUTES

September 22, 2025 from 1:00 – 3:00 PM
Contra Costa Regional Medical Center
2500 Alhambra Avenue, Martinez, CA – Building 1 First Floor Conference Room

VOTING MEMBERS PRESENT: Supervisor John Gioia, District I; Supervisor Ken Carlson, District IV; Dayana Carcamo-Molina MD; Tarun Bhandari MD; NON-VOTING MEMBERS PRESENT: David Culberson, CCRMC Chief Executive Officer; Sergio Urcuyo, MD, CCRMC Chief Medical Officer; Sara McNeil MD, Medical Staff President; Grant Colfax, MD Contra Costa Director of Health Services; Brian Buchanan, Contra Costa Health Services Chief Financial Officer; Helena Martey RN, CCRMC Interim Chief Nursing Officer; GUESTS PRESENT: Geena Jester MD, Hospital Medical Director; Andrea Sandler MD, Associate Ambulatory Care Medical Director; Gabriela Sullivan MD, Ambulatory and Specialty Medical Director; Jasmin Contreras RN, Director, Safety and Performance Improvement; Roberto Vargas, Director, Safety and Performance Improvement; Ira Beda Sabio RN, Inpatient Associate Nursing Manager; Leah Carlon, Health Care Risk Manager, Safety & Performance Improvement; Dora Regalado, Health Services Director of Personnel; Emily Parmenter, Strategic Initiatives; Rajiv Pramanik, Adalberto Garibay, Lieutenant Chief of Security; Lavonna Martin, Rachel Birch, Matt Kaufmann, Jackie Zahn, Manny Bowlby, Corticha Flucus; GUESTS ABSENT: Nancy Hendra,

AGENDA ITEM	ACTION
I. CALL TO ORDER AND INTRODUCTIONS Meeting Chair – Supervisor John Gioia, District I • Meeting called to order at **1:01 PM** by Supervisor Gioia • Location of meeting at three locations under the Brown Act: CCRMC Building 1 Conference Room; Supervisor Carlson's office in Pleasant Hill; Supervisor Gioia's office in El Cerrito; Public may attend meeting remotely VIA Zoom Webinar or Call In. • Agenda has been posted outside Supervisors' offices and CCRMC. Public is invited to attend publicly or remotely.	Inform
II. APPROVAL OF MINUTES – July 28, 2025 Supervisor Gioia *In open session, voting members of Contra Costa Regional Medical Center Joint Conference Committee voted to accept the July 28,2025 Joint Conference Committee minutes.* No public comment.	Motion: By: Carcamo-Molina Seconded by Bhandari Ayes: Gioia, Carcamo-Molina, Bhandari Absent: Carlson Abstain: None
III. PUBLIC COMMENT Supervisor Gioia *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 two minutes or*	Inform

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. No public comment.	
IV. ADMINISTRATIVE UPDATE Dora Regalado, Health Services Director of Personnel, David Culberson, Chief Executive Officer, Contra Costa Regional Medical Center and Health Clinics; Sergio Urcuyo, MD, Chief Medical Officer, Contra Costa Regional Medical Center and Health Clinics; Leah Carlon, MPH, CPHRM, Health Care Risk Manager A. HR Work Group Update – Dora Regalado, Contra Costa Health Personnel Director • Shared where HR Work Group are with staffing and the progress made throughout the challenges and some steps taken to continue to improve and work with CCRMC and Health Centers. ○ Recruitment Process Updates 23% reduction in hiring timeline from 137 days last year 2024. ○ CCRMC has the lowest vacancies rate across Contra Costa Health. CCRMC and Health Centers have 3100 positions and currently have 260 vacant positions working toward where the needs are. ○ Active hiring dashboard about 6 months, continue to optimize some challenges with receiving data working with internal partner IT helping Contra Costa Health Personnel to connect our request to hiring dashboard 90% resolved. • Infrastructure Challenges and Needs ○ Need to Strengthen & Modernize Administrative Support ○ Operational Considerations • Contra Costa Health Personnel strategic focus areas include working with CCRMC leadership on prioritization of leadership hiring and administrative infrastructure, reduction in overtime and contract labor usage, continue to modernize job specification, improve workforce systems and increase effort to hire providers. • Focusing on hiring vacancies that are vital for our operation Licensed Vocational Nurses, Certified Medical Assistants, Providers: ED, Ambulatory Care, OB/GYN, RNs. *Supervisor Gioia – Request regular updates on infrastructure challenges and needs " Need to Strengthen & Modernize Administrative Support in recognizing Medical Staff."*	Inform A, B, C Approval D

Dr. Colfax – Recommend providing the denominator on vacancies needed.

Supervisor Gioia – Informed the reason for the created working group it's taken longer to hire we felt it's important to speed up process in order to be competitive and hire our staff as quickly as possible.

G. Sullivan – Explained the recruiting issue county wide explained we only have 3 posting at a time we share with LinkedIn. Contra Costa College is not usually findable and not good for CCRMC which shows nothing posted.

Dora R. – Informed that with LinkedIn, Contra Costa have a lot of pages working with analyst on recruitment.

B. Hospital & Health Centers Operations Update – David Culberson, CCRMC Chief Executive Officer
   - Leadership and Key Position Recruitment
     - Chief Medical Officer - Sergio Urcuyo, MD
     - Interim Associate Medical Director-David Piccinati, MD
     - Deputy Chief Financial Officer- David Lee
     - Chief Operating Officer – Finalizing Salary Reallocation with Central Human Resources
     - Chief Nursing Officer – Completing Final Interviews with Medical Staff and Nursing Leadership
     - Chief Plant Operations – Offer to Candidate in Process
   - Preparation for Surveys
     - The Joint Commission October 2025-Februrary 2026
   - Parking Structure Update
     - Currently David Culberson, Shannon Abella and Team with Sara Price have begun a transportation demand management study. W-Trans has been hired by Public Works on behalf of CCRMC to get an accurate cost and alternative strategies.
     - Next Steps
       - On-Site silent survey parking occupancy in October 2025
       - Electronic Survey for Employees in Late September and Early October 2025
   - CCRMC Seismic Project Update revised 150M
     - Food Service/Cafeteria Building Replacement
     - Sprinkler Line Bracing Non Performance Category (NPC-4)
     - Water, Wastewater and Fuel Storage Non Performance Category (NPC-5)

No public comments.

C. Hospital & Health Centers Capital Planning Updates – David Culberson, CCRMC Chief Executive Officer • Medicare participation – Capital needs are need, and plan needs to identify source of finding and • Categorize in 3 years & 5 years (2025-2030) • Parking Structure – 145M dollars by end of 2029 must have seismic complete will compare by year which is included in the packet. • In process or completed – Nursing team are auditing, Cooling tower then on to replacement, generated from public health that are underway and in process. D. Operational Policy Review- Leah Carlon, MPH, CPHRM, Health Care Risk Manager • Consent: Operational Policies Regulatory Requirement ○ 4 Operational: 2 Revised, 2 New	Motion: Carlson Second by Carcamo-Molina Ayes: Gioia, Carlon, Carcamo-Molina, Bhandari Abstain: None
No public comment. Motion passes.	
V. MEDICAL STAFF UPDATE Sarah McNeil, MD, Medical Staff President A. Medical Staff General Updates– on empaneled patients, primary care providers (PCPs), and no-show rates • Numbers are still higher, and access has been huge factor HR 1. • Regarding No-Show Rate Sarah McNeil, MD brought up the want to do preventative healthcare, work on hiring more providers and work with helping the impact and access of doing things for patients. ○ Solutions (Access for patients) ○ Hire more providers ○ Retain more providers ○ Non-providers ○ Maximizing space ○ Urgent Care B. CCRMC JCC Expedited Privileges Subcommittee minutes per Subcommittee charter, minutes from September subcommittee meeting approving expedited privileges. • JCC Subcommittee Meetings Medical Executive Committee (MEC), Patient Safety and Performance Improvement Committee (PSPIC). C. Patient Care Policy Review– summary of changes for approved clinical policies • Emotional support animals as needed	Inform A, B Item C – Approval Motion: Carlson Second by Bhandari Ayes: Gioia, Carlson, Carcamo – Molina, Bhandari Abstain: None

Dr. Colfax - What is the average panel size that JCC is rising for? *S. McNeil-addressed that across the country average panel sized are about 2500 and we are about that. Average Primary Care Provider would have to work 28 hours a day. Estimated burn out seems to happen around 1200 to 1500 as estimated panel size.* *Sup Gioia – informed still evaluating the impacts of HR 1. on our system. recognizing that any potential financial impact Medicaid and other federal funding reductions could affect the decisions moving forward.* *G. Sullivan – informed third next available rolls up to these numbers that depends not only the number of patients assigned but on the availability of doctors to see patients.*	
No Public Comment.	
VI. Adjourn at 2:05PM	Inform
VII. NEXT MEETING: November 22, 2025	

Minutes approved by Chair: Supervisor John Gioia, District I

_____ _____

Supervisor John Gioia **Date**

Minutes by Corticha Flucus

File #: 25-4949 **Agenda Date:** 11/24/2025 **Agenda #:** 4.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee and Professional Affairs Committee
Subject: Administrative Update
Presenter: David Culberson, Chief Executive Officer, Contra Costa Regional Medical Center and Health Clinics; Brian Buchanan, Interim Chief Financial Officer; Leah Carlon, MPH, CPHRM, Health Care Risk Manager

Information:

A. Hospital & Health Centers Operations Update (information only) - Several administrative updates, including leadership team, Baby Friendly Recognition, Significant Capital Projects, CCHP Medicare D -SNP, Ambulatory Care Volume, House Resolution 1 (HR 1), Seismic Project Update, and Survey Readiness. Also sharing notice from CMS that CCRMC received regarding mandatory participation in the Transforming Episode Accountability Model (TEAM).

B. Finance Report (informational only) - review of finance report from CFO's office.

C. Operational Policy Review (action: approve) - Review summary of changes for operational policies approved in CCRMC committees, recommend approve policies as reviewed and revised.

Recommendation(s)/Next Step(s):

A. Hospital & Health Centers Operations Update - **Information only**

B. Finance Report - **Information only**

C. Operational Policy Review - **Action: *approve***

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Administrative Update

David Culberson, CEO
Contra Costa Regional Medical Center and Clinics

November 24, 2025

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CCRMC Update November 2025

- Leadership Team Member Update
- Baby Friendly Recognition
- Significant Capital Projects
- Contra Costa Health Plan Medicare D-SNP
- Ambulatory Care Volume
- House Resolution 1 (HR 1)
- Seismic Project Update
- Survey Readiness

Contra Costa Health Leadership Update

- Harmandeep Madra, RN, MSN Chief Nursing Officer November 17, 2025
- Rick Ortiz, Chief of Plant Operations, October 15, 2025
- Thanks to Helena Martey, MSN, Interim Chief Nursing Officer
  - Helena to return to Ambulatory Care Nursing Leadership Upon Harm Madra Joining CCRMC

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Baby Friendly Redesignation

- CCRMC Has Been Redesignated as Baby Friendly By Baby Friendly - USA
- Criteria Established by WHO and UNICEF For Best Breastfeeding Support of Babies and Mothers
- Proven Improved Outcomes, Including Reduced Morbidity and Mortality
- Designation is from 2026-2031
- Thanks to the Entire OB, L&D, Post Partum, Nursery and Ambulatory Teams
- Special Thanks to Dr. Joan Roux For Coordinating Teams and Visits
- Congratulations!

Medicare Transforming Episode Accountability Model (TEAM)

- CCRMC Has Met Criteria For Mandatory Participation in Transforming Episode Accountability Model (TEAM) By CMS
- Inclusion in TEAM is Required For Hospitals In Core Based Statistical Areas (CBSAs)
- TEAM is Mandatory January 1, 2026 – December 31, 2030
- CCRMC is Required to Assume Responsibility for Cost and Quality of Care Beginning With Surgical Procedure and Continuing for the First 30 Days After the Medicare Beneficiary is Discharged From the Hospital
- Procedures at CCRMC Include: Lower Extremity Joint Replacement, Major Bowel Procedure, Surgical Hip/Femur Fracture Treatment and Spinal Fusion

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Significant Capital Projects

- Anesthesia Machines: Board Approval October 21
- Interventional Radiology: C-Arm in OR
  - Service Began October 26, 2025
  - Replacement Room in Diagnostic Imaging in Design Process
- Seismic Project: CCRMC Hospital and Food Service Building
- Nurse Call System: CCRMC Hospital: Currently Being Designed
- Washer/Disinfector: West County Health Center and Hospital SPD
- Parking Structure: CCRMC Martinez Campus: Parking Study Underway

Contra Costa Health Plan

- Contra Costa Health Plan (CCHP) Will Add a Medicare Dual Eligible-Special Needs Plan (D-SNP) in January 2026
- It Will Also Enroll Dual Eligible-Special Need Plan (D-SNP) Beginning January 2026
- D-SNP Will Require CCRMC to Modify Operations and Processes
  - Increased Focus on Member Satisfaction, Coding, and Utilization Management
  - D-SNP Eligible Members May Select Any Credentialled Provider From CCHP Roster
  - Open Enrollment Began in October and Runs Through December
    - CCHP Is Distributing Promotional Materials

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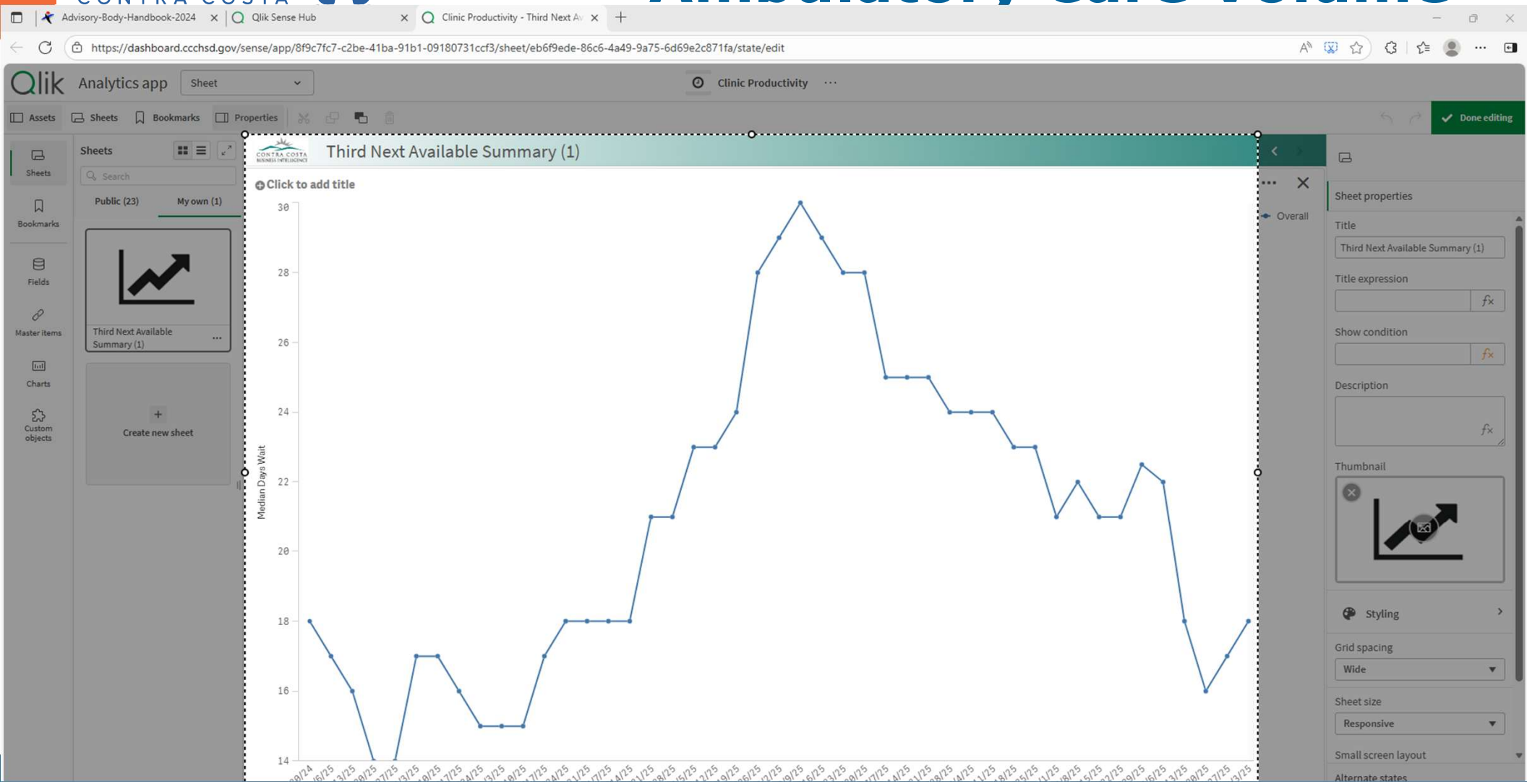
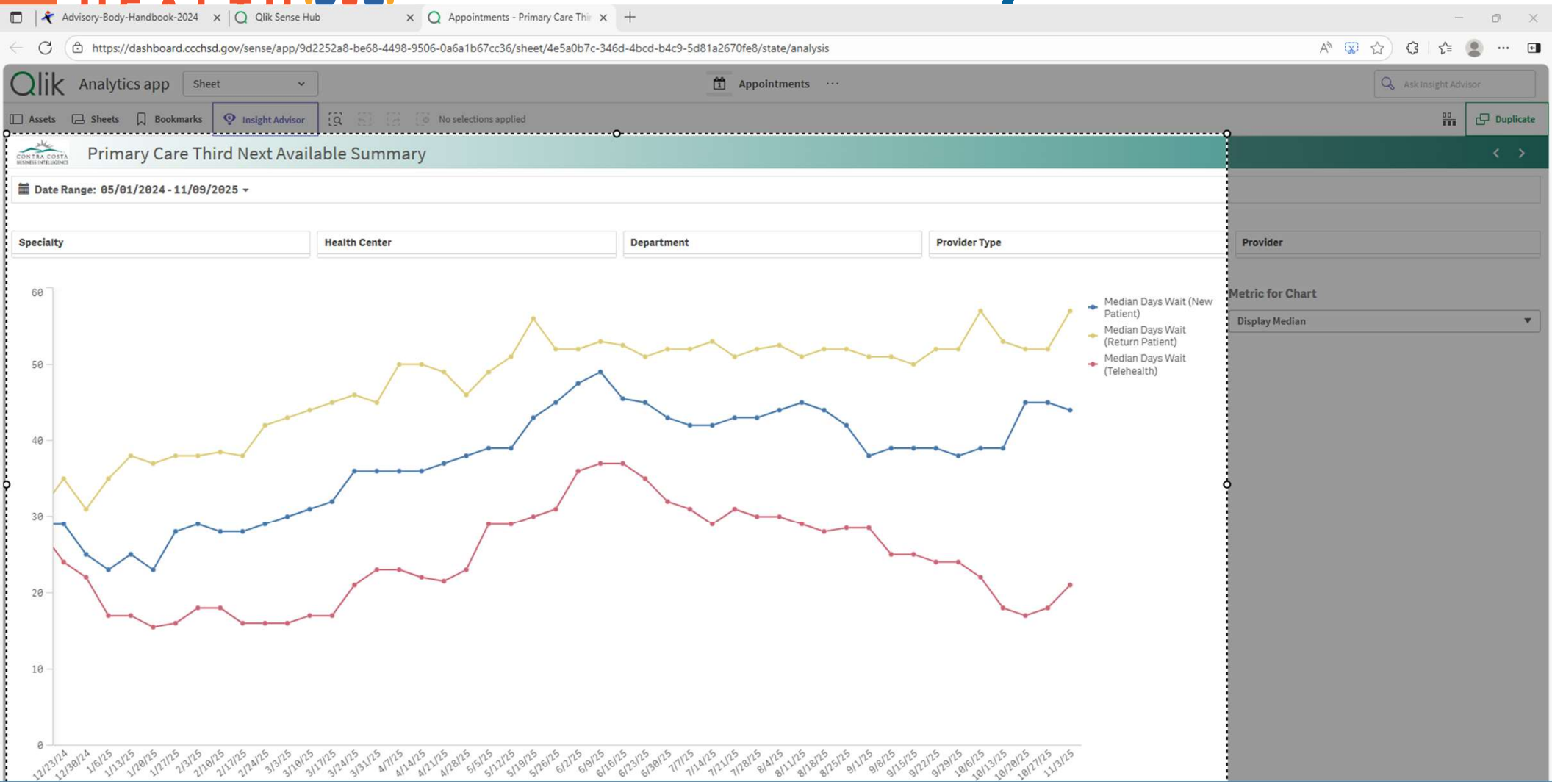
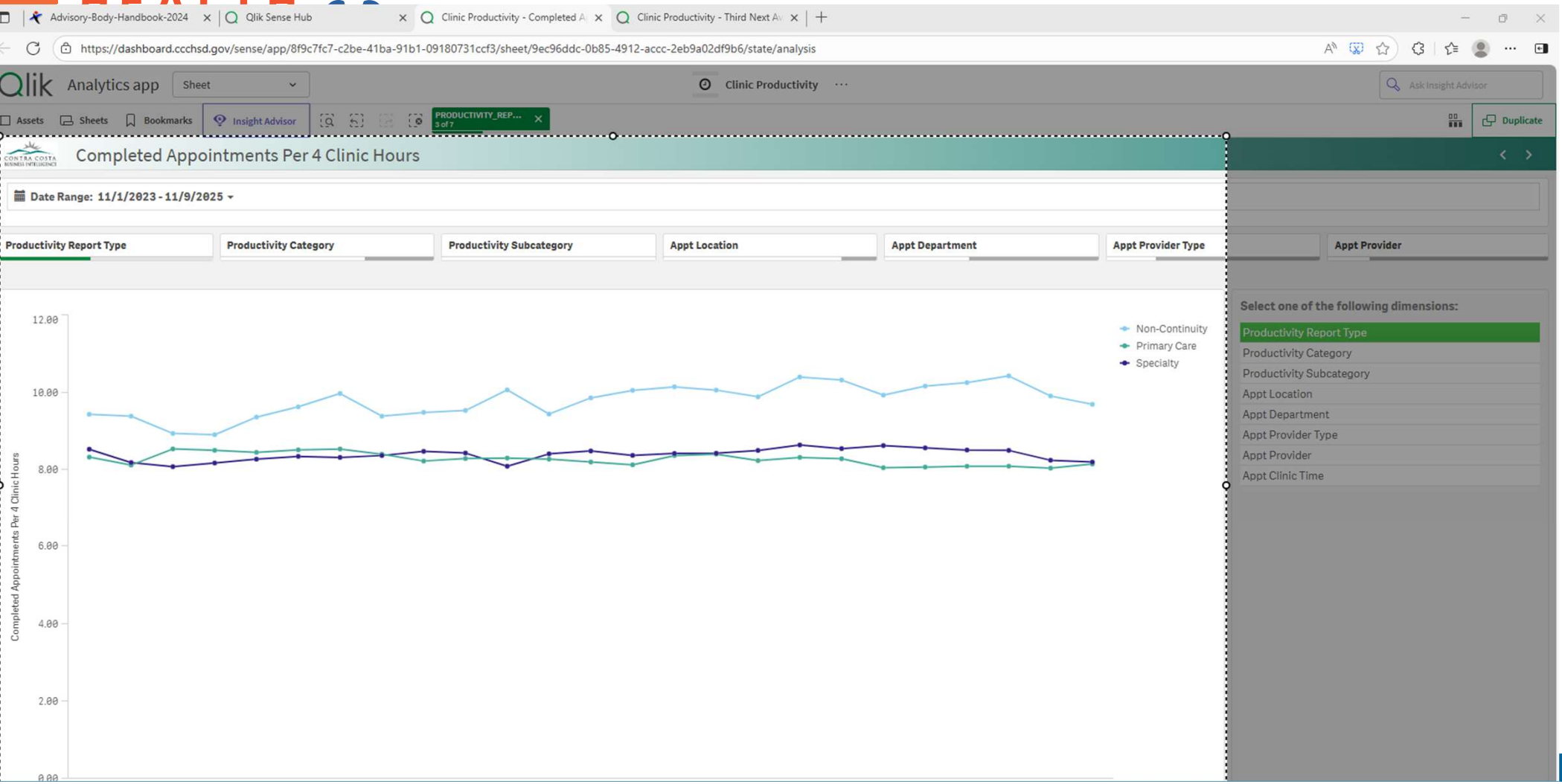
Ambulatory Care Volume



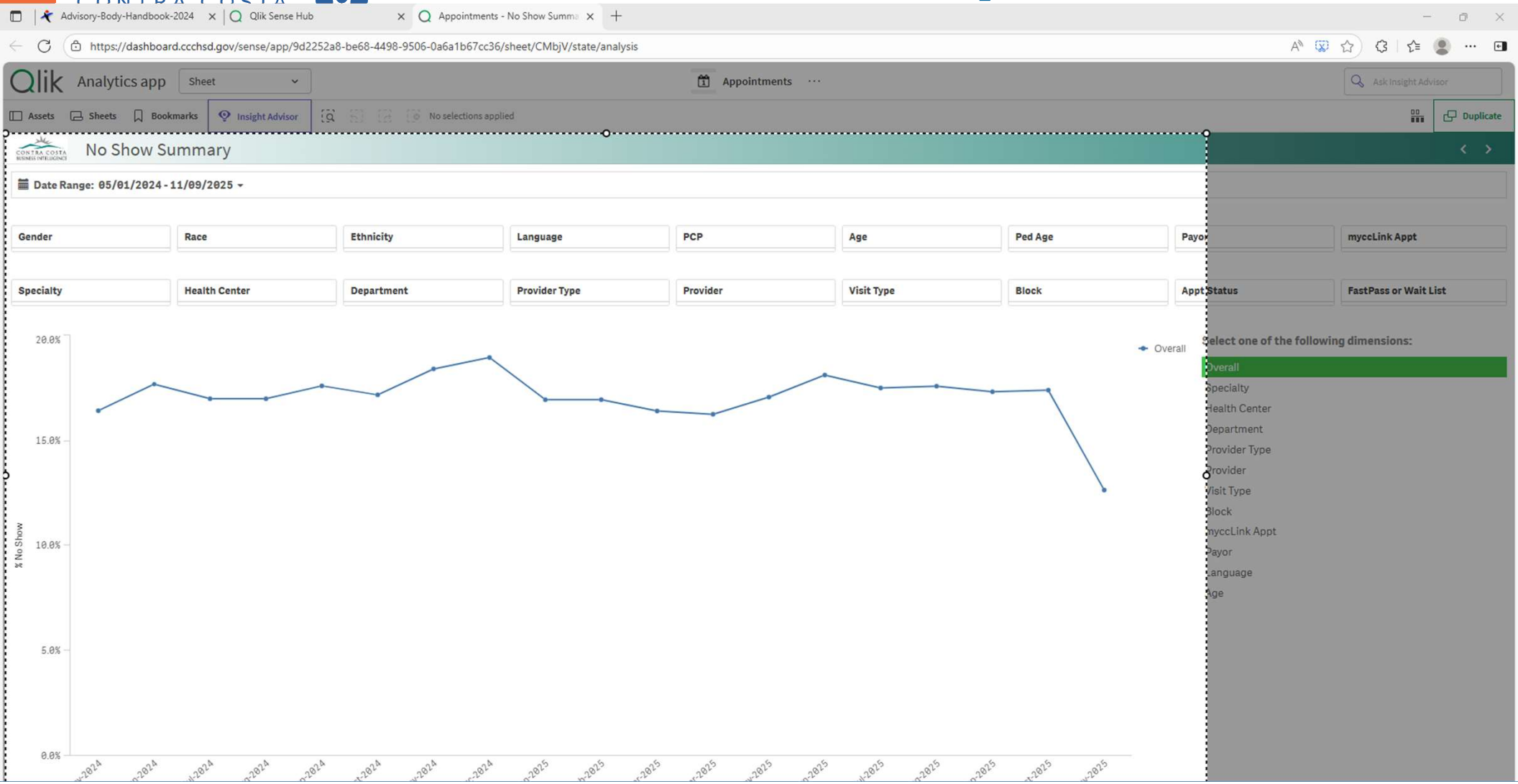
Ambulatory Care Volume



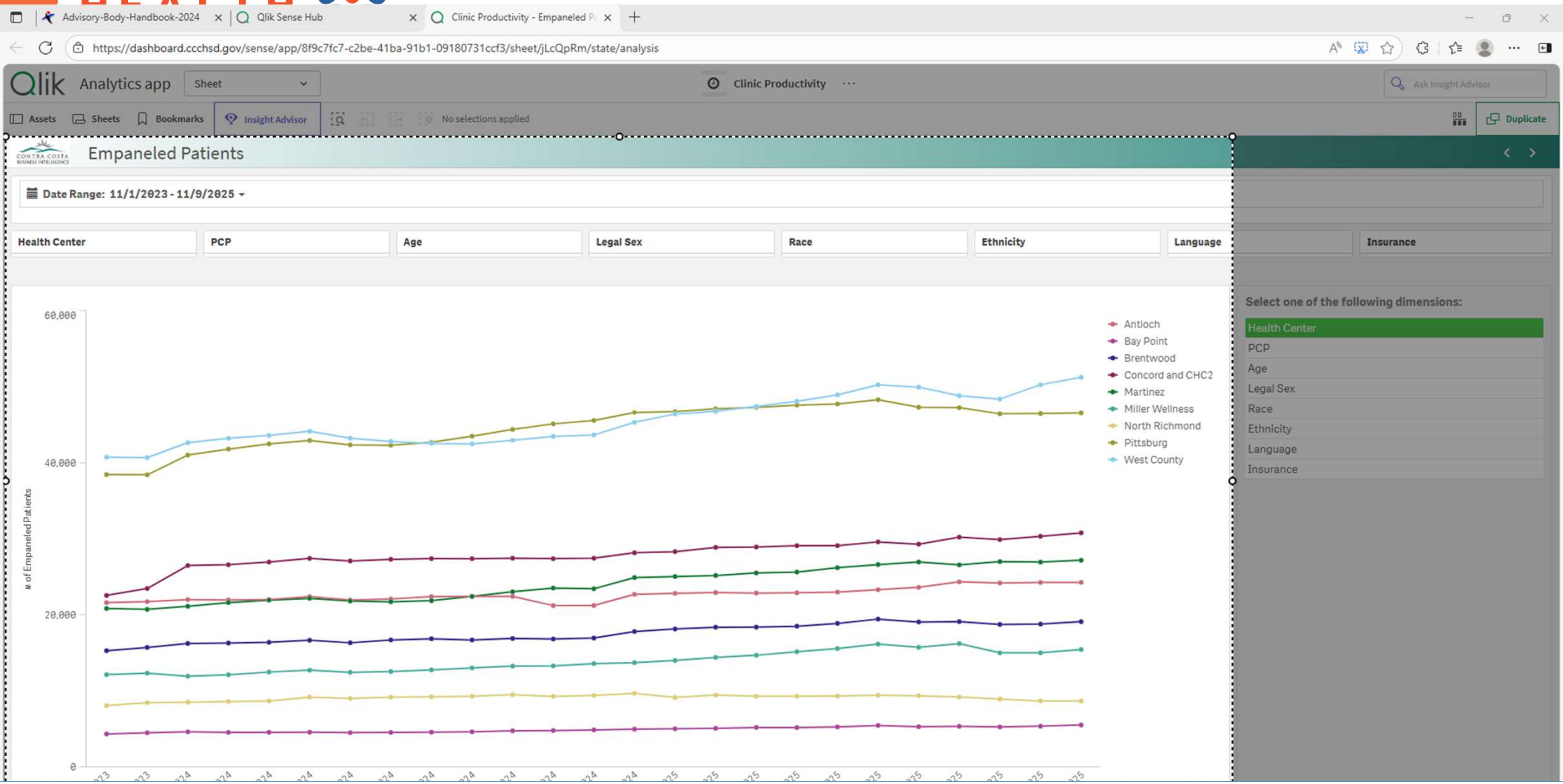
Ambulatory Care Volumes



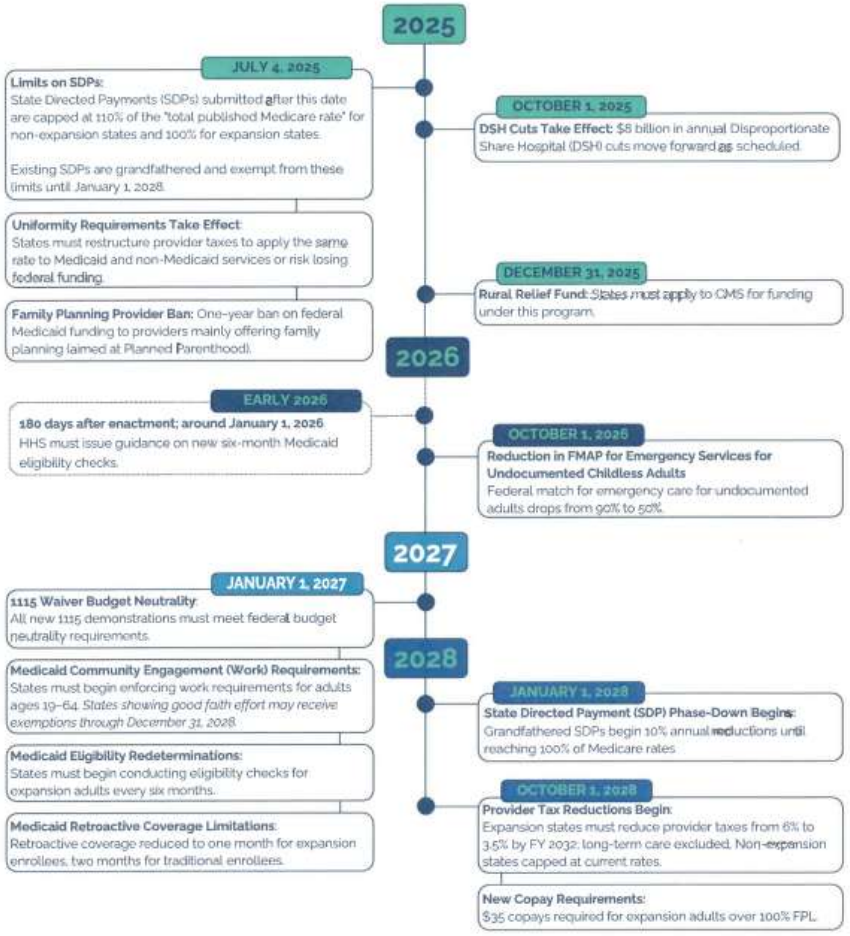
Ambulatory Care Volume



Ambulatory Care Volume



H.R. 1 IMPLEMENTATION TIMELINE



CAPH CALIFORNIA ASSOCIATION OF PUBLIC HOSPITALS & HEALTH SYSTEMS

Rev. 7/18/2025

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HR 1 Strategic Planning

- Evaluation of Current Inpatient and Ambulatory Care Volumes and Capacity
- Projection of Anticipated Changes to Volume and Revenue
- Estimation of Continued Medi-Cal Enrollment in CCHP
- Increased Linkage With CCHP For Inpatient and Ambulatory Services
- Development of Basic Health Plan for Newly Uninsured

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HR 1 Operations Planning

- Performance Improvement Teams In Process
  - Facility Optimization
  - Facility Optimization: Clinical
  - Information Technology
  - Labor and Workforce
  - Pharmacy
  - Revenue Cycle
  - Service Optimization
  - Supply Chain

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Seismic Project Update

- Seismic Compliance is Three Projects:
  - Replacement of Food Services Building
  - Bracing of Sprinkler Lines in Hospital and Lab Buildings
  - Creation of 72-Hour Storage for Potable Water and Wastewater
- Ward E Will Be Demolished (Projected Fall 2026)
- Kitchen Will Remain Operational During Construction
- New Building Will Be Three Stories with Kitchen and Cafeteria on First Floor

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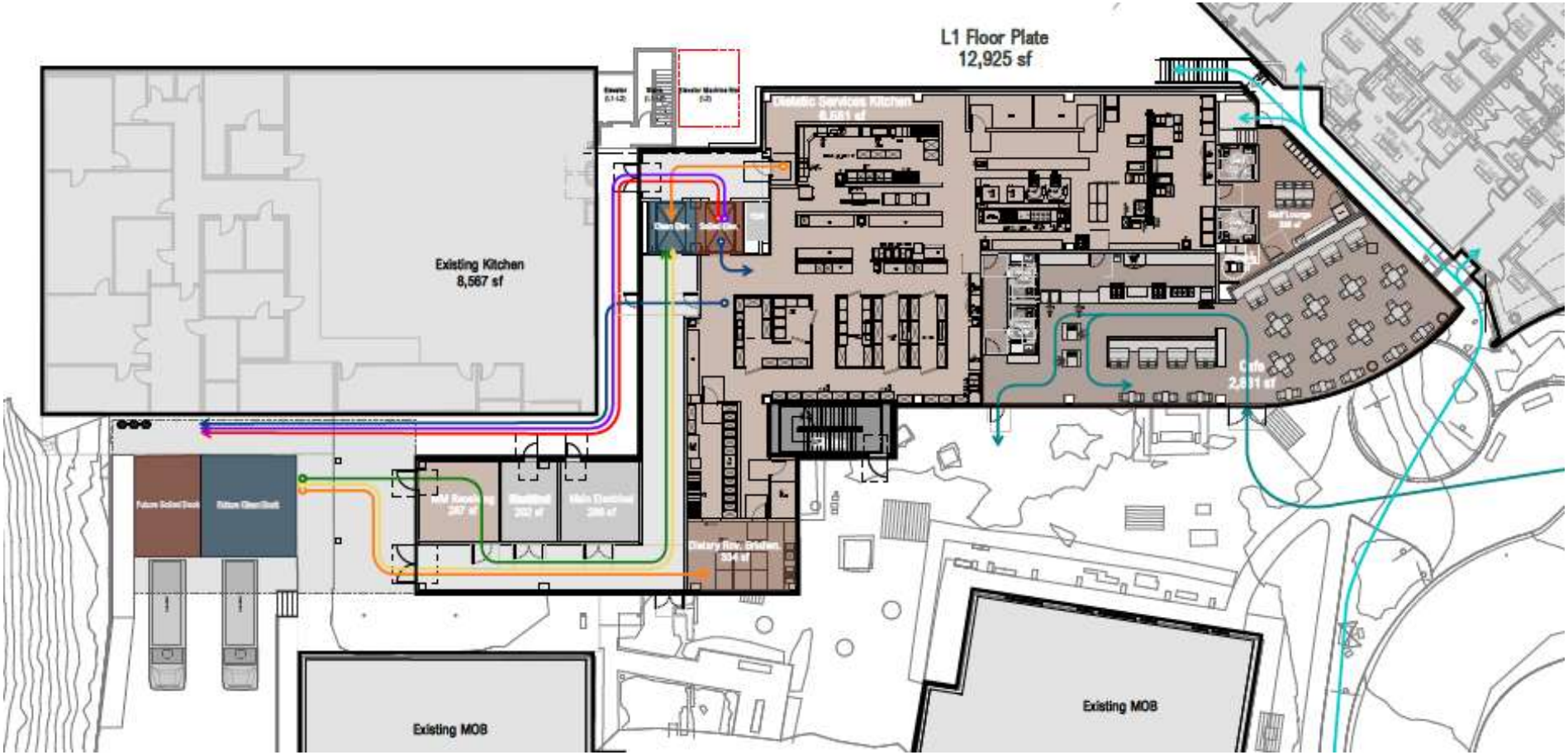
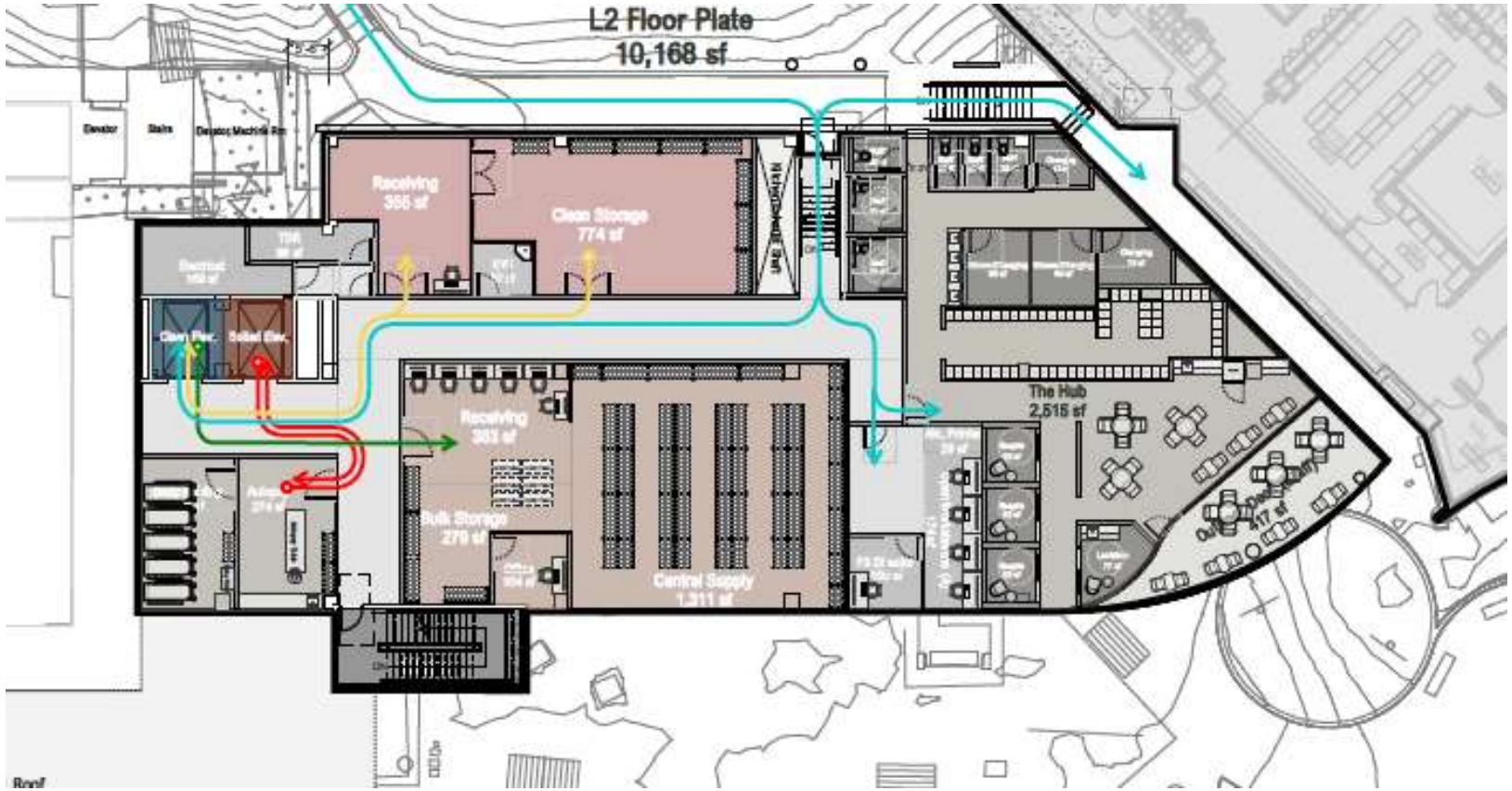
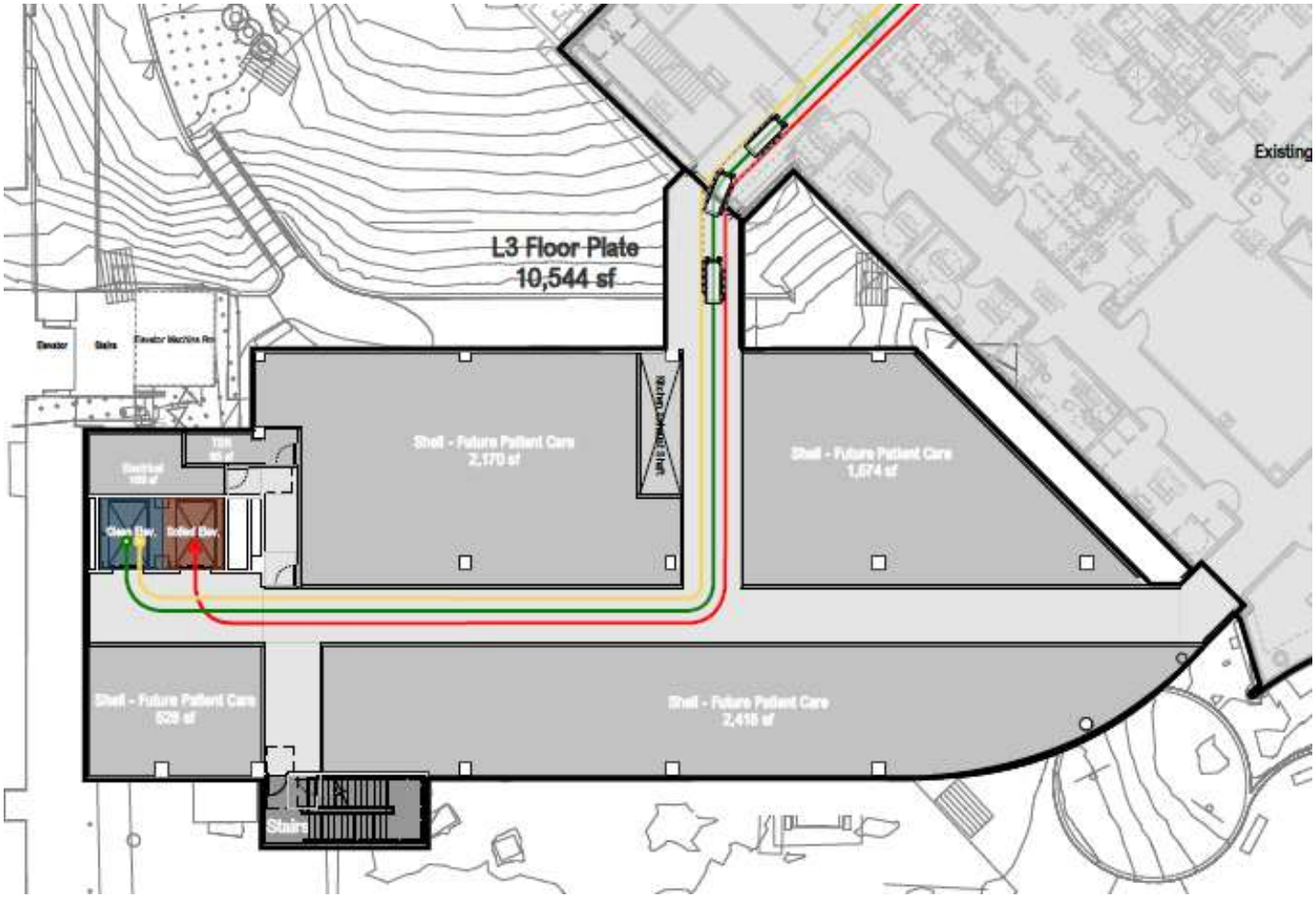
CCRMC New Cafeteria Building

Coming soon!


Inspiration
The Café is the jewel, it's what is Unique and Special.
It's the Heart of the Campus.


L1 Floor Plate
12,925 sf
Existing Kitchen
8,567 sf
Existing MOB
Existing MOB


L2 Floor Plate
10,168 sf
Elevator
Stairs
Receiving
366 sf
Clean Storage
774 sf
Receiving
383 sf
Bulk Storage
276 sf
Central Supply
1,311 sf
The Hub
2,515 sf
Roof


L3 Floor Plate
10,544 sf
Existing
Elevator
Stairs
Elevator Machine Rm
Shell - Future Patient Care
2,170 sf
Shell - Future Patient Care
1,674 sf
Shell - Future Patient Care
629 sf
Shell - Future Patient Care
2,416 sf
Stairs

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Survey Readiness

- General Acute Care Hospital (GACH) Survey by Department of Health Care Services Expected in 2025
- Next Joint Commission Triennial Survey Anticipated Early 2026
- Contra Costa Health Plan Surveys Anticipated Throughout 2025
- Survey Readiness Is Expected at All Times!
- Check for Outdates: Supplies and Medications
- Hand Hygiene: Wash and Gel Your Hands!

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Thank You

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop 00-00-00
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

October 20, 2025

Hospital Administrator / Compliance Officer
Contra Costa Regional Medical Center (CCN 050276)
50 Douglas Dr, Ste 310E
Martinez, CA 94553-4003

RE: Request to Provide Points of Contact for the CMS Transforming Episode Accountability Model (TEAM)

Dear Contra Costa Regional Medical Center (CCN 050276),

The Centers for Medicare & Medicaid Services (CMS) is reaching out regarding Contra Costa Regional Medical Center (CCN 050276) participation in the Transforming Episode Accountability Model (TEAM).

CMS has determined that your hospital meets the **criteria for mandatory participation** in TEAM. Specifically, this includes being an acute care hospital paid under Inpatient Prospective Payment System (IPPS) and Outpatient Prospective Payment System (OPPS) with a CMS Certification Number (CCN) primary address located in one of the mandatory Core Based Statistical Areas (CBSAs) selected for participation in TEAM. As a result, your hospital is included as a mandatory participant in TEAM, which begins January 1, 2026, and ends on December 31, 2030.

TEAM is a mandatory, episode-based CMS alternative payment model in which selected acute care hospitals will coordinate care for beneficiaries with Original Medicare for episode categories that begin with one of the following procedures: coronary artery bypass graft (CABG), lower extremity joint replacement (LEJR), major bowel procedure, surgical hip/femur fracture treatment (SHFFT), and spinal fusion. Participating hospitals will assume responsibility for the cost and quality of care beginning with the procedure and continuing through the first 30 days after the Medicare beneficiary is discharged from the hospital. For more information about TEAM, please visit the CMS TEAM website at https://www.cms.gov/priorities/innovation/innovation-models/team-model

To facilitate onboarding and future coordination, CMS is compiling a verified list of Points of Contact (POCs) for each TEAM participant. These individuals will serve as your hospital's main liaisons for model-related communications, data access authorization, and deliverables submission.

Over the past several weeks, we have reached out to Contra Costa Regional Medical Center (CCN 050276) via phone and email to confirm the appropriate POCs for the Model. To date, we have not received a response.

We kindly request you reach out to CMMI_TEAM@cms.hhs.gov and provide the following details by **November 7, 2025** to avoid any delays in communication regarding your hospital's participation in TEAM.

- Your hospital's CCN
- Names, email addresses, and phone numbers of at least **two** POCs for TEAM

This will ensure we have the appropriate representatives for your hospital to receive important communications.

If you are not the appropriate recipient for this request, we kindly ask that you forward this letter to your hospital's compliance, quality, or leadership team.

Please email CMMI_TEAM@cms.hhs.gov if you have further questions about TEAM.

Thank you for your attention to this matter, and we look forward to your response.

Best regards,
Anna Goldman
Director, Division of Payment Models
CMS

Consolidated EF1 Financial Projection

Based on Year to Date: September 2025

PRELIMINARY DRAFT

CONTRA COSTA HEALTH

CC - Hospital	FY 2025 ACTUAL	FY 2026 FORECAST	VARIANCE (FORECAST V PY ACTUAL) ($)	(%)
FFS Revenue	**393,928,456**	**404,934,143**	**11,005,687**	**2.8%**
Supplemental Revenue	338,213,601	262,240,371	❶ (75,973,230)	(22.5%)
Total Net Patient Revenue	**732,142,056**	**667,174,513**	**(64,967,543)**	**(8.9%)**
Governmental Support & Realignment Revenue	34,700,380	33,009,382	(1,690,998)	(4.9%)
Grants & Donations	7,049,938	4,834,120	❷ (2,215,818)	(31.4%)
Charges to Gen Fund Units	59,668,538	59,758,912	90,374	0.2%
Other Revenue	6,607,361	4,296,726	❸ (2,310,635)	(35.0%)
Total Other Revenue	**108,026,217**	**101,899,140**	**(6,127,077)**	**(5.7%)**
Total Operating Revenue (ex Subsidies)	**840,168,273**	**769,073,653**	**(71,094,620)**	**(8.5%)**
Expenses				
Salaries, Wages, & Benefits	577,213,136	601,596,955	❹ (24,383,819)	(4.2%)
Professional Fees & Purchased Services	154,351,496	154,025,346	326,150	0.2%
Supplies & Drugs	67,439,129	69,082,041	(1,642,912)	(2.4%)
Other Expenses	60,065,074	63,914,475	❺ (3,849,401)	(6.4%)
Total Operating Expenses	**859,068,835**	**888,618,817**	**(29,549,982)**	**(3.4%)**
Expenses as a % of Operating Revenue	*102.2%*	*115.5%*		
EBIDA	**(18,900,562)**	**(119,545,164)**	**(100,644,602)**	**(532.5%)**
EBIDA (%)	*(2.2%)*	*(15.5%)*		
Subsidy (+)	125,912,276	117,100,259	❻ (8,812,017)	(7.0%)
Net Income (incl. Subsidy)	**107,011,714**	**(2,444,906)**	**(109,456,620)**	**(102.3%)**

Key Variance Drivers

❶ Non-recurring supplemental revenue in 2025 ($57M) and reduction in CY GPP ($20M)

❷ Reductions in Collaborative Care Implementation Project (CCIP), hypertension, EMS, and other grant revenue

❸ Non-recurring gain driven by early extinguishment of debt in 2025

❹ Increase due to market and merit adjustments

❺ Increase in software and occupancy costs

❻ Reduced Subsidy driven by an early payment of debt in 2025 (2015 A/B Bonds)

1

Key Federal and State Policy Changes

FY 2025-26	FY 2026-27	FY 2027-28	FY 2028-29+
Policy Passed, but Implementation Guidance Pending	First Wave of Cuts, but Enforcement and Exemptions Unclear	Eligibility Restrictions Begin, but Operational Details Remain Unclear	Long-Term Structural Shifts with Unknown Depth and Timing
Federal Impacts			
▪ H.R. 1, "One Big Beautiful Bill," signed ▪ DSH (GPP) Cuts Begin (Oct)	▪ FMAP Reduction (Oct) ▪ CalAIM 1115 Waiver Expires (Dec 31) ▪ Work Requirements and Eligibility Changes (Jan)		▪ State Directed Payment Phase-down to Medicare rates begins ▪ MCE Cost Sharing for 100-133% FPL Individuals (Deductibles up to $35)
State Impacts			
▪ California FY2025-26 Budget passed ▪ UIS Enrollment Freeze (Jan)	▪ PPS Elimination for FQHCs (Jul) ▪ UIS Dental Coverage Elimination (Jul) ▪ UIS Premiums Start (Jan) ▪ Prop 56 Reductions (Jul)	▪ Employer Contributions Under Study for Medi-Cal Covered Employees	
CCHP Membership Loss			
(5,000)	(82,500)	(5,000)	(5,000)
Cumulative Membership Loss: (97,500)			
Funding Reduction			
($20,507,000)	($92,396,000)	($102,231,000)	($125,891,000)
Cumulative Funding Reduction: ($341,025,000)			
Level of Modeling and Policy Uncertainty			
Low	Medium	High	High
H.R. 1 was enacted, but federal agencies have yet to issue detailed regulations. States and Health plans face uncertainty around timing, enforcement mechanisms, and scope of programmatic changes (e.g. DSH cuts, provider tax rules)	*Major provisions like DSH/GPP cuts, FMAP reductions, and PPS elimination take effect – but ambiguity remains around how these will be operationalized, monitored, or phased in. Legal and legislative pushback could delay or soften impacts*	*Federal work and redetermination requirements kick in, but implementation standards, enforcement thresholds, and allowable state flexibilities remain undefined. State response to coverage loss is still unknown*	*State Directed Payment reductions begin at 10% annually, but future federal administrations or waivers may alter the trajectory. Long-term Medicaid financing and delivery system reforms may either reinforce or reverse earlier cuts*

2

Operational Policy Agenda 11-24-25

Title	Area	Revised?	Summary of Changes
Responding to Immigration Enforcement	Contra Costa Health	Yes	This is a Contra Costa Health policy. Updates were made to align with SB 81. County Counsel reviewed and added their changes. Dr. Colfax approved this policy.
Inmate - Patient Policy (Formerly Policy for Treatment of Prisoner Patients)	Hospital & Health Centers	Yes	This is a Contra Costa Health Policy. Updates were made to align with SB81. County Counsel reviewed and added their changes. Dr. Colfax and David Culberson approved the policy.
Policy for Consent to Medical Treatment	Hospital & Health Centers	Yes	Updates for 2024 CMS/CHA guidelines. Clarifies necessary aspect of informed consent. Allows for Advanced Practice Providers (e.g., NP, PA) as practitioners. Other verbiage updates to make more in line with CMS guidelines.
Procedure for Consent to Medical Treatment	Hospital & Health Centers	Yes	Updates for 2024 CMS/CHA guidelines. Clarifies necessary aspect of informed consent. Allows for Advanced Practice Providers (e.g., NP, PA) as practitioners. Other verbiage updates to make more in line with CMS guidelines.

Origination: 06/08/2025 **Last Approved:** 8/19/2025 **Effective:** 8/20/2025 **Last Revised:** 11/10/25~~08/19/2025~~xxx **Next Review:** ~~8/20/2026~~xxx	**Owner:** Gilbert Salinas Lavonna Martin Grant Colfax, MD **Area**: Administration

129 A - POLICY FOR RESPONDING TO IMMIGRATION ENFORCEMENT ISSUES

POLICY STATEMENT:

Contra Costa Health (CCH) is committed to everyone in need of and who are eligible for our services, regardless of immigration status.

The purpose of this policy is to provide guidance to CCH staff in responding to immigration enforcement activities, including monitoring and receiving visitors, immigration officer presence at CCH facilities, notifying minor patients' parents or guardians of immigration enforcement actions, and information sharing.

Unless required by state or federal law, CCH staff shall not allow any person to access the nonpublic areas of a CCH facility for immigration enforcement, unless the person has a valid judicial warrant or court order that specifically grants access to the nonpublic areas of the facility.

This policy applies to all CCH operated facilities including Contra Costa Regional Medical Center, Health Centers, Behavioral Health Clinics, including substance use treatment programs, Public Health Clinics, Homeless emergency and medical respite shelters and permanent supportive housing programs. This policy applies to all employees, medical staff, clinical residents, contractors, and volunteers.

CCH has onsite administrators at each facility to manage potential immigration enforcement issues. The role of these administrators is to ensure staff members and contractors are appropriately dealing with immigration enforcement inquiries and requests and are complying with internal procedures. Onsite administrators in need of guidance may contact the Chief Equity Officer in the Office of the Director at Gilbert.Salinas@cchealth.org. All CCH reception and frontline staff should have the name and contact information for their direct supervisor, who is available for each shift, and the contact information for the Sheriff's Office. (See Attachment A for-contact info for the Sheriff.)

Although U.S. Immigration and Customs Enforcement (ICE) and U.S. Customs and Border Protection (CBP) are the federal agencies with primary responsibility for federal immigration enforcement, there are instances in which other agencies may also attempt to enforce immigration laws. **While the policy references immigration officers, the policy pertains to any law enforcement officer or agency attempting to enforce immigration laws.** While immigration officers typically wear uniforms, staff should be aware that an immigration officer may also appear in civilian clothing.

GUIDELINES:

Monitoring and Receiving Visitors at CCH Facilities

Immigration officers may enter public areas of CCH facilities without a warrant or consent and

may question any person present (with that person's consent). CCH staff should not interfere with immigration officer activity in a public area of a facility, though CCH staff should alert their direct supervisor and if the direct supervisor is not available contact the onsite administrator of the presence of immigration officers in the facility and document the activity if feasible. This documentation may be in the form of an email addressed to the direct supervisor.

No visitor, including immigration enforcement officers, shall enter or remain in non-public areas of a CCH facility without having registered with the facility, in accordance with the facility's rules and regulations regarding visitors. If there are no exigent circumstances necessitating immediate action (such as urgent national security or public safety threat), and if the visitor does not possess a judicial warrant or court order that provides a basis for the visit, the visitor must provide the following information to the direct supervisor:

- Name, address, occupation.
- Age, if less than 21 years.
- Purpose in entering the healthcare facility.
- Proof of identity.

(The direct supervisor should attempt to obtain this information even if the visitor or officer presents a court order.)

Frontline and reception area staff should neither confirm nor deny the presence of a patient to an immigration officer, should refer the officer to their direct supervisor, and proceed as set forth in Section III.

CCH staff shall report entry by immigration enforcement officers to their direct supervisor, as would be required for any unexpected or unscheduled outside visitor coming into the facility.

Responding to Immigration Law Enforcement Presence at CCH Facilities

CCH staff shall immediately notify their direct supervisor of any request (including subpoenas, complaints, warrants, or court orders) by an immigration enforcement officer to access a non-public area of a CCH facility or a patient, including to obtain information about a patient or a patient's family, or any request for the review of CCH documents. Please notify the Sheriff's office onsite security representative also.

A. Interaction Protocol

CCH staff shall take the following steps in response to an officer present at a CCH facility for immigration enforcement purposes:

1. Always remain calm and professional.
2. Advise the officer that before proceeding with the officer's request, CCH staff must first notify and receive directions from their direct supervisor.
3. Immediately contact their direct supervisor for assistance. Decline to answer questions and wait for their direct supervisor or the onsite manager to arrive. Staff should provide their name and title to the officer if requested.
4. If possible, the direct supervisor should handle all steps that follow. If the direct supervisor at the site is not available, staff may contact the onsite manager.
5. Verify that the officer is an immigration officer (or another federal officer). Ask to see, and make a copy of or note, the officer's credentials (name, agency, and badge number). Also ask for and copy or note the name and telephone number of the officer's supervisor.
6. Ask the officer to explain the purpose of the officer's visit and note the response.
7. Ask the officer to produce any documentation that authorizes CCH facility access.
8. Make copies of all documents provided by the officer. The direct supervisor may ask another staff member to copy the information.
9. If the circumstances warrant, advise the officer that the facility is not obstructing the

officer's progress.

10. State that CCH does not consent to entry to non-public areas of the facility. For law enforcement to access a private/restricted area within the facility, a valid judicial warrant is required absent exigent circumstances or consent. If an officer is in a public area or waiting room, the officer may remain in the area, during normal business hours of operation Monday through Friday 8 am – 5 pm.

11. Without expressing consent, respond according to the requirements of the officer's documentation. See Section III(B), below, regarding documentation categories and the appropriate response. Ask the officer to wait while the documents are reviewed.

12. Document the officer's actions in as much detail as possible without interfering with the officer's movements.

13. If the officer orders staff to provide immediate access to a non-public area of the facility, CCH staff should comply with the officer's order. CCH staff should not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other document. **CCH staff may say, "I do not consent and am not authorized to grant consent. But because I have no other choice at this time, I will not interfere with your order".** If an officer enters a non-public area without authority, CCH personnel shall document the officer's actions.

14. If the officer enters a non-public area of the facility, the direct supervisor should always accompany the officer while the officer is in the non-public area. If feasible, the direct supervisor may record the activities of the officer. If possible, the officer should be directed away from patients and confidential areas.

15. If an immigration officer removes a patient or another individual, the direct supervisor may ask the officer where the individual is being taken.

16. If an immigration officer seizes records or other items, the direct supervisor should document which items are taken and request that the officer provide a receipt.

17. The direct supervisor should complete an incident report that includes the information gathered as described above and the officer's statements and actions.

B. Documentation Categories and Response Protocol

An immigration officer may present any of the following documents:

1. A **federal judicial warrant** (either a search-and-seizure warrant or an arrest warrant; see Exhibits A.1 and A.2): A judicial warrant is issued by a "U.S. District Judge" or "U.S. Magistrate Judge" from "U.S. District Court". A judicial warrant is a court order that authorizes the search of property, seizure of property, or arrest based on probable cause.

   A judicial warrant should specify an address, time for execution, the place or person to be searched for, and any items to be seized, all described with specificity. The warrant must be signed by a judge or magistrate judge to be valid. Prompt compliance usually is required, but where feasible, the direct supervisor should notify and consult with the County Counsel's Office before responding.

   If the officer has a valid judicial warrant, the direct supervisor should pay close attention and verbally object if officers go beyond the scope of their authority to search or seize objects as specified in the warrant (e.g., if the warrant allows a search of the emergency room, officers may not use the warrant to search private patient examination rooms). If possible, this verbal objection should be witnessed by at least one other staff member. The objection should be documented in writing and acknowledged by the staff members. If the officer orders staff to provide immediate access to a non-public area of the facility, CCH staff should comply with the officer's order. CCH staff should not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other

document.

2. An **ICE administrative "warrant"** (see Exhibits B.1 and B.2): An administrative warrant is issued by the "Department of Homeland Security", an "Immigration Judge", or an "Immigration Officer".

   If the direct supervisor has not yet arrived, inform the officer that CCH cannot respond to the warrant until it has been reviewed by the direct supervisor. Provide a copy of the warrant to the direct supervisor as soon as possible. Staff should not give ICE any information or allow ICE to enter any non-public areas of the facility. If ICE requests or attempts to access a non-public area, Staff should verbally deny ICE access to any non-public area of the facility and if possible, have this denial witnessed by at least one other staff member. The denial should be documented in writing and acknowledged by the staff members. If the officer orders staff to provide immediate access to a non-public area of the facility, CCH staff should comply with the officer's order. CCH staff should not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other document.

   An administrative warrant does not give officers the authority to enter private areas or seize records.

3. A **subpoena** for production of documents or other evidence (see Exhibits C.1 and C.2): This is a document requesting documents or evidence. Immediate compliance is not required. CCH staff should not provide documents on the spot and should not consent to an officer search. Inform the officer that CCH cannot respond to the subpoena until it has been reviewed by an area supervisor and legal counsel. Staff should handle the subpoena pursuant to existing subpoena protocols. Staff is not required to give ICE any information or allow ICE to enter any non-public areas of the facility. If ICE requests or attempts to access a non-public area, Staff should verbally deny ICE access to any non-public area of the facility and if possible, have this denial witnessed by at least one other staff member. The denial should be documented in writing and acknowledged by the staff members. The direct supervisor should contact the onsite Administrator and the Office of the County Counsel for assistance as soon as possible following receipt of the subpoena.

4. A **notice to appear** (see Exhibit D): This is a document notifying a person of removal proceedings. This document is not directed at CCH. CCH staff should not deliver or facilitate service of this document to the person named in the document. CCH staff should not provide access to non-public areas to search. CCH staff should not give ICE any information. If ICE requests or attempts to access a non-public area, Staff should verbally deny ICE access to any non-public area of the facility and if possible, have this denial witnessed by at least one other staff member. The denial should be documented in writing and acknowledged by the staff members. The direct supervisor should notify the onsite administrator of any notice to appear.

5. A **court order**: Staff should provide the court order to their direct supervisor. If ICE requests or attempts to access a non-public area, Staff should verbally deny ICE access to any non-public area of the facility and if possible, have this denial witnessed by at least one other staff member. The denial should be documented in writing and acknowledged by the staff members. The direct supervisor should notify the onsite Administrator who will consult with the County Counsel's Office regarding handling of the order.

Responding to Immigration Enforcement Present Out in the Field

A. Interaction Protocol

1. **Handling when staff meet with a client in their home and immigration enforcement officers arrive at the client's home.**
   - During any interaction, staff should ensure that their actions are consistent with the purpose of the client visit and do not exceed the scope of their employment.
   - Staff should not hide a client or assist the client in evading an officer.
   - Staff should not engage with immigration officers. If an officer asks a question, the staff member may state, "I am not authorized to answer any questions."
   - Staff may leave if they choose to do so. Staff may also observe the interaction if they are not interfering with officers' actions and it is safe to do so. Staff should prioritize their personal safety.
   - If immigration officers ask staff to move or leave, staff should do so.
   - If the client is detained, staff may ask the immigration officers where the client is being taken.
   - When the interaction concludes, staff should report the incident to their direct supervisor.

2. **Handling when staff meet with a client in a public space, such as a coffee shop or park, and immigration officers approach the client.**
   - Staff should conduct themselves as noted above.
   - If the meeting is at a business location and staff of the business direct people leave, staff should exit the building.
3. **Handling when immigration officers are present at a community event at which staff are in attendance (like a health fair).**
   - If the event is at a county facility, staff should proceed as stated in this policy under **Responding to Immigration Law Enforcement Presence at CCH Facilities.**
   - Otherwise, staff should conduct themselves as noted above.
   - If event or facility staff direct people to leave, staff should leave the area.

4. **Handling when immigration officers approach a county vehicle in which staff is transporting a client.**
   - As with any interaction with law enforcement:
     - If staff believe that law enforcement is attempting to pull them over, staff should pull over and stop in a safe place, turn off the vehicle, and put their hands on the steering wheel.
     - If the officer approaches the vehicle, staff may ask the officer which agency they work for.
     - If asked, staff should show their driver's license, registration, and proof of insurance to the officer (through a partially opened window).
     - If the officer asks to search for the vehicle, staff may refuse consent to search. However, if the officer states they have the authority to search, staff should state they are not consenting to a search but otherwise follow the officer's directions.
     - Staff may ask if they are free to leave.
   - Otherwise, staff should conduct themselves as noted above.

Parental Notification of Immigration Law Enforcement Actions
CCH staff must receive consent from a minor patient's parent or guardian (provided the child is

not legally regarded as their own personal representative of their medical records) before a minor patient can be interviewed or searched by any officer seeking to enforce civil immigration laws at a CCH facility, unless the officer presents a valid, effective warrant signed by a judge, or presents a valid, effective court order. (See Section III(B).)

CCH staff shall immediately notify the minor patient's parent, guardian, or the foster parent and social worker of a dependent child if a law enforcement officer requests or gains access to a patient for immigration enforcement purposes, unless such access followed a judicial warrant that restricts the disclosure of the information to the parent or guardian.

Requests for Patient/Client Information and Information Sharing
California and federal laws and regulations give all patients or clients, regardless of immigration status, the right to keep their medical records private in most circumstances. CCH Health Information Management (HIM) will not release information to third parties for immigration enforcement purposes, except as required by law or court order.

CCH staff should limit collecting information about immigration status, citizenship, and national origin to only what is necessary and required by law. CCH staff should avoid including this information in medical and billing records, limit collection to the individual seeking care, not their family members, and promptly respond to requests to remove such information from medical records, as permitted by law.

In connection with any information request issued for immigration enforcement purposes, CCH HIM staff should document and verify the following information:

- The specific agency the requester is from.
- The form of the request (e.g., subpoena, court order, etc.).
- Whether the requester is a law enforcement agency.
- The specific types of protected health information the requester seeks.
- The reason the requester wants the information, including any legal authority claimed.
- Whether the request requires patient notification and if so, whether the requester provided proof of notification.

CCH staff who receive a document labeled "subpoena"," "warrant", or "order", should contact their direct supervisor to determine if the document has been issued by a court or judicial officer, and whether the request for PHI is narrowly tailored as required by HIPAA. Requests received by mail or by email should be directed to the direct supervisor for initial handling.

The direct supervisor should notify the Chief Equity Officer, who will consult with the County Counsel's Office to help determine when and to what extent CCH is required to comply with requests that seek immigration-related information or are for, or appear to be for, immigration enforcement purposes.

If CCH is required to make a disclosure of patient information to immigration enforcement authorities without the patient's authorization in compliance with a court order, subpoena, or judicial warrant, HIM should document the disclosure in compliance with all existing CCH policies and procedures for such disclosures. Such documentation should include information that supported the decision to disclose the information. Disclosures to law enforcement are subject to the accounting-of-disclosures requirement under the HIPAA Privacy Rule.

Additional Provisions

CCH staff should ensure that patients have access to information about their privacy rights and inform them that their healthcare information is protected by federal and state laws by providing

patients with the Notice of Privacy Practices pursuant to current CCH policy.

CCH staff should be cognizant of information that is in open view of the public, such as files and computer screens. Even without a warrant, immigration officers may examine anything in plain view, including conversation in private areas that can be heard from public areas.

Only onsite administrators have the authority to validate court orders or warrants and permit immigration officer entry into non-public areas. If the officer orders staff to provide immediate access to a non-public area of the facility, CCH staff should comply with the officer's order. CCH staff should not attempt to physically interfere with the officer, even if the officer appears to be acting without consent or appears to be exceeding the purported authority given by a warrant or other document.

All public-facing staff, direct supervisors, and onsite administrators should be familiar with the provisions of this policy. It is the responsibility of the onsite administrators to ensure that all public-facing staff, including temporary staff, have read this policy.

CCH staff **should not**:

- Act as interpreters for immigration officers.
- Hide patients or escort patients or others out of the facility to avoid contact with immigration officers or otherwise assist a person in evading immigration officers.
- Provide any false or misleading information to immigration officers.
- Provide patients or others with legal advice.
- Obstruct or interfere with immigration officers.

RELATED LINKS:

Attachment A: Managing an Interaction with ICE

Attachment B: Judicial and Administrative Warrant Samples

APPROVALS:

Joint Conference Committee:
Health Services Director: Grant Colfax, MD
Chief Equity Officer: Gilbert Salinas
Date Approved: 11/10/25

Managing an Interaction with ICE

CONTRA COSTA HEALTH

An employee contacted by U.S. Immigration & Customs Enforcement (ICE) while working at a CCH facility should...

- **Immediately notify their direct supervisor**
- **If your supervisor is not available, contact your worksite's administrator on duty**
- **The Chief of Security for your site or a designee can help with interpreting legal paperwork, but will not directly interact with ICE. If not available, call 925-370-5315 or 925-383-2367 for a Sheriff's Office representative**

For more detailed information, go to iSITE and view the Protocols for Responding to Immigration Enforcement Issues

June 2025

Managing an Interaction with ICE

CONTRA COSTA HEALTH

An employee contacted by U.S. Immigration & Customs Enforcement (ICE) while working or at a CCH facility should...

- Immediately notify their direct supervisor
- If your supervisor is not available, contact your worksite's administrator on duty
- The Chief of Security for your site or a designee can help with interpreting legal paperwork, but will **NOT** directly interact with ICE. If not available, call **925-370-5315** or **925-383-2367** for a Sheriff's Office representative

Supervisor determines ICE representative has legal paperwork

ICE may have the right to search the site or make an arrest. Contact County Counsel immediately by calling **925-655-2200**

No paperwork

You are **NOT** required to provide ICE access to non-public areas. You are **NOT** required to give ICE any information. You may ask ICE to leave. Notify County Counsel immediately by calling **925-655-2200**

ICE representative still demands access

Do **NOT** physically interfere with ICE. You may say, "I do not consent. But because I have no other choice at this time, I will not interfere with your order." Document ICE's actions, if safe to do so

For more detailed information, go to iSITE and view the Protocols for Responding to Immigration Enforcement Issues

June 2025

AO 93 (Rev. 11/13) Search and Seizure Warrant

UNITED STATES DISTRICT COURT

for the

In the Matter of the Search of *(Briefly describe the property to be searched or identify the person by name and address)*	)	Case No.

SEARCH AND SEIZURE WARRANT

To: Any authorized law enforcement officer

An application by a federal law enforcement officer or an attorney for the government requests the search of the following person or property located in the _____ District of _____
(identify the person or describe the property to be searched and give its location):

I find that the affidavit(s), or any recorded testimony, establish probable cause to search and seize the person or property described above, and that such search will reveal *(identify the person or describe the property to be seized)*:

YOU ARE COMMANDED to execute this warrant on or before _____ *(not to exceed 14 days)*
❒ in the daytime 6:00 a.m. to 10:00 p.m. ❒ at any time in the day or night because good cause has been established.

Unless delayed notice is authorized below, you must give a copy of the warrant and a receipt for the property taken to the person from whom, or from whose premises, the property was taken, or leave the copy and receipt at the place where the property was taken.

The officer executing this warrant, or an officer present during the execution of the warrant, must prepare an inventory as required by law and promptly return this warrant and inventory to _____.
(United States Magistrate Judge)

❒ Pursuant to 18 U.S.C. § 3103a(b), I find that immediate notification may have an adverse result listed in 18 U.S.C. § 2705 (except for delay of trial), and authorize the officer executing this warrant to delay notice to the person who, or whose property, will be searched or seized *(check the appropriate box)*
❒ for _____ days *(not to exceed 30)* ❒ until, the facts justifying, the later specific date of _____.

Date and time issued: _____ _____
Judge's signature

City and state: _____ _____
Printed name and title

AO 442 (Rev. 11/11) Arrest Warrant

UNITED STATES DISTRICT COURT

for the

United States of America
v.

Case No.

Defendant

ARREST WARRANT

To: Any authorized law enforcement officer

YOU ARE COMMANDED to arrest and bring before a United States magistrate judge without unnecessary delay

(name of person to be arrested) _____,

who is accused of an offense or violation based on the following document filed with the court:

❒ Indictment ❒ Superseding Indictment ❒ Information ❒ Superseding Information ❒ Complaint

❒ Probation Violation Petition ❒ Supervised Release Violation Petition ❒ Violation Notice ❒ Order of the Court

This offense is briefly described as follows:

Date: _____

_____
Issuing officer's signature

City and state: _____

_____
Printed name and title

Return

This warrant was received on *(date)* _____, and the person was arrested on *(date)* _____
at *(city and state)* _____.

Date: _____

_____
Arresting officer's signature

_____
Printed name and title

ATTACHMENT B.1 - EXAMPLE ADMINISTRATIVE WARRANT

U.S. DEPARTMENT OF HOMELAND SECURITY **Warrant for Arrest of Alien**

File No. _____

Date: _____

To: Any immigration officer authorized pursuant to sections 236 and 287 of the Immigration and Nationality Act and part 287 of title 8, Code of Federal Regulations, to serve warrants of arrest for immigration violations

I have determined that there is probable cause to believe that _____ is removable from the United States. This determination is based upon:

☐ the execution of a charging document to initiate removal proceedings against the subject;

☐ the pendency of ongoing removal proceedings against the subject;

☐ the failure to establish admissibility subsequent to deferred inspection;

☐ biometric confirmation of the subject's identity and a records check of federal databases that affirmatively indicate, by themselves or in addition to other reliable information, that the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law; and/or

☐ statements made voluntarily by the subject to an immigration officer and/or other reliable evidence that affirmatively indicate the subject either lacks immigration status or notwithstanding such status is removable under U.S. immigration law.

YOU ARE COMMANDED to arrest and take into custody for removal proceedings under the Immigration and Nationality Act, the above-named alien.

_____
(Signature of Authorized Immigration Officer)

_____
(Printed Name and Title of Authorized Immigration Officer)

Certificate of Service

I hereby certify that the Warrant for Arrest of Alien was served by me at _____ (Location)

on _____ (Name of Alien) on _____ (Date of Service), and the contents of this notice were read to him or her in the _____ (Language) language.

_____ Name and Signature of Officer

_____ Name or Number of Interpreter (if applicable)

Form I-200 (Rev. 09/16)

ATTACHMENT B.2 - EXAMPLE ADMINISTRATIVE WARRANT

DEPARTMENT OF HOMELAND SECURITY

U.S. Immigration and Customs Enforcement

WARRANT OF REMOVAL/DEPORTATION

File No: _____

Date: _____

To any immigration officer of the United States Department of Homeland Security:

_____

(Full name of alien)

who entered the United States at _____ on _____

(Place of entry) (Date of entry)

is subject to removal/deportation from the United States, based upon a final order by:

- ☐ an immigration judge in exclusion, deportation, or removal proceedings
- ☐ a designated official
- ☐ the Board of Immigration Appeals
- ☐ a United States District or Magistrate Court Judge

and pursuant to the following provisions of the Immigration and Nationality Act:

I, the undersigned officer of the United States, by virtue of the power and authority vested in the Secretary of Homeland Security under the laws of the United States and by his or her direction, command you to take into custody and remove from the United States the above-named alien, pursuant to law, at the expense of:

_____

(Signature of immigration officer)

_____

(Title of immigration officer)

_____

(Date and office location)

ATTACHMENT C.1 - EXAMPLE SUBPOENA

1. To (Name, Address, City, State, Zip Code)	DEPARTMENT OF HOMELAND SECURITY **IMMIGRATION ENFORCEMENT SUBPOENA** to Appear and/or Produce Records 8 U.S.C. § 1225(d), 8 C.F.R. § 287.4
Subpoena Number	
2. In Reference To (Title of Proceeding) (File Number, if Applicable)	

By the service of this subpoena upon you, **YOU ARE HEREBY SUMMONED AND REQUIRED TO:**

(A) ☐ **APPEAR** before the U.S. Customs and Border Protection (CBP), U.S. Immigration and Customs Enforcement (ICE), or U.S. Citizenship and Immigration Services (USCIS) Official named in Block 3 at the place, date, and time specified, to testify and give information relating to the matter indicated in Block 2.

(B) ☒ **PRODUCE** the records (books, papers, or other documents) indicated in Block 4, to the CBP, ICE, or USCIS Official named in Block 3 at the place, date, and time specified.

Your testimony and/or production of the indicated records is required in connection with an investigation or inquiry relating to the enforcement of U.S. immigration laws. Failure to comply with this subpoena may subject you to an order of contempt by a federal District Court, as provided by 8 U.S.C. § 1225(d)(4)(B).

3. (A) CBP, ICE or USCIS Official before whom you are required to appear Name Title Address Telephone Number	(B) Date (C) Time ☒ a.m. ☐ p.m.
4. Records required to be produced for inspection	

If you have any questions regarding this subpoena, contact the CBP, ICE, or USCIS Official identified in Block 3.

5. Authorized Official

(Signature)

(Printed Name)

(Title)

(Date)

DHS Form I-138 (6/09)

EXAMPLE C.2 - EXAMPLE SUBPOENA

AO 88B (Rev. 02/14) Subpoena to Produce Documents, Information, or Objects or to Permit Inspection of Premises in a Civil Action

UNITED STATES DISTRICT COURT

for the

_____ *Plaintiff*	)	
v.	)	Civil Action No.
_____ *Defendant*	)	

SUBPOENA TO PRODUCE DOCUMENTS, INFORMATION, OR OBJECTS OR TO PERMIT INSPECTION OF PREMISES IN A CIVIL ACTION

To:

_____

(Name of person to whom this subpoena is directed)

❒ *Production:* **YOU ARE COMMANDED** to produce at the time, date, and place set forth below the following documents, electronically stored information, or objects, and to permit inspection, copying, testing, or sampling of the material:

Place:	Date and Time:

❒ *Inspection of Premises:* **YOU ARE COMMANDED** to permit entry onto the designated premises, land, or other property possessed or controlled by you at the time, date, and location set forth below, so that the requesting party may inspect, measure, survey, photograph, test, or sample the property or any designated object or operation on it.

Place:	Date and Time:

The following provisions of Fed. R. Civ. P. 45 are attached – Rule 45(c), relating to the place of compliance; Rule 45(d), relating to your protection as a person subject to a subpoena; and Rule 45(e) and (g), relating to your duty to respond to this subpoena and the potential consequences of not doing so.

Date: _____

CLERK OF COURT

OR

_____ _____

Signature of Clerk or Deputy Clerk *Attorney's signature*

The name, address, e-mail address, and telephone number of the attorney representing *(name of party)* _____ _____, who issues or requests this subpoena, are:

Notice to the person who issues or requests this subpoena

If this subpoena commands the production of documents, electronically stored information, or tangible things or the inspection of premises before trial, a notice and a copy of the subpoena must be served on each party in this case before it is served on the person to whom it is directed. Fed. R. Civ. P. 45(a)(4).

U.S. Department of Homeland Security

Notice to Appear

In removal proceedings under section 240 of the Immigration and Nationality Act:

Subject ID: **FINS:**

File No: _____

DOB: Event No:

In the Matter of:

Respondent: _____ currently residing at:

_____

(Number, street, city and ZIP code) (Area code and phone number)

☐ 1. You are an arriving alien.

☐ 2. You are an alien present in the United States who has not been admitted or paroled.

☐ 3. You have been admitted to the United States, but are removable for the reasons stated below.

The Department of Homeland Security alleges that you:

☐ This notice is being issued after an asylum officer has found that the respondent has demonstrated a credible fear of persecution or torture.

☐ Section 235(b)(1) order was vacated pursuant to: ☐ 8CFR 208.30(f)(2) ☐ 8CFR 235.3(b)(5)(iv)

YOU ARE ORDERED to appear before an immigration judge of the United States Department of Justice at:

_____

(Complete Address of Immigration Court, including Room Number, if any)

on _____ at _____ to show why you should not be removed from the United States based on the

(Date) *(Time)*

charge(s) set forth above.

_____

(Signature and Title of Issuing Officer)

Date: _____ _____

(City and State)

See reverse for important information

Form I-862 (Rev. 08/01/07)

INMATE – PATIENT POLICY

PURPOSE STATEMENT: Delineation of the roles and responsibilities of law enforcement and CCRMC and Health Centers ensures that the appropriate safety and security measures are implemented when an Inmate-Patient is seen or admitted to a Contra Costa Health Services facility.

POLICY STATEMENT:

Contra Costa Health provides compassionate, high-quality care to all patients, without distinction or exclusion based on incarceration status. Inmate-Patients are afforded the same rights as patients who are not in custody of a Law Enforcement Agency, except for rights curtailed for the safety and security of the Inmate-Patient, other patients, the staff, and the public.

An Inmate-Patient is a patient who is in Law Enforcement Agency (LEA) custody, including, local, state, tribal, and federal agencies. The LEA that brings an Inmate-Patient to CCCRMC or Health Centers retains complete responsibility for the security, supervision, and custody of the Inmate-Patient for the duration of their medical visit or hospital stay.

The Health Services Security Unit (HSSU) is not responsible for the supervision, care or custody of the Inmate-Patient, including Inmate-Patients in the custody of the Contra Costa County Office of the Sheriff.

To ensure the safety and security of other patients, the Inmate-Patient, staff, and the public, CCRMC and Health Centers staff shall cooperate with all directives given by the LEA. If, in a staff member's opinion, a law enforcement directive will cause or may cause or contribute to a negative medical outcome, or there are other concerns, such as a conflict with hospital policy, the staff member shall promptly escalate this concern to the direct supervisor.

DEFINITIONS:

"In custody" means in the custody of a Law Enforcement Agency.

"Inmate-Patient" means a patient who is in the custody of a Law Enforcement Agency.

"Law Enforcement Agency" or "LEA" means any local, state, tribal, or federal law enforcement agency.

"Responsible officer" means the Law Enforcement Agency representative on site with direct responsibility for the care, custody, and supervision of an Inmate-Patient.

"Officer" means a peace officer, which includes police officers, LEA agents, and Sheriff's Deputies.

"Staff" means the staff of CCRMC and Health Centers.

GUIDELINES:

~~i.~~ I. General Guidelines for Hospital: ~~Staff:~~

A. Law Enforcement Agencies shall be notified of the following CCRMC and Health Centers policies. Staff may provide a copy of this policy to the responsible officer. Staff will report incidents of significant non-adherence to their supervisor.

1. LEA Verification. If an officer brings an Inmate-Patient to CCRMC or a Health Center for a medical visit or hospital admission, staff should take steps to verify the LEA with which the officer is affiliated and request that the officer show identification or credentials (name, agency, and badge number).
2. Video Recording/ Body Cameras. Body worn camera use is at the Officer's discretion, however, staff may request the Officer turn off or adjust the position of the camera to safeguard the privacy of other patients and to attempt to minimize active recording in patient care areas.
3. Restraints Applied by LEA. Nursing staff will check all restraints for adequate circulation and proper fit (skin breaks/tightness) and may pad the restraints if necessary. Officers are required to adhere to Penal Code § 3407: leg restraints, waist chains, or handcuffing behind the body shall not be used on known pregnant Inmate-Patients, or while in recovery after delivery. A pregnant Inmate-Patient in labor, during delivery, or in recovery after delivery, shall not be restrained by the wrists, ankles, or both, unless deemed necessary for the safety and security of the Inmate-Patient, the staff, or the public. Nursing staff shall escalate any concerns about the improper use of restraints to their supervisor.
4. Inmate-Patient Searches. The responsible officer conducts all searches of the Inmate-Patient, their bed, and their immediate surroundings. Staff do not participate in LEA searches.

B. Privacy and Confidentiality. ~~-~~Inmate-Patients do not have all the same rights to control their medical information as individuals who are not in custody. CCRMC and Health Center staff shall follow all established policies and procedures with regard to the disclosure of health information. Requests made by an Officer for the immediate release of an Inmate-Patient's health information should be promptly escalated.

C. Use of Medical Equipment. LEA do not use CCRMC and Health Centers' medical equipment with the exceptions of wheelchairs, crutches, walkers, and other mobility aids as approved by the Charge Nurse. ~~Nurse Program Manager during business hours or to the Medical Center Supervisor outside of business hours. etc.~~

~~D.~~ Visits to Inmate-Patients. All visits to Inmate-Patients are subject to advance approval by the responsible officer, without exception. Staff will notify the officer responsible when a visitor arrives to check in for a visit. Staff may not direct visitors to the Inmate-Patient's location without the express permission of the officer responsible. Staff shall contact HSSU if an unauthorized visitor refuses to leave the premises, attempts entry despite the visit denial, or otherwise fails to abide by CCRMC rules.

Staff are strictly prohibited from accepting cash, personal effects, gifts or another item from the visitor which are intended for the Inmate-Patient. Staff shall notify the officer responsible if a request to do so is made.

Visitors to Inmate-Patients are required to abide by all regular CCRMC visiting rules, such as displaying their visitor pass and observing CCRMC's visiting hours.

~~E.~~D. Telephone Privileges.

1. Upon admission, the telephone will be removed from the Inmate-Patient's bedside and provided to the responsible officer if requested. Telephone privileges are at the discretion of the officer responsible.

2. Outgoing Inmate-Patient telephone calls, when allowed by the officer responsible, will be via collect only.

3. Staff are prohibited from making calls on behalf of an Inmate-Patient

~~F.~~E. Mail Privileges.

1. Incoming mail addressed to an Inmate-Patient shall be given to the officer responsible.

2. Staff are prohibited from mailing any items on behalf of an Inmate-Patient. Staff shall

report any requests made by the Inmate-Patient to the officer responsible.

~~G.~~F. Communication

1. Clinical or patient care concerns ~~will be~~ are communicated to the charge nurse and the ~~designated~~ officer responsible. Administrative issues ~~should be~~are communicated to the Nurse Program Manager during business hours or to the Medical Center outside of business hours.
   ~~Day-to-day issues not relating to the Health Insurance Portability and Accountability Act (HIPAA), will be communicated directly to the unit Charge Nurse and the officer responsible. Administrative issues should be directed to the Nurse Program Manager/designee; on weekends, evening, or night shifts, contact the Medical Center Supervisor by pager (243).~~

~~1.~~2. "No unauthorized communication" shall be posted on the Inmate-Patient's door. ~~Nursing staff are responsible for posting the sign.~~

~~H.~~G. Meal Service/Dietary. Nursing ~~S~~staff shall notify Nutrition Services of Inmate-Patient admissions for safety tray.

~~I.~~H. Special Precautions and Considerations:

1. Use of Bathroom or Shower: The LEA or responsible officer will take special security precautions when Inmate-Patient needs to ambulate or use the bathroom or shower. Nursing staff will communicate with the officer responsible for receiving ~~direction~~directions regarding walks and bathroom use.
2. Discharge Information. Staff ~~is~~are prohibited from disclosing the discharge date in the presence of the Inmate-Patient until immediately prior to discharge. Staff shall inform the responsible officer and receive permission prior to informing the Patient.

~~J.~~I. Responding to Unusual Clinical Events or Emergencies:

1. **Code Blue** (Life threatening): If a Code Blue is called for an Inmate-Patient, the responsible officer will remove all law enforcement applied restraints and stand aside. If the code blue is for a patient in the same room, the Deputy/Officer will stand aside, while staying as close to the door as possible.
2. **Code Red** (fire): In the event of an evacuation, the responsible officer will remain with the Inmate-Patient until the Code Red ends.
3. **Disaster**: ~~In the event of a natural or human-made disaster, the responsible officer receives instructions from the HSSU Chief or designee supervisor.~~In the event of a natural or man-made disaster, the responsible officer shall remain with the Inmate-Patient and shall receive instructions from the HSSU Chief or their designee.

II. General Guidelines for Health Centers:

A. ~~Where~~When possible, Inmate-Patient should not wait to be seen in the general patient waiting areas. If another, more private area is available, ~~the Inmate-Patient and Deputy~~ staff will ~~should be~~ escort~~ed~~ the Inmate-Patient and officer to the designated area. ~~In~~At the Martinez Health Center, four "sub-waiting rooms" are designated for this purpose: 1S, 2S, 3S, 3N.

B. Staff ~~should~~will expedite Inmate-Patients ~~being seen~~ as soon as possible after arrival to minimize their time in the health center.

C. If a surgery is scheduled, ~~If~~ the ~~I~~inmate-~~P~~patient is ~~scheduled for surgery, he or she is~~ requested to sign the relevant paperwork. ~~; nevertheless, t~~For security reasons the ~~I~~inmate-~~P~~patient is not informed of the surgery date ~~for security reasons~~. Relevant paperwork (including the procedure date) is placed in a sealed envelope and handed to the ~~Deputy~~responsible officer ~~for transportation back to the detention facility~~.

D. If a return appointment is required, the Patient-Inmate ~~requires a return appointment he or she~~ will not be informed of the ~~new~~ appointment date and time for security reasons. ~~Again, the r~~Relevant paperwork is placed in a sealed envelope and handed to the responsible officer~~deputy for transportation back to the detention facility~~.

~~**RELATED LINKS: (ADD LINKS)**~~

~~Procedure for Inmates in Health Center (PolicyStat ID 16554674)~~

~~Policy for Obtaining Consent to Photograph, Interview, Publish or Videotape (PolicyStatID 16706893)~~

~~Policy for Partners in Care Visitation (PolicyStat 17417369)~~

~~Policy 129A- Responding to Immigration Enforcement Issues~~

~~**ATTACHMENTS:**~~

~~(Attach relevant policies, such as patients' rights)~~

REFERENCES:

TJC Standard PC 02.01.01 The Hospital provides the patient with care, treatment, and service according to his or her individualized care plan.

California Code of Regulations, Title 22, Section 79799 (22 CCR § 79799) - Inmate-Patients' Rights

Policy for Obtaining Consent to Photograph, Interview, Publish or Videotape (PolicyStat ID 16706893)

Policy for Partners in Care Visitation (PolicyStat ID 17417369)

Policy 129A- Responding to Immigration Enforcement Issues

APPROVALS:

David Culberson, CEO, Contra Costa Regional Medical Center and Health Centers, 11/10/25

Dr. Grant Colfax, CEO and Director Health Services, 11/10/25

Status **Pending** PolicyStat ID **19308963**

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Next Review	3 years after approval

Owner	David Piccinati: Associate Medical Director
Area	Hospital & Health Centers

Policy for Consent to Medical Treatment

POLICY STATEMENT:

This policy outlines the importance of obtaining the consent of patients receiving medical treatment at Contra Costa Regional Medical Center and Health Centers (CCRMC & HC). It is the ~~physician's or provider~~practitioner's duty to inform the patient about the recommended care and of the alternatives, including risks of ~~refusing to undergo~~declining the recommended procedure. ~~Staff~~When written consent is ~~responsible to obtain the signature of the patient after the physician has completely~~required (procedure with anesthesia, deep sedation, or procedural sedation), staff will verify documentation of written informed ~~and consented the patient except for the minor procedures~~consent prior to the procedure.

GUIDELINES:

During hospitalization or clinic treatment, important rights of a patient are affected. The consent of the patient to those activities of the treating ~~physician~~practitioner(s) and health services personnel which might affect those rights, establishes a defense to any subsequent charge that such rights were transgressed without permission.

Both personal and property rights of the patient are affected during the treatment process. Of paramount concern is the potential for committing a battery against the patient. A charge of battery can arise out of the slightest physical contact and would include treatment without patient consent.

~~Due to the nature of hospitalization and medical treatment, the courts have held that the patient's consent, depending on the complexity of treatment, must be informed. The principle of informed consent is met when the signer:~~

A. ~~knows what they/he/she is signing~~

B. ~~knows what procedures are being recommended or contemplated~~

C. ~~knows what alternative methods of treatment are available~~

D. ~~knows the risks and benefits involved and the expected outcome of the treatment and its alternative(s).~~

In order to give informed consent, the patient must be informed of:

1. The nature of the procedure;
2. The risks, complications, and expected benefits or effects of the procedure and expected outcome;
3. Any alternatives to the treatment and their risks and benefits (including the alternative of deciding not to have the procedure);
4. Any potentially conflicting interest the provider may have, such as research or financial interests.

Informed consent should be used for treatments and procedures that are complicated in that the average layperson would not understand the nature of the treatment or procedure and associated risks and benefits without additional explanation. For example: a medical procedure performed in the operating room.

Simple consent is required for treatments or procedures where risks and benefits are commonly understood by the average layperson and activities where consent is included in Consent to Services (See Attachments). Simple consent is needed for hospital and clinic lab personnel to draw blood for anonymous HIV testing on behalf of the Public Health Department. Other examples include chest x-ray and nursing services.

The activities related to hospitalization also raise the potential for allegations of false imprisonment and invasion of privacy. Evidence of the patient's informed consent establishes a defense for the attending physician(s) and CCRMC & HC.

CCRMC & HC will not permit any medical treatment (except for emergency treatment) unless the patient or a person legally authorized to act on the patient's behalf has consented thereto.

Consent to medical treatment must be freely given by the patient or legally authorized representative and will not be obtained through the exercise of either duress or coercion. ~~A patient's informed consent for surgery/diagnostic/therapeutic~~Consent for these procedures ~~will be evidenced in writing. Consent for these procedures~~ is valid for maximum of three (3) months from date of ~~signing~~informed consent unless ~~the specific consent form states~~stated otherwise.

~~Simple consent is required for treatments or procedures where risks and benefits are commonly understood by the average layperson and activities where consent is included in Consent to Treat. Simple consent is needed for hospital and clinic lab personnel to draw blood for anonymous HIV testing on behalf of the Public Health Department. Other examples include chest x-ray and nursing services.~~

~~As per the Centers for Medicare and Medicaid Services~~Procedures which require anesthesia, ~~procedures~~

whichdeep sedation, or procedural sedation require anesthesiaa written informed consent (deep sedation or anesthesiaAttachment A: Procedure or Treatment Consent) require a written. The information discussed during informed consent with information about the risks, benefits, and alternatives of the procedure. The information discussed during informed consent should be documented in the medical record. Patients undergoingThis consent can be documented either on a procedure with anesthesia or deep sedation require a written consent. This form or as an electronic consent can be documented either on a procedure consent form or as an electronic consent in the electronicin the medical record. Patients undergoing a procedure without anesthesia nor deep sedation may consent verbally but the discussion of the risks, benefits and alternatives should be documented in the medical record. In all cases, the patient should be informed of the type of procedure, its risks, benefits and alternatives as part of the consent process.

For procedures which do not require anesthesiawritten informed consent, a verbal informed consent is sufficient. The verbal consent should include the risks, benefits or alternatives to the procedure and estimated recovery times when appropriateelements discussed above. The consent discussion should be documented in a procedure notethe medical record. Topical or local analgesia such as a lidocaine injection is **not** considered anesthesia (ie. does not cause sedation or change in consciousness.)

Notwithstanding the consent described in this paragraph, if the undersigned is a foster parent (as defined by Health and Safety Code section 1527), the consent only applies to ordinary medical treatment (including, but not limited to, immunizations, physical examinations, and X-rays) in accordance with Health and Safety Code section 1530.6 and as otherwise prescribed by the juvenile court.

RELATED LINKS:

Procedure for Consent to Medical Treatment

Procedure for Consent to Medical Treatment
Attachment A:Attachment A: Contra Costa Regional Medical Center and Health Centers Procedure or Treatment Consent
Attachment B: CHA Decision Makers for Medical Treatment of Adults (https://calhospital.org/wp-content/uploads/2021/04/quickreferenceguides.pdf)
Attachment C:

Attachment B: CHA Decision Makers for Medical Treatment of Adults

Attachment C:

1. CHA Consent Requirements for Medical Treatment of Minors (https://calhospital.org/wp-content/uploads/2021/04/quickreferenceguides.pdf)
2. Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent (MR44-7 and MR 44-A-1)
3. MR 497-6 Authorization for Minor to Receive Follow-Up Outpatient Treatment Without Presence of Parental/Legal Representative
4. Caregiver's Authorization Affidavit, MR 673 (English), MR 674 (Spanish)
5. MR 99-4 Self-sufficient Minor Information Form

6. Authorization by Juvenile Court for Treatment of a Minor (MR 498)

Attachment D: Procedure Specific Consents and Referenced California Law

California law requires that consent be obtained in writing for certain procedures and for treatments for specific types of conditions, including:

1. sterilizations, Cal. Admin. Code §§ 51305.1 - 51305.4.
2. hysterectomy, Cal. Health & Safety Code § 1690.
3. breast cancer, Cal. Health & Safety Code § 109275.
4. prostate cancer, Cal. Health & Safety Code § 109280 and § 109282.
5. gynecological cancers, Cal. Health & Safety Code § 109278.
6. psychosurgery, Cal. Welfare & Institutions Code § 5326.6 and electroconvulsive therapy, Cal.

Attachment E: Refusal to Permit Medical Treatment (MR242)

Attachment ~~D: Procedure Specific Consents and Referenced California Law~~
~~Attachment E:~~ Refusal to Permit Medical Treatment (MR242)
~~Attachment~~ F: Consent for Blood or Blood Products Transfusion (MR39C) and CDPH "A Patient's Guide to Blood Transfusion." 03/2022 A Patient's Guide to Blood Transfusion | MBC (ca.gov)
~~Attachment G: Limited English Proficiency policy~~
~~Attachment H. 4V Minor Consent Medi-Cal Services https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEPM/4V-MinorConsent-12-16-21.pdf~~

Attachment G: Procedure for Patient Interpreter Services

Attachment H. 4V Minor Consent Medi-Cal Services

REFERENCES:

~~Centers for Medicare and Medicaid Services Memo# QSO-24-10 Hospitals. 4.1.2024~~
~~California Hospital Association: *2024 Consent Manual: Patient consent to treatment and related health care law* (50th edition, 2024)~~
~~Health Services Department Policies and Procedures, Policy No. 402 – "Access to Services for Limited English Proficient, Deaf and Hearing Impaired Persons"~~
~~The Joint Commission Standard RI.01.01.01, "The hospital respects, protects and promotes patient rights."~~
~~The Joint Commission Standard RI.01.03.01, "The hospital honors the patient's right to give or withhold informed consent."~~
~~AMA Code of Medical Ethics, 2.1.2 Decisions for Adult Patients Who Lack Capacity~~
~~22 California Code of Regulations §§ 51305.1 - 51305.4~~
~~California Welfare & Institutions Code §§ 5326.5 and 5326.6~~
~~California Penal Code § 242, People v. Longoria, 34 Cal. App. 4th 12, 14~~

Centers for Medicare and Medicaid Services Memo# QSO-24-10 Hospitals. 4.1.2024

California Hospital Association: *2024 Consent Manual: Patient consent to treatment and related health care law* (50th edition, 2024)

Health Services Department Policies and Procedures, Policy No. 402 – "Access to Services for Limited English Proficient, Deaf and Hearing Impaired Persons"

The Joint Commission Standard RI.01.01.01, "The hospital respects, protects and promotes patient rights."

The Joint Commission Standard RI.01.03.01, "The hospital honors the patient's right to give or withhold informed consent."

AMA Code of Medical Ethics, 2.1.2 Decisions for Adult Patients Who Lack Capacity

22 California Code of Regulations §§ 51305.1 - 51305.4

California Welfare & Institutions Code §§ 5326.5 and 5326.6

California Penal Code § 242, People v. Longoria, 34 Cal. App. 4th 12, 14

APPROVALS:

Patient Care Policy and Evaluation Committee: 2/2023, 12/2023, 9/2024
Medical Executive Committee: 2/2023, 12/2023, 09/2024, 9/2024
Joint Conference Committee: 3/2023, 3/2024, 3/2025

Attachments

CONSENT TO SERVICES and CONDITIONS OF SERVICES OR ADMISSION.pdf

Definition of General Anesthesia and Levels of Sedation-Analgesia.docx

Approval Signatures

Step Description	Approver	Date
Ambulatory Clinical Practice Committee	Helena Martey: Chief Nursing Officer - Interim	Pending
	David Piccinati: Associate Medical Director	11/2025

Standards

No standards are associated with this document

History

Comment by Piccinati, David: Associate Medical Director on 11/14/2025, 12:34PM EST

> I updated all the links and made sure they point to the relevant documents in policystat, other than the below:
> - Authorization by Juvenile Court for Treatment of a Minor (MR 498) is not available on PolicyStat

Draft saved by Piccinati, David: Associate Medical Director on 11/14/2025, 2:49PM EST

Edited by Piccinati, David: Associate Medical Director on 11/14/2025, 2:57PM EST

> Updates for 2024 CMS/CHA guidelines. Clarifies necessary aspect of informed consent. Allows for APPs as practitioners. Other verbiage updates to make more in line with CMS guidelines. The actual consent form has been significantly revamped as well.

Last Approved by Piccinati, David: Associate Medical Director on 11/14/2025, 2:57PM EST

Status **Pending** PolicyStat ID **19308958**

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Owner	David Piccinati: Associate Medical Director
Area	Hospital & Health Centers

Procedure for Consent to Medical Treatment

PURPOSE STATEMENT:

Obtaining the consent of patients receiving medical treatment at Contra Costa Regional Medical Center and Health Centers (~~CCH~~CCRMC & HC) must be performed. This document provides direction related to obtaining consent staff may encounter when caring for a patient.

As a general rule, patient consent should be documented in writing. The Consent to Services and Conditions of Services or Admission (see attachment) contains a clause that documents the patient's consent to uncomplicated procedures such as routine blood tests, X-rays, nursing and other services that may be performed during the patient's hospitalization, outpatient visit, or emergency room treatment. This is also known as simple consent.

Conversely, informed consent should be used for treatments and procedures that are complicated in that the average layperson would not understand the nature of the treatment or procedure and associated risks and benefits. For example: a medical procedure performed in the operating room.

PROCEDURE:

~~Routine Procedure~~

- ~~A. Physician or proceduralist - The physician or proceduralist is responsible for providing and documenting information, which includes the nature of the treatment, its risks and benefits, alternatives.~~
  - ~~1. It is required that the physician or proceduralist document in the medical record that a discussion was held with the patient and that informed consent was obtained. Patients undergoing a procedure with anesthesia or deep sedation require a written~~

consent. This consent can be documented either on a procedure consent form or as an electronic consent in the electronic medical record.

2. Patients undergoing a procedure without anesthesia or deep sedation may consent verbally. The information discussed during informed consent should be documented in the electronic medical record as a procedure note or an electronic consent
3. If a surgery or procedure is scheduled by a resident, the name of the staff physician authorizing the surgery, supervising the resident, and participating in the informed consent must be recorded in the medical record.
4. The physician or proceduralist must write the following on the consent form: the name of the procedure to be performed, the name of the physician giving the informed consent and the name of the expected surgeon(s) including any residents in training. The physician or proceduralist should document the information provided to the patient regarding the procedure, risks, benefits, and alternative treatments in a medical record note. See Attachment A: Contra Costa Health Procedure or Treatment Consent.
5. Sensitive exams such as breast, pelvic, prostate or rectal exams must be consented for by the patient and must also include obtaining the patient's consent when a training or education related exam is performed outside of the medically necessary procedure.
6. Nurse - will verify documentation of written informed consent prior to procedures requiring anesthesia or deep sedation.

B. Patient (Adult) - The patient or his/her/their legal representative signs and dates the consent form. For examples of legal representatives see Attachment C: CHA Decision Makers for Medical Treatment of Adults.
Patient (Minor) - For minors see Attachment D: CHA Consent Requirements for Medical Treatment of Minors and linked policies for special situations in policy Consent for Medical Treatment of Minors Ambulatory Care Policy 3006. Legal caregivers must sign Caregiver's Authorization Affidavit (MR673) attesting to the above prior to giving consent.

C. Witness:

1. The witness signature is only required in specific circumstances:
    a. Psychosurgery
    b. Refusal of care forms (blood, AMA, RhoD admin., prophylactic newborn eye treatment, newborn screening, etc.)
    c. Research (Institutional Review Board or IRB)
    d. Patient's mark is required in lieu of signature. If the person who is required to sign is physically unable to write his or her name but has mental capacity to make the decision, the person's mark should be obtained. This is done by the hospital representative first writing the person's name in full and then having the person place an "X" beneath it. Note: two people shall witness the person place his or her mark on the consent form, and both shall sign the consent form as witnesses.
    e. Patient declines to sign due to religious beliefs.

f. ~~Advanced Health Care Directive, Anatomical Donor Form or Certificate of Religious Belief. Note: Two witnesses are required for advanced healthcare directive, anatomical donor form, or certificate of religious belief.~~

2. ~~The witness must be over 18 years of age and a responsible employee of the facility (i.e., RN, LVN, MA, admitting clerk). This person shall observe the patient signing the consent form, sign his/her own name as a witness to the patient's signature, and enter the date and time of the patient's signature. The witness is not responsible for the content of the form.~~

D. ~~Procedure - Specific Consents:~~
~~California law requires that consent be obtained in writing for certain procedures and for treatments for specific types of conditions, including (see Attachment E):~~

1. ~~sterilizations, Cal. Admin. Code §§ 51305.1 - 51305.4.~~
2. ~~hysterectomy, Cal. Health & Safety Code § 1690.~~
3. ~~breast cancer, Cal. Health & Safety Code § 109275.~~
4. ~~prostate cancer, Cal. Health & Safety Code § 109280 and § 109282.~~
5. ~~gynecological cancers, Cal. Health & Safety Code § 109278.~~
6. ~~psychosurgery, Cal. Welfare & Institutions Code § 5326.6 and~~
7. ~~electroconvulsive therapy, Cal. Welfare & Institutions Code § 5326.6~~

E. ~~Distribution of copies:~~
~~The original copy of the consent form is sent to the Health Information Management (HIM) Department for scanning into the patient's medical record. A copy of the original consent form may be given to the patient. An electronic copy of a surgical consent form will be accepted by the performing department.~~

~~Blood Transfusion Consent~~

WHO CAN OBTAIN INFORMED CONSENT

The disclosure of the material information and obtaining informed consent shall be the responsibility of the licensed healthcare practitioner (hereto referred to as “practitioner”) who, acting within the scope of their professional licensure, performs or orders the procedure or treatment for which informed consent is required. (Cal. Code Regs. Tit. 22, § 73524)

ROUTINE PROCEDURE

A. In order to give informed consent, the patient must be informed of:

1. The nature of the procedure;
2. The risks, complications, and expected benefits or effects of the procedure including its likelihood of success;
3. Reasonable alternatives to the treatment and their risks and benefits (including the

alternative of deciding not to have the procedure);

4. Any potentially conflicting interest the practitioner may have, such as research or financial interests.

B. It is required that the practitioner document in the medical record that a discussion was held with the patient and that informed consent was obtained.

1. Patients undergoing a procedure with anesthesia, deep sedation, or procedural sedation require a written consent. This consent can be documented either on a procedure consent form (Attachment A: Procedure or Treatment Consent) or as an electronic consent in the electronic medical record.

    a. The practitioner must write the following on the consent form: the name of the procedure to be performed and the name of the practitioner giving the informed consent. The practitioner should also document the information provided to the patient.

    b. Nurse - will verify documentation of written informed consent prior to procedures requiring written consent.

    c. Patient (Adult) - The patient or their legal representative signs and dates the consent form.

    d. Patient (Minor) - For minors see Attachment D: CHA Consent Requirements for Medical Treatment of Minors and linked policies for special situations. Legal caregivers must sign Caregiver's Authorization Affidavit (MR 673) attesting to the above prior to giving consent.

    e. Distribution of copies: The original copy of the consent form is sent to the Health Information Management (HIM) Department for scanning into the patient's medical record. A copy of the original consent form may be given to the patient. An electronic copy of a surgical consent form will be accepted in lieu of a paper form.

2. Patients undergoing a procedure not requiring written consent may consent verbally. The information discussed during informed consent should be documented in the medical record.

3. Consent must be provided if practitioners other than the operating practitioner will be performing examinations or invasive procedures conducted for educational and training purposes. Other practitioners include, but are not limited to, other physicians, residents, advanced practice providers, and medical and other applicable students (such as nurse practitioner and physician assistant).

    These examinations or invasive procedures conducted for educational and training purposes include, but are not limited to, breast, pelvic, prostate, and rectal examinations, as well as others specified under state law. A written consent form is

required for patients undergoing anesthesia procedures, but patients with the ability to verbally affirm consent for procedures that do not require anesthesia should have their medical record reflect that consent was given. In both instances there is written documentation of consent for any examinations.

C. Identification of the Non-Primary Practitioner(s)

1. Practitioners other than the operating practitioner, including but not limited to residents, who will perform important tasks related to the surgery, in accordance with the hospital's policies (and in the case of residents, based on their skill set and under the supervision of the responsible practitioner); and

2. Qualified medical practitioners who are not physicians will perform important parts of the surgery or administration of anesthesia within their scope of practice and for which they have been granted privileges by the hospital.

D. Procedure - Specific Consents:

1. California law requires that specific consent be obtained in writing for certain additional procedures and for treatments for specific types of conditions (see Attachment E).

WITNESSES

The witness signature is only required in specific circumstances:

1. Psychosurgery
2. Refusal of care forms (blood, AMA, RhoD admin., prophylactic newborn eye treatment, newborn screening, etc.)
3. Research (Institutional Review Board or IRB)
4. Patient's mark is required in lieu of signature. If the person who is required to sign is physically unable to write their name but has mental capacity to make the decision, the person's mark should be obtained. This is done by the hospital representative first writing the person's name in full and then having the person place an "X" beneath it. If the patient is unable to place an "X" have the patient communicate their decision using the chosen method. Immediately document the patient's decision in the record, the method used, the names of individuals assisting (if any), the time and date. **Note: two people shall witness the person place their mark on the consent form, and both shall sign the consent form as witnesses.**
5. Patient declines to sign due to religious beliefs.
6. Advanced Health Care Directive, Anatomical Donor Form or Certificate of Religious Belief. Note: Two witnesses are required for advanced healthcare directive, anatomical donor form, or certificate of religious belief.

The witness must be over 18 years of age and a responsible employee of the facility (i.e., RN, LVN, MA,

admitting clerk). This person shall observe the patient signing the consent form, sign his/her own name as a witness to the patient's signature, and enter the date and time of the patient's signature. The witness is not responsible for the content of the form.

BLOOD TRANSFUSION CONSENT

A. ~~Informed patient consent for blood product transfusion is required to ensure that patients are informed of the very small but real risks of infectious diseases or allergic reactions and to give individuals with personal or religious objections to transfusion the opportunity to refuse (even if lifesaving).~~

   Informed patient consent for blood product transfusion is required to ensure that patients are informed of the very small but real risks of infectious diseases or allergic reactions and to give individuals with personal or religious objections to transfusion the opportunity to refuse (even if lifesaving).

B. ~~Informed patient consent is required for elective (planned) surgery where there is a likelihood of need for transfusion:~~

   Informed patient consent is required for elective (planned) surgery where there is a reasonable likelihood of need for transfusion:

   1. ~~Patients must be given the opportunity to donate autologous blood preoperatively (Gann Act).~~

      Patients must be given the opportunity to donate autologous blood preoperatively (Gann Act).

   2. If the surgery is elective (no life-threatening emergency) and it is medically feasible to collect the patient's blood ahead of time, the hospital and physician should allow adequate time for autologous donation.

   3. If the patient declines autologous donation or explicitly waives the waiting time, that is permissible

   4. ~~One consent is valid for each admission so long as transfusions are for the same indication or condition. However, a new consent must be obtained for each admission or for different indications.~~

      One consent is valid for each admission so long as transfusions are for the same indication or condition. However, a new consent must be obtained for each admission or for different indications.

C. ~~In emergencies, see Emergency Treatment Exception, above.~~

   In emergencies, see Emergency Treatment Exception, below.

D. ~~See Attachment G: "Consent for Blood or Blood Products Transfusion" (MR39C)Attachment HCDPH "A Patient's Guide to Blood Transfusion."~~ A Patient's Guide to Blood Transfusion | MBC ~~(ca.gov)~~

See Attachment G: "Consent for Blood or Blood Products Transfusion" (MR39C) Attachment HCDPH "A Patient's Guide to Blood Transfusion." A Patient's Guide to Blood Transfusion | MBC (ca.gov)

~~Emergency Treatment Exception~~

EMERGENCY TREATMENT EXCEPTION

The emergency treatment exception applies only when consent cannot be given by the patient or the patient's legal representative. In the case of a medical emergency, a ~~physician~~practitioner must determine whether the treatment appears to be immediately required and necessary to prevent the patient's death, severe disability or to alleviate severe pain. If treatment is immediately required for above stated reasons, medical treatment may begin with justification documented by the ~~physician~~practitioner in the medical record. Emergency consent is the only type of consent which may be documented after treatment due to the urgency of the treatment.

~~Consent by Telephone, Voice or Video Call~~

~~Consent obtained via telephone or video call - surgeon or proceduralist will obtain informed consent for the procedure from designated family member, power of attorney or other trusted person stated by the patient. Nurse will verify informed consent with the person providing via the telephone or video call.~~

~~Securing Consent from Limited English Proficiency Patients~~

Other Circumstances in Which a Practitioner is Not Required to Obtain Informed Consent

A. When the patient has requested that they not be so informed

B. If the practitioner believes that such disclosure would seriously harm, rather than benefit, the patient ("therapeutic privilege")

Neither exception should be relied upon by the practitioner unless it is extremely clear that the facts and circumstances of the case justify invoking it. The practitioner's decision to not disclose information will be measured in terms of what "a reasonable person" would have done, not what another practitioner would have done.

The practitioner should fully document in the patient's medical record the facts that resulted in this conclusion. The practitioner should also document what, if any, information was disclosed to the patient.

Consent by Telephone, Voice or Video Call

If the practitioner states that they have obtained consent to treat the patient, hospital personnel should verify that the patient's legal representative and practitioner have discussed the patient's condition and the recommended treatment and that the patient's legal representative has, in fact, given consent. If the treatment requires informed consent, hospital personnel should verify that the patient's representative has given informed consent. However, hospital employees should not attempt to answer questions

about the nature of the treatment or its risks, benefits, and alternatives. These questions should be answered only by the responsible practitioner.

Securing Consent from Limited English Proficiency Patients

If a patient or the patient's legal representative cannot communicate with the ~~physician~~practitioner because of language or communication barriers, the ~~physician~~practitioner will utilize our ~~Health Care Interpreter Network for translation~~contracted interpreter services. The interpreter's responsibilities include translating the recommended medical treatment that the patient or patient's legal representative needs to receive before deciding whether to give consent. After interpretation has been completed, the consent form is signed by the patient or the patient's legal representative.

Certified bilingual ~~providers~~practitioners may provide informed consent to a patient for a procedure that the ~~provider~~practitioner is familiar with in their certified bilingual language.

If the patient ~~declines~~refuses an interpreter and requests a family member, friend or other accompanying person interpret, this is permitted and should be documented in the consent note. ~~See (~~Attachment ~~I Limited English Proficiency Policy.~~H: Procedure for Patient Interpreter Services)

~~Consent for Recurring Procedures~~

Consent for Recurring Procedures

For recurring treatments or procedures such as infusions (i.e. chemotherapy, IVIG, blood/blood products), or serial debridement, it is not required to provide an informed consent each episode. The initial consent should note that it pertains to recurring treatments or procedures. The patient's consent remains in effect until the patient revokes it or if the patient's condition or circumstances change enough to affect the nature of the treatment or procedure, the risks or the alternatives. A new consent should be initiated.

~~Refusal to Consent~~

Refusal to Consent

If a patient or patient's legal representative refuses to consent to a medical treatment which has been recommended ~~to they/her/him by a physician~~by a practitioner, ~~a Refusal to Permit Medical Treatment (MR-242), or other appropriate refusal form or~~this shall be documented in a detailed note~~, shall be completed and scanned into~~ in the patient~~'~~'s medical record. ~~See Attachment F.~~

The ~~physician~~practitioner should discuss with the patient or patient's legal representative, the nature of the treatment, its risks and benefits, its alternatives and their risks and benefits, and the consequences of refusing the treatment. Information about the patient's legal representative such as relationship and name should be included in the ~~physician'~~practitioner's documentation of a consent by telephone, voice or video call.

~~Incorrect or Incomplete Consent~~

Incorrect or Incomplete Consent

When an incorrect or incomplete consent is identified, the staff member who discovers the issue will inform the ~~physician or proceduralist~~practitioner in order to complete a new consent prior to procedure.

~~Decisions for Adult Patients Who Lack Capacity~~

Decisions for Adult Patients Who Lack Capacity

Respect for patient autonomy is central to professional ethics and ~~physicians~~practitioners should involve patients in health care decisions commensurate with the patient's decision-making capacity. Even when a medical condition or disorder impairs a patient's decision-making capacity, the patient may still be able to participate in some aspects of decision making. ~~Physicians~~Practitioners should engage patients with impaired capacity in decisions involving their own care to the greatest extent possible, including when the patient has previously designated a surrogate to make decisions on his or her behalf.

~~When a patient lacks decision-making capacity, the physician has an ethical responsibility to:~~

If an adult patient lacks the capacity to make a health care decision, the following people may make health care decisions on the patient's behalf, in the following descending order of priority:

A. The patient's orally designated surrogate if named during a period in which the patient was deemed to have capacity.
    1. The designation of a surrogate is effective only during the course of treatment/ illness, during the hospital stay, or for 60 days, whichever period is shorter.
B. The patient's agent named in an advance health care directive or a power of attorney for health care.
C. The conservator or guardian of the patient having the authority to make health care decisions for the patient.

If a patient lacks the capacity to make a health care decision but does not have a decision maker listed above (an orally designated surrogate, agent, conservator, or guardian), then a health care provider may choose a surrogate from the list below, as appropriate in the given situation. The surrogate must be an adult who has demonstrated special care and concern for the patient, is familiar with the patient's personal values and beliefs to the extent known, and is reasonably available and willing to serve. A surrogate may be chosen from any of the following persons:

A. The patient's spouse or domestic partner.
B. An adult child of the patient.
C. A parent of the patient.
D. An adult sibling of the patient.
E. An adult grandchild of the patient.

F. An adult relative or close personal friend.

Although there is a hierarchy or priority among potential decision makers if a patient has an orally designated surrogate, agent, conservator, or guardian, there is no hierarchy or priority among the rest of the above-listed potential surrogates.

Consult an ethics committee or other institutional resource when:

A. No surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;

B. Ongoing disagreement about a treatment decision cannot be resolved; or

C. The practitioner determines that the surrogate's decision:

D. Is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;

E. Could not reasonably be judged to be in the patient's best interest;

F. Primarily serves the interests of the surrogate or other third party rather than the patient.

Legal Consent Requirements for Medical Treatment of Minors:

A. ~~Identify an appropriate surrogate to make decisions on the patient's behalf:~~

1. ~~The person the patient designated as surrogate through a durable power of attorney for health care or other mechanism; or~~
2. ~~A family member or other intimate associate, in keeping with applicable law and policy if the patient has not previously designated a surrogate.~~
3. ~~The patient's legal representative, such as a court-appointed conservator.~~

B. ~~Recognize that the patient's surrogate is entitled to the same respect as the patient.~~

C. ~~Provide advice, guidance, and support to the surrogate.~~

D. ~~Assist the surrogate in making decisions in accordance with the standard of substituted judgment, basing decisions on:~~

1. ~~The patient's preferences (if any) as expressed in an advance directive or as documented in the medical record;~~
2. ~~The patient's views about life and how it should be lived;~~
3. ~~The patient's attitudes toward sickness, suffering, and certain medical procedures.~~

E. ~~Assist the surrogate in making decisions in accordance with the best interest standard when the patient's preferences and values are not known and cannot reasonably be inferred, such as when the patient has not previously expressed preferences or has never had decision-making capacity. Best interest decisions should be based on:~~

1. ~~The pain and suffering associated with the intervention;~~

2. ~~The degree of and potential for benefit;~~
3. ~~Impairments that may result from the intervention;~~
4. ~~Quality of life as experienced by the patient.~~

F. ~~Consult an ethics committee or other institutional resource when:~~
   1. ~~No surrogate is available or there is ongoing disagreement about who is the appropriate surrogate;~~
   2. ~~Ongoing disagreement about a treatment decision cannot be resolved; or~~
   3. ~~The physician determines that the surrogate's decision:~~
      a. ~~Is clearly not what the patient would have decided when the patient's preferences are known or can be inferred;~~
      b. ~~Could not reasonably be judged to be in the patient's best interest;~~
      c. ~~Primarily serves the interests of the surrogate or other third party rather than the patient.~~

G. California Family Code provides that a minor may, without parental consent, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling. Attachment I: 4V Minor Consent Medi-Cal Services.

H. Except in emergency situations (and some special situations listed under paragraph D below,) minors (under 18 years of age) who present at the hospital or health center must be accompanied by or must have authorization from a parent, foster parent, legal representative, or authorized caregiver to receive care.

I. Please see special consent situations for minors (See Attachment D, CHA Consent Requirements for medical treatment of Minors.)

J. ~~Legal Consent Requirements for Medical Treatment of Minors:~~
   1. ~~California Family Code provides that a minor may, **without parental consent**, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling. Attachment J: 4V *Minor Consent Medi-Cal Services*.~~
   2. ~~Except in emergency situations (and some special situations listed under #4 below,) minors (under 18 years of age) who present at the hospital or health center must be accompanied by or must have authorization from a parent, foster parent, legal representative, or authorized caregiver to receive care.~~
   3. ~~Please see special consent situations for minors (See Attachment D, *CHA Consent Requirements for medical treatment of Minors*.)~~
   4. ~~The above guidelines apply to non-emergent medical care provided to minors. Emergency medical care may be provided to a minor. The emergency treatment exception applies only when consent cannot be given by the minor's legal representative. In the case of a medical emergency, a physician must determine~~

~~whether the treatment appears to be immediately required and necessary to prevent the patient's death, severe disability or to alleviate severe pain. If treatment is immediately required for above stated reasons, medical treatment may begin with justification documented by the physician in the medical record. Emergency consent is the only type of consent which may be documented after treatment due to the urgency of the treatment.~~

The above guidelines apply to non-emergent medical care provided to minors. Emergency medical care may be provided to a minor. The emergency treatment exception applies only when consent cannot be given by the minor's legal representative. In the case of a medical emergency, a practitioner must determine whether the treatment appears to be immediately required and necessary to prevent the patient's death, severe disability or to alleviate severe pain. If treatment is immediately required for above stated reasons, medical treatment may begin with justification documented by the practitioner in the medical record. Emergency consent is the only type of consent which may be documented after treatment due to the urgency of the treatment.

RELATED LINKS:

Policy for Consent to Medical Treatment

~~Attachment A: Contra Costa Regional Medical Center and Health Centers Procedure or Treatment Consent~~Attachment A: Contra Costa Regional Medical Center and Health Centers Procedure or Treatment Consent

Attachment B: CHA Decision Makers for Medical Treatment of Adults

Attachment C:

1. ~~CHA Consent Requirements for Medical Treatment of Minors (https://calhospital.org/wp-content/uploads/2021/04/quickreferenceguides.pdf)~~CHA Consent Requirements for Medical Treatment of Minors
2. Authorization for Third Party to Consent to Treatment of Minor Lacking Capacity to Consent (~~MR44-7 and MR44-A-1~~MR44-7 and MR 44-A-1)
3. ~~Authorization for Minor to Receive Follow-up Outpatient Treatment Without Presence of Parent/Legal Representation (MR497-6)~~MR 497-6 Authorization for Minor to Receive Follow-Up Outpatient Treatment Without Presence of Parental/Legal Representative
4. Caregiver's Authorization Affidavit, ~~MR673 (English)~~MR 673 (English), ~~MR674 (Spanish)~~MR 674 (Spanish)
5. ~~Self-sufficient Minor Information Form (MR99-4)~~MR 99-4 Self-sufficient Minor Information Form
6. Authorization by Juvenile Court for Treatment of a Minor (MR 498)

Attachment ~~E~~D: Procedure Specific Consents and Referenced California Law

California law requires that consent be obtained in writing for certain procedures and for treatments for specific types of conditions, including (see Attachment E):

1. sterilizations, Cal. Admin. Code §§ 51305.1 - 51305.4.
2. hysterectomy, Cal. Health & Safety Code § 1690.
3. breast cancer, Cal. Health & Safety Code § 109275.
4. prostate cancer, Cal. Health & Safety Code § 109280 and § 109282.
5. gynecological cancers, Cal. Health & Safety Code § 109278.
6. psychosurgery, Cal. Welfare & Institutions Code § 5326.6 and electroconvulsive therapy, Cal. Welfare & Institutions Code § 5326.6

Attachment ~~F~~E: Refusal to Permit Medical Treatment (MR242)

Attachment ~~G~~F: ~~Consent for Blood or Blood Products Transfusion (MR39C)~~Consent for Blood or Blood Products Transfusion (MR39C) and CDPH "A Patient's Guide to Blood Transfusion." June 2018 A Patient's Guide to Blood Transfusion | MBC (ca.gov)

~~Attachment H: Limited English Proficiency policy~~

~~Attachment I: 4V Minor Consent Medi-Cal Services https://www.dhcs.ca.gov/services/medi-cal/eligibility/Documents/MEPM/4V-MinorConsent-12-16-21.pdf~~

Attachment H: Procedure for Patient Interpreter Services

Attachment I: 4V Minor Consent Medi-Cal Services

REFERENCES:

Centers for Medicare and Medicaid Services Memo# QSO-24-10 Hospitals. 4.1.2024

California Hospital Association: *2024 Consent Manual: Patient consent to treatment and related health care law* (50th edition, 2024)

Health Services Department Policies and Procedures, Policy No. 402 – "Access to Services for Limited English Proficient, Deaf and Hearing Impaired Persons"

The Joint Commission Standard RI.01.01.01, "The hospital respects, protects and promotes patient rights."

The Joint Commission Standard RI.01.03.01, "The hospital honors the patient's right to give or withhold inormed consent."

AMA Code of Medical Ethics, 2.1.2 Decisions for Adult Patients Who Lack Capacity

22 California Code of Regulations §§ 51305.1 - 51305.4

California Welfare & Institutions Code §§ 5326.5 and 5326.6

California Penal Code § 242, People v. Longoria, 34 Cal. App. 4th 12, 14

APPROVALS:

Clinical Practice Committee/Ambulatory Clinical Practice Committee: 9/24

Patient Care Policy and Evaluation Committee: 2/2023, 9/24

Medical Executive Committee: 2/2023, 9/24

Attachments

CONSENT TO SERVICES and CONDITIONS OF SERVICES OR ADMISSION.pdf

Approval Signatures

Step Description	Approver	Date
Ambulatory Clinical Practice Committee	Helena Martey: Chief Nursing Officer - Interim	Pending
	David Piccinati: Associate Medical Director	11/2025

Standards

No standards are associated with this document

History

Draft saved by Piccinati, David: Associate Medical Director on 11/14/2025, 2:53PM EST

Edited by Piccinati, David: Associate Medical Director on 11/14/2025, 2:57PM EST

> Updates for 2024 CMS/CHA guidelines. Clarifies necessary aspect of informed consent. Allows for APPs as practitioners. Other verbiage updates to make more in line with CMS guidelines. The actual consent form has been significantly revamped as well.

Last Approved by Piccinati, David: Associate Medical Director on 11/14/2025, 2:57PM EST

File #: 25-4950 **Agenda Date:** 11/24/2025 **Agenda #:** 5.

Advisory Board: Medical Services (CCRMC) Joint Conference Committee and Professional Affairs Committee
Subject: Medical Staff Update
Presenter: Sarah McNeil, MD, Medical Staff President

Information:

A. CCRMC JCC Expedited Privileges Subcommittee minutes (**informational only**) - per Subcommittee charter, sharing minutes from the September and October subcommittee meeting approving expedited privileges for listed providers.

B. Patient Care Policy Review (**action: approve**) - Review summary of changes for operational policies approved in CCRMC committees, recommend approve policies as reviewed and revised.

Recommendation(s)/Next Step(s):

A. CCRMC JCC Expedited Privileges Subcommittee minutes - **Informational only**

B. Patient Care Policy Review - **Action: *approve***

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Patient Care Policy Agenda 11-24-25

* ***Indicates policy is pending Medical Executive Committee's approval on 12-1-25.***

Title	Area	Revised?	Summary of Changes
Policy for Chaperones for Sensitive Physical Exams	Ambulatory Care	Revised	Reviewed no changes
Standardized Procedures for Treatment by the Resource Trained Nurse	Ambulatory Care	Revised	No Comment Provided
Policy for Disaster Response Responsibilities of Employees	Ambulatory Care	Unchanged	No Comment Provided
Ambulatory Physician Privileges	Hospital & Health Centers	Unchanged	No Comment Provided
CCRMC & Health Centers Medical Staff Bylaws	Hospital & Health Centers	Unchanged	No Comment Provided
Community Health Privileges	Hospital & Health Centers	Unchanged	No Comment Provided
Internal Medicine Specialty: Pain Medicine	Hospital & Health Centers	Unchanged	No Comment Provided
Management of Reusable Instruments Prior to Return to the Sterile Processing Department	Infection Control	Revised	Removed dead space and added, punctuations where needed.
Policy on Reporting Reportable Diseases	Infection Control	Revised	Attachment added which displays Title 17 reportable disease list
Policy for Controlled Air Purifying Respirator (CAPR) *	Infection Control	Unchanged	No Comment Provided
Policy For Nursing Documentation	Nursing	New	No Comment Provided
Policy for Teclistamab-cqyv (TECVAYLI®) and Talquetamab-tgvs (TALVEY®) *	Pharmacy	Revised	Updated Policy to include TALVEY.
Policy for Respiratory Care Practitioner Response to Emergency Events *	Respiratory	New	No Comment Provided
Policy for Mechanical Ventilation Management *	Respiratory	Revised	Policy Statement: redefine ventilator settings. References: Reviewed and updated.
Policy for Medication Administration and Documentation *	Respiratory	Revised	Policy Statement: Redefine. References: Reviewed and updated.
Policy for Non-Invasive Positive Pressure Ventilation *	Respiratory	Revised	Policy Statement: Redefined to reflect current clinical practice. References: Reviewed and updated.
Policy for Patient Assessment and Documentation *	Respiratory	Revised	Policy Statement and Guidelines section: Redefine. References: Reviewed and Updated.
Policy for Pulse Oximetry *	Respiratory	Revised	Policy Statement: Redefine. Guidelines: provide updates to reflect current department clinical practice. References: Reviewed and update.
Policy for Respiratory Care Equipment Management *	Respiratory	Revised	Title: Added “Respiratory Care” to define the department. Policy Statement: Revised for clarity. Guidelines: Updated and redefined.

Title	Area	Revised?	Summary of Changes
Policy for Respiratory Care Services Department Disaster Plan *	Respiratory	Revised	Under the Policy Statement, the word "arterial" was removed from the blood gas analysis section to encompass all types of blood gas. The Approval Section has also been removed.
Policy for Sputum Induction *	Respiratory	Revised	Policy Statement: Redefined to reflect current clinical practice. References: Reviewed and updated.
Policy for the Administration of Therapeutic Oxygen *	Respiratory	Revised	Policy Statement - Redefine. Purpose section added, and also statement redefine. References - provided update references.
Policy for Small Volume Nebulizer Treatment (Hand-Held) *	Respiratory	Unchanged	No Comment Provided

Status **Pending** PolicyStat ID **18923170**

Origination	12/2011
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2025
Next Review	3 years after approval
Owner	Kelley Taylor: Ambulatory Care Clin Supv
Area	Ambulatory Care

Policy for Chaperones for Sensitive Physical Exams

POLICY STATEMENT:

To specify how chaperones for sensitive (genital, breast or rectal) exams should be offered, provided, declined, and documented. To provide policy that is patient centered, supported by the established ethical and legal principals, and consistent with the recommendations of the American Academy of Pediatrics, The American College of Obstetrics and Gynecology, and the American Academy of Family Practice.

GUIDELINES:

A. All patients aged 12 and over undergoing a genital, rectal or breast exam should be offered a chaperone for the exam, and their response should be documented by staff.

B. Either a staff member or a family member/guardian is an acceptable chaperone, depending upon the patient's request. The name of the chaperone in the exam room should be documented in ccLink.

C. Patients declining a chaperone are not required to have one unless the examining provider determines it is indicated. This should be documented in ccLink.

D. Provider preference is one indication for a chaperone.

E. If a chaperone is indicated and declined, the provider is not obligated to do the exam, and should discuss with the patient their options, including seeking care elsewhere. This should be documented by the provider in ccLink.

F. This policy applies uniformly to all staff and patients. It does not differ with patient, provider, or chaperone gender.

NURSE RESPONSIBILITY:

A. At the point that it is apparent that a sensitive exam is intended (either on arrival, or when the provider expresses this intention):

1. The staff member rooming or preparing the patient will ask the patient (or parent/guardian if the patient is under 12 years old) in a private setting whether they would like a chaperone present for the exam and document the response. If a patient under the age of 12 years declines a chaperone, the provider is notified, and documentation is made.

A. It is recommended that staff members serve as chaperones for sensitive exams.

PROVIDER RESPONSIBILITY:

A. Providers performing sensitive exams should ensure a chaperone is present if requested.
B. Providers should make clear to the staff they work with, their preferences regarding chaperones.
C. The examining provider should document the presence and name, or absence of, a chaperone in ccLink.
D. Alternatives to undergoing the exam, including seeking care elsewhere, should be given and documented by providers to patients who refuse a chaperone that the provider has determined is indicated.

DOCUMENTATION IN CCLINK SHOULD INCLUDE:

A. The name, title, or relationship of the chaperone is present in the room during the exam.
B. If the patient declines a chaperone and the exam is done without a chaperone.
C. If the patient declines a chaperone, the provider requires a chaperone and the exam is not done.
D. Options for care discussed with the patient.

REFERENCES:

Committee on Practice and Ambulatory Medicine

Pediatrics May 2011, 127 (5) 991-993; DOI: https://doi.org/10.1542/peds.2011-0322

APPROVALS:

Ambulatory Care Policy Committee: 12/2011, 5/2013, 4/2017, 4/2020, ~~7/2025~~8/2025

Ambulatory Care Committee: 12/2011, 5/2013, 4/2017, 4/2020

Medical Executive Committee: 1/2012, 5/2013, 5/4017/ 4/2020

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	10/2025
Ambulatory Policy Committee	Laura R. Colebourn [LC]	10/2025
Ambulatory Clinical Practice Committee	Helena Martey: Chief Nursing Officer-Exempt	09/2025
	Kelley Taylor: Ambulatory Care Clin Supv	09/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 19165307

Origination	05/2019	Owner	Kelley Taylor: Ambulatory Care Clin Supv
Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval		
Last Revised	10/2025		
Next Review	3 years after approval		

Standardized Procedures for Treatment by the Resource Trained Nurse

PURPOSE STATEMENT:

The following are Standing orders for the treatment of the below infectious diseases and or consultation to provide timely care of these patients. Consultation with a provider is available if needed for any reason.

PROCEDURES:

CANDIDIASIS, VULVOVAGINAL:

A. Setting:
~~Positive finding of Candida on Potassium Hydroxide (KOH) prep and symptoms consistent with symptomatic Candida infection (vaginal discharge, vaginal or vulvar itching or discomfort or dysuria).~~

1. Positive finding of Candida on Potassium Hydroxide (KOH) prep and symptoms consistent with symptomatic Candida infection (vaginal discharge, vaginal or vulvar itching or discomfort or dysuria).

B. Recommended Treatment:

1. Short course (1-7 days) of topical OTC formulations of Clotrimazole, OR
2. Miconazole 2% vaginal cream, one applicator per vagina at bedtime for 7days, OR
3. Clotrimazole 1% vaginal cream, one applicator per vagina at bedtime for 7 days, OR
4. Fluconazole 150 mg oral tablet – single dose (non-pregnant.)

   If pregnant or possibly pregnant (delayed menses):
   Clotrimazole 1% PV X7 Days or Miconazole 2% PV for 7 days and avoid Fluconazole.

C. Precaution:
Allergies to medicine.

D. Partner Treatment - Not indicated.

E. Education:

1. Educate that this is not considered a sexually transmitted disease.
2. Educate that risk factors are antibiotics, diabetes, pregnancy and weakened immune system,

use of douches or intravaginal agents that change the normal vaginal environment.

3. Treatment creams may weaken latex condoms and diaphragm (check product labeling.)

F. Follow-up:
Routine follow-up not indicated unless symptoms persist.

G. Consultation with provider:

1. If treatment failure or contraindications to recommended treatments.
2. More than 3 documented episodes in past year (may need evaluation for other risk factors for recurrent infection.)
3. Children under 12 years old.

~~F. Follow-up:~~

~~Routine follow-up not indicated unless symptoms persist.~~

~~G. Consultation with provider:~~

1. ~~If treatment failure or contraindications to recommended treatments.~~
2. ~~More than 3 documented episodes in past year (may need evaluation for other risk factors for recurrent infection.)~~
3. ~~Children under 12 years old.~~

CHLAMYDIA:

~~A. Setting:~~
~~Positive finding of Chlamydia on Nucleic Acid Amplification Testing (NAAT) testing of urine or genital/rectal/pharyngeal swab; or positive culture of any site.~~
~~* See I below for patients to seek consultation prior to treating.~~

~~B. Recommended Regimen in Pregnancy and in patients who might be Pregnant (delayed menses):~~

1. ~~Azithromycin 1 gram orally as single dose.~~
2. ~~Alternate Regimen: Amoxicillin 500mg orally 3 times/day for 7days.~~

~~C. Recommended Treatment for Adolescents, Adults, and Partner Treatment if not Pregnant:~~

1. ~~Doxycycline 100mg orally 2 times/day for 7days.~~
2. ~~Alternate Regimens (if intolerant or allergic):~~

a. ~~Azithromycin 1g orally in a single dose, OR~~
b. ~~Levofloxacin 500mg orally once daily for 7days.~~

~~D. Reinforce education at time of visit.~~

1. ~~If prescribing a 7-day course of antibiotics, the prescription must be prescribed to patient's pharmacy and patient will self-administer at home.~~
2. ~~Prescription will be "e-prescribed". Alternate treatment option for those who do not have insurance, and qualify for FPACT, and do not want to pay for their prescription: the nurse will arrange transportation for any issue that prevents a patient from coming into the clinic for treatment. The nurse will in turn schedule a treatment nurse appointment and arrange for in clinic administration of treatment in any Women's Health clinic or Sexual Health Clinic. Provide education over the phone.~~

~~E. Precautions:~~

~~Allergies to medicine.~~

~~F. Expedited Partner Treatment (EPT)~~

1. ~~The Resource Nurse can "e- prescribe" a prescription for patient and partner (all sexual partners) – see above Recommended Regimen in Pregnancy/Patients who might be Pregnant) and Recommended Treatment for Adolescents, Adults and Partner Treatment if not Pregnant.~~
2. ~~The instructions should read "for the treatment of patient and partner".~~
3. ~~Partner definition: Limited to the number of known sex partners regardless of presence of symptoms in previous 60 days (or most recent sex partner if none in the previous 60 days).~~
4. ~~Encourage partners to come into clinic for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic or Women's Health Clinic.~~

~~G. Education:~~

1. ~~Recommend abstinence until 7 days after initiation of partner and patient's treatment.~~
2. ~~Discuss safe sex practices; encourage testing for other STDs including HIV not already done.~~
3. ~~Patient should notify all partners in the last 60 days.~~
4. ~~Instructions should include clear instructions, warnings, and clinic referrals should be provided.~~
5. ~~If e-prescribing partner therapy, educational materials with clinic referral information directed to the partners should be given to patient to accompany patient-delivered partner therapy.~~
6. ~~Patients with a diagnosis of chlamydia should be tested for HIV, Gonorrhea and Syphilis.~~
7. ~~MSM who are HIV Negative with a rectal chlamydia diagnosis should be offered HIV PrEP.~~

~~H. Follow-up:~~

1. ~~Recommend patient schedule an appointment: STD Clinic, Women's Health Clinic (if female), or in any other family medicine or short notice clinic. Follow-up is recommended to re-test patient and to discuss safe sex education and testing for other STDs.~~
2. ~~Follow-up testing is recommended 3-5 weeks after completion of treatment for pregnant women. All others follow-up testing recommended at 3 months after treatment.~~

~~I. Consultation with provider:~~

1. ~~If treatment failure or contraindications to recommended and alternative treatments.~~
2. ~~Symptoms suggestive of Pelvic Inflammatory Disease (abdominal pain, fever, etc.).~~
3. ~~Symptoms of epididymitis or prostatitis (abdominal pain, fever, scrotal pain or swelling).~~
4. ~~Post-partum woman (infant may need treatment.)~~

A. Setting:
   1. Positive finding of Chlamydia on Nucleic Acid Amplification Testing (NAAT) testing of urine or genital/rectal/pharyngeal swab; or positive culture of any site.
      * See I below for patients to seek consultation prior to treating.

B. Recommended Regimen in Pregnancy and in patients who might be Pregnant (delayed menses):
   1. Azithromycin 1 gram orally as single dose.
   2. Alternate Regimen: Amoxicillin 500mg orally 3 times/day for 7days.

C. Recommended Treatment for Adolescents, Adults, and Partner Treatment if not Pregnant:
   1. Doxycycline 100mg orally 2 times/day for 7days.
   2. Alternate Regimens (if intolerant or allergic):
   3. Azithromycin 1g orally in a single dose, OR

4. Levofloxacin 500mg orally once daily for 7days.

D. Reinforce education at time of visit.
   1. If prescribing a 7-day course of antibiotics, the prescription must be prescribed to patient's pharmacy and patient will self-administer at home.
   2. Prescription will be "e-prescribed". Alternate treatment option for those who do not have insurance, and qualify for FPACT, and do not want to pay for their prescription: the nurse will arrange transportation for any issue that prevents a patient from coming into the clinic for treatment. The nurse will in turn schedule a treatment nurse appointment and arrange for in clinic administration of treatment in any Women's Health clinic or Sexual Health Clinic. Provide education over the phone.

E. Precautions:
   1. Allergies to medicine.

F. Expedited Partner Treatment (EPT)
   1. The Resource Nurse can "e- prescribe" a prescription for patient and partner (all sexual partners) – see above Recommended Regimen in Pregnancy/Patients who might be Pregnant) and Recommended Treatment for Adolescents, Adults and Partner Treatment if not Pregnant.
   2. The instructions should read "for the treatment of patient and partner".
   3. Partner definition: Limited to the number of known sex partners regardless of presence of symptoms in previous 60 days (or most recent sex partner if none in the previous 60 days).
   4. Encourage partners to come into clinic for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic or Women's Health Clinic.

G. Education:
   1. Recommend abstinence until 7 days after initiation of partner and patient's treatment.
   2. Discuss safe sex practices; encourage testing for other STDs including HIV not already done.
   3. Patient should notify all partners in the last 60 days.
   4. Instructions should include clear instructions, warnings, and clinic referrals should be provided.
   5. If e-prescribing partner therapy, educational materials with clinic referral information directed to the partners should be given to patient to accompany patient-delivered partner therapy.
   6. Patients with a diagnosis of chlamydia should be tested for HIV, Gonorrhea and Syphilis.
   7. MSM who are HIV Negative with a rectal chlamydia diagnosis should be offered HIV PrEP.

H. Follow-up:
   1. Recommend patient schedule an appointment: STD Clinic, Women's Health Clinic (if female), or in any other family medicine or short notice clinic. Follow-up is recommended to re-test patient and to discuss safe sex education and testing for other STDs.
   2. Follow-up testing is recommended 3-5 weeks after completion of treatment for pregnant women. All others follow-up testing recommended at 3 months after treatment.

I. Consultation with provider:
   1. If treatment failure or contraindications to recommended and alternative treatments.
   2. Symptoms suggestive of Pelvic Inflammatory Disease (abdominal pain, fever, etc.).

3. Symptoms of epididymitis or prostatitis (abdominal pain, fever, scrotal pain or swelling).
4. Post-partum woman (infant may need treatment.)

GONORRHEA:

~~A. Setting:~~

~~Positive finding of uncomplicated gonorrhea on NAAT testing of urine, or pharynx/genital/rectal/swab; positive culture of any site.~~

~~B. Recommended Treatment:~~

1. ~~For patients weighing 150kg or less: Ceftriaxone 500mg IM X 1.~~
2. ~~For patients weighing 150kg or more: Ceftriaxone 1g IM.~~
3. ~~If Chlamydia has not been excluded, treat for Chlamydia.~~

~~C. Alternate Treatment (If patient unable to come into clinic for treatment):~~

1. ~~Cefixime 800mg orally (single dose) one time treatment.~~
2. ~~For pregnant patients and patients who might be Pregnant (delayed menses), if allergic to cephalosporin, contact GYN On Call to discuss treatment option: Gentamycin vs Desensitization.~~

~~D. Precautions:~~

~~Allergies to medicine including anaphylaxis to penicillin or cephalosporins.~~

~~E. Expedited Partner Treatment (EPT):~~

1. ~~First-choice partner management strategy: Attempt to bring partners in for treatment.~~
2. ~~Those with partners who are unlikely to seek timely care order Cefixime 800 mg orally single dose.~~
3. ~~The Resource Nurse can e-prescribe a prescription for non-pregnant patients and all non-pregnant sexual partners for: 800mg Cefixime orally (single dose). The instructions for medications should read "for the treatment of patient and partner(s)". If partner is pregnant, they should follow-up with their Prenatal Provider.~~
4. ~~Partner definition: Limited to the number of known sex partners in previous 60 days (or most recent sex partner if none in the previous 60 days).~~
5. ~~If e-prescribing partner therapy- education materials with clinic referral information directed to the partners should be given to the patient for patient-delivered partner therapy.~~

~~F. Education:~~

1. ~~Recommend abstinence until 7 days after initiation of partner and patient treatment.~~
2. ~~Discuss safe sex practices; encourage testing for other STDs including HIV if not already done.~~
3. ~~Instructions should include clear instructions, warnings, and clinic referrals should be provided.~~
4. ~~Patients with a diagnosis of gonorrhea should be tested for HIV and Syphilis.~~
5. ~~MSM who are HIV Negative with a rectal gonorrhea diagnosis should be offered HIV PrEP.~~

~~G. Follow-up:~~

1. ~~Recommend patient schedule an appointment with PCP or, in STD Clinic, or in Women's Health Clinic (if female) or in any other Family Medicine or Short Notice Clinic. Follow up is recommended to discuss partner notification, safe sex education, and testing for other STDs.~~
2. ~~Test of cure is unnecessary for persons with uncomplicated urogenital or rectal gonorrhea who are treated with any of the recommended or alternative treatment.~~

3. ~~Retest all persons who have been treated for gonorrhea 3 months after treatment.~~
4. ~~If retesting at 3months is not possible, retest within 12months after initial treatment.~~
5. ~~Follow up testing in 3-5 weeks after completing treatment for pregnant women.~~

~~H. Consultation with provider:~~

1. ~~If treatment failure or contraindications to recommended and alternative treatments.~~
2. ~~Symptoms suggestive of Pelvic Inflammatory Disease (abdominal pain, fever, etc.).~~
3. ~~Symptoms suggestive of epididymitis or prostatitis (abdominal pain, fever, scrotal pain or swelling.)~~
4. ~~Post-partum woman (Infant may need treatment.)~~

~~I. CMR reporting:~~

~~Gonorrhea is a reportable disease and will be reported by the resource nurse.~~

A. Setting:
   1. Positive finding of uncomplicated gonorrhea on NAAT testing of urine, or pharynx/genital/rectal/swab; positive culture of any site.

B. Recommended Treatment:
   1. For patients weighing 150kg or less: Ceftriaxone 500mg IM X 1.
   2. For patients weighing 150kg or more: Ceftriaxone 1g IM.
   3. If Chlamydia has not been excluded, treat for Chlamydia.

C. Alternate Treatment (If patient unable to come into clinic for treatment):
   1. Cefixime 800mg orally (single dose) one time treatment.
   2. For pregnant patients and patients who might be Pregnant (delayed menses), if allergic to cephalosporin, contact GYN On Call to discuss treatment option: Gentamycin vs Desensitization.

D. Precautions:
   1. Allergies to medicine including anaphylaxis to penicillin or cephalosporins.

E. Expedited Partner Treatment (EPT):
   1. First-choice partner management strategy: Attempt to bring partners in for treatment.
   2. Those with partners who are unlikely to seek timely care order Cefixime 800 mg orally single dose.
   3. The Resource Nurse can e-prescribe a prescription for non-pregnant patients and all non-pregnant sexual partners for: 800mg Cefixime orally (single dose). The instructions for medications should read "for the treatment of patient and partner(s)". If partner is pregnant, they should follow-up with their Prenatal Provider.
   4. Partner definition: Limited to the number of known sex partners in previous 60 days (or most recent sex partner if none in the previous 60 days).
   5. If e-prescribing partner therapy- education materials with clinic referral information directed to the partners should be given to the patient for patient-delivered partner therapy.

F. Education:
   1. Recommend abstinence until 7 days after initiation of partner and patient treatment.
   2. Discuss safe sex practices; encourage testing for other STDs including HIV if not already done.

3. Instructions should include clear instructions, warnings, and clinic referrals should be provided.
4. Patients with a diagnosis of gonorrhea should be tested for HIV and Syphilis.
5. MSM who are HIV Negative with a rectal gonorrhea diagnosis should be offered HIV PrEP.

G. Follow-up:

1. Recommend patient schedule an appointment with PCP or, in STD Clinic, or in Women's Health Clinic (if female) or in any other Family Medicine or Short Notice Clinic. Follow up is recommended to discuss partner notification, safe sex education, and testing for other STDs.
2. Test of cure is unnecessary for persons with uncomplicated urogenital or rectal gonorrhea who are treated with any of the recommended or alternative treatment.
3. Retest all persons who have been treated for gonorrhea 3 months after treatment.
4. If retesting at 3months is not possible, retest within 12months after initial treatment.
5. Follow up testing in 3-5 weeks after completing treatment for pregnant women.

H. Consultation with provider:

1. If treatment failure or contraindications to recommended and alternative treatments.
2. Symptoms suggestive of Pelvic Inflammatory Disease (abdominal pain, fever, etc.).
3. Symptoms suggestive of epididymitis or prostatitis (abdominal pain, fever, scrotal pain or swelling.)
4. Post-partum woman (Infant may need treatment.)

I. CMR reporting:

1. Gonorrhea is a reportable disease and will be reported by the resource nurse.

STREPTOCOCCAL THROAT INFECTION:

~~A. Setting:~~
~~Positive throat culture showing Group A Streptococcus.~~

~~B. Recommended Treatment:~~

~~1. Children less than 1yr old, consult PCP or call Pediatrician.~~
~~2. Children over 1yo: Amoxicillin 50mg/kg/day once a day orally for 10d. Max daily dose 1000mg/day.~~
~~3. Adults over 27 kg: Pen VK 500 mg three times a day for 10 days, or Amoxicillin 500mg PO twice a day for 10d, or Amoxicillin 1000mg orally once a day for 10 days, or Penicillin G Benzathine (Bicillin L-A): 1.2million units IM as a single dose.~~

~~C. Alternative Treatments (if allergic to penicillin):~~

~~1. Children less than one year old: consult with the provider.~~
~~2. Children more than one year: Azithromycin 12mg/kg (maximum 500 mg/dose) on day 1, followed by 6mg/kg (maximum 250mg/dose) on days 2-10. Given once a day orally for 10 days~~
~~3. Adults: Azithromycin 500 mg orally once on day 1, then 250 mg orally daily on days 2 through day 5, OR~~
~~4. Clindamycin 300mg orally three times a day for 10days.~~

~~D. Precautions:~~

~~Allergies to medicine.~~

~~E. Education:~~

1. ~~Encourage generous fluid intake.~~
2. ~~Use warm saltwater gargles PRN.~~
3. ~~Complete all medications, even if feeling better, to prevent rheumatic fever complications.~~
4. ~~Infection Control: wash hands, don't share food or drinks, no kissing, discard present toothbrush to decrease risk of re-infection.~~

~~F. Follow-up:~~

~~Seek care if symptoms persist, unable to keep down fluids or medications, any trouble breathing.~~

~~G. Consultation with provider if:~~

1. ~~Severe symptoms or fever over 101 degrees F.~~
2. ~~Severe dysphasia or any dyspnea.~~
3. ~~Children under 1 year old.~~
4. ~~If treatment failure or contraindications to recommended and alternative treatments~~

A. Setting:
   1. Positive throat culture showing Group A Streptococcus.

B. Recommended Treatment:
   1. Children less than 1yr old, consult PCP or call Pediatrician.
   2. Children over 1yo: Amoxicillin 50mg/kg/day once a day orally for 10d. Max daily dose 1000mg/day.
   3. Adults over 27 kg: Pen VK 500 mg three times a day for 10 days, or Amoxicillin 500mg PO twice a day for 10d, or Amoxicillin 1000mg orally once a day for 10 days, or Penicillin G Benzathine (Bicillin L-A): 1.2million units IM as a single dose.

C. Alternative Treatments (if allergic to penicillin):
   1. Children less than one year old: consult with the provider.
   2. Children more than one year: Azithromycin 12mg/kg (maximum 500 mg/dose) on day 1, followed by 6mg/kg (maximum 250mg/dose) on days 2-10. Given once a day orally for 10 days
   3. Adults: Azithromycin 500 mg orally once on day 1, then 250 mg orally daily on days 2 through day 5, OR
   4. Clindamycin 300mg orally three times a day for 10days.

D. Precautions:
   1. Allergies to medicine.

E. Education:
   1. Encourage generous fluid intake.
   2. Use warm saltwater gargles PRN.
   3. Complete all medications, even if feeling better, to prevent rheumatic fever complications.
   4. Infection Control: wash hands, don't share food or drinks, no kissing, discard present toothbrush to decrease risk of re-infection.

F. Follow-up:

1. Seek care if symptoms persist, unable to keep down fluids or medications, any trouble breathing.

G. Consultation with provider if:

1. Severe symptoms or fever over 101 degrees F.
2. Severe dysphasia or any dyspnea.
3. Children under 1 year old.
4. If treatment failure or contraindications to recommended and alternative treatments

TRICHOMONAS:

~~A. Setting:~~

~~Positive finding of trichomonas on antigen test, wet prep, pap smear or urinalysis in non-pregnant patients only.~~

~~B. Recommended Treatment:~~

1. ~~For Females: Metronidazole 500 mg orally twice a day for 7 days~~
2. ~~For Males: Metronidazole 2g orally single dose.~~

~~C. Precautions:~~

~~Allergies to medicine.~~

~~D. Partner Treatment:~~

1. ~~First-choice partner management strategy: Attempt to bring partners in for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic.~~
2. ~~Those with partners who are unable or unlikely to seek timely clinical services, the Resource Nurse can e-prescribe a prescription for patient and all partners regardless of symptoms. The instructions should read "For the treatment of patient and partner".~~
3. ~~Partner definition: Limited to the number of known sex partner in previous 60 days (or most recent sex partner if none in the previous 60 days).~~
4. ~~If e-prescribing partner therapy- educational materials with clinic referral information directed to the partners should be given to patient for patient-delivered partner therapy.~~

~~E. Education:~~

1. ~~Recommended abstinence for 7 days post treatment and absence of symptoms of patient and partner.~~
2. ~~Discuss safe sex practices; encourage testing for other STDs including HIV if not already done.~~
3. ~~Instructions should include clear instructions, warnings, and clinic referrals should be provided.~~

~~F. Follow-up:~~

1. ~~Recommend patient make appointments with PCP, Women's Clinic, or STD Clinic for follow-up.~~
2. ~~Test of cure 3weeks to 3 months after initiation of treatment.~~

~~Consultation with provider:~~

1. ~~If treatment failure or contraindications to recommended treatment.~~
2. ~~Children under 12.~~

A. Setting:

1. Positive finding of trichomonas on antigen test, wet prep, pap smear or urinalysis in non-pregnant patients only.

B. Recommended Treatment:
   1. For Females: Metronidazole 500 mg orally twice a day for 7 days
   2. For Males: Metronidazole 2g orally single dose.

C. Precautions:
   1. Allergies to medicine.

D. Partner Treatment:
   1. First-choice partner management strategy: Attempt to bring partners in for complete clinical evaluation, STD testing, counseling, and treatment with their PCP or in STD clinic.
   2. Those with partners who are unable or unlikely to seek timely clinical services, the Resource Nurse can e-prescribe a prescription for patient and all partners regardless of symptoms. The instructions should read "For the treatment of patient and partner".
   3. Partner definition: Limited to the number of known sex partner in previous 60 days (or most recent sex partner if none in the previous 60 days).
   4. If e-prescribing partner therapy- educational materials with clinic referral information directed to the partners should be given to patient for patient-delivered partner therapy.

E. Education:
   1. Recommended abstinence for 7 days post treatment and absence of symptoms of patient and partner.
   2. Discuss safe sex practices; encourage testing for other STDs including HIV if not already done.
   3. Instructions should include clear instructions, warnings, and clinic referrals should be provided.

F. Follow-up:
   1. Recommend patient make appointments with PCP, Women's Clinic, or STD Clinic for follow-up.
   2. Test of cure 3weeks to 3 months after initiation of treatment.

G. Consultation with provider:
   1. If treatment failure or contraindications to recommended treatment.
   2. Children under 12.

URINARY TRACT INFECTION (UTI):

Treatment of complicated patients deferred to the provider, except see recommendations for Pregnancy in C below.

~~A. Complicated patients defined as, but not limited to:~~

~~1. Chronic renal disease.~~

~~2. Diabetes Mellitus.~~

~~3. Immunodeficiency (patients who are HIV+, currently receiving chemotherapy or biotherapy, taking prednisone long term, organ transplant recipients).~~

~~4. Fever, flank pain, nausea and vomiting present.~~

~~5. Recent UTI (within 6 months).~~

6. Urologic abnormalities.
7. Patients being followed by anticoagulation clinic.
8. Males of all ages.

Treatment for uncomplicated patients with symptoms of UTI such as pain and burning with urination, frequency, urgency, and /or suprapubic pain. Antibiotic therapy can generally be administered empirically without obtaining a urine culture.

B. Settings For Non-Pregnant Women:

1. Call Patient to obtain information on symptoms of UTI and document in chart.
2. Order treatment if urine culture with > 50,000 cfu/ml and with symptoms of lower UTI.
3. Notify provider if urine culture with >100,000 cfu/ml and without signs or symptoms of UTI.

Recommended Empiric Antibiotic Treatment for UTI in Non-Pregnant Women:

1. Nitrofurantoin monohydrate/macro-crystals (Macrobid) 100 mg orally twice a day for 5 days - Preferred, or
2. If there are reasons to avoid the recommended above treatment (such as GFR <60 ml/min or history of hypersensitivity), then Cephalexin 500 mg orally twice a day for 5 days, or
3. If there are reasons to avoid the recommended above treatment (such as hypersensitivity), then Trimethoprim/sulfamethoxazole (Bactrim) 160/800 mg orally twice a day for 3 days.
4. For Group B Strep positive urine cultures: Amoxicillin 500 mg three times a day for 7 days, if no history of hypersensitivity to it.
5. If none of the above listed empiric antibiotics are appropriate, contact the provider.

* If final sensitivities show resistance for final antibiotic, notify provider.

C. Settings for Pregnant Women:

1. Treat without waiting for sensitivity result if Urine culture with >100,000 cfu/ml and symptoms of lower UTI.
2. Hold antibiotics for asymptomatic bacteriuria until culture and sensitivity results are available.
3. Order the treatment for UTI regardless of current diagnosis of Diabetes Mellitus or Gestational Diabetes.
4. Order the treatment for UTI regardless of history of prior UTI. Notify prenatal provider if patient was previously treated for UTI during THIS Pregnancy to consider UTI prophylaxis. If recurrent UTI in Pregnancy: RN will order post-treatment urine culture.
5. For any consultations and concerns the resource Nurse will contact ordering provider, the prenatal provider, or on-call Ob/GYN (in that order).
6. Recommended empiric antibiotics in Pregnant women, order for 5 days:

a. Cephalexin 500 mg orally three times per day – Preferred, or
b. Amoxicillin 500 mg orally three times a day, or
c. Amoxicillin 875 mg twice a day, or
d. If there are reasons to avoid above treatment, Nitrofurantoin (Macrobid) 100 mg twice a day, which should be avoided in first trimester and after 38 weeks if other options are available.
e. For GBS (Group B Strep) positive urine culture: Amoxicillin 500 mg three times a day.
f. If none of the listed options is appropriate, contact the provider.

~~D. Empiric antibiotics for uncomplicated UTI (afebrile) in Children (<18 years old):~~

1. ~~2 months -12 years old: Cephalexin 25 mg/kg/dose (max 500 mg/dose) PO TID x 7 days.~~
2. ~~13-17 years old: Nitrofurantoin (Macrobid) 100 mg/dose PO BID for 4 days. If nitrofurantoin is contraindicated, then Cephalexin 25 mg/kg/dose (max 500 mg/dose) PO BID x 4 days.~~
3. ~~Notify the provider if none of listed antibiotics are appropriate or if child has symptoms of Pyelonephritis: fever, flank or back pain).~~

~~E. Precautions:~~

~~Allergies to medicine.~~

~~F. Education:~~

1. ~~Encourage generous fluid intake~~
2. ~~To reduce risk of infection, patients should: urinate after sexual intercourse and wipe front to back after using restroom.~~

~~G. Follow-up as needed:~~

~~Seek care if symptoms persist, unable to keep down fluids or medications~~

~~H. Consultation with provider:~~

1. ~~Complicated patients as defined above.~~
2. ~~Available culture sensitivities show resistance to recommended and alternative treatments.~~
3. ~~If treatment failure or contraindications to recommended and alternative treatments.~~

A. Complicated patients defined as, but not limited to:
    1. Chronic renal disease.
    2. Diabetes Mellitus.
    3. Immunodeficiency (patients who are HIV+, currently receiving chemotherapy or biotherapy, taking prednisone long term, organ transplant recipients).
    4. Fever, flank pain, nausea and vomiting present.3
    5. Recent UTI (within 6 months).
    6. Urologic abnormalities.
    7. Patients being followed by anticoagulation clinic.
    8. Males of all ages.

B. Treatment for uncomplicated patients with symptoms of UTI such as pain and burning with urination, frequency, urgency, and /or suprapubic pain. Antibiotic therapy can generally be administered empirically without obtaining a urine culture.

C. Settings For Non-Pregnant Women:
    1. Call Patient to obtain information on symptoms of UTI and document in chart.
    2. Order treatment if urine culture with > 50,000 cfu/ml and with symptoms of lower UTI.
    3. Notify provider if urine culture with >100,000 cfu/ml and without signs or symptoms of UTI.

D. Recommended Empiric Antibiotic Treatment for UTI in Non-Pregnant Women:
    1. Nitrofurantoin monohydrate/macro-crystals (Macrobid) 100 mg orally twice a day for 5 days - Preferred, or

2. If there are reasons to avoid the recommended above treatment (such as GFR <60 ml/min or history of hypersensitivity), then Cephalexin 500 mg orally twice a day for 5 days, or
3. If there are reasons to avoid the recommended above treatment (such as hypersensitivity), then Trimethoprim/sulfamethoxazole (Bactrim) 160/800 mg orally twice a day for 3 days.
4. For Group B Strep positive urine cultures: Amoxicillin 500 mg three times a day for 7 days, if no history of hypersensitivity to it.
5. If none of the above listed empiric antibiotics are appropriate, contact the provider.
   * If final sensitivities show resistance for final antibiotic, notify provider.

E. Settings for Pregnant Women:
1. Treat without waiting for sensitivity result if Urine culture with >100,000 cfu/ml and symptoms of lower UTI.
2. Hold antibiotics for asymptomatic bacteriuria until culture and sensitivity results are available.
3. Order the treatment for UTI regardless of current diagnosis of Diabetes Mellitus or Gestational Diabetes.
4. Order the treatment for UTI regardless of history of prior UTI. Notify prenatal provider if patient was previously treated for UTI during THIS Pregnancy to consider UTI prophylaxis. If recurrent UTI in Pregnancy: RN will order post-treatment urine culture.
5. For any consultations and concerns the resource Nurse will contact ordering provider, the prenatal provider, or on-call Ob/GYN (in that order).
6. Recommended empiric antibiotics in Pregnant women, order for 5 days:
7. Cephalexin 500 mg orally three times per day – Preferred, or
8. Amoxicillin 500 mg orally three times a day, or
9. Amoxicillin 875 mg twice a day, or
10. If there are reasons to avoid above treatment, Nitrofurantoin (Macrobid) 100 mg twice a day, which should be avoided in first trimester and after 38 weeks if other options are available.
11. For GBS (Group B Strep) positive urine culture: Amoxicillin 500 mg three times a day.
12. If none of the listed options is appropriate, contact the provider.

F. Empiric antibiotics for uncomplicated UTI (afebrile) in Children (<18 years old):
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2. 13-17 years old: Nitrofurantoin (Macrobid) 100 mg/dose PO BID for 4 days. If nitrofurantoin is contraindicated, then Cephalexin 25 mg/kg/dose (max 500 mg/dose) PO BID x 4 days.
3. Notify the provider if none of listed antibiotics are appropriate or if child has symptoms of Pyelonephritis: fever, flank or back pain).

G. Precautions:
1. Allergies to medicine.

H. Education:
1. Encourage generous fluid intake
2. To reduce risk of infection, patients should: urinate after sexual intercourse and wipe front to back after using restroom.

I. Follow-up as needed:

1. Seek care if symptoms persist, unable to keep down fluids or medications

J. Consultation with provider:

1. Complicated patients as defined above.
2. Available culture sensitivities show resistance to recommended and alternative treatments.
3. If treatment failure or contraindications to recommended and alternative treatments.

SYPHILIS:

A. Results

1. If the initial nontreponemal test (RPR or VDRL), followed by confirmatory treponemal test (TP-PA, EIA, or CIA) are positive, nurse will assume present OR past infection and call patient to assess. If patient has previously been treated for Syphilis, defer to PCP for management (document in chart and route to PCP). If patient has not been treated previously, move to section B.
2. If nontreponemal test is reactive and treponemal test is nonreactive, repeat the treponemal testing if patient is at high risk of recent exposure (had condomless sex with an unknown or multiple partners within the last 6-8 weeks). Only repeat once. If patient is not at high risk, the patient most likely has a false positive, do not repeat. Do not diagnose with syphilis. Document in chart and route to PCP.
3. Treponemal reactive, nontreponemal nonreactive: do nothing, provider can follow up.
4. Single reactive test (RPR reactive only): Do not diagnose Syphilis. Await confirmatory testing (treponemal testing).

B. Assess for symptoms

1. PRIMARY SYPHILIS SYMPTOMS
    a. Single/multiple, painless or painful ulcer(s) on *any* mucosal surface of the skin (often on the genitals).
2. SECONDARY/NEURO/CARDIAC/OTIC/OCULAR SYPHILIS SYMPTOMS
    a. **SECONDARY SYMPTOMS:** fever/chills, diffuse lymphadenopathy, maculopapular rash sometimes involving palms/soles, mucous patches, patchy alopecia, condyloma lata
    b. **NEUROLOGIC SYMPTOMS:** Headache, confusion, ataxia, weakness/numbness, neuropathy, decreased patellar/Achilles reflex
    c. **CARDIAC SYMPTOMS:** Chest pain
    d. **OTIC SYMPTOMS:** Decreased hearing, tinnitus, vertigo
    e. **OCULAR SYMPTOMS:** Eye redness/pain, lurry/double vision, vision loss

C. For SYMPTOMATIC patients with SECONDARY/NEURO/CARDIAC/OTIC/OCULAR SYPHILIS, pregnant and non-pregnant, make an appointment with PCP or short notice provider within 7 days. If there is no appointment available, call the sexual health clinic at 925-608-5350 for warm hand off so treatment can be initiated as soon as possible.

D. For ASYMPTOMATIC OR for PRIMARY SYPHILIS, treat patients per recommended medication below.

1. NON-PREGNANT
    a. If known infection is <1 year:
        i. Benzathine Penicillin G 2.4 million units IM single dose

ii. IF Penicillin Allergic or unable to do IM dosing

~~a. Doxycycline 100mg PO BID for 14 days~~

1. Doxycycline 100mg PO BID for 14 days

b. If known infection is >1 year (or if duration of infection is unknown and onset of sex was >1 year):

i. Benzathine Penicillin G 2.4 million units IM once weekly x 3 weeks

ii. IF Penicillin Allergic or unable to do IM dosing

~~a. Doxycycline 100mg PO BID x 28 days~~

1. Doxycycline 100mg PO BID x 28 days

2. PREGNANT

a. If known infection is <1 year:

i. Benzathine Penicillin G 2.4 million units IM single dose

b. If known infection is >1 year (or if duration of infection is unknown and onset of sex was >1 year):

i. Benzathine Penicillin G 2.4 million units IM once weekly x 3 weeks

ii. If Penicillin allergic, advise patient that penicillin is the only proven effective therapy; pregnant patients with true penicillin allergy should undergo desensitization and receive penicillin G. Consult OB on call via AMION. Doxycycline is absolutely contraindicated in pregnancy.

E. If with an assigned PCP, make appointment for follow up with PCP. If unassigned, make an appt with sexual health clinic for follow up at 925-608-5350. Patients should also be tested for HIV and other STIs, as coinfection is common. Order other STI testing, such as HIV and GC/Chlam, if it has not been done recently.

F. Condomless sexual activity should be avoided until at least 7 days after treatment is complete AND until symptoms have resolved to prevent transmission. Notify patient that all recent sexual partners should be notified, evaluated, and treated as appropriate. Syphilis is a reportable disease, and patients should be advised that public health authorities may contact them for partner notification and disease control.

G. Advise patients that follow-up is essential. They will need to return for repeat serologic testing at 6 and 12 months (and at 24 months for late syphilis) to confirm treatment response. Inadequate serologic response may require further evaluation for neurosyphilis and/or retreatment. This will be addressed at the follow up visit with the provider.

RELATED LINKS:

Policy for Standard Protocols for Resource Nurse for Critical and Urgent Test Value Notifications

Procedure for Outpatient Critical and Urgent Test Results

Diagnostic Imaging Department Definitions of Critical and Urgent Abnormal Results

REFERENCES:

A. 2024 TJC Standard PC.02.02.01: "The hospital coordinates the patient's care, treatment and services based on the patient's needs."

B. Department of Public Health STD Control Branch. (2021). Retrieved from cdph.ca.gov: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/California-STI-Treatment-Guidelines-for-Adults-and-Adolescents.pdf

C. Michael E Pichichero, M. (2021, August 24). Retrieved from uptodate.com: https://www.uptodate.com/

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D. Miriam Baron Barshak, M. L. (2021, October 26). Retrieved from uptodate.com: https://www.uptodate.com/contents/group-b-streptococcal-infections-in-nonpregnant-adults?search=Group%20B%20streptococcal%20infections%20in%20nonpregnant%20adults&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

E. Scott Moses, M. (2021, January 15). *fpnotebook.com*. Retrieved from https://fpnotebook.com/Uro/ID/UrnryTrctInfctn.htm

F. Thomas M Hooton, M. G. (2021, March 15). Retrieved from uptodate.com: https://www.uptodate.com/contents/acute-simple-cystitis-in-women?search=Acute%20Cystitis%20in%20Women&source=search_result&selectedTitle=1~150&usage_type=default&display_rank=1

G. U.S. Department of Health and Human Services. (2021, July). *cdc.gov*. Retrieved from https://www.cdc.gov/std/treatment-guidelines/pocket-guide.pdf

H. Workowski, Kimberly A. "Sexually transmitted infections treatment guidelines, 2021." MMWR. Recommendations and Reports 70 (2021).

I. Hamill, Matthew M., Khalil G. Ghanem, and Susan Tuddenham. "State-of-the-art review: neurosyphilis." Clinical Infectious Diseases (2023): ciad437.

J. California Department of Public Health: Opt-out ED HIV, HCV, and Syphilis Screening. Available from: https://www.cdph.ca.gov/Programs/CID/DCDC/CDPH%20Document%20Library/DCL-Opt-Out-ED-HIV-HCV-and-Syphilis-Screening.

K. California Department of Public Health (2024) Emergency Department Screening & Treatment for Syphilis. https://bridgetotreatment.org/resource/edsp-screening-treatment-for-syphilis/

L. Syphilis | Red Book: 2024–2027 Report of the Committee on Infectious Diseases | Red Book Online | American Academy of Pediatrics

APPROVALS:

Ambulatory Clinical Practice Committee: 11/2021, 04/2024, 5/2025 (added Syphilis)

Ambulatory Policy Committee: 5/2019, 12/2021, 09/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	10/2025
Ambulatory Policy Committee	Laura R. Colebourn [TT]	10/2025
Ambulatory Clinical Practice Committee	Helena Martey: Chief Nursing Officer-Exempt [TT]	10/2025
	Kelley Taylor: Ambulatory Care Clin Supv [TT]	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19006670**

Origination	08/2012
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2025
Next Review	3 years after approval

Owner	Kelley Taylor: Ambulatory Care Clin Supv
Area	Ambulatory Care

Policy for Disaster Response Responsibilities of Employees

POLICY STATEMENT:

Under California law, when a disaster, each state, county, and city employee becomes part of the Disaster Service Workforce which will respond to the disaster. In the event that a disaster involves the Contra Costa Regional Medical Center, ambulatory care employees may be asked to go to CCRMC to provide help as part of the hospital labor pool.

GUIDELINES:

When a disaster is declared, employees should do the following:

A. If at work, employees should remain until relieved or sent home by someone in authority;

B. If at home, employees should take care of their immediate situation; and if physically able, and unless previously directed otherwise by telephone call from supervisor or an official announcement on the radio, should report to their primary work location at the next regularly scheduled shift.

C. Monitor radio KCBS 740 AM (and Local TV is possible)

D. Call in the Health Services Department's Employee Emergency Hotline (1-866-946-9911). This will be used to provide instructions to staff when there is a disaster or other emergency requiring special work-related instructions to CCHS employees.

E. If an employee is not able to report to the designated primary work site, s/he should then report to the nearest Health Services Department clinic, or office and report to the manager in charge.

F. If an employee is not able to get into Contra Costa County (i.e., bridges and roads are out) s/he

should report to the closest County of residence office or health clinic and report to the manager in charge.

G. Specific time records are important for damage reimbursement from the state and federal governments. After arriving at the work site for disaster duty, all employees should keep a specific log or time sheet detailing the time spent and specific activities performed.

REFERENCES:

A. CCHS POLICY #106A "Contra Costa Health Services Emergency Plan"

B. California Government Code Section 3100

APPROVALS:

Ambulatory Clinical Practice Committee: 9/2020, 10/2020, 9/2025
Ambulatory Policy Committee: 9/2020, 12/2020
Medical Executive Council: 9/2020, 1/2021

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: County Hosp Exec Dir-Exem	09/2025
	Kelley Taylor: Ambulatory Care Clin Supv	09/2025

Standards

No standards are associated with this document

Ambulatory Physician
Privileges

Name:
(Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Required Qualifications

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME)—or American Osteopathic Association (AOA)—accredited residency in Family Medicine or Internal Medicine. Family Medicine training is required for Pediatric Privileges.
Certification	Documentation of current certification or board eligibility (with achievement of certification within 3 years) leading to certification in Family Medicine by the American Board of Family Medicine or Family Practice and Osteopathic Manipulative Treatment by the American Osteopathic Board of Family Physicians. OR Internal Medicine by the American Board of Internal Medicine or the American Osteopathic Board of Internal Medicine.
Continuing Education	As per California license and section-specific requirements below.

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Adult Medicine (Initial or Reappointment)	Provision of care, reflective of the scope of privileges requested, for at least 200 adult medicine patient visits during the past 24 months. If requesting pediatric privileges, at least 100 pediatric patients. Please provide clinical activity/procedure log. Experience must correlate to requested privileges OR Successful completion of an ACGME—or AOA—accredited residency or clinical fellowship within the past 24 months.
Pediatric Medicine (Initial or Reappointment)	Provision of care, reflective of the scope of privileges requested, for at least 100 pediatric patient visits during the past 24 months. Please provide clinical activity/procedure log. Experience must correlate to requested privileges. OR Successful completion of an ACGME—or AOA—accredited residency or clinical fellowship within the past 24 months.

Ambulatory Physician Core Privileges

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to.	Division/ Dept Chair: initial to recommend
(initials)	**Adult Medicine Core Privileges** **E**valuate, diagnose, treat, and provide consultation to all patients 18 years old and above, with a wide variety of illnesses, diseases, injuries, and functional disorders of the circulatory, respiratory, endocrine, metabolic, musculoskeletal, hematopoietic, gastroenteric, integumentary, nervous, female reproductive and family planning, genitourinary systems, and including mild to moderate psychiatric disorders, dependence or addiction to alcohol or other drugs, and medical management of chronic pain. Assess, stabilize, consult, and determine disposition of patients with emergent conditions. Procedures include, but are not limited to: performance of history and physical; arthrocentesis and joint injections; cryotherapy (e.g. for removal of warts); excision of cutaneous and subcutaneous lesions, tumors, and nodules and superficial foreign body; facilitate medical groups; fluorescein exam; incision and drainage of abscesses; local anesthesia; management of uncomplicated, minor, closed fractures and uncomplicated dislocations; nasal packing for hemostasis; pap smears; POCT (point of care testing); peripheral nerve blocks; provider performed microscopy (PPM); removal of IUD; removal of a nonpenetrating foreign body from the eye, nose, ear, or vagina; simple skin excision and biopsy; simple wound care and management of superficial burns; subcutaneous, intradermal and intramuscular injections; suture of uncomplicated laceration; toenail trephination and removal; venipuncture.	(initials)
(initials)	**Pediatric Core Privileges** Evaluate, diagnose, and treat pediatric patients who have common illnesses, injuries, or disorders from birth through 21 years old. This includes routine uncomplicated newborn care in the hospital (i.e. L&D, nursery, postpartum, etc.), assessment of physical, emotional, and social health, treating acute and chronic disease, and determining the disposition of patients with emergent conditions. Procedures include but are not limited to: performance of history and physical; bladder catheterization, cryotherapy (e.g. for removal of warts); excision of cutaneous and subcutaneous lesions, nodules, and superficial foreign body; facilitate medical groups; incision and drainage of abscesses; local anesthesia; management of uncomplicated, minor, closed fractures and uncomplicated dislocations; nasal packing for hemostasis; POCT (point of care testing); peripheral nerve blocks; provider performed microscopy (PPM); removal of IUD; removal of a nonpenetrating foreign body from the eye, nose, ear, or vagina; simple skin excision and biopsy; simple wound care and management of superficial burns; subcutaneous, intradermal and intramuscular injections; suture of uncomplicated laceration; toenail trephination and removal; venipuncture.	(initials)

Ambulatory Physician Special/Non-Core Privileges

To obtain these privileges, you must provide documentation of the minimum number of procedures required (provider, supervising attending, or during department in-service). Privileges will be considered based on applicability, scope of practice, and documentation of experience.

Applicant: initial to request	Non-core privileges are requested individually, in addition to requesting core privileges.	Division/ Dept Chair: initial to recommend
(initials)	**Nexplanon Insertion & Removal**	(initials)

	Initial Request: Completion of the Nexplanon training program. Please submit Training Certification. *Reappointment/Renewal:* none - MSO has on file.	
(initials)	**EMB and/or Insertion of IUD** *Initial Request:* Residency training in EMB and IUD Insertion OR completion of a hands-on training under the supervision of a qualified preceptor. AND 4 successful EMB/IUD insertions within the past 24 months. *Renewal/Reappointment:* 2 successful EMB/IUD insertions in the past 24 months.	(initials)
(initials)	**Paracentesis** *Initial Request:* Residency training in paracentesis OR completion of a hands-on training in paracentesis under the supervision of a qualified preceptor. AND 2 paracentesis procedures in the past 24 months. *Renewal/Reappointment*: 1 paracentesis procedure in the past 24 months	(initials)
(initials)	**Early pregnancy management: manual uterine aspiration (MUA) and treatment with methotrexate** *Initial Request*: Training during or following residency with 50 MUAs. AND 6 MUAs in the past 24 months. *Renewal/Reappointment:* 6 MUAs in the past 24 months.	(initials)
(initials)	**Acupuncture** *Initial Request:* 200 Hours CME or 10 years of experience. AND 10 cases in the last 24 months *Renewal/Reappointment:* 10 cases in the past 24 months.	(initials)
(initials)	**HIV/AIDS care** *Initial Request and Renewal/Reappointment: Re*quirements of AB 2168 (see attached) must be met.	(initials)
(initials)	**Care of Newborn with Complications in the Level 2 Nursery** *Routine care of well newborns does not require this privilege.* Including but not limited to the admission and care of the late preterm infant 34 – 36 weeks gestation without significant complications, low birth weight, transient hypoglycemia, sepsis risk factors, mild respiratory issues with need for no or minimal respiratory support, in utero drug exposure not requiring medical management, mild to moderate hyperbilirubinemia, and congenital issues without significant clinical impact. This includes attendance at deliveries with mild to moderate risk factors if NRP certification is current. *Initial Request:* Completion of residency training in the past 24 months that included at least 1 month in the Nursery. OR 10 encounters with this level of care in the past 24 months. *Renewal/Reappointment:* 10 inpatient encounters in the past 24 months. **Specialty Department Chair/Head reviewed (name): _____**	(initials)
(initials)	**Inpatient obstetrics with consultation** Admit, evaluate, and manage patients with uncomplicated term pregnancy, with an expectation of uncomplicated vaginal delivery. Procedures include but are not limited to: amniotomy, assisting with delivery of twins, assisting with fetal versions, augmentation of labor, episiotomy, fetal heart rate monitoring (external and internal), induction of labor, initial management of postpartum hemorrhage, normal spontaneous vaginal delivery; POCUS (please see request below); postpartum	(initials)

	care, post-delivery removal of placenta with consultation; repair of 1st and 2nd-degree lacerations; repair of cervical, 3rd, and 4th-degree lacerations with consultation; surgical assisting; vacuum-assisted delivery with consultation. *Initial Request:* Completion of residency in the last 24 months with documentation of at least 4 months of obstetrical rotation during family medicine residency, 80 patients delivered, and ultrasound training OR 8 deliveries in the past 24 months. *Renewal/Reappointment:* 8 deliveries in the last 24 months. **Specialty Department Chair/Head reviewed (name): _____**	
(initials)	**Low-risk obstetrics (prenatal and postpartum)** Evaluate, diagnose, and treat low-risk patients who are pregnant, intend to become pregnant, or are recently post-pregnancy. Management of patients with obesity with BMI </=60; chronic Hypertension with BP < 150/100 **WITHOUT** medication; GDM on diet or orals with A1c < 6.5; AMA; history of pre-eclampsia in one previous pregnancy at >/= 37 weeks; history of cesarean section; substance abuse with or without buprenorphine therapy; cholestasis of pregnancy; size vs. date discrepancies with EFW > 10%; UTI; anemia with hemoglobin > 8; vaginitis. Procedures include but are not limited to: third-trimester POCUS (please request below) *Initial Request:* training during family medicine residency of at least 2 months of obstetrics, including prenatal/postpartum care and POCUS. OR 50 prenatal/postpartum visits in the past 24 months. *Renewal/Reappointment:* 50 patients plus attestation of 8 Units AAFP/ACOG CME in prenatal care in the past 24 months as well as complete CClearn OB/GYN Q 2 years	(initials)
(initials)	**All focused and limited POCUS (Point of Care Ultrasound)** *Initial Request:* Successful completion of an accredited POCUS training OR 15 hours of Point of Care Ultrasound CME. AND 6 hours of hands-on POCUS relevant to privileges being requested. *Renewal/Reappointment*: 20 ultrasounds in the past 24 months.	
(initials)	Basic First and Second Trimester POCUS for dating, location, and viability of pregnancy. *Initial Request*: 30 ultrasounds in the past 24 months. *Renewal/Reappointment*: 20 ultrasounds in the past 24 months.	(initials)
(initials)	Third trimester OB POCUS for placental location, viability, presentation, amniotic fluid assessment *Initial Request:* 20 ultrasounds in the past 24 months. *Renewal/Reappointment*: 8 ultrasounds in the past 24 months.	(initials)

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

_____

_____

_____

_____

Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PROVIDER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center Hospital and Clinics, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Provider's Signature: _____ Date: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ **Recommend All Requested Privileges**
☐ **Recommend Privileges with the Following Conditions/Modifications:**
☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:

_____

_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Status **Pending** PolicyStat ID **19083523**

Origination	07/2024
Last Approved	N/A
Effective	Upon Approval
Last Revised	07/2024
Next Review	1 year after approval

Owner	Sarah Mcneil: OBGYN Fam Med Adv Obst Ex
Area	Hospital & Health Centers
References	TJC 2025

CCRMC & Health Centers Medical Staff Bylaws

Definitions

The following definitions apply to these Medical Staff Bylaws:

1. **Administrator** means the Chief Executive Officer of Contra Costa Regional Medical Center and Health Centers, or designee.
2. **Advanced Practice Providers** means non-physician licensed providers who are providing a medical level of care and decision-making, including but not limited to clinical psychologists, physician assistants, nurse practitioners, chiropractors, certified nurse midwives, optometrists, certified registered nurse anesthetists, and similar providers who have been granted privileges to provide services under the supervision of the Medical Staff.
3. **Board** or **Governing Body** means the County Board of Supervisors or their designee, the Joint Conference Committee.
4. **Chief Medical Officer** of CCRMC Hospital and Health Centers means the physician appointed by the Director of the Health Services Department to oversee the clinical activities of CCRMC Hospital and Health Centers.
5. **Clinical Privileges** or **Privileges** mean the permission granted to a Practitioner to render specific diagnostic, therapeutic, medical, dental, or surgical services with the Hospital.
6. **County** means the County of Contra Costa, California.
7. **Department** or **Clinical Department** means a clinical structure of the Medical Staff as further identified in these Bylaws.
8. **Department Chair** means the practitioner elected or appointed, pursuant to these Bylaws, to be responsible for the function of a Clinical Department.

9. **Ex-officio** means service as a member of a body by virtue of an office, or positions held and, unless expressly provided, without voting rights.
10. **Health Centers** means the outpatient clinical facilities operated by the County where the Members of this Medical Staff provide patient care.
11. **Hospital** or **Medical Center** means the Contra Costa Regional Medical Center.
12. **Medical Director** means a physician appointed by the Administrator to oversee clinical activities.
13. **Medical Executive Committee** or **MEC** is a standing committee of elected and appointed Medical Staff leaders that is responsible for the oversight and administration of Contra Costa Health Medical Staff operations, as further defined in Part I: Governance, of these Bylaws.
14. **Medical Staff Year** means the twelve (12) month period commencing on July 1 of each year and ending on June 30 of the following year.
15. **Member** or **Medical Staff Member** means any Practitioner or who has been appointed to the Medical Staff pursuant to these Bylaws.
16. **Member in Good Standing** means a practitioner whose membership and/or privileges are not involuntarily limited, restricted, suspended, or otherwise encumbered for disciplinary reasons (excluding leave of absence).
17. **Patient Contact** is defined as an inpatient admission, consultation, an inpatient or outpatient surgical procedure, or shifts performed by an emergency department practitioner, hospitalist, pathologist, radiologist, anesthesiologist, or practitioner in a provider-based clinic.
18. **Physician** means an individual who has received a Doctor of Medicine or Doctor of Osteopathy degree and is currently fully licensed to practice medicine in the State of California.
19. **Practitioner** means an appropriately licensed medical physician, osteopathic physician, dentist, oral and maxillofacial surgeon, or an Advanced Practice Provider who has been granted clinical privileges at the Hospital and Health Centers.
20. **Rules** or **Rules and Regulations** mean the Medical Staff Rules and Regulations that are contained under separate cover and are adopted pursuant to the Bylaws.

Part I: Governance

Section 1. Medical Staff Purpose and Authority

1.1 Purpose

The purpose of this Medical Staff is to:

1.1.1 Organize the activities of physicians and other clinical practitioners who practice at Contra Costa Regional Medical Center (“Hospital”) and Health Centers to carry out, in conformity with these bylaws, the functions delegated to the Medical Staff by the Governing Body (“Board”).

1.1.2 To assure that all patients treated by any of its members receive the best possible high quality and safe care without bias.

1.1.3 To provide professional performance that is consistent with the mission and goals of Contra Costa Health Services.

1.2 Authority

Consistent with the authority granted by the Board, the Medical Staff will exercise such power as is reasonably necessary to discharge its responsibilities under these bylaws and associated rules and regulations, and policies and under the Governing Authority Bylaws of the CCCRMC and Health Centers.

Section 2. Medical Staff Membership and Clinical Privileges

2.1 Nature

Membership on the Medical Staff is a privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, oral and maxillofacial surgeons, podiatrists, and nurse practitioners who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, statutes, regulations, policies, and procedures of the Medical Staff and the Hospital and Health Centers.

2.2 Qualifications for Membership

The qualifications for Medical Staff membership are delineated in Sections 2 (Medical Staff Membership and Clinical Privileges) and 3 (Categories of Medical Staff) of these bylaws. The qualifications for privileges are delineated in Parts I and III of these bylaws (Governance and Credentials Procedures Manual).

Requests for Medical Staff membership and/or clinical privileges will be processed only when the potential applicant meets the current minimum qualifying criteria approved by the Board.

2.3 Nondiscrimination

No person shall be appointed, promoted, disciplined, reduced, removed or in any way favored, disfavored, or discriminated against on the basis of political, religious or union activities, age, sex, gender, gender identity, gender expression, sexual orientation, race, religion, skin color, national origin, body size, physical or mental impairment, marital status, or ability; providing those qualities do not pose a threat to the quality of patient care or substantially impair their capability to fulfill required staff obligations.

2.4 Conditions and Duration of Appointment

The Board shall make initial appointment and reappointment to the Medical Staff for membership and/or clinical privileges. The Board shall act on appointment and reappointment only after the Medical Staff has had an opportunity to submit a recommendation from the Medical Executive Committee (MEC) except for temporary, emergency, and disaster privileges. Appointment and reappointment to the Medical Staff for membership and/or clinical privileges shall be for no more than twenty-four (24)

calendar months.

2.5 Responsibilities

Each member shall:

2.5.1 Provide for appropriate, timely, and continuous care of their patients at the level of quality and efficiency generally recognized as appropriate by medical professionals in the same or similar circumstances.

2.5.2 Participate, as assigned or requested, in quality/performance improvement/peer review activities and in the discharge of other MedicalStaff functions (including service on appropriate Medical Staff committees) as may be required.

2.5.3 Submit to any [pertinent] type of health evaluation as requested by the officers of the Medical Staff, the Administrator, and/or Department Chair when it appears necessary to protect the well-being of patients and/or staff, or when requested by the MEC or credentials committee as part of an evaluation of the member's ability to exercise privileges safely and competently, or as part of a post-treatment monitoring plan consistent with the provisions of any Medical Staff and Hospital and Health Centers policies addressing member health or impairment.

2.5.4 Abide by the Medical Staff Bylaws and any other rules and regulations, policies, procedures, and standards of the Medical Staff, and the Hospital and Health Centers.

2.5.5 When requested by the Medical Staff Office, provide evidence of professional liability coverage of a type and in an amount sufficient to cover the clinical privileges granted or an amount established by the Board, whichever is higher. In addition, members shall comply with any financial responsibility requirements that apply under state law to the practice of their profession. Each member with privileges shall notify the Medical Staff Office immediately of any and all malpractice claims filed in any court of law against the Medical Staff member.

2.5.6 Agree to release from any liability to the fullest extent permitted by law, all persons for their conduct in connection with investigating and/or evaluating the quality of care or professional conduct provided by the Medical Staff member and their credentials.

2.5.7 Prepare and complete in timely fashion, according to Medical Staff and Hospital and Health Centers policies, the medical and other required records for all patients to whom the member provides care in the Hospital and Health Centers.

a. The content of all provider documentation is delineated in the Rules and Regulations.
b. Per Joint Commission, a medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and Hospital and Health Centers policy.

An updated examination of the patient, including any changes in the patient's condition, shall be

completed and documented within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, when the medical history and physical examination is completed within thirty (30) days before admission or registration. The updated examination of the patient, including any changes in the patient's condition, must be completed and documented by a physician, an oral and maxillofacial surgeon, dentist, podiatrist, or other qualified licensed individual in accordance with State law and Hospital and Health Centers policy.

2.5.8 Use, access, and release confidential information only as necessary for treatment, payment, or healthcare operations, in a secure and compliant manner, in accordance with the Health Insurance Portability and Accountability Act (HIPAA), state and federal privacy laws and regulations, and hospital policies. For these Bylaws, confidential information means patient information, peer-review information, and the hospital's business information, which has been designated as confidential by the hospital or its representatives prior to disclosure.

2.5.9 Participate in any competency evaluation when determined necessary by the MEC and/or Board to properly delineate that member's clinical privileges.

2.5.10 Disclose to the Medical Staff any ownership or financial interest that may conflict with, or have the appearance of conflicting with, the interests of the Medical Staff or Hospital and Health Centers. Medical Staff leadership will deal with conflict-of-interest issues per the County's "Conflict of Interest" policy.

2.6 Medical Staff Member Rights

Medical Staff members in the Active Category (defined in Section 3) have the following rights. An Active Member may:

2.6.1 Meet with the MEC on matters relevant to the responsibilities of the MEC that may affect patient care or safety. In the event such member is unable to resolve a matter of concern after working with their Department Chair or other appropriate Medical Staff leader(s), that member may, upon written notice to the Medical Staff President two (2) weeks in advance of a regular meeting, meet with the MEC to discuss the issue.

2.6.2 Initiate a recall election of an Officer of the Medical Staff by following the procedure outlined in these Bylaws, regarding removal from office.

2.6.3 Initiate a call for a general staff meeting to discuss a matter relevant to the Medical Staff by presenting a petition signed by twenty percent (20%) of the members of the Active Category. Upon presentation of such a petition, the MEC shall schedule a general staff meeting for the specific purposes addressed by the petitioners. No business other than that detailed in the petition may be transacted.

2.6.4 Challenge any rule, regulation, or policy established by the MEC. If a rule, regulation, or policy is thought to be inappropriate, any Medical Staff member may submit a petition signed by twenty percent (20%) of the members of the Active Category. Upon presentation of such a petition, the adoption and amendment procedure in these Bylaws will be followed.

2.6.5 Call for a Department meeting by presenting a petition signed by twenty percent (20%) of the members of the Department. Upon presentation of such a petition the Department Chair will schedule a Department meeting.

The rights in this section do not pertain to issues involving individual peer review, formal investigations of professional performance or conduct, denial of requests for appointment or clinical privileges, or any other matter relating to individual membership or privileges. Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan) provides recourse in these matters.

2.7 Staff Dues

The MEC shall annually determine the amount of dues or assessments, if any, for each category of Medical Staff membership, and determine the manner of expenditure of such funds.

Section 3. Categories of the Medical Staff

3.1 The Active Category

3.1.1 Qualifications

The Active Category consists of physicians, dentists, podiatrists, and nurse practitioners who meet the following criteria:

a. Have regular patient contacts at the Hospital and/or Health Centers
b. Routinely attend Medical Staff, Hospital, and/or Health Center meetings.
c. Are Employed or contracted directly by the Hospital and/or Health Centers.

In the event that a member of the Active Category does not meet the qualifications for reappointment to the Active Category, and if the member is otherwise abiding by all Bylaws, rules, regulations, and policies of the Medical Staff and Hospital, the member may be appointed to another Medical Staff category if they meet the eligibility requirements for such category.

3.1.2 Prerogatives

Members of the Active Category may:

a. Attend and vote on all matters presented at general and special meetings of the Medical Staff, their department, and/or committees to which they are a member
b. Attend and vote on all matters presented at general and special meetings of the Medical Staff, their department, and/or committees to which they are a member
c. Attend staff or Hospital and Health Centers education programs
d. Hold Medical Staff office
e. Participate on or be the Chair of any committee in accordance with any qualifying criteria set forth in these Medical Staff Bylaws or Medical Staff policies.

3.1.3 Responsibilities

Member of the Active Category Shall:

a. Contribute to the organizational and administrative affairs of the Medical Staff;
b. Review and maintain their Contra Costa Health email account and communications at least weekly with updated away messages if on leave;
c. Actively participate as requested or required in activities and functions of the Medical Staff, including quality/performance improvement and peer review, credentialing, risk, and utilization management as requested, medical records completion and in the discharge of other staff functions as may be required; and
d. Fulfill or comply with any applicable Medical Staff or hospital policies or procedures.

3.2 The Courtesy Category

3.2.1 Qualifications

The Courtesy category is reserved for members who have clinical privileges but do not meet the eligibility requirements for the Active Category (e.g., locum tenens, irregular patient care).

3.2.2 Prerogatives

Members of this category may:

a. Attend Medical Staff, Department meetings of which they are a member and any Medical Staff or Hospital education programs;
b. Not vote on matters presented by the entire Medical Staff or Department or be an officer of the Medical Staff; and
c. Serve on Medical Staff committees but cannot be a voting member.

3.2.3 Responsibilites

Members of this category shall:

a. Have the same responsibilities as Active Category members.
b. Depending on the frequency of service, Courtesy members may check their email less frequently: at least quarterly with encouragement to check as regularly as patients are seen (monthly or weekly).

3.3 Honorary Recognition

The status of Honorary Recognition is restricted to those individuals recommended by the MEC and approved by the Board. This recognition is entirely discretionary and may be rescinded by the MEC at any time. Practitioners granted Honorary Recognition shall be those members who have retired from active practice, who are of outstanding reputation, and have provided distinguished service to the hospital. They may attend Medical Staff/Department meetings, continuing medical education activities, and may be appointed to committees as non-voting members. They shall not hold clinical privileges, hold office, or be eligible to vote.

3.4 Modification of Membership

On its own, upon recommendation of the Credentials Committee, or pursuant to a request by a member, the MEC may recommend a change in the Medical Staff category of a member consistent with the requirements of the Bylaws. A change in membership will be deemed an automatic administrative action if the member meets or fails to meet the criteria of a specific category.

Section 4. Officers of the Medical Staff

4.1 Officers of the Medical Staff

4.1.1 President

4.1.2 President-Elect

4.1.3 Immediate Past-President

4.2 Qualifications of Officers

Each Officer must be:

4.2.1 An MD, DO, DDS, DMD, or DPM

4.2.2 A member in good standing at the time of nomination, election, and throughout the term

4.2.3 A member of the Active Category

4.2.4 Board certified

4.2.5 Willing to faithfully discharge the duties of the office, and exercise the authority of the office held when working with the Departments and Medical Staff

Officers may not simultaneously hold a leadership position on another hospital's Medical Staff or in a facility that is directly competing with the hospital. Noncompliance with this requirement will result in the officer being automatically removed from office unless the MEC determines that allowing the officer to maintain their position is in the best interest of the hospital. The MEC shall have discretion to determine what constitutes a "leadership position" at another hospital.

4.3 Election of Officers

4.3.1 During the last quarter of the calendar year of even-numbered years, the MEC shall offer at least one nominee for the office of President-Elect. Nominations can be suggested by Department Chairs and vetted by the MEC.

4.3.2 Nominations must be announced, and the names of the nominees distributed to all members of the active Medical Staff at least fourteen (14) days prior to the election.

4.3.3 Officers shall be elected at least two months before the term of the current officers expires.

4.3.4 The Medical Staff Office, on behalf of the MEC, shall send ballots via an electronic voting system to all Active Members of the Medical Staff to their Contra Costa Health email address. No proxy voting will be permissible. Active Members will be given at least fourteen (14) calendar days to vote.

4.3.5 The Medical Staff President and at least one other member of the MEC shall verify the votes unless the Medical Staff President is a candidate. In that case, the MEC shall designate a second member of the MEC to verify the votes.

4.3.6 The nominee who receives the greatest number of votes cast will be elected. In the event of a tie vote, the MEC will make arrangements for a repeat vote(s) deleting the candidate with the lowest number of votes until one candidate receives a greater number of votes.

4.4 Term of Office

All officers serve a term of two (2) years. They shall take office on July 1. An individual may be reelected for successive terms or automatically assume a position as defined below:

4.4.1 The President may serve a maximum of four consecutive terms. If nonconsecutive, the number of terms a President may serve is not subject to limit.

4.4.2 At the conclusion of the President's term(s) of office, the President shall automatically assume the office of Immediate Past-President for as long as the next President is in office.

4.4.3 Should the incumbent President be re-elected, the office of President-Elect shall remain vacant until the next regularly scheduled election for President.

4.5 Vacancies of Office

4.5.1 If the office of the President becomes vacant after an election but before the end of the current President's term, the President-Elect will assume office to fill that vacancy and will serve the remainder of the current President's term and their own full term as President.

4.5.2 If the office of the President becomes vacant while the election is underway, the Immediate Past President will serve as Acting President until the results of that election are determined. Once those results are determined, the President-Elect will assume office and will serve the remainder of the current President's term and their own full term as President.

4.5.3 At any other times, if the office of the President becomes vacant, the Immediate Past President will serve as Acting President pending the outcome of a special election to be conducted as expeditiously as possible. The MEC may determine however, not to call a special election if a regular election for the office is to be held within ninety (90) days. The winner of a special election will serve only the remainder of the current President's term.

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

4.5.5 Any Medical Staff Officer may resign at any time by giving written notice to the MEC. Such

resignation takes effect on the date specified in the notice, or if no date is specified, on the date of receipt of the notice.

4.5.6 If the office of the President becomes vacant after an election but before the end of the current President's term, the President-Elect will assume office to fill that vacancy and will serve the remainder of the current President's term and their own full term as President.

4.5.7 If the office of the President becomes vacant while the election is underway, the Immediate Past President will serve as Acting President until the results of that election are determined. Once those results are determined, the President-Elect will assume office and will serve the remainder of the current President's term and their own full term as President.

4.5.8 At any other times, if the office of the President becomes vacant, the Immediate Past President will serve as Acting President pending the outcome of a special election to be conducted as expeditiously as possible. The MEC may determine however, not to call a special election if a regular election for the office is to be held within ninety (90) days. The winner of a special election will serve only the remainder of the current President's term.

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

4.5.10 Any Medical Staff Officer may resign at any time by giving written notice to the MEC. Such resignation takes effect on the date specified in the notice, or if no date is specified, on the date of receipt of the notice.

4.6 Duties of Officers

4.6.1 Medical Staff President: The President shall represent the interests of the Medical Staff to the MEC and the Board. The President is the primary elected officer of the Medical Staff and is the Medical Staff's advocate and representative in its relationships to the Board and the administration of the Hospital and Health Centers. The President, jointly with the MEC, provides direction to and oversees Medical Staff activities related to assessing and promoting continuous improvement in the quality of clinical services and all other functions of the Medical Staff as outlined in the Medical Staff bylaws, rules, regulations, and policies. Specific responsibilities and authority are to:

a. Call and preside at all general and special meetings of the Medical Staff;
b. Serve as chair of the MEC and as ex officio member of all other Medical Staff committees without vote, and to participate as invited by the Administrator or the Board on Hospital and Health Centers or Board committees;
c. Enforce Medical Staff bylaws, rules, regulations;
d. Except as stated otherwise, recommend appointment of committee chairs of Medical Staff standing and ad hoc committees to the MEC for approval;
e. In consultation with hospital administration, appoint Medical Staff members to appropriate Hospital and Health Centers committees or to serve as Medical Staff advisors or liaisons to carry out specific functions;

f. In consultation with the Joint Conference Committee, appoint the Medical Staff members to appropriate Board committees when those are not designated by position or by specific direction of the Board or otherwise prohibited by state law;

g. Support and encourage Medical Staff leadership and participation on clinical performance improvement activities;

h. Report to the Board, the MEC's recommendations concerning appointment, reappointment, delineation of clinical privileges or specified services, and corrective action with respect to practitioners who are applying for appointment or privileges, or who are granted privileges or providing services in the Hospital and Health Centers;

i. Continuously evaluate and periodically report to the Hospital and Health Centers administration, MEC, and the Board regarding the effectiveness of the credentialing and privileging processes;

j. Review and enforce compliance with standards of ethical conduct and professional demeanor among the practitioners on the Medical Staff in their relations with each other, the Board, hospital management, other professional and support staff, and the community the hospital serves;

k. Communicate and represent the opinions and concerns of the Medical Staff and its individual members on organizational and individual matters affecting Hospital and Health Centers operations to hospital administration, the MEC, and the Board;

l. Attend Board meetings and Board committee meetings as invited by the Board;

m. Ensure that the decisions of the Board are communicated and carried out within the Medical Staff; and

n. Perform such other duties and exercise such authority commensurate with the office as are set forth in the Medical Staff Bylaws.

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

4.6.3 Immediate Past President: This officer will serve as a consultant to the President and President-Elect and provide feedback regarding their performance of assigned duties. This officer shall perform such further duties to assist as the President may request from time to time.

4.7 Removal from Office

Criteria for removal are failure to meet the responsibilities assigned within these bylaws, failure to comply with policies and procedures of the Medical Staff, or for conduct that damages the hospital, its goals, or programs, and/or physical or mental infirmities that render the officer incapable of fulfilling the duties of office.

4.7.1 Removal by petition and vote: The Medical Staff may initiate the removal of any officer if at least twenty percent (20%) of the active members sign a petition advocating for such action.

Removal shall become effective upon an affirmative vote by two thirds (2/3) of those active staff members casting ballot votes.

4.7.2 Removal for cause: Removal for cause shall be for failure to meet those qualifications or responsibilities assigned within these bylaws. The MEC voting members will determine if the member has failed in their duties and/or qualifications and make a recommendation to the Board for approval of the removal.

Section 5. Advanced Practice Providers

5.1 Definitions

5.1.1 Advance Practice Provider (APP) means a health care professional, other than a physician, dentist, podiatrist, or clinical psychologist, who holds a license, as required by California law, to provide certain professional services.

5.1.2 APP Clinical Privileges or Service Authorization means the permission granted by the Governing Body, upon the recommendation of the Interdisciplinary Practice Committee and Credentials Committee, to provide preventative, diagnostic, and therapeutic services within the scope of the APP's training and expertise.

5.2 Categories of APPs Eligible to Apply for APP Clinical Privileges or Service Authorizations and Rules

5.2.1 The categories of APPs, based upon occupation or profession that shall be eligible to apply for APP Clinical Privileges shall be designated by the Governing Board, upon recommendation of the MEC. Currently, APP includes the following categories:

Nurse Practitioners who are registered nurses with additional training, expertise, certification, and licensing that are recognized and authorized by the State of California to provide specific diagnostic and therapeutic services. NPs who are eligible for NP 103 status must apply and maintain NP 103 status in order to gain and maintain active privileges. NPs hired prior to 2025 are exempt from this provision, though encouraged to apply. Nurse practitioner without NP 103 or NP 104 status must function with standardized procedures and require a supervising physician to maintain credentials, all NP 103 and NP 104 will work within their scope of practice without standardized procedures per state law (AB 890, 2020).

Optometrists who are licensed by the State of California to provide specific optometric services.

Midwives (Certified Nurse Midwives, Licensed Midwives, Certified Professional Midwives) who are health care providers with additional training, expertise, and certification that is recognized and authorized by the State of California, under the supervision of a licensed physician or surgeon, to attend cases of uncomplicated childbirth and to provide prenatal, intrapartum, and postpartum care.

Physician Assistants who are healthcare professionals with specialized medical training from a

program associated with a medical school and who are licensed by the California Physician Assistant Board to provide patient education, evaluation, and health care services under the supervision of a licensed physician.

Chiropractors who are health care providers with training, expertise, and knowledge in the practice of chiropractic and are licensed and regulated by the State of California under the Board of Chiropractic Examiners.

5.3 Eligibility and General Qualifications

APP is eligible for a Service Authorization in this Hospital and Health Centers if they:

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

5.4 Specific Qualifications

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

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

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

Nurse Practitioners: A Nurse Practitioner shall have a current, valid, unrestricted license and furnishing number that authorizes ordering of drugs or devices if applicable to the Nurse Practitioner’s practice.

Midwives: A Midwife shall have a current, valid, unrestricted license and furnishing number that authorizes ordering of drugs or devices if applicable to the Midwife's practice.

Physician Assistants: A Physician's Assistant shall have a current, valid, unrestricted license and furnishing number that authorizes the Physician's Assistant to provide drug and medication orders, if applicable to the Physician's Assistant's practice.

Optometrists: An optometrist shall have a current, valid, unrestricted license and furnishing number that authorizes ordering of drugs or devices if applicable to the Optometrist's practice.

Chiropractors: A Chiropractor shall have a current, valid, unrestricted license authorizing the practitioner to provide chiropractic treatment and care within the State of California.

5.5 Waiver of Qualifications

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

5.6 Prerogatives

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

Provision of specified patient care services consistent with the Service Authorization granted to the APP and within the scope and licensure or certification of that APP;

Vote on matters presented at their department and/or committees to which they are a member. Serve on Medical Staff and Hospital committees except as otherwise provided in the Bylaws;

Attend any medical staff or hospital education programs;

Vote for the department chair for the department to which they are a member.

5.7 Responsibilities

Each APP shall:

Meet those responsibilities required by the Medical Staff Rules and Regulations.

Retain appropriate responsibility within their area of professional competence for the care of each patient in the Hospital or Health Centers for whom they are providing services.

Participate, when requested, in patient care and audit and other quality review evaluation and monitoring activities required of APPs and other functions as may be required by the Medical Staff from time to time.

5.8 Procedure for Granting Initial and Renewal Services

Authorizations

An APP who practices under Standardized Procedures must apply and qualify for a Service Authorization. An APP must reapply for a renewed Service Authorization every two years.

APP application for initial granting and renewal of service authorization shall be submitted to the Interdisciplinary Practice Committee (IPC), which may delegate the processing of such applications to the Credentials Committee. Credentialing and Privileging is processed in a parallel manner to that provided for the Medical Staff by the Bylaws. At the discretion of the Credential Committee, an initial application of reappointment may be sent to the IPC for review.

The Credential Committee shall, as delegated by the IPC, make recommendations to the MEC and the Governing Body regarding the granting of individual Service Authorizations to APP applicants.

Upon approval by the MEC and the Governing Body, an applicant APP shall be granted Service Authorization and assigned to the clinical department appropriate to their occupation and training. The APP is subject to the relevant rules and regulations of that department.

5.9 Termination, Suspension, or Restriction of Service Authorizations

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

Section 6. Medical Staff Organization

6.1 Organization of the Medical Staff

6.1.1 The Medical Staff shall be organized into departments and divisions. The purpose of divisions may be to spread out work geographically for larger departments in need of local leadership, or to divide departments where specialty or scope is important to the duties of the division. The function of departments and divisions is described in the Rules & Regulations. The Clinical Departments and Divisions listed here are organized by the Medical Staff and the chairs of these Departments and Divisions are formally recognized by the MEC as voting members. These positions are elected by Active department or division members.

a. Anesthesia
b. Critical Care Medicine
c. Dental
d. Diagnostic Imaging
e. Emergency Medicine
f. Family and Adult Medicine

1. West Division (WCHC and North Richmond)
2. Martinez Division (MHC and Miller Wellness)
3. Concord Division
4. East Division (Pittsburg and Bay Point)
5. Far East Division (Antioch and Brentwood)

g. Hospital Medicine
h. Internal and Specialty Medicine
i. Obstetrics and Gynecology
j. Pathology
k. Pediatrics, Inpatient
l. Pediatrics, Outpatient
m. Psychiatry/Psychology
n. Public Health
o. Surgery

6.1.2 The MEC, with approval of the Board, may designate and/or dissolve new Medical Staff departments or divisions as it determines will best promote the Medical Staff needs for promoting performance improvement, patient safety, and effective credentialing and privileging.

6.2 Assignment to Department

The MEC will, after considering the recommendations of the Chair of the appropriate Department, approve Department assignments for all providers in accordance with their qualifications. Each providers will be assigned to one primary Department, in which they will have voting rights. They may participate in other departments as non-voting members. Clinical privileges are independent of Department assignment.

6.3 Qualifications, Selection, Term, and Removal of Department/ Division Chair voted on by Medical Staff

All Department Chairs must be Active members of the Medical Staff in good standing at the time of nomination, election, and throughout their term, have relevant clinical privileges, and be certified by an appropriate specialty board.

Each Department/Division Chair shall serve a term of two (2) years commencing on July 1 and may be elected to serve successive terms. In the first quarter of the calendar year, the Active members of the applicable Department/Division shall elect a Chair.

a. In odd numbered years, chairs will be elected for the following departments and divisions: Family and Adult Medicine, Anesthesia, Inpatient and Outpatient Pediatrics, Internal (Specialty) Medicine, Hospital Medicine, Pathology, Public Health, and Dentistry. Division Chairs: Martinez,

Concord, East.

b. In even numbered years, chairs will be elected for the follow departments and divisions: Emergency Medicine, Surgery, Psychiatry/Psychology, Diagnostic Imaging, Obstetrics & Gynecology, and Critical Care. Division Chairs: West, Far East.

The Medical Staff President shall request nominations for Department/Division Chairs voted on by Medical Staff at the first MEC meeting of the calendar year. The MSP or a designee will send an email to all Active Medical Staff Members of the affected departments in the first quarter of the year announcing the election process, including the call for nominations. Nominations may be submitted via email by any department member within the nominating department to the Medical Staff Office. Though any department member may nominate a chair, only those assigned to the department as their primary department may vote in the election.

Candidates may submit a written statement not to exceed one page to the Medical Staff Office.

The Medical Staff Office shall send via Contra Costa Health email a list of nominees who are eligible to hold a Department/Division Chair position and their written statements (if applicable) to all Active members of the Medical Staff in the applicable Department. Only candidates listed on the ballot may be considered for the position. A ballot will be sent electronically to the voting members of the department (those who are assigned primarily to that department). Voting members will have at least fourteen (14) days to respond via electronic ballot.

Department/Division Chairs shall be elected by majority vote of the Voting members of the Department who submitted votes, subject to approval by the MEC based on qualification requirements as stated above.

If the post of Chair of a Department/Division is vacated or the Chair is removed, the Medical Staff President can appoint an acting Chair, subject to MEC approval, to carry out the duties of the Chair until an election is possible. If the remainder of the term is greater than one year, then anyone in the Department may request a special election.

Department/Division Chairs may be removed from office by the MEC if two-thirds (2/3) of the Active members of the department recommend such action by petition, or, in the absence of such recommendation, the MEC may remove a Chair on its own by a two-thirds (2/3) vote of MEC voting members if the MEC determines that the Chair has failed to demonstrate to the satisfaction of the MEC that they are effectively carrying out the responsibilities of the position.

Department Chairs will be removed from office if the following occurs:

A. The Chair ceases to be a member in good standing of the Medical Staff;

B. The Chair suffers an involuntary loss or significant limitation of practice privileges; or

C. The Chair ceases to meet the qualifications defined in this section.

If a Department Chair is removed, a new election will be held according to the vacancy process described in this section. The Department Chair who was removed, cannot run in that election, but can run in future elections if eligible.

6.4 Responsibilities of Department Chair

6.4.1 Chairs may delegate duties to an Assistant Chair, Division Chair, or other Departmental Member when appropriate. They must appoint an Interim Chair for any planned absence.

6.4.2 Responsibilities include:

A. To endeavor to uphold the Bylaws, Rules & Regulations, and policies within the Department.

B. Act as presiding Officer of departmental meetings.

C. Attend MEC monthly meetings as a representative of the department.

D. Provide, at minimum, an annual report to MEC regarding pertinent activities of the department.

To uphold, continually assess, and improve the quality and safety of all clinically related activities of the Department To develop and implement policies and procedures to reflect required changes consistent with current practice, problem resolution, and standards changes;

a. Collaborate with the Quality Department to ensure regular Peer Review of department members

b. Mentor and support all department members

c. Cultivate leadership from within the department; consider succession planning

d. To collaborate with nursing, residency, administration, ancillary patient care services, and other departments on all activities related to the Department. For example, but not limited to:

e. Recommend off-site sources for needed patient care services not provided by the Medical Staff Department

f. Recommend to the Administrator sufficient numbers of qualified and competent persons to provide patient care and service;

g. Maintain quality control programs as appropriate;

h. Make recommendations for space, facilities, budget, equipment, and other resources needed by the Department to provide patient care services

i. Support the instruction, supervision, and evaluation of Residents within the Department

j. To coordinate and integrate interdepartmental and intradepartmental services and communication;

k. Credentialing and privileging

   i. Complete regular OPPE (Ongoing Professional Performance Evaluation) for department members

   ii. When appropriate, complete FPPE (Focused Professional Performance Evaluation) for department members

   iii. To recommend to the credentials committee the criteria for requesting clinical privileges that are relevant to the care provided in that Department;

l. To recommend clinical privileges for each member of the Department within the scope of the Department;

m. To orient new persons in the Department and

n. To coordinate, organize, and/or promote provider education for the Department

6.5 Committees

a. Administrative Affairs (voting)

b. Ambulatory Policy (voting)

c. Cancer

d. Continuing Medical Education

e. Credentials (voting)

f. Ethics

g. Interdisciplinary Practice (voting)

h. Medication Safety (reports to Patient Safety (PSPIC))

i. Patient Care Policy and Evaluation (PCP&E) (voting)

j. Patient Safety and Performance Improvement

k. Peer Review Oversight

l. Utilization Management

6.6 Designation and Substitution

There shall be an MEC and such other standing and ad hoc committees as established by the MEC and enumerated in the Rules and Regulations.

6.6.1 Meetings of these committees will be either standing or special.

6.6.2 Those functions requiring participation of, rather than direct oversight by the Medical Staff, may be discharged by Medical Staff representation on such Hospital and Health Centers committees as are established to perform such functions.

6.6.3 The President of the Medical Staff may appoint ad hoc committees as necessary to address time-limited or specialized tasks.

6.6.4 The Medical Staff President, with the approval of the MEC, shall appoint chairpersons and members of standing committees unless otherwise specified in the Bylaws or Rules & Regulations.

6.7 Medical Executive Committee (MEC)

6.7.1 Committee Membership and Composition:

a. The MEC shall be a standing committee consisting of the following voting members: the officers of the Medical Staff, the Chairs of the Credentials, Administrative Affairs, Ambulatory

Policy, PCP&E, and Performance Improvement committees, Department Chairs, and Division Chairs. The chair will be the Medical Staff President. The non-voting attendees to the MEC shall consist of the Administrator, CMO, Hospital Medical Director and associates, Ambulatory Care Director and associates, Contra Costa Health Plan Representative, Public Health administrator, Nursing Leadership representative, Medical Staff Office representative, Chief Quality Officer, Health Services representatives, and others invited by the MSP.

6.7.2 Removal from MEC:

a. An officer or Department/Division Chair who is removed from their position in accordance with the processes defined in these Bylaws will automatically lose their membership on the MEC.

b. When a Committee Chair or Department/Division Chair resigns or is removed from these positions, their replacement will serve on the MEC.

c. Other members of the MEC may be removed by a two-thirds (2/3) affirmative vote of MEC members.

6.7.3 Duties

The duties of the MEC, as delegated by the Medical Staff, shall be to:

a. Serve as the final decision-making body of the Medical Staff in accordance with the Medical Staff bylaws and provide oversight for all Medical Staff functions;

b. Coordinate the implementation of policies adopted by the Board;

c. Submit recommendations to the Board concerning all matters relating to appointment, reappointment, staff category, Department assignments, clinical privileges, and corrective action;

d. Report to the Board and to the staff for the overall quality and efficiency of professional patient care services provided by individuals with clinical privileges and coordinate the participation of the Medical Staff in organizational performance improvement activities;

e. Take reasonable steps to encourage and monitor professionally ethical conduct and competent clinical performance on the part of practitioners with privileges including collegial and educational efforts and investigations, when warranted;

f. Make recommendations to the Board on medical administrative and hospital management matters;

g. Keep the Medical Staff up-to-date concerning the licensure and accreditation status of the hospital;

h. Participate in identifying community health needs and in setting hospital goals and implementing programs to meet those needs;

i. Review and act on reports from Medical Staff committees, Departments, and other assigned activity groups;

j. Formulate, and recommend to the Board, Medical Staff rules, policies, and procedures;

k. Request evaluations of practitioners privileged through the Medical Staff process when there is question about an applicant or practitioner's ability to perform privileges requested or currently granted;

l. Make recommendations concerning the structure of the Medical Staff, the mechanism by which Medical Staff membership or privileges may be terminated, and the mechanisms for fair hearing procedures;

m. Consult with administration on the quality, timeliness, and appropriateness of contracts for patient care services provided to the hospital by entities outside the hospital;

n. Oversee appropriate utilization of care associated with regulatory and payor compliance plan as pertains to the Medical Staff;

o. Hold Medical Staff leaders, committees, and Departments accountable for fulfilling their duties and responsibilities;

p. Make recommendations to the Medical Staff for changes or amendments to the Medical Staff bylaws; and

q. Act for the organized Medical Staff between meetings of the organized Medical Staff.

6.7.4 Meeting

The MEC shall meet at least 10 times per year and more often as needed to perform its assigned functions. Permanent records of its proceedings and actions shall be maintained and filed with the Hospital.

Section 7. Medical Staff Meetings

7.1 Medical Staff Meetings

7.1.1 An annual meeting and other general meetings, if any, of the Medical Staff shall be held at a time determined by the MEC. Notice of the meeting shall be given to all Medical Staff members via appropriate media and posted conspicuously.

7.1.2 Except as otherwise specified in these bylaws, the actions of a majority of the members present and voting at a meeting of the Medical Staff is the action of the group. Action may be taken without a meeting of the Medical Staff by presentation of the matter to each member eligible to vote, by electronic ballot, and their vote recorded in accordance with procedures approved by the MEC. Such vote shall be binding so long as the matter that is voted on receives a majority of the votes cast.

7.2 Special Meetings of the Medical Staff

7.2.1 The Medical Staff President may call a special meeting of the Medical Staff sua sponte. The Medical Staff President must call a special meeting if so directed by resolution of the MEC. Such request or resolution shall state the purpose of the meeting. The Medical Staff President shall designate the time and place of any special meeting.

7.2.2 Written or electronic notice stating the time, place, and purposes of any special meeting of the Medical Staff shall be conspicuously posted and shall be sent to each member of the Medical Staff at least three (3) days before the date of such meeting. No business shall be transacted at any special meeting, except that stated in the notice of such meeting.

7.3 Regular Meetings of Medical Staff Committees and Departments

Committees and Departments may, by resolution, provide the time for holding regular meetings without notice other than such resolution.

7.4 Special Meetings of Commitees and Departments

A special meeting of any committee may be called by the Committee Chair; the Chair of a Department may call a special meeting of the Department; and the Medical Staff President may call a special meeting of the medical staff.

7.5 Quorum

7.5.1 Medical Staff Meetings: Those eligible Medical Staff members present and voting on an issue in any number will constitute a quorum.

7.5.2 MEC, Credentials Committee, and Medical Staff Peer Review Committee: A quorum will exist when fifty percent 50% of the members are present. When dealing with Category 1 requests for routine appointment, reappointment, and clinical privileges the MEC quorum will consist of at least three members.

7.5.3 Department meetings or Medical Staff committees other than those listed above: Those present and eligible Medical Staff members voting on an issue with constitute a quorum.

7.6 Attendance Requirements

7.6.1 Members of the Medical Staff are encouraged to attend meetings of the Medical Staff.

7.6.2 MEC, Credentials Committee, PCP&E, and APC meetings: Members of these committees are expected to attend at least fifty [50] percent of the meetings held.

7.6.3 Special meeting attendance requirements: Whenever there is a reason to believe that a practitioner is not complying with Medical Staff or hospital policies or has deviated from standard clinical or professional practice, the Medical Staff President or the applicable Department Chair or Medical Staff committee chair may require the practitioner to confer with them or with a standing or ad hoc committee that is considering the matter. The practitioner will be given special notice of the meeting at least five (5) days prior to the meeting. This notice shall include the date, time, place, issue involved and that the practitioner's appearance is mandatory. Failure of the practitioner to appear at any such meeting after two notices, unless excused by the MEC for an adequate reason, will result in an automatic termination of the practitioner's membership and privileges. Such termination does not give rise to the right to a hearing, but would automatically be rescinded if and when the practitioner participates in the previously referenced meeting.

7.6.4 Nothing in the foregoing paragraph shall preclude the initiation of precautionary restriction or suspension of clinical privileges as outlined in Part II of these bylaws (Investigations, Corrective Action, Hearing and Appeal Plan).

7.7 Participation by the Administrator

7.7.1 The Administrator is an ex-officio member of the MEC, without vote.

7.7.2 The committee may go in to closed session, with Medical Staff Department/Division chairs and Committee chairs only, when desired. The MSP may invite other guests to the closed session.

7.8 Notice of Meetings

Written or electronic notice stating the place, day, and hour of any special meeting or of any regular meeting not held pursuant to resolution shall be delivered or sent to each member of the Department or committee not less than three (3) days before the time of such meeting by the person or persons calling the meeting. The attendance of a member at a meeting shall constitute a waiver of notice of such meeting.

7.9 Action of Committee or Department

The recommendation of a majority of its members present at a meeting at which a quorum is present (if applicable) shall be the action of a committee or Department. Such recommendation will then be forwarded to the MEC for action.

7.10 Rights of Ex officio Members

Except as otherwise provided in these bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members, except that they shall not vote, be able to make motions, or be counted in determining the existence of a quorum.

7.11 Minutes

Minutes of each regular and special meeting of a committee or department shall be prepared and shall include a record of the attendance of members and the vote taken on each matter. The presiding Committee chair or Department Chair shall authenticate the minutes. A permanent file of the minutes of each meeting shall be maintained by the Medical Staff Office or departments.

Section 8. Conflict Resolution

8.1 Conflict Resolution

8.1.1 In the event the Board acts in a manner contrary to a recommendation by the MEC, the matter may (at the request of the MEC) be submitted to a Joint Conference Committee composed of the officers of the Medical Staff and an equal number of members of the Board for review and recommendation to the full the Board. The committee will submit its recommendation to the Board within thirty (30) days of its meeting.

8.1.2 To promote timely and effective communication and to foster collaboration between the Board, management, and Medical Staff, the chair of the JCC, the Administrator, or the Medical Staff President may call for a meeting between appropriate leaders, for any reason, to seek direct input, clarify any issue, or relay information directly, provided such meeting meets all applicable legal requirements including but not limited to those under the Brown Act.

Section 9. Review, Revision, Adoption, and Amendment

9.1 Medical Staff Responsibility

9.1.1 The Medical Staff shall have the responsibility to formulate, review at least biennially, and recommend to the Board any Medical Staff bylaws, rules, regulations, policies, procedures, and amendments as needed. Amendments to the bylaws and rules & regulations shall be effective when approved by the Board. The Medical Staff can exercise this responsibility through its elected and appointed leaders or through direct vote of its membership.

9.1.2 Such responsibility shall be exercised in good faith and in a reasonable, responsible, and timely manner. This applies as well to the review, adoption, and amendment of the related rules, policies, and protocols developed to implement the various sections of these bylaws.

9.2 Proposal of Amendments

When a new rule, regulation, or policy is proposed, the proposing party (either the MEC or the organized Medical Staff) will communicate the proposal to the other party prior to vote. If the MEC proposes to adopt a rule or regulation, or an amendment thereto, it first communicates the proposal to the Medical Staff.

9.2.1 Proposed amendments to these bylaws may be originated by the MEC or by a petition signed by twenty percent (20%) of the members of the Active Category.

9.3 Methods of Adoption and Amendment to these Bylaws

9.3.1 Each Active member will be eligible to vote on the proposed amendment via secure electronic ballot in a manner determined by the MEC.

9.3.2 All active members of the Medical Staff shall receive at least 14 days advance notice of the proposed changes followed by 14 days to vote on the proposed changes.

9.3.3 The amendment shall be considered approved or denied by the Medical Staff based on a simple majority of the votes received.

9.3.4 Amendments so adopted shall be effective when approved by the Board.

9.4 Methods of Adoption and Amendment to any Medical Staff Rules, Regulations, and Policies

9.4.1 The Medical Staff may adopt additional rules, regulations, and policies as necessary to carry out its functions and meet its responsibilities under these bylaws. A Rules & Regulations and/or Policies Manual may be used to organize these additional documents.

9.4.2 The MEC shall vote on the proposed language changes at a regular meeting, or at a special meeting called for such purpose. Following an affirmative vote by the MEC, rules and regulations

may be adopted, amended, or repealed, in whole or in part and such changes shall be effective when approved by the Board. Policies and procedures will become effective upon approval of the MEC.

a. In addition to the process described above, the organized Medical Staff itself may recommend directly to the Board an amendment(s) to any rule, regulation, or policy by submitting a petition signed by [twenty percent (20%)] of the members of the Active Category. Upon presentation of such petition, the adoption process outlined above will be followed.

9.5 Urgent Compliance Amendments to the Bylaws

In cases of a documented need for an urgent amendment necessary to comply with law, regulation, and/or accreditation standards, the MEC may provisionally adopt, and the Board may provisionally approve an urgent amendment to the Bylaws without prior notification of the Medical Staff. In such cases, the MEC immediately informs the Medical Staff. The Medical Staff will then vote on the amendment with the next Bylaws annual review.

9.6 Technical, Administrative, and/or Legal Revisions

The MEC may adopt such amendments to these bylaws, rules, regulations, and policies that are, in the committee's judgment, technical or legal modifications, or clarifications. Such modifications may include reorganization or renumbering, punctuation, spelling, or other errors of grammar or expression and shall be effective when approved by the Board. Neither the organized Medical Staff nor the Board may unilaterally amend the Medical Staff bylaws or rules and regulations.

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

Section 1. Collegial, Educational, and/or Informal Proceedings

1.1 Intervention Efforts

These bylaws encourage medical staff leaders and hospital and health centers management to use progressive steps, beginning with collegial and education efforts, to address questions relating to an individual's clinical practice and/or professional conduct. The goal of these progressive steps is to help the individual voluntarily respond to resolve questions that have been raised. All collegial intervention efforts by medical staff leaders and hospital management shall be considered confidential and part of the hospital's performance improvement and professional and peer review activities. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders and hospital management. When any observations arise suggesting opportunities for a practitioner to improve their clinical skills or professional behavior, the matter should be referred for peer review in accordance with the peer review and performance improvement policies

adopted by the medical staff and hospital. Collegial intervention efforts may include but are not limited to the following:

a. Educating and advising colleagues of all applicable policies, including those related to appropriate behavior, emergency call obligations, and the timely and adequate completion of medical records;
b. Following up on any questions or concerns raised about the clinical practice and/or conduct of privileged practitioners and recommending such steps as proctoring, monitoring, consultation, and letters of guidance; and
c. Sharing summary comparative quality, utilization, and other relevant information to assist individuals to conform their practices to appropriate norms.

If it appears that the practitioner's performance places patients in danger or compromises the quality of care following collegial intervention efforts, or in cases where it appears that patients may be placed in harm's way while collegial interventions are undertaken, the MEC will consider whether it should be recommended to the Board to restrict or revoke the practitioner's membership and/or privileges. Before issuing such a recommendation the MEC may authorize an investigation for the purpose of gathering and evaluating any evidence and its sufficiency.

Section 2. Investigations

2.1 Initiation

A request for an investigation must be submitted in writing or in person at an MEC meeting by any individual to the MEC, when there is a concern about conduct, performance, or competence of a practitioner. The request must be supported by references to the specific activities or conduct that is of concern. If the MEC itself initiates an investigation, it shall appropriately document its reasons in the meeting minutes and notify the practitioner. The MEC may initiate an investigation based on allegations of acts, demeanor, or conduct reasonably likely to be:

2.1.1 Detrimental to patient, practitioner, and/or associate safety

2.1.2 Unethical or illegal

2.1.3 Contrary to Medical Staff Bylaws, Rules & Regulations, and/or policies

2.1.4 Below applicable professional standards

2.1.5 Disruptive to hospital and/or health centers operations

2.2 Investigation

2.2.1 If the MEC decides that an investigation is warranted, it shall direct an investigation to be undertaken through the adoption of a formal resolution documented in the minutes. In the event the Board believes the MEC has incorrectly determined that an investigation is unnecessary, it may direct the MEC to proceed with an investigation.

2.2.2 The MEC may conduct the investigation itself or may assign the task to an appropriate

standing or ad hoc committee of the medical staff. The identify of the provider being investigated will be known to the ad hoc committee or to all of MEC if the group performs the investigation as a whole.

2.2.3 If the investigation is delegated to a committee other than the MEC, such committee shall proceed with the investigation promptly and forward a written report of its findings, conclusions, and recommendations to the MEC as soon as feasible. The committee conducting the investigation shall have the authority to review all documents it considers relevant, to interview individuals, to consider appropriate clinical literature and practice guidelines, and to utilize the resources of an external consultant if it deems a consultant is necessary and such action is approved by the MEC and the Administrator. The investigating body may also require the practitioner under review to undergo a physical and/or mental examination and may access the results of such exams.

2.2.4 The investigating body shall notify the practitioner in question of the allegations that are the basis for the investigation and provide to the practitioner an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

2.2.5 Meeting between the practitioner in question and the investigating body (and meetings with any other individuals the investigating body chooses to interview) shall not constitute a “hearing” as that term is used in the hearing and appeals sections of these bylaws. The procedural rules with respect to hearings or appeals shall not apply to these meetings either. The individual being investigated shall not have the right to be represented by legal counsel before the investigating body nor to compel the medical staff to engage external consultation.

2.2.6 Despite the status of any investigation, the MEC shall retain the authority and discretion to take whatever action may be warranted by the circumstances, including suspension of the practitioner in question, termination of the investigative process; or other action.

2.2.7 An external peer review consultant should be considered when:

a. Litigation seems likely;
b. The hospital is faced with ambiguous or conflicting recommendations from medical staff committees, or where there does not appear to be a strong consensus for a particular recommendation. In these circumstances consideration may be given by the MEC or the Board to retain an objective external reviewer;
c. There is no one on the medical staff with expertise in the subject under review, or when the only physicians on the medical staff with appropriate expertise are direct competitors, partners, or associates of the practitioner under review.

2.3 MEC Action

As soon as feasible after the conclusion of the investigation the MEC shall take action that may include, without limitation:

a. Determining no corrective action is warranted, and if the MEC determines there was not credible evidence for the complaint in the first instance, removing any adverse information

from the practitioner's file;

b. Deferring action for a reasonable time when circumstances warrant;
c. Issuing letters of education, admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude appropriate Department Chairs from issuing informal written or oral warnings prior to an investigation. In the event such letters are issued, the affected practitioner may make a written response, which shall be placed in the practitioner's file;
d. Recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring/proctoring;
e. Recommending denial, restriction, modification, reduction, suspension, or revocation of clinical privileges;
f. Recommending reductions of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care;
g. Recommending suspension, revocation, or probation of medical staff membership; or
h. Taking other actions deemed appropriate under the circumstances.

2.4 Subsequent Action

If the MEC recommends any termination or restriction of the practitioner's membership or privileges that qualifies for a right to a hearing as defined in these bylaws, the practitioner shall be entitled to the procedural rights afforded in this Hearing and Appeal Plan. The Board shall act on the MEC's recommendation unless the member requests a hearing, in which case the final decision shall be determined as set forth in this Hearing and Appeal Plan.

Section 3. Corrective Action

3.1 Automatic Relinquishment/Voluntary Resignation

In the triggering circumstances, described below, the practitioner's privileges and/or membership will be considered relinquished, or limited as described, and the action shall be final without a right to hearing. The affected practitioner will be notified of the automatic action via the email address provided at appointment and/or verified at reappointment, and by mail if deemed necessary by the MEC.

Where a bona fide dispute exists between any complainant and practitioner as to whether the circumstances have occurred, the relinquishment, suspension, or limitation will stand until the MEC determines it is not applicable. The MEC will make such a determination as soon as feasible. The MEC may reinstate the practitioner's privileges or membership after determining that the triggering circumstances have been rectified or are no longer present. If the triggering circumstances have not been resolved within sixty (60) days, the practitioner will have to reapply for membership and/or privileges once the issue has been resolved unless otherwise stated below. In addition, further corrective action may be recommended in accordance with these bylaws whenever any of the following actions occur:

3.1.1 Licensure

a. Revocation and suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, expired, or voluntarily relinquished, medical staff membership and clinical privileges shall be automatically relinquished by the practitioner as of the date such action becomes effective.

b. Restriction: Whenever a practitioner's license or other legal credential authorizing practice in this state is limited or restricted by an applicable licensing or certifying authority, any clinical privileges that the practitioner has been granted at this hospital and/or health centers that are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

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

3.1.2 Medicare, Medicaid, Tricare (a managed-care program that replaced the former Civilian Health and Medical Program of the Uniformed Services), or other state or federal programs

Whenever a practitioner is sanctioned or barred from Medicare, Medicaid, Tricare, or other state or federal programs, medical staff membership and clinical privileges shall be considered automatically relinquished as of the date such action becomes effective. Any practitioner listed on the United States Department of Health and Human Services Office of the Inspector General's List of Excluded Individuals/Entities or other state or federal exclusion lists will be considered to have automatically relinquished their privileges.

3.1.3 Controlled substances

a. DEA certificate or [state] Controlled Substance Registration (CSR): Whenever a practitioner's United States Drug Enforcement Agency (DEA) certificate or state CSR is revoked, limited, or suspended, the practitioner will 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. If prescribing medications is a requirement for privileges, the practitioner's privileges will be automatically and correspondingly suspended or revoked.

b. Probation: Whenever a practitioner's DEA certificate or state CSR is subject to probation, the practitioner'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. If prescribing medications is a requirement for privileges, the practitioner's privileges will be automatically and correspondingly suspended or revoked.

3.1.4 Medical record completion requirements: A practitioner will be considered to have voluntarily relinquished the privilege to admit new patients or schedule new procedures whenever they fail to complete medical records within time frames established by the MEC, as documented in the Rules & Regulations and hospital and health centers policy. This relinquishment of privileges shall not apply to patients admitted or already scheduled at the time of relinquishment, to emergency patients, or to imminent deliveries. The relinquished privileges will be automatically restored upon completion of the medical records and compliance with medical records policies.

A prolonged period of automatic suspension or a repeated pattern of automatic suspensions for incomplete medical records may be grounds for further corrective action by the Medical Staff and may result in adverse reports to governmental and licensing authorities.

3.1.5 Professional liability insurance: Failure of a practitioner to maintain professional liability insurance in the amount required by state regulations and medical staff and Board policies and sufficient to cover the clinical privileges granted shall result in immediate automatic relinquishment of a practitioner's clinical privileges. If within 60 calendar days of the relinquishment the practitioner does not provide evidence of required professional liability insurance (including prior acts or "nose" coverage for any period during which insurance was not maintained), the practitioner shall not be considered for reinstatement and shall be considered to have voluntarily resigned from the medical staff. The practitioner must notify the medical staff office immediately of any change in professional liability insurance carrier or coverage.

3.1.6 Medical Staff dues/special assessments: Failure to promptly pay medical staff dues or any special assessment shall be considered an automatic relinquishment of a practitioner's appointment. If within 60 calendar days after written warning of the delinquency the practitioner does not remit such payments, the practitioner shall be considered to have voluntarily resigned membership on the medical staff.

3.1.7 Failure to satisfy the special appearance requirement: A practitioner who fails without good cause to appear at a meeting where their appearance is required in accordance with these bylaws shall be considered to have automatically relinquished all clinical privileges with the exception of emergencies and imminent deliveries. These privileges will be restored when the practitioner complies with the appearance requirement. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff.

3.1.8 Failure to participate in an evaluation: A practitioner who fails to participate in an evaluation of their qualifications for medical staff membership or privileges as required under these bylaws (whether an evaluation of physical or mental health or of clinical management skills) or fails to authorize release of this information to the MEC, shall be considered to have automatically relinquished all privileges. These privileges will be restored when the practitioner complies with the requirement for an evaluation. Failure to comply within 30 calendar days will be considered a voluntary resignation from the medical staff and the practitioner must reapply for staff membership and privileges.

3.1.9 Failure to become board certified [or failure to maintain board certification]: A practitioner who fails to become board certified [or maintain board certification] in compliance with these bylaws or medical staff credentialing policies will be deemed to have immediately and voluntarily relinquished their medical staff appointment and clinical privileges.

3.1.10 Failure to Execute Release and/or Provide Documents: A practitioner who fails to execute a general or specific release of information and/or provide documents when requested by the Medical Staff President or designee to evaluate the competency and credentialing/privileging qualifications of the practitioner shall be considered to have automatically relinquished all privileges. If the release is executed and/or documents provided within thirty (30) calendar days of

notice of the automatic relinquishment, the practitioner may be reinstated. After thirty (30) calendar days, the member will be deemed to have resigned voluntarily from the staff and must reapply for staff membership and privileges.

3.2 MEC Deliberation

As soon as feasible after action is taken or warranted as described above, the MEC 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 in these bylaws.

3.3 Precautionary [Summary] Restriction or Suspension

3.3.1 Criteria for Initiation

a. A precautionary restriction or suspension may be imposed when a good faith belief exists that immediate action must be taken to protect the life or well-being of patient(s); or to reduce a substantial and imminent likelihood of significant impairment of the life, health, and safety of any person or when medical staff leaders and/or the Administrator determines that there is a need to carefully consider any event, concern, or issue that, if confirmed, has the potential to adversely affect patient or employee safety or the effective operation of the institution. Under such circumstances, the Administrator or designee, Medical Staff President or designee, MEC, or the practitioner's Department Chair may restrict or suspend the medical staff membership or clinical privileges of such practitioner as a precaution. A suspension of all or any portion of a practitioner's clinical privileges at another hospital may be grounds for a precautionary suspension of all or any of the practitioner's clinical privileges at this hospital and health centers.
b. Unless otherwise stated, such precautionary restriction or suspension shall become effective immediately upon imposition and the person or body responsible shall promptly give written notice to the practitioner, the MEC, the Administrator, and the board.
c. The restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. The precautionary suspension is not a complete professional review action in and of itself, and it shall not imply any final finding regarding the circumstances that caused the suspension.
d. Unless otherwise indicated by the terms of the precautionary restriction or suspension, the practitioner's patients shall be promptly assigned to another medical staff member by the Medical Staff President or designee, considering, where feasible, the wishes of the affected practitioner and the patient in the choice of a substitute practitioner.

3.3.2 MEC action

a. As soon as feasible, but within 14 calendar days after such precautionary suspension has been imposed, the MEC shall meet to review and consider the action and if necessary begin the investigation process as noted above.
b. Upon request and at the discretion of the MEC, the practitioner will be given the opportunity to address the MEC concerning the action, on such terms and conditions as the MEC may impose, although in no event shall any meeting of the MEC, with or without the practitioner,

constitute a “hearing” as defined in this Hearing and Appeal Plan, nor shall any procedural rules with respect to Hearing and Appeal Plan apply.

c. The MEC may modify, continue, or terminate the precautionary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision.

3.3.3 Procedural rights

Unless the MEC promptly terminates the precautionary restriction or suspension prior to or immediately after reviewing the results of any investigation described above, the member shall be entitled to the procedural rights afforded by this Hearing and Appeal Plan once the restrictions or suspension lasts more than 14 calendar days.

Section 4. Initiation and Notice of Hearing

4.1 Initiation of Hearing

Any practitioner eligible for medical staff membership or physicians eligible for privileges without membership shall be entitled to request a hearing whenever an unfavorable recommendation with regard to clinical competence or professional conduct has been made by the MEC or the Board. Hearings will be triggered only by the following "adverse actions" when the basis for such action is related to clinical competence or professional conduct:

a. Denial of medical staff appointment or reappointment;
b. Revocation of medical staff appointment;
c. Denial or restriction of requested clinical privileges, but only if the restriction is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct;
d. Involuntary reduction or revocation of clinical privileges;
e. Application of a mandatory concurring consultation requirement, or an increase in the stringency of a pre-existing mandatory concurring consultation requirement, when such requirement only applies to an individual medical staff member and is imposed for more than fourteen (14) calendar days; or
f. Suspension of staff appointment or clinical privileges, but only if such suspension is for more than fourteen (14) calendar days and is not caused by the member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.
g. Any other restriction(s) on Medical Staff membership or Clinical Privileges which is reportable pursuant to Section 805 of the Business and Professions Code.

4.2 Exceptions: Hearings will not be triggered by the following actions:

a. Issuance of a letter of guidance, warning, or reprimand;
b. Imposition of a requirement for proctoring (i.e., observation of the practitioner's performance by a peer in order to provide information to a medical staff peer review committee) with no restriction on privileges;
c. Failure to process a request for a privilege when the applicant/member does not meet the eligibility criteria to hold that privilege;
d. Conducting an investigation into any matter or the appointment of an ad hoc investigation committee;
e. Requirement to appear for a special meeting under the provisions of these bylaws;
f. Automatic relinquishment or voluntary resignation of appointment or privileges;
g. Imposition of a precautionary suspension that does not exceed fourteen (14) calendar days;
h. Denial of a request for leave of absence, or for an extension of a leave;

i. Determination that an application is incomplete or untimely;

j. Determination that an application will not be processed due to misstatement or omission;

k. Decision not to expedite an application;

l. Denial, termination, or limitation of temporary privileges unless for demonstrated incompetence or unprofessional conduct;

m. Determination that an applicant for membership does not meet the requisite qualifications/ criteria for membership;

n. Ineligibility to request membership or privileges or continue privileges because a relevant specialty is closed under a medical staff development plan or covered under an exclusive provider agreement;

o. Imposition of supervision pending completion of an investigation to determine whether corrective action is warranted;

p. Termination of any contract with or employment by hospital or health centers;

q. Proctoring, monitoring, and any other performance monitoring requirements imposed in order to fulfill any Joint Commission standards on focused professional practice evaluation;

r. Any recommendation voluntarily accepted by the practitioner;

s. Expiration of membership and privileges as a result of failure to submit an application for reappointment within the allowable time period;

t. Change in assigned membership category;

u. Refusal of the credentials committee or MEC to consider a request for appointment, reappointment, or privileges within five (5) years of a final adverse decision regarding such request;

v. Removal or limitations of emergency department call obligations;

w. Any requirement to complete an educational assessment;

x. Retrospective chart review;

y. Any requirement to complete a health and/or psychiatric/psychological assessment required under these bylaws;

z. Appointment or reappointment for duration of less than 24 months; or

aa. A member's failure to complete medical records or any other reason unrelated to clinical competence or professional conduct.

4.3 Notice of Recommendation of Adverse Action

When a precautionary [summary] suspension lasts more than fourteen (14) calendar days or when a recommendation is made, which, according to this plan entitles an individual to request a hearing prior to a final decision of the Board, the affected individual shall promptly (but no longer than five (5) calendar days) be given written notice by the President of the Medical Staff or designee, delivered either in person or by email to the email address provided at the time of appointment and/or verified at reappointment, and followed up by certified mail, return receipt requested if deemed necessary. This notice shall contain:

a. A statement of the recommendation made and the general reasons for it (Statement of Reasons);
b. Notice that the individual shall have thirty (30) calendar days following the date of the receipt of such notice within which to make a written request for a hearing on the recommendation;
c. Notice that the recommendation, if finally adopted by the board, may result in a report to the state licensing authority (or other applicable state agencies) and the National Practitioner Data Bank; and
d. The individual shall receive a copy of Part II of these bylaws outlining procedural rights with regard to the hearing.

4.4 Request for Hearing

A practitioner shall have thirty (30) calendar days following the date of the receipt of such notice within which to request the hearing. The request shall be made in writing to the President of the Medical Staff or designee (contact information shall be included in the notice to the practitioner). In the event the affected individual does not request a hearing within the time and in the manner required by this policy, the individual shall be deemed to have waived the right to such hearing and to have accepted the recommendation made. Such recommended action shall become effective immediately upon final board action.

4.5 Notice of Hearing and Statement of Reasons

Upon receipt of the practitioner's timely request for a hearing, the President of the Medical Staff or designee in consultation with the Administrator, shall schedule the hearing and shall give written notice to the person who requested the hearing. The notice shall include:

a. The time, place, and date of the hearing;
b. A proposed list of witnesses (as known at that time, but which may be modified) who will give testimony or evidence on behalf of the MEC, (or the Board), at the hearing;
c. The names of the hearing panel members and presiding officer or hearing officer, if known; and
d. A statement of the specific reasons for the recommendation as well as the list of patient records and/or information supporting the recommendation. This statement, and the list of supporting patient record numbers and other information, may be amended or added to at any time, even during the hearing so long as the additional material is relevant to the continued appointment or clinical privileges of the individual requesting the hearing, and that the individual and the individual's counsel have sufficient time to study this additional information and rebut it.

The hearing shall begin as soon as feasible, but no sooner than thirty (30) calendar days after the notice of the hearing unless an earlier hearing date has been specifically agreed to in writing by both parties.

4.6 Witness List

At least fifteen (15) calendar days before the hearing, each party shall furnish to the other a written list of the names of the witnesses intended to be called. Either party may request that the other party provide

either a list of, or copies of, all documents that will be offered as pertinent information or relied upon by witnesses at the Hearing Panel and which are pertinent to the basis for which the disciplinary action was proposed. The witness list of either party may, in the discretion of the presiding officer, be supplemented or amended at any time during the course of the hearing, provided that notice of the change is given to the other party as soon as reasonably possible. The presiding officer shall have the authority to limit the number of witnesses.

Section 5. Hearing Panel and Presiding Officer or Hearing Officer

5.1 Hearing Panel

a. When a hearing is requested, a hearing panel of not fewer than three individuals will be appointed by the MEC, with consultation of the Administrator. If any member of the MEC has a perceived or actual conflict of interest, they shall recuse themselves from the decision about the hearing panel appointment.

b. No individual appointed to the hearing panel shall have actively participated in the consideration of the matter involved at any previous level. However, mere knowledge of the matter involved shall not preclude any individual from serving as a member of the hearing panel. Employment by, or a contract with, the hospital or an affiliate shall not preclude any individual from serving on the hearing panel. Hearing panel members need not be members of the hospital medical staff. When the issue before the panel is a question of clinical competence, all panel members shall be clinical practitioners. Panel members need not be clinicians in the same specialty as the member requesting the hearing.

c. The hearing panel shall not include any individual who is in direct economic competition with the affected practitioner or any such individual who is in professional practice with or related to the affected practitioner. This restriction on appointment shall include any individual designated as the chair or the presiding officer.

d. The Medical Staff President or designee shall notify the practitioner requesting the hearing of the names of the panel members and the date by which the practitioner must object, if at all, to appointment of any member(s). Any objection to any member of the hearing panel or to the hearing officer or presiding officer shall be made in writing to the Medical Staff President, who, in conjunction with the MEC, shall determine whether a replacement panel member should be identified. Although the practitioner who is the subject of the hearing may object to a panel member, they are not entitled to veto that member's participation. Final authority to decide and appoint panel members will rest with the MEC and the Medical Staff President.

5.2 Hearing Panel Chairperson or Presiding Officer

In lieu of a hearing panel chair, the Administrator, acting for the Board and after considering the recommendations of the Medical Staff President (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may appoint an attorney at law or other individual experienced in legal proceedings as presiding officer. The presiding officer should have no on-going financial relationship with either the hospital and health centers, organized medical staff, or the practitioner. Such

presiding officer will not act as a prosecuting officer, or as an advocate for either side at the hearing. The presiding officer may participate in the private deliberations of the hearing panel and may serve as a legal advisor to it, but shall not be entitled to vote on its recommendation.

5.2.1 If no presiding officer has been appointed, a chair of the hearing panel shall be appointed by the MEC in consultation with the Administrator, to serve as the presiding officer and shall be entitled to one vote.

5.2.2 The presiding officer (or hearing panel chair) shall do the following:

a. Act to insure that all participants in the hearing have a reasonable opportunity to be heard and to present oral and documentary evidence subject to reasonable limits on the number of witnesses and duration of direct and cross examination, applicable to both sides, as may be necessary to avoid cumulative or irrelevant testimony or to prevent abuse of the hearing process;

b. Prohibit conduct or presentation of evidence that is cumulative, excessive, irrelevant, or abusive, or that causes undue delay. In general, it is expected that a hearing will last no more than fifteen hours;

c. Maintain decorum throughout the hearing;

d. Determine the order of procedure throughout the hearing;

e. Have the authority and discretion, in accordance with these bylaws, to make rulings on all questions that pertain to matters of procedure and to the admissibility of evidence;

f. Act in such a way that all information reasonably relevant to the continued appointment or clinical privileges of the individual requesting the hearing is considered by the hearing panel in formulating its recommendations;

g. Conduct argument by counsel on procedural points and may do so outside the presence of the hearing panel; and

h. Seek legal counsel when appropriate. Legal counsel to the hospital may advise the presiding officer or panel chair.

5.3 Hearing Officer

As an alternative to the hearing panel described above, the Administrator, acting for the Board and in conjunction with the Medical Staff President (or those of the chair of the Board, if the hearing is occasioned by a Board determination) may instead appoint a hearing officer to perform the functions that would otherwise be carried out by the hearing panel. The hearing officer may be an attorney in non-clinical matters.

5.3.1 The hearing officer may not be any individual who is in direct economic competition with the individual requesting the hearing, and shall not act as a prosecuting officer or as an advocate to either side at the hearing. In the event a hearing officer is appointed instead of a hearing panel, all references to the “hearing panel” or “presiding officer” shall be deemed to refer instead to the hearing officer, unless the context would clearly require otherwise.

a. Pre-Hearing and Hearing Procedure

5.4 Provision of Relevant Information

5.4.1 There is no right to formal "discovery" in connection with the hearing. The presiding officer, hearing panel chair, or hearing officer shall rule on any dispute regarding discoverability and may impose any safeguards, including denial or limitation of discovery to protect the peer review process and ensure a reasonable and fair hearing. In general, the individual requesting the hearing shall be entitled, upon specific request, to the following, subject to a stipulation signed by both parties, the individual's counsel and any experts that such documents shall be maintained as confidential consistent with all applicable state and federal peer review and privacy statutes and shall not be disclosed or used for any purpose outside of the hearing:

a. Copies of, or reasonable access to, all patient medical records referred to in the Statement of Reasons, at their expense;
b. Reports of experts relied upon by the MEC;
c. Copies of redacted relevant committee minutes;
d. Copies of any other documents relied upon by the MEC or the Board; and
e. Evidence unrelated to the reasons for the recommendation or to the individual's qualifications for appointment or the relevant clinical privileges shall be excluded.

No information regarding other practitioners shall be requested, provided, or considered.

5.4.2 Prior to the hearing, on dates set by the presiding officer or agreed upon by counsel for both sides, but in no event later than five (5) business days before the hearing, each party shall provide the other party with all proposed exhibits. All objections to documents or witnesses to the extent then reasonably known shall be submitted in writing prior to the hearing. The presiding officer shall not entertain subsequent objections unless the party offering the objection demonstrates good cause.

5.4.3 There shall be no contact by the individual who is the subject of the hearing with those individuals appearing on the hospital's witness list concerning the subject matter of the hearing without the written agreement of MEC or its counsel; nor shall there be contact by the hospital with individuals appearing on the affected individual's witness list concerning the subject matter of the hearing, unless by written agreement of that individual or their counsel.

5.5 Pre-Hearing Conference

The presiding officer may require a representative for the individual and for the MEC (or the Board) to participate in a pre-hearing conference. At the pre-hearing conference, the presiding officer shall resolve all procedural questions, including any objections to exhibits or witnesses, and determine the time to be allotted to each witness's testimony and cross-examination. The appropriate role of attorneys will be decided at the pre-hearing conference.

5.6 Failure to Appear

Failure, without good cause, of the individual requesting the hearing to appear and proceed at such a

hearing shall be deemed to constitute a waiver of all hearing and appeal rights and a voluntary acceptance of the recommendations or actions pending, which shall then be forwarded to the Board for final action. Good cause for failure to appear will be determined by the presiding officer, chair of the hearing panel, or hearing officer.

5.7 Record of Hearing

The hearing panel shall maintain a record of the hearing by a reporter present to make a record of the hearing or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the hearing at that individual's expense. The hearing panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of California.

5.8 Hearing Rights

5.8.1 At the hearing both sides shall have the following rights, subject to reasonable limits determined by the presiding officer:

a. To call and examine witnesses to the extent available;

b. To present evidence and introduce exhibits determined to be relevant by the hearing panel, regardless of its admissibility in a court of law;

c. To cross-examine any witness on any matter relevant to the issues and to rebut any evidence;

d. To have representation by counsel or other person of the practitioner's or MEC's [or Board's] choice who may be present at the hearing, advise their client, and participate in resolving procedural matters. Attorneys may argue the case for their client. Both sides shall notify the other of the name of their counsel at least ten (10) calendar days prior to the date of the hearing; and

e. To submit a written statement at the close of the hearing.

5.8.2 Any individuals requesting a hearing who do not testify on their own behalf may be called and examined as if under cross-examination.

5.8.3 The hearing panel may question the witnesses, call additional witnesses or request additional documentary evidence.

5.9 Admissibility of Evidence

The hearing shall not be conducted according to legal rules of evidence. Hearsay evidence shall not be excluded merely because it may constitute legal hearsay. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.

5.10 Burden of Proof

It is the burden of the MEC (or Board) to demonstrate that the action recommended is valid and appropriate. It is the burden of the practitioner under review to demonstrate that they satisfy, on a continuing basis, all criteria for initial appointment, reappointment, and clinical privileges and fully complies with all medical staff and hospital policies.

5.11 Post-Hearing Memoranda

Each party shall have the right to submit a post-hearing memorandum, and the hearing panel may request such a memorandum to be filed within fourteen (14) business days, following the close of the hearing.

5.12 Official Notice

The presiding officer shall have the discretion to take official notice of any matters, either technical or scientific, relating to the issues under consideration. Participants in the hearing shall be informed of the matters to be officially noticed and such matters shall be noted in the record of the hearing. Either party shall have the opportunity to request that a matter be officially noticed or to refute the noticed matter by evidence or by written or oral presentation of authority. Reasonable additional time shall be granted, if requested by either party, to present written rebuttal of any evidence admitted on official notice.

5.13 Postponements and Extensions

Postponements and extensions of time beyond any time limit set forth in this policy may be requested by anyone but shall be permitted only by the presiding officer on a showing of good cause.

5.14 Persons to be Present

The hearing shall be restricted to those individuals involved in the proceeding. Administrative personnel may be present as requested by the Medical Staff President or Administrator. All members of the hearing panel shall be present – virtually if necessary, absent good cause, for all stages of the hearing and deliberations.

5.15 Order of Presentation

The Board or the MEC, depending on whose recommendation prompted the hearing initially, shall first present evidence in support of its recommendation. Thereafter, the individual who requested the hearing shall present evidence.

5.16 Basis of Recommendation

The hearing panel shall recommend in favor of whichever side demonstrates the preponderance of evidence introduced at the hearing.

5.17 Adjournment and Conclusion

The presiding officer may recess the hearing and reconvene the same at the convenience and with the agreement of the participants. Upon conclusion of the presentation of evidence by the parties and questions by the hearing panel, the hearing shall be closed.

5.18 Deliberations and Recommendation of the Hearing Panel

Within twenty (20) calendar days after final adjournment of the hearing, the hearing panel shall conduct its deliberations outside the presence of any other person (except the presiding officer, if one is appointed) and shall render a recommendation, accompanied by a report, signed by all the panel members, which shall contain a concise statement of the reasons for the recommendation.

5.19 Disposition of Hearing Panel Report

5.19.1 The hearing panel shall deliver its report and recommendation to the President of the Medical Staff and the Administrator, who shall forward it, along with all supporting documentation, to the Board for further action.

5.19.2 The President of the Medical Staff or designee shall also send a copy of the report and recommendation, certified mail, return receipt requested, to the individual who requested the hearing, and to the MEC for information and comment.

5.19.3 If the hearing panel report confirms the original adverse recommendation, the practitioner shall have the right to appellate review as outlined below.

5.19.4 If the hearing panel report differs from the original MEC [or Board] recommendation, the MEC [or Board] may uphold its original recommendation or modify or adjust its recommendation and submit its new recommendation in writing to the affected practitioner, including a statement of the basis for its recommendation.

a. Appeal to the Hospital Board

5.20 Time for Appeal

Within ten (10) calendar days after the hearing panel makes a recommendation, or after the MEC [or Board] makes its final recommendation, either the practitioner subject to the hearing or the MEC may appeal an adverse recommendation. The request for appellate review shall be in writing, and shall be delivered to the Administrator or designee either in person or by certified mail, and shall include a brief statement of the reasons for appeal and the specific facts or circumstances which justify further review. If such appellate review is not requested within ten (10) calendar days, both parties shall be deemed to have accepted the recommendation involved, and the hearing panel's report and recommendation shall be forwarded to the board.

5.21 Grounds for Appeal

The grounds for appeal shall be limited to the following:

a. There was substantial failure to comply with the medical staff bylaws prior to or during the hearing so as to deny a fair hearing; or

b. The recommendation of the hearing panel was made arbitrarily, capriciously, or with prejudice; or

c. The recommendation of the hearing panel was not supported by substantial evidence based upon the hearing record.

5.22 Time, Place, and Notice

Whenever an appeal is requested as set forth in the preceding sections, the chair of the Board [or committee containing at least two Board members] shall schedule and arrange for an appellate review as soon as arrangements can be reasonably made, taking into account the schedules of all individuals involved. The affected individual shall be given notice of the time, place, and date of the appellate review. The chair of the Board may extend the time for appellate review for good cause.

5.23 Nature of Appellate Review

a. The chair of the Board shall appoint a review panel composed of at least two (2) members of the Board to consider the information upon which the recommendation before the Board was made. Members of this review panel may not be direct competitors of the practitioner under review and should not have participated in any formal investigation leading to the recommendation for corrective action that is under consideration.

b. The review panel may, but is not required to, accept additional oral or written evidence subject to the same procedural constraints in effect for the hearing panel or hearing officer. Such additional evidence shall be accepted only if the party seeking to admit it can demonstrate that it is new, relevant evidence and that any opportunity to admit it at the hearing was denied. If additional oral evidence or oral argument is conducted, the review panel shall maintain a record of any oral arguments or statements by a reporter present to make a record of the review or a recording of the proceedings. The cost of such reporter shall be borne by the hospital, but copies of the transcript shall be provided to the individual requesting the review at that individual's expense. The review panel may, but shall not be required to, order that oral evidence shall be taken only on oath or affirmation administered by any person designated to administer such oaths and entitled to notarize documents in the State of California.

c. Each party shall have the right to present a written statement in support of its position on appeal. In its sole discretion, the review panel may allow each party or its representative to appear personally and make a time-limited thirty-minute (30) oral argument. The review panel shall recommend final action to the Board.

d. The Board may affirm, modify, or reverse the recommendation of the review panel or, in its discretion, remand the matter for further review and recommendation, or make its own decision based upon the Board's ultimate legal responsibility to grant appointment and clinical privileges.

5.24 Final Decision of the Hospital Board

Within thirty (30) calendar days after receiving the review panel's recommendation, the Board shall render a final decision in writing, including specific reasons for its action, and shall deliver copies thereof to the affected individual and to the Medical Staff President to send to the Chairs of the Credentials Committee and MEC, in person or by email with a follow-up by certified mail, return receipt requested if determined necessary for receipt of the information.

5.25 Right to One Appeal Only

No applicant or medical staff member shall be entitled as a matter of right to more than one (1) hearing or appellate review on any single matter which may be the subject of an appeal. In the event that the Board ultimately determines to deny medical staff appointment or reappointment to an applicant, or to revoke or terminate the medical staff appointment and/or clinical privileges, that individual may not apply within five (5) years for medical staff appointment or for those clinical privileges at this hospital and health centers unless the Board advises otherwise.

Part III: Credentials Procedures Manual

Section 1. Medical Staff Credentials Committee

1.1 Composition

Membership of the medical staff Credentials Committee shall consist of at least five (5) members of medical staff of the Active Category who are experienced leaders that are not Department Chairs. The Medical Staff President will appoint the Chair and other members. Members will be appointed for three (3) year terms with the initial terms staggered such that approximately one third of the members will be appointed each year. The chair will be appointed for a three (3) year term. The chair and members may be reappointed for additional terms without limit. The committee may also invite medical staff to attend Credentials Committee meetings, such as representatives from hospital administration and the Board.

1.2 Meetings

The medical staff Credentials Committee shall meet on call of the chair or Medical Staff President.

1.3 Responsibilities

1.3.1 To review and recommend action on all applications and reapplications for membership on the medical staff including assignments of medical staff category., e.g., Active Category, Honorary Category, and Courtesy Category;

1.3.2 To review and recommend action on all requests regarding privileges from eligible practitioners;

1.3.3 To recommend eligibility criteria for the granting of medical staff membership and

privileges;

1.3.4 To develop, recommend, and consistently implement policy and procedures for all credentialing and privileging activities;

1.3.5 To review, and where appropriate take action on, reports concerning credentialing that are referred to it from other medical staff committees, medical staff or hospital leaders;

1.3.6 To perform such other functions as requested by the MEC or the Medical Staff President.

1.4 Confidentiality

This committee shall function as a peer review committee consistent with federal and state law, including but not limited to, Business and Professions Code sections 805 et seq; and Evidence Code section 1157. All members of the committee shall, consistent with the medical staff and hospital confidentiality policies, keep in strict confidence all papers, reports, and information obtained by virtue of membership on the committee.

1.4.1 The credentials file is the property of the hospital and will be maintained with strictest confidence and security. The files will be maintained by the designated agent of the hospital in locked file cabinets or in secure electronic format. Medical staff and administrative leaders may access credential files for appropriate peer review and institutional reasons. Files may be shown to accreditation and licensure agency representatives with permission of the Administrator, Medical Staff President, or designee.

1.4.2 Individual practitioners may review their credentials file under the following circumstances:

Only upon written request approved by the Medical Staff President, credentials chair or Chief Medical Officer. Review of such files will be conducted in the presence of the medical staff service professional, medical staff leader, or a designee of administration. Confidential letters of reference may not be reviewed by practitioners and will be sequestered in a separate file and removed from the formal credentials file prior to review by a practitioner. Nothing may be removed from the file. Only items supplied by the practitioner or directly addressed to the practitioner may be copied and given to the practitioner. The practitioner may make notes for inclusion in the file. A written or electronic record will be made and placed in the file confirming the dates and circumstances of the review.

Section 2. Qualifications for Membership and/or Privileges

2.1 The following qualifications must be met and continuously maintained by all applicants for medical staff appointment, reappointment, or clinical privileges:

2.1.1 Demonstrate that they have successfully graduated from an approved school of medicine,

osteopathy, dentistry, podiatry, clinical psychology, optometry or applicable recognized course of training in a clinical profession eligible to hold privileges;

2.1.2 Have a current unrestricted state or federal license as a practitioner, applicable to their profession, and providing permission to practice within the state of California;

2.1.3 Possess a current, valid, unrestricted drug enforcement administration (DEA) number if applicable;

2.1.4 Possess a valid NPI number (if applicable);

2.1.5 Have a record that is free from current Medicare/Medicaid sanctions and not be listed on a state or federal exclusion, debarment, and/or sanction list, such as the OIG List of Excluded Individuals/Entities;

2.1.6 Provide evidence of professional liability insurance appropriate to all privileges requested and of a type and in an amount established by the Board after consultation with the MEC.

2.2 Practitioner-Specific Qualifications Include:

2.2.1 A physician applicant, MD, or DO, must have successfully completed an allopathic or osteopathic residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association (AOA) and be currently board certified or become board certified within the timeframe defined by the appropriate specialty board;

2.2.2 Dentists must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation;

2.2.3 Oral and maxillofacial surgeons must have graduated from an American Dental Association approved school of dentistry accredited by the Commission of Dental Accreditation and successfully completed an American Dental Association approved residency program and be board certified or become board certified within the appropriate number of years of completing formal training as defined by the American Board of Oral and Maxillofacial Surgery;

2.2.4 A podiatric physician, DPM, must have successfully completed a two-year (2) residency program in surgical, orthopedic, or podiatric medicine approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association (APMA), and be board certified or become board certified within the appropriate number of years of completing formal training as determined by the American Board of Foot and Ankle Surgery or the American Board of Podiatric Orthopedics and Primary Podiatric Medicine;

2.2.5 A psychologist must have an earned a doctorate degree, (PhD or Psy.D, in psychology) from an educational institution accredited by the American Psychological Association and have completed at least two (2) years of clinical experience in an organized healthcare setting, supervised by a licensed psychologist, one (1) year of which must have been post doctorate, and have completed an internship endorsed by the American Psychological Association (APA), and be board certified as appropriate to the area of clinical practice;

2.2.6 A certified registered nurse anesthetist (CRNA) must have graduated from an approved program of anesthesia accredited by the Council on Accreditation of Nurse Anesthesia Educational Programs or a predecessor or successor agency. Certification by the National Board on Certification and Recertification for Nurse Anesthetists (NBCRNA), or by a predecessor or successor agency to either, or be actively seeking initial certification and obtain the same on the first examination for which eligible, is required for initial applicants and reapplicants.

2.2.7 A certified nurse midwife (CNM) must have successfully completed an Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives – ACNM) accredited nurse midwifery program. Current active certification by the American Midwifery Certification Board (AMCB) or be actively seeking initial certification and obtain the same on the first examination for which eligible, is required for initial applicants and reapplicants.

2.2.8 A nurse practitioner (NP) must have completed a masters, post-masters, or doctorate degree in a nurse practitioner program accredited by the Commission on Collegiate of Nursing Education (CCNE) or the Accreditation Commission for Education in Nursing (ACEN). Current certification by the American Nurses Credentialing Center (ANCC) or the American Association of Critical Care Nurses (AACN) or an equivalent body or be actively seeking initial certification and obtain the same on the first examination for which eligible, is required for initial applicants and reapplicants. NPs that are eligible for NP103 status must apply and maintain NP 103 status in order to gain and maintain active privileges with CCH. NPs hired prior to 2025 are exempt from this provision, though encouraged to apply.

2.2.9 A physician assistant (PA) must have completed an Accreditation Review Commission on Education for the Physician Assistant (ARC-PA) approved program (prior to January 2001 – Commission on Accreditation of Allied Health Education Programs). Current certification by the National Commission on Certification of Physician Assistants (NCCPA) as a PA-C, or be actively seeking initial certification and obtain the same on the first examination for which eligible, is required for initial applicants and reapplicants.

2.3 Exceptions

2.3.1 All practitioners who are current medical staff members and/or held privileges prior to January 1, 2020, and who have met prior qualifications for membership and/or privileges shall be exempt from board certification requirements.

2.3.2 If there is documented evidence that a practitioner demonstrates an equivalent competence in the areas of the requested privileges, the Board may create an additional exception for the practitioner after consultation with the MEC.

Section 3. Initial Appointment Procedure

3.1 Completion of Application

3.1.1 All requests for applications for appointment to the medical staff and requests for clinical privileges shall be sent to the medical staff office. Upon receipt of the request, the medical staff

office will provide the applicant an application package, which will include a complete set or overview of the medical staff bylaws or reference to an electronic source for this information. This package will enumerate the eligibility requirements for medical staff membership and/or privileges and a list of expectations of performance for individuals granted medical staff membership or privileges (if such expectations have been adopted by the medical staff).

A completed application includes, at a minimum:

a. A completed, signed, dated application form;

b. A completed privilege delineation form if requesting privileges;

c. Copies of all requested documents and information necessary to confirm the applicant meets criteria for membership and/or privileges and to establish current competency;

d. All applicable fees;

e. A current picture ID card issued by a state or federal agency (e.g. driver's license or passport);

f. Receipt of all references; references shall come from peers knowledgeable about the applicant's experience, ability, and current competence to perform the privileges being requested;

g. Relevant practitioner-specific data as compared to aggregate data, when available; and

h. Morbidity and mortality data, when available.

An application shall be deemed incomplete if any of the above items are missing or if the need arises for new, additional, or clarifying information in the course of reviewing an application. An incomplete application will not be processed. Anytime in the credentialing process it becomes apparent that an applicant does not meet all eligibility criteria for membership or privileges, the credentialing process will be terminated and no further action taken. An applicant is not entitled to a hearing when the application is not processed due to incomplete information or because the applicant does not meet all eligibility criteria for membership or privileges.

3.1.2 The burden is on the applicant to provide all required information. It is the applicant's responsibility to ensure that the medical staff office receives all required supporting documents verifying information on the application and to provide sufficient evidence, as required in the sole discretion of the hospital, that the applicant meets the requirements for medical staff membership and/or the privileges requested. If information is missing from the application, or new, additional, or clarifying information is required, a letter requesting such information will be sent to the applicant. If the requested information is not returned to the medical staff office within forty-five (45) calendar days of the receipt of the request letter, the application will be deemed to have been voluntarily withdrawn.

3.1.3 Upon receipt of a completed application the Credentials Chair or designee, in collaboration with the medical staff office, will determine if the requirements of sections 2.2 and 2.3 are met. In the event the requirements of sections 2.2 and 2.3 are not met, the potential applicant will be notified that s/he is ineligible to apply for membership or privileges on the medical staff, the

application will not be processed and the applicant will not be eligible for a fair hearing. If the requirements of sections 2.2 and 2.3 are met, the application will be accepted for further processing.

3.1.4 Individuals seeking appointment shall have the burden of producing information deemed adequate by the hospital and health centers for a proper evaluation of current competence, character, ethics, and other qualifications, and of resolving any doubts.

3.1.5 Upon receipt of a completed application, the medical staff office will verify current licensure, education, relevant training, and current competence from the primary source whenever feasible, or from a credentials verification organization (CVO). When it is not possible to obtain information from the primary source, reliable secondary sources may be used if there has been a documented attempt to contact the primary source. In addition, the medical staff office will collect relevant additional information which may include:

a. A valid picture ID issued by a state or federal agency (for example, a driver's license or passport) at the time of initial granting of membership and/or privileges;

b. Information from all prior and current liability insurance carriers concerning claims, suits, settlements, and judgments, (if any) during the past ten (10) years at the time of initial granting of membership and/or privileges, and the past twenty-four (24) months thereafter;

c. Verification of the applicant’s past clinical work experience for at least the past five (5) years;

d. Licensure status in all current or past states of licensure at the time of initial granting of membership or privileges; in addition, the medical staff office will primary source verify licensure at the time of renewal or revision of clinical privileges, whenever a new privilege is requested, and at the time of license expiration;

e. Information from the AMA or AOA Physician Profile, Federation of State Medical Board, state and federal exclusion lists such as the OIG list of Excluded Individuals/ Entities or SAM (System for Award Management) and FACIS (Fraud and Abuse Control Information System);

f. Information from professional training programs including residency and fellowship programs;

g. Information from the National Practitioner Data Bank (NPDB); in addition the NPDB will be queried at the time of renewal of privileges and whenever a new privilege(s) is requested, but at a minimum every twenty-four (24) months;

h. Other information about adverse credentialing and privileging decisions;

i. An internet search to determine if other pertinent information is available;

j. Three (3) peer recommendations (at the time of initial granting of membership and/or privileges only), as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant’s clinical and professional performance and can evaluate the applicant’s current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform

requested privileges;

k. Information from any other sources relevant to the qualifications of the applicant to serve on the medical staff and/or hold privileges;

l. All continuing medical education classes attended by the applicant in the last twenty-four (24) months; and

m. Morbidity and mortality data and relevant practitioner-specific data as compared to aggregate data, when available.

Note: In the event there is undue delay in obtaining required information, the medical staff office will request assistance from the applicant. During this time period, the "time periods for processing" the application will be appropriately modified. Failure of an applicant to adequately respond to a request for assistance after forty-five calendar (45) days will be deemed a withdrawal of the application.

3.1.6 When the items identified in Section 3.1 above have been obtained, the file will be considered verified and complete and eligible for evaluation.

3.2 Applicant's Attestation, Authorization, and Acknowledgement

The applicant must complete and sign the application form. By signing this application the applicant:

3.2.1 Attests to the accuracy and completeness of all information on the application or accompanying documents and agreement that any [substantive] inaccuracy, omission, or misrepresentation, whether intentional or not, may be grounds for termination of the application process without the right to a hearing or appeal. If the inaccuracy, omission, or misstatement is discovered after an individual has been granted appointment and/or clinical privileges, the individual's appointment and privileges may be automatically revoked effective immediately upon notification of the individual without the right to a hearing or appeal.

3.2.2 Consents to appear for any requested interviews in regard to their application.

3.2.3 Authorizes the hospital and health centers medical staff representatives to consult with prior and current associates and others who may have information bearing on their professional competence, character, ability to perform the privileges requested, ethical qualifications, ability to work cooperatively with others, and other qualifications for membership and the clinical privileges requested.

3.2.4 Consents to hospital and health centers medical staff representatives' inspection of all records and documents that may be material to an evaluation of:

a. Professional qualifications and competence to carry out the clinical privileges requested;

b. Physical and mental/emotional health status to the extent relevant to safely perform requested privileges;

c. Professional and ethical qualifications;

d. Professional liability actions including currently pending claims involving the applicant; and

e. Any other issue relevant to establishing the applicant's suitability for membership and/or privileges.

3.2.5 Releases from liability and promises not to sue, all individuals and organizations who provide information to the hospital or the medical staff, including otherwise privileged or confidential information to the hospital representatives concerning their background; experience; competence; professional ethics; character; physical and mental health to the extent relevant to the capacity to fulfill requested privileges; emotional stability; utilization practice patterns; and other qualifications for staff appointment and clinical privileges.

3.2.6 Authorizes the hospital and health centers medical staff and administrative representatives to release any and all credentialing and peer review information to other hospitals, medical associations, licensing boards, appropriate government bodies and other health care entities or to engage in any valid discussion relating to the past and present evaluation of the applicant's training, experience, character, conduct, judgment, or other matters relevant to the determination of the applicant's overall qualifications upon appropriately signed release of information document(s). Acknowledges and consents to agree to an absolute and unconditional release of liability and waiver of any and all claims, lawsuits, or challenges against any medical staff or hospital representative regarding the release of any requested information and further, that all such representatives shall have the full benefit of this release and absolute waiver as well as any legal protections afforded under the law.

3.2.7 Acknowledges that the applicant has had access to the medical staff bylaws, including all rules, regulations, policies and procedures of the medical staff, and agrees to abide by their provisions.

3.3 If an individual institutes legal action, notwithstanding section 3.2.5 through 3.2.7, and does not prevail, they shall reimburse the hospital and any member of the medical staff named in the action for all costs incurred in defending such legal action, including reasonable attorney(s) fees.

3.3.1 Agrees to provide accurate answers to all questions, including the below, and agrees to immediately notify the hospital and health centers in writing should any of the information regarding these items change during processing of this application or the period of the applicant's medical staff membership or privileges. If the applicant answers any of the following questions affirmatively and/or provides information that raises a concern the applicant will be required to submit a written explanation of the circumstances involved.

a. Have any disciplinary actions been initiated or are any pending against you by any state licensure board?

b. Has your license to practice or registration in any state ever been relinquished, denied,

challenged, limited, suspended, or revoked, whether voluntarily or involuntarily?

c. Have you ever been asked to surrender your professional license?

d. Have you ever been suspended, sanctioned, excluded, or otherwise restricted from participating in any private, federal, or state health insurance program (for example, Medicare, TriCare, or Medicaid)?

e. Have you ever been the subject of an investigation by any private, federal, or state agency concerning your participation in any private, federal, or state health insurance program?

f. Has your DEA certificate or any state controlled substance license ever been relinquished, limited, denied, suspended, or revoked?

g. Is your DEA certificate or any state controlled substance license currently being challenged?

h. Has your employment, medical staff membership, or clinical privileges ever been terminated, reduced, suspended, diminished, revoked, refused, or limited at any hospital, physician group practice or other health care facility, whether voluntarily or involuntarily?

i. Have you ever withdrawn your application for appointment, reappointment, or clinical privileges or resigned from the medical staff before a hospital's or health facility's Board made a decision?

j. Have you ever been the subject of a formal or informal disciplinary or corrective action investigation?

k. Have you ever been the subject of an investigation because of inappropriate conduct, disruptive behavior, or unprofessional actions (e.g. sexual harassment)?

l. Explain any gaps in practice greater than ninety (90) days.

m. Have you ever been the subject of focused individual monitoring at any hospital or health care facility other than to confirm competency immediately following an initial grant of a privilege(s)?

n. If you are not currently board certified please answer the questions below (if board certified skip to (o) below):

    i. Have you ever been examined by any specialty board, but failed to pass the examination? Please provide details.

    ii. If not certified, have you applied for the certification exam?

    iii. Have you ever been accepted to take the certification exam?

    iv. If yes, what dates are you scheduled to take the certification exam?

o. Have any professional liability claims or suits ever been filed against you or are any presently pending?

p. Have any judgments or settlements been made against you in professional liability cases? (If yes, please provide a short synopsis of the allegations and outcome of the case).

q. Have you ever been refused or denied coverage, had coverage cancelled, or had specific privileges excluded by a malpractice liability carrier?

r. Have you ever entered into an agreement with the federal or state government as a result of violations of state or federal regulations or law (e.g. a corporate integrity agreement)?

s. Are you currently taking any substances or medications which could impair your ability to safely perform the privileges which you are requesting in this application?

t. Have you ever been disciplined or formally reprimanded because of inappropriate conduct, disruptive behavior, or unprofessional interactions (e.g. sexual harassment)?

u. Have you ever been terminated, resigned or non-renewed from any healthcare employment or from a group practice?

3.4 Application Evaluation

3.4.1 Credentialing Process: An expedited review and approval process may be used for initial appointment or for reappointment. (See Section 4.3.1.) An applicant is not eligible for the expedited process if the application is deemed incomplete, or if the MEC makes a final recommendation that is adverse or has limitations. All initial applications for membership and/or privileges will be designated Category 1 or Category 2 as defined below.

Category 1: A completed application that does not raise any of the concerns identified in the criteria for Category 2. Applicants in Category 1 will be granted medical staff membership and/or privileges after review and action by the following: Department Chair and Credentials Chair acting on behalf of the Credentials Committee, the MEC and a Board committee consisting of at least two Board members.

Category 2: If one or more of the below criteria are identified in the course of reviewing a completed and verified application, the application will be treated as Category 2. Applications in Category 2 must be reviewed and acted on by the Department Chair, Credentials Committee, MEC, and the Board. The Credentials Committee may request that an appropriate subject matter expert assess selected applications. At all stages in this review process, the burden is upon the applicant to provide evidence that s/he meets the criteria for membership on the medical staff and for the granting of requested privileges. Criteria for Category 2 applications include but are not necessarily limited to the following:

a. The applicant is found to have experienced an involuntary termination of medical staff membership or involuntary limitation, reduction, denial, or loss of clinical privileges at another organization or has a current challenge or a previously successful challenge to licensure or registration;

b. Applicant is, or has been, under investigation by a state medical board or has prior disciplinary actions or legal sanctions;

c. Applicant has had two (2) or more filed within the past five (5) years or one final adverse judgment or settlement in a professional liability action;

d. Applicant changed medical schools or residency programs or has gaps in training or practice;

e. Applicant has changed practice affiliations more than three times in the past ten (10) years (excluding telemedicine and locum tenens practitioners);

f. Applicant has practiced or been licensed in three (3) or more states post residency/ fellowship (excluding telemedicine and locum tenens practitioners);

g. Applicant has one or more reference responses that raise concerns or questions;

h. Discrepancy is found between information received from the applicant and references or verified information;

i. Applicant has an adverse National Practitioner Data Bank report;

j. The request for privileges are not reasonable based upon applicant's experience, training, and demonstrated current competence, and/or is not in compliance with applicable criteria;

k. Applicant has been removed from a managed care panel for reasons of professional conduct or quality;

l. Applicant has potentially relevant physical, mental, and/or emotional health problems;

m. Other reasons as determined by a medical staff leader or other representative of the hospital which raise questions about the qualifications, competency, professionalism, or appropriateness of the applicant for membership or privileges.

3.4.2 Applicant Interview

a. All applicants for appointment to the medical staff and/or the granting of clinical privileges may be required to participate in an interview at the discretion of the Department Chair, Credentials Committee, MEC, or Board. The interview may take place in person or virtually at the discretion of the hospital or its agents. The interview may be used to solicit information required to complete the credentials file or clarify information previously provided, e.g., clinical knowledge and judgment, professional behavior, malpractice history, reasons for leaving past healthcare organizations, or other matters bearing on the applicant's ability to render care at the generally recognized level for the community. The interview may also be used to communicate medical staff performance expectations.

b. Procedure: the applicant will be notified if an interview is requested. Failure of the applicant to appear for a scheduled interview will be deemed a withdrawal of the application.

3.4.3 Department Chair Action

a. All completed applications are presented to the Department Chair for review, and recommendation. The Department Chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The Department Chair, in consultation with the medical staff professional, determines whether the application is forwarded as a Category 1 or Category 2. The Department Chair may obtain input if necessary from an appropriate subject matter expert. If a Department Chair believes a conflict of interest exists that might preclude their ability to make an unbiased recommendation they will notify the credentials chair and forward the application without comment.

b. The Department Chair forwards to the medical staff Credentials Committee the following:

i. A recommendation as to whether the application should be acted on as Category 1 or Category 2;

ii. A recommendation as to whether to approve, modify, or deny the applicant's request for membership and/or privileges;

iii. A recommendation to define those circumstances that require monitoring and evaluation of performance after initially granting clinical privileges; and

iv. Comments to support these recommendations/information.

3.4.4 Medical Staff Credentials Committee Action

If the application is designated Category 1, it is presented to the credentials chair or designee for review and recommendation. The credentials chair reviews the application to ensure that it fulfills the established standards for membership and/or clinical privileges. The credentials chair has the opportunity to determine whether the application is forwarded to the MEC as a Category 1 or may change the designation to a Category 2. If forwarded as a Category 1, the credentials chair acts on behalf of the medical staff Credentials Committee and the application is presented to the MEC for review and recommendation. If designated Category 2, the medical staff Credentials Committee reviews the application and forwards the following to the MEC:

a. A recommendation to approve, modify, or deny the applicant's request for membership and/or privileges;
b. A recommendation to define those circumstances which require monitoring and evaluation of performance after initial grant of clinical privileges; and
c. Comments to support these recommendations.

3.4.5 MEC Action

If the application is designated Category 1, it is presented to the MEC. The Medical Staff President has the opportunity to determine whether the application is forwarded as a Category 1 or may change the designation to a Category 2 based on the defined criteria. The application is reviewed to ensure that it fulfills the established standards for membership and/or clinical privileges. The MEC forwards the following to the Board:

a. A recommendation as to whether the application should be acted on as Category 1 or Category 2;
b. A recommendation to approve, modify, or deny the applicant's request for membership and/or privileges;
c. A recommendation to define those circumstances that require monitoring and evaluation of performance after initially granting clinical privileges; and
d. Comments to support these recommendations.

Whenever the MEC makes an adverse recommendation to the Board, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

3.4.6 Board Action

The Board reviews the application and votes for one of the following actions:

a. If the application is designated by the MEC as Category 1 it is presented to the Board or an appropriate subcommittee of at least two (2) members where the application is reviewed to ensure that it fulfills the established standards for membership and clinical privileges. If the Board or subcommittee agrees with the recommendations of the MEC, the application is approved and the requested membership and/or privileges are granted for a period not to

exceed twenty-four (24) months. If a subcommittee takes action, it is reported to the entire Board at its next scheduled meeting. If the Board or subcommittee disagrees with the recommendation, then the procedure for processing Category 2 applications will be followed.

b. If the application is designated as a Category 2, the Board reviews the application and votes for one of the following actions:
    i. The Board may adopt or reject in whole or in part a recommendation of the MEC or refer the recommendation to the MEC for further consideration stating the reasons for such referral back and setting a time limit within which a subsequent recommendation must be made. If the Board concurs with the applicant's request for membership and/or privileges it will grant the appropriate membership and/or privileges for a period not to exceed twenty-four (24) months;
    ii. If the board's action is adverse to the applicant, a special notice, stating the reason, will be sent to the applicant who shall then be entitled to the procedural rights provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan); or
    iii. The Board shall take final action in the matter as provided in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan).

c. Notice of final decision: Notice of the Board's final decision shall be given, through the Administrator or the President of the Medical Staff to the MEC and to the Chair of each Department concerned. The applicant shall receive written notice of appointment and special notice of any adverse final decisions in a timely manner. A decision and notice of appointment includes the staff category to which the applicant is appointed, the Department to which they are assigned, the clinical privileges they may exercise, the timeframe of the appointment, and any special conditions attached to the appointment.

3.4.7 Time periods for processing: Except for good cause, each application will be processed within 180 (one-hundred eighty) calendar days. These time periods are deemed guidelines and do not create any right to have an application processed within these precise periods. If the provisions of Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) are activated, the time requirements provided therein govern the continued processing of the application.

Section 4. Reappointment

4.1 Criteria for Reappointment

4.1.1 It is the policy of the hospital and health centers to approve for reappointment and/or renewal of privileges only those practitioners who meet the criteria for initial appointment as identified in section 2 and 3. The MEC must also determine that the practitioner provides effective care that is consistent with the hospital standards regarding ongoing quality and the hospital performance improvement program. For appointment or renewal, the practitioner must provide the information enumerated in Section 4.2 below. All reappointments and renewals of clinical privileges are for a period not to exceed twenty-four (24) months.

4.1.2 The granting of new clinical privileges to existing medical staff members or other

practitioners with privileges will follow the steps described in Section 3 above concerning the initial granting of new clinical privileges and the focused professional practice evaluation process as described in these Bylaws and Rules & Regulations.

4.1.3 The Medical Staff President or their designee shall substitute for the Department Chair in the evaluation of current competency of the Department Chair, and recommend appropriate action to the Credentials Committee.

4.1.4 In the event a practitioner does not utilize the facilities or resources of the institution for purposes of patient care through either admission, regular patient contacts, performance of a procedure, consultation, or referral, during a two year period they may not be eligible for reappointment or continued privileges. Such practitioner may apply as a new applicant at any time subsequent to the expiration of current appointment or privileges. This provision applies to individuals who have been granted a leave of absence, moved their practice location, established a relationship with another institution or otherwise find no need to utilize the clinical resources of the institution. Exceptions to this provision may be made by the Board upon recommendation of the MEC.

4.2 Information Collection and Verification

4.2.1 From appointee: On or before four (4) months prior to the date of expiration of a medical staff appointment or grant of privileges, a representative from the medical staff office will notify the practitioner of the date of expiration and supply them with an application for reappointment for membership and/or privileges. At least sixty (60) calendar days prior to the expiration the practitioner must return the following to the medical staff office:

a. A completed reapplication form, which includes complete information to update their file on items listed in their original application, any required new, additional, or clarifying information, and any required fees or dues;
b. Information concerning continuing training and education internal and external to the hospital during the preceding period; and
c. Signature on the reapplication form, by which the appointee agrees to the same terms as identified in Section 3.2 above.

4.2.2 From internal and/or external sources: The medical staff office collects and verifies information regarding each practitioner's professional and collegial activities to include those items listed in Section 3.1 (unless specified otherwise).

4.2.3 The following information is also collected and verified:

a. A summary of clinical activity at this hospital and health centers;
b. Performance and conduct in this hospital and health centers and other healthcare organizations (if available) in which the practitioner has provided clinical care since the last reappointment, including patient care, medical/clinical knowledge, practice-based learning and improvement, interpersonal and communication skills, professionalism, and system-based practice;

c. Documentation of any required hours of continuing medical education activity;

d. Service on the medical staff, in one or more departments, and on hospital committees;

e. Timely and accurate completion of medical records;

f. Compliance with all applicable bylaws, policies, rules, regulations, and procedures of the hospital and medical staff;

g. Any significant gaps in employment or practice since the previous appointment or reappointment; and

h. When sufficient peer review data is not available to evaluate competency, one or more peer recommendations, as selected by the Credentials Committee, chosen from practitioner(s) who have observed the applicant's clinical and professional performance and can evaluate the applicant's current medical/clinical knowledge, technical and clinical skills, clinical judgment, interpersonal skills, communication skills, and professionalism as well as the physical, mental, and emotional ability to perform requested privileges.

4.2.4 Failure, without good cause, to provide any requested information, at least forty-five (45) calendar days prior to the expiration of appointment will result in a cessation of processing of the application and automatic expiration of appointment when the appointment period is concluded. Once the information is received, the medical staff office verifies this additional information and notifies the practitioner of any additional information that may be needed to resolve any doubts about performance or material in the credentials file.

4.3 Evaluation of Application for Reappointment of Membership and/or Privileges

4.3.1 Expedited review reappointment applications will be categorized as described in Section 3.3.1 above.

4.3.2 The reappointment application will be reviewed and acted upon as described in Sections 3 above. For the purpose of reappointment an "adverse recommendation" by the Board as used in section 3 means a recommendation or action to deny reappointment, or to deny or restrict requested clinical privileges or any action that would entitle the applicant to a Fair Hearing under Part II of the medical staff bylaws. The terms "applicant" and "appointment" as used in these sections shall be read respectively, as "staff appointee" and "reappointment."

Section 5. Clinical Privileges

5.1 Exercise of privileges

A practitioner providing clinical services at the hospital may exercise only those privileges granted to them by the Board or emergency or disaster privileges as described herein. Privileges may be granted by the Board, upon recommendation of the MEC to practitioners who are not members of the medical staff. Such individuals may be physicians serving short-term locum tenens positions, telemedicine physicians, or house staff such as residents moonlighting in the hospital, or others deemed appropriate by the MEC and Board.

5.2 Requests

When applicable, each application for appointment or reappointment to the medical staff or for privileges must contain a request for the specific clinical privileges the applicant desires. Specific requests must also be submitted for temporary privileges and for modifications of privileges in the interim between reappointments and/or granting of privileges.

5.3 Basis for Privileges Determination

5.3.1 Requests for clinical privileges will be considered only when accompanied by evidence of education, training, experience, and demonstrated current competence as specified by the hospital in its Board approved criteria for clinical privileges.

5.3.2 Privileges for which no criteria have been established:

In the event a request for a privilege is submitted for a new technology, a procedure new to the hospital, an existing procedure used in a significantly different manner, or involving a cross-specialty privilege for which no criteria have been established, the request will be tabled for a reasonable period of time, usually not to exceed sixty (60) calendar days. During this time the MEC will:

a. Review the community, patient, and hospital need for the privilege and, if a need is found, request that members of the Credentials Committee review the efficacy and clinical viability of the requested privilege and, if efficacious and viable, confirm that this privilege is approved for use in the setting-specific area of the hospital by appropriate regulatory agencies (FDA, OSHA, etc.);
b. Meet with hospital and health center administration to ensure that the new privilege is consistent with the hospital's mission, values, strategic, operating, capital, information, and staffing plans;
c. If a-b, above, are met, reach agreement with management and seek approval of the Board to exercise the privilege at the hospital and health centers; and
d. Work with hospital and health center administration to ensure that any/all exclusive contract issues, if applicable, are resolved in such a way to allow the new or cross-specialty privileges in question to be provided without violating the existing contract.

Upon recommendation from the Credentials Committee and appropriate Department or subject matter experts (as determined by the Credentials Committee), the MEC will formulate the necessary criteria and recommend these to the Board. Once objective criteria have been established, the original request will be processed as described herein:

i. For the development of criteria, the medical staff service professional (or designee) will compile information relevant to the privileges requested which may include, but need not be limited to, position and opinion papers from specialty organizations, white papers from the Credentialing Resource Center and others as available, position and opinion statements from interested individuals or groups, and documentation from other hospitals in the region as

appropriate. The requesting practitioner may be requested to provide a full briefing concerning the new technique or procedure including names of other hospitals in which it is used, any peer-reviewed research, any product literature or educational syllabus and the names of any residency or other training directors responsible for providing training in this area;

ii. Criteria to be established for the privilege(s) in question include education, training, board status, certification (if applicable), experience, and evidence of current competence. Proctoring requirements will be addressed including who may serve as proctor and how many proctored cases will be required; and

iii. If the privileges requested overlap two or more specialty disciplines, an ad hoc committee will be appointed by the credentials chair to recommend criteria for the privilege(s) in question. This committee will consist of at least one, but not more than two, members from each involved discipline. The chair of the ad hoc committee will be a member of the Credentials Committee who has no vested interest in the issue.

5.3.3 Requests for clinical privileges will be consistently evaluated on the basis of prior and continuing education, training, experience, utilization practice patterns, current ability to perform the privileges requested, and demonstrated current competence, ability, and judgment. Additional factors that may be used in determining privileges are patient care needs and the hospital's capability to support the type of privileges being requested and the availability of qualified coverage in the applicant's absence. The basis for privileges determination to be made in connection with periodic reappointment or a requested change in privileges must include documented clinical performance and results of the practitioner's performance improvement program activities. Privilege determinations will also be based on pertinent information from other sources, such as peers and/or faculty from other institutions and health care settings where the practitioner exercises clinical privileges.

5.3.4 The procedure by which requests for clinical privileges are processed are as outlined in Section 3 above.

5.4 Special Conditions for Dental Privileges

Requests for clinical privileges for dentists are processed in the same manner as all other privilege requests. Privileges for surgical procedures performed by dentists and/or oral and maxillofacial surgeons will require that all dental patients receive a basic medical evaluation (history and physical) by a physician member of the medical staff with privileges to perform such an evaluation, which will be recorded in the medical record. Oral and maxillofacial surgeons may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in oral and maxillofacial surgery and demonstrated current competence.

5.5 Special Conditions for Podiatric Privileges

Requests for clinical privileges for podiatrists are processed in the same manner as all other privilege requests. All podiatric patients will receive a basic medical evaluation (history and physical) by a

physician member of the medical staff that will be recorded in the medical record. Podiatrists may be granted the privilege of performing a history and physical on their own patients upon submission of documentation of completion of an accredited postgraduate residency in podiatric surgery and demonstrated current competence. Special Conditions for Practitioners Eligible for Privileges Without Membership

Requests for privileges from practitioners eligible for privileges without membership are processed in the same manner as requests for clinical privileges by providers eligible for medical staff membership, with the exception that such individuals are not eligible for membership on the medical staff and do not have the rights and privileges of such membership. Only those categories of practitioners approved by the Board for providing services at the hospital are eligible to apply for privileges.

5.6 Special Conditions for Practitioners Who Require a Supervising Physician

Advance Practice Professionals (APPs) may, subject to any licensure requirements or other limitations, exercise independent judgment only within the areas of their professional competence and participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care. The privileges of these APPs shall terminate immediately, without the right to a hearing, in the event that the employment of the APP with the hospital is terminated for any reason or if the employment contract or sponsorship of the APP with a physician member of the medical staff organization is terminated for any reason.

5.7 Special Conditions for Residents or Fellows in Training

Residents or fellows in training in the hospital and health centers shall not normally hold membership on the medical staff and shall not normally be granted specific clinical privileges. Rather, they shall be permitted to function clinically only in accordance with the written training protocols developed by the MEC or designee in conjunction with the residency training program. The protocols must delineate the roles, responsibilities, and patient care activities of residents and fellows including which types of residents may write patient care orders, under what circumstances why they may do so, and what entries a supervising physician must countersign. The protocol must also describe the mechanisms through which resident directors and supervisors make decisions about a resident's progressive involvement and independence in delivering patient care and how these decisions will be communicated to appropriate medical staff and hospital and health centers leaders.

The post-graduate education program director must communicate periodically with the MEC and the Board about the performance of its residents, patient safety issues, and quality of patient care and must work with the MEC to assure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

5.8 Telemedicine Privileges

5.8.1 Requests for telemedicine privileges at the hospital and health centers that includes patient care, treatment, and services will be processed through one of the following mechanisms:

a. The hospital fully privileges and credentials the practitioner according to established policies and these bylaws; or

b. The hospital and health centers (originating site) privileges physicians or other licensed practitioners using credentialing information from a distant site if the distant site is a Joint Commission-accredited or a Medicare-participating organization; and the distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services; or

c. The originating site may choose to use the credentialing and privileging decision from the distant site to make a final privileging decision if all the following requirements are met:

    i. The distant site is a Joint Commission-accredited or a Medicare-participating organization.

    ii. The physician or other licensed practitioner is privileged at the distant site for those services to be provided at the originating site.

    iii. The distant site provides the originating site with a current list of the physician's or other licensed practitioner's privileges.

    iv. The originating site has evidence of an internal review of the physician's or other licensed practitioner's performance of these privileges and sends to the distant site information that is useful to assess the physician's or other licensed practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse outcomes related to sentinel events considered reviewable by The Joint Commission that result from the telemedicine services provided and complaints about the distant site physician or other licensed practitioner from patients, physicians or other licensed practitioners, or staff at the originating site. This occurs in a way consistent with any hospital policies or procedures intended to preserve any confidentiality or privilege of information established by applicable law.

    v. The distant-site physician or other licensed practitioner has a license that is issued or recognized by the state in which the patient is receiving telemedicine services.

5.9 Temporary Privileges

The Administrator, or designee, acting on behalf of the Board and based on the recommendation of the MEC through the Medical Staff President or designee, may grant temporary privileges. As described more fully below, temporary privileges may be granted only in two (2) circumstances: 1) to fulfill an important patient care, treatment, or service need, or 2) when an initial applicant with a complete application that raises no concerns is awaiting review and approval of the MEC and the Board.

5.9.1 Important Patient Care, Treatment, or Service Need: Temporary privileges may be granted on a case by case basis when an important patient care, treatment, or service need exists that mandates an immediate authorization to practice, for a limited period of time, not to exceed 120 calendar days. When granting such privileges the organized medical staff verifies current licensure and current competence.

5.9.2 Clean (Category 1) Application Awaiting Approval: Temporary privileges may be granted for up to one hundred and twenty (120) calendar days when the new applicant for medical staff

membership and/or privileges is waiting for review and recommendation by the MEC and approval by the Board. Criteria for granting temporary privileges in these circumstances include 1) complete application 2) verification of application, 3) positive recommendation from the Department Chair, and 4) positive recommendation from the Credentials Committee. Additionally, the application must meet the criteria for Category 1, expedited credentialing consideration as noted in section 3 of this manual.

5.9.3 Special requirements of consultation and reporting may be imposed as part of the granting of temporary privileges. Except in unusual circumstances, temporary privileges will not be granted unless the practitioner has agreed in writing to abide by the bylaws, rules, and regulations and policies of the medical staff and hospital in all matters relating to their temporary privileges. Whether or not such written agreement is obtained, these bylaws, rules, regulations, and policies control all matters relating to the exercise of clinical privileges.

5.9.4 Rights of the Practitioner with Temporary Privileges: A practitioner is not entitled to the procedural rights afforded in Part II of these bylaws (Investigation, Corrective Action, Hearing and Appeal Plan) because their request for temporary privileges is refused or because all or any part of their temporary privileges are terminated or suspended unless the decision is based on clinical incompetence or unprofessional conduct.

5.9.5 Emergency Privileges: In the case of a medical emergency, any practitioner is authorized to do everything possible to save the patient's life or to save the patient from serious harm, to the degree permitted by the practitioner's license, regardless of Department affiliation, staff category, or level of privileges. A practitioner exercising emergency privileges is obligated to summon all consultative assistance deemed necessary and to arrange appropriate follow-up.

5.9.6 Disaster Privileges: Disaster privileges may be granted under the following conditions:

a. If the County's Emergency Operations Plan has been activated and the organization is unable to meet immediate patient needs, the CEO and other individuals as identified in the County's Emergency Operations Plan with similar authority, may, on a case by case basis consistent with medical licensing and other relevant state statutes, grant disaster privileges to selected LIPs. These practitioners must present a valid government-issued photo identification issued by a state or federal agency (e.g., driver's license or passport) and at least one of the following:
    i. A current picture hospital ID card that clearly identifies professional designation;
    ii. A current license to practice;
    iii. Primary source verification of the license;
    iv. Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), or Medical Reserve Corps (MRC), Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal organizations or groups;
    v. Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such

authority having been granted by a federal, state, or municipal entity); or

vi. Identification by a current hospital or medical staff member (s) who possesses personal knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster.

b. The medical staff has a mechanism (i.e., badging) to readily identify volunteer practitioners who have been granted disaster privileges.

c. The medical staff oversees the professional performance of volunteer practitioners who have been granted disaster privileges by direct observation, mentoring, or clinical record review. The organization makes a decision (based on information obtained regarding the professional practice of the volunteer) within 72 hours whether disaster recovery privileges should be continued.

d. Primary source verification of licensure begins as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the organization. If primary source verification cannot be completed in 72 hours, there is documentation of the following: 1) why primary source verification could not be performed in 72 hours; 2) evidence of a demonstrated ability to continue to provide adequate care, treatment, and services; and 3) an attempt to rectify the situation as soon as possible.

e. Once the immediate situation has passed and such determination has been made consistent with the institution's Disaster Plan, the practitioner's disaster privileges will terminate immediately.

f. Any individual identified in the institution's Disaster Plan with the authority to grant disaster privileges shall also have the authority to terminate disaster privileges. Such authority may be exercised in the sole discretion of the hospital and will not give rise to a right to a hearing or an appeal.

Section 6. Clinical Competency Evaluation

6.1 Focused Professional Practice Evaluation (FPPE)

All initially requested privileges shall undergo a period of FPPE. The Credentials Committee, [after receiving a recommendation from the Department Chair] and with the approval of the MEC will define the circumstances which require monitoring and evaluation of the clinical performance of each practitioner following their initial grant of clinical privileges at the hospital. Such monitoring may utilize prospective, concurrent, or retrospective proctoring, including but not limited to: chart review, the tracking of performance monitors/indicators, external peer review, simulations, morbidity and mortality reviews, and discussion with other healthcare individuals involved in the care of each patient. The Credentials Committee will also establish the duration for such FPPE and triggers that indicate the need for performance monitoring.

6.2 Ongoing Professional Practice Evaluation (OPPE)

The medical staff will also engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Information from this evaluation process will be factored into the decision to

maintain existing privileges, to revise existing privileges, or to revoke an existing privilege prior to or at the time of reappointment. OPPE shall be undertaken as part of the medical staff's evaluation, measurement, and improvement of practitioner's current clinical competency. In addition, each practitioner may be subject to FPPE when issues affecting the provision of safe, high quality patient care are identified through the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.

Section 7. Reapplication After Adverse Action, Modifications of Membership Status or Privileges, and Resignation

7.1 Reapplication after adverse credentials decision

Except as otherwise determined by the MEC or Board, a practitioner who has received a final adverse decision or who has resigned or withdrawn an application for appointment or reappointment or clinical privileges while under investigation or to avoid an investigation is not eligible to reapply to the medical staff or for clinical privileges for a period of five (5) years from the date of the notice of the final adverse decision or the effective date of the resignation or application withdrawal. Any such application is processed in accordance with the procedures then in force. As part of the reapplication, the practitioner must submit such additional information as the medical staff and/or Board requires demonstrating that the basis of the earlier adverse action no longer exists. If such information is not provided, the reapplication will be considered incomplete and voluntarily withdrawn and will not be processed any further.

7.2 Request for modification of appointment status or privileges

A practitioner, either in connection with reappointment or at any other time, may request modification of staff category, Department assignment, or clinical privileges by submitting a written request to the medical staff office. A modification request must be on the prescribed form and must contain all pertinent information supportive of the request. All requests for additional clinical privileges must be accompanied by information demonstrating additional education, training, and current clinical competence in the specific privileges requested. A modification application is processed in the same manner as a reappointment, which is outlined in Section 5 of this manual. A practitioner who determines that they no longer exercises, or wishes to restrict or limit the exercise of, particular privileges that they have been granted shall send written notice, through the medical staff office, to the Credentials Committee, and MEC. A copy of this notice shall be included in the practitioner's credentials file.

7.3 Resignation of staff appointment or privileges

A practitioner who wishes to resign their staff appointment and/or clinical privileges must provide

written notice to the appropriate Department Chair or Medical Staff President. The resignation shall specify the reason for the resignation and the effective date. A practitioner who resigns their staff appointment and/or clinical privileges is obligated to fully and accurately complete all portions of all medical records for which they are responsible prior to the effective date of resignation. Failure to do so shall result in an entry in the practitioner's credentials file acknowledging the resignation and indicating that it became effective under unfavorable circumstances.

7.4 Exhaustion of administrative remedies

Every practitioner agrees that they will exhaust all the administrative remedies afforded in the various sections of this manual, the Governance and the Investigation, Corrective Action, Hearing and Appeal Plan before initiating legal action against the hospital or its agents.

7.5 Reporting requirements

The Administrator or their designee shall be responsible for assuring that the hospital satisfies its obligations under State law and the Health Care Quality Improvement Act of 1986 and its successor statutes. Whenever a practitioner's privileges are limited, revoked, or in any way constrained, the hospital must, in accordance with State and Federal laws or regulations, report those constraints to the appropriate State and Federal authorities, registries, and/or data bases, such as the NPDB. Actions that must be reported include, but are not limited to, any negative professional review action against a physician or dentist related to clinical incompetence or misconduct that leads to a denial of appointment and/or reappointment; reduction in clinical privileges for greater than thirty (30) calendar days; resignation, surrender of privileges, or acceptance of privilege reduction either during an investigation or to avoid an investigation.

Section 8. Leave of Absence

8.1 Leave Request

A leave of absence from the Medical Staff must be requested for any absence from the medical staff and/or patient care responsibilities longer than thirty (30) days and whether such absence is related to the individual's physical or mental health or to the ability to care for patients safely and competently. Under such circumstances, the Administrator, in consultation with the Medical Staff President, may trigger an automatic medical leave of absence. A practitioner who wishes to obtain a voluntary leave of absence from the Medical Staff must provide written notice to the Medical Staff President stating the reasons for the leave and approximate period of time of the leave, which may not exceed one year except for military service or express permission by the Board. Requests for leave must be forwarded with a recommendation from the MEC and affirmed by the Board. While on leave of absence, the practitioner may not exercise clinical privileges or prerogatives and has no obligation to fulfill medical staff responsibilities. Leaves of absence are matters of courtesy, not of right. In the event that a practitioner has not demonstrated good cause for a leave, or where a request for extension is not granted, the determination shall be final, with no recourse to a hearing and appeal. Each member who is under MOU or contract and will have to refer to their MOU or contract for further details on LOA.

8.2 Termination of Leave

At least thirty (30) calendar days prior to the termination of the leave, or at any earlier time, the practitioner may request reinstatement by sending a written notice to the Medical Staff President. The practitioner must submit a written summary of relevant activities during the leave if the MEC or Board so requests. A practitioner returning from a leave of absence for health reasons must provide a report from their physician that answers any questions that the MEC or Board may have as part of considering the request for reinstatement. The MEC makes a recommendation to the Board concerning reinstatement, and the applicable procedures concerning the granting of privileges are followed. If the practitioner's current grant of membership and /or privileges is due to expire during the leave of absence, the practitioner must apply for reappointment, or their appointment and/or clinical privileges shall lapse at the end of the appointment period.

8.3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to the procedural rights provided in Part II of these bylaws. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

APPROVALS:

Medical Staff: 7/15/2024

Joint Conference Committee: 7/22/2024

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	10/2025
	Sarah Mcneil: OBGYN Fam Med Adv Obst Ex	10/2025

Standards

No standards are associated with this document

Community Health
Privileges

Name:
Date Completing this packet:

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Education/Training	Successful completion of an Accredited Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) and accredited residency in Preventive Medicine, Emergency Medicine, Obstetrics and Gynecology, Pediatrics, Internal Medicine, or Family Medicine.
Certification	Current certification or Board eligibility leading to certification in Preventive Medicine, Pediatrics, Internal Medicine, Emergency Medicine, Obstetrics and Gynecology, or Family Medicine by the appropriate Board. Board certification must be achieved within the Board eligibility timeframe following graduation from residency.
Continuing Education	As required by California license AND As required for special/non-core privileges as written below.

Community Health Core Privileges

For EACH core privilege requested you must demonstrate the following. If applying for two core privileges, you need to provide documentation of clinical experience in EACH.

Clinical Experience (Initial)	Documentation of required current experience: Prior experience as Health Officer or Deputy Health Officer with attestation of completion of consultation of 50 encounters in past 24 months with 25 in the last 12 months OR completion of 8U CME credits
Clinical Experience (Reappointment)	Active Certification in accordance with Medical Staff Bylaws AND Provision of care for at least 50 patient encounters in past 24 months with 25 in the last 12 months with completion of 8 CME credits or approved training for each privilege requested over past 24 months OR successful completion of accredited residency in past 24 months. AND The Public Health Medical Director, Health Officer or the Public Health Director must certify the clinical need of the applicant. AND 10 Health Officer Call Days /AMION

You do not have to provide all of the care or the procedures listed, but given your training and expertise, you are allowed to do what is listed under each Core Privilege.

Request		**Chair Recommends**

☐	**Community Health Core Privileges**: Evaluate, diagnose, treat, and provide prevention methods and to all- [pediatric and adults] patients with tuberculosis, Latent TB, or exposures to TB. Evaluate, diagnose, treat, and provide consultation to all- [pediatric and adults] patients using medication assisted treatments for substance use disorders. Evaluate, diagnose, treat, and consultation to all- [pediatrics and adults] patients with sexually transmitted disease or exposure to a sexually transmitted disease, and provide prevention methods to those at risk for sexually transmitted disease or as primary prevention for any patient. Evaluate, diagnose, treat, and consultation to all- [pediatrics and adults] patients with communicable diseases or exposures to communicable diseases, and provide prevention methods to those at risk for communicable diseases or as primary prevention for any patient.	☐

Focused Professional Practice Evaluation (FPPE) Requirements

1. Active Medical License and Meets Eligibility Requirements for Membership on Medical Staff
2. Attestation of participation in 25 Health Officer cases reviews.
3. 8 CEU in Community Health/Public Health approved by Department Chair, Health Officer or Designee.
4. Approval by Department Chair, Health Officer or Designee.
5. 10 HO call days scheduled on AMION
6. Letter to waive requirements must be included with application and signed by Health Officer if indicated.

ACKNOWLEDGMENT OF PRACTITIONER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Practitioner's Signature: _____ **Date: _____**

DEPARTMENT / DIVISION CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ **Recommend All Requested Privileges**
☐ **Recommend Privileges with the Following Conditions/Modifications:**
☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	Condition/Modification/Explanation

Notes:

_____
_____
_____

Public Health Medical Director/Health Officer Name (Print): _____

Public Health Medical Director/Health Officer Signature: _____

Date: _____

Internal Medicine Specialties

Pain Medicine

Privileges

Name: (Please Print)

Instructions to applicant

1. Initial to the left of each privilege requested.
2. Sign form and submit **with the required documentation/case log/certificate(s). Experience can be from direct patient care, precepting, CCRMC simulation lab, or documented outside trainings.** Medical Staff Office can help you pull relevant reports from EPIC.

Required Qualifications

Education/Training	Successful completion of an Accreditation Council for Graduate Medical Education (ACGME) – or American Osteopathic Association (AOA)– accredited residency as listed below.
Certification	***Initial Applicants:*** To be eligible to apply for privileges in Pain Medicine or the applicant must meet the following criteria: Documentation of successful completion of an Accreditation Council for Graduate Medical Education (ACGME)– or American Osteopathic Association (AOA)– accredited residency in relevant specialty (e.g. internal medicine, family medicine, pediatrics, psychiatry, emergency medicine, surgery, preventive medicine, or obstetrics and gynecology **AND** Documentation of current subspecialty certification or board eligibility leading to subspecialty certification (with achievement of certification within the required time frame set forth by the Board) in Pain Medicine by the American Board of Preventive Medicine, Physical Medicine and Rehabilitation, Fellowship **or** department-approved equivalent training and experience **AND** Documentation of provision of inpatient, outpatient, or consultative services reflective of the scope of privileges requested for 50 patients within the past 24 months, If no clinical long within last 24 months active FPPE will be required with privilege request submission.
Continuing Education	Continuing education in accordance with requirements to maintain certification and licensure in this specialty.

For EACH core privilege requested, you must demonstrate the following Clinical Experience:

Initial Applicants	Documentation of Maintenance of Certification (ABMS) or OCC (On-Going Continuous Certification) is required.
Renewal	Maintain Board Certification in primary field of practice and must meet all criteria to maintain eligibility for medical staff membership. **AND** Current documented competence with ongoing OPPE and 50 cases with acceptable results, reflective of the scope of privileges requested, for the past 24 months based on results of ongoing professional practice evaluation and outcomes.

Core Privileges

This is not intended to be an all-encompassing procedures list. It defines the types of activities/procedures/privileges that the majority of practitioners in this specialty perform at this organization and inherent activities/procedures/privileges requiring similar skill sets and techniques, as determined by the department chair.

To the Applicant: If you wish to exclude any procedures, due to lack of current competency, please strike through the procedures that you do not wish to request and then initial and date.

Applicant: initial to request	**For Core Privileges:** you do not have to do all these procedures, but having the privilege allows you to.	Division/ Dept Chair: initial to recommend
☐	**Pain Medicine Requested** Evaluate, diagnose, treat, and provide consultation for adult patients with acute or chronic pain conditions in the ambulatory, emergency, inpatient and intensive care setting. Includes performance of history and physical exam. Procedures may include but are not limited to: fluoroscopy and ultrasound Guided Procedures such as nerve Blocks & Radiofrequency Ablations: -Injections: (Cervical, Lumbar, Caudal Steroid, Fibrin and Blood Patch Epidurals, Sacroiliac Joint, etc): (PREMPT, Joint/Bursa Injection , Trigger Point Injections, etc) -Neuromodulation: (Spinal cord stimulator trial/placement, DRG Implantation, Peripheral nerve stimulation) -Sympathetic Blocks/ Palliative Neurolysis: (Stelate Ganglion, Celiac Plexus, Inferior Hypogastric) -Facial/Head Injections (Gasserian Ganglion, Greater/Lesser Occipital Nerve Blocks/RFA)	☐

Other Privileges

If you wish to obtain any privilege not listed above, please list it here and the Credentials Committee will review.

_____

_____

_____
_____
_____

Initial Focused Professional Practice Evaluation (iFPPE) Requirements

For initial requests, providers must complete ALL iFPPE forms through Medical Staff Office (MSO) and return to MSO.

ACKNOWLEDGMENT OF PROVIDER

I have requested only those privileges for which by education, training, current experience, and documented performance I am qualified to perform and for which I wish to exercise at Contra Costa Regional Medical Center Hospital and Clinics, and I understand that:

a. In exercising any clinical privileges granted, I will adhere by hospital and medical staff policies and rules applicable generally and any applicable to the particular situation.
b. Any restriction on the clinical privileges granted to me is waived in an emergency situation, and in such situation my actions are governed by the applicable section of the medical staff bylaws or related documents.

Provider's Signature: _____ Date: _____

DEPARTMENT CHAIR'S RECOMMENDATION

I have reviewed the requested clinical privileges and supporting documentation for the above-named applicant and:

☐ **Recommend All Requested Privileges**
☐ **Recommend Privileges with the Following Conditions/Modifications:**
☐ **<u>Do Not</u> Recommend the Following Requested Privileges:**

Privilege	**Condition/Modification/Explanation**

Notes:
_____
_____
_____

Department Chair Name (Print): _____

Department Chair Signature: _____

Date: _____

Status **Pending** PolicyStat ID **18913412**

Origination	10/2016	Owner	Kathy Ferris: Infection Control Coord
Last Approved	N/A	Area	Infection Control
Effective	Upon Approval		
Last Revised	09/2025		
Next Review	3 years after approval		

Management of Reusable Instruments Prior to Return to the Sterile Processing Department

~~PURPOSE~~POLICY STATEMENT:

At Contra Costa Regional Medical Center and Health Centers, re-usable instruments will be wiped down or rinsed to remove all visible soil, placed in a covered rigid container with a bio-hazard symbol and transported to the Soiled Utility Room. Once in the Soiled Utility Room, the instruments will be kept moist by using a sterile transport gel while awaiting pick-up by Sterile Processing Technician.

In the Operating Room, during the operation, instruments will be managed according to accepted operating room practice. At the end of the procedure, instruments will be kept moist for return to the Sterile Processing Department for cleaning, disinfection and sterilization.

Appropriate Personal Protective Equipment (PPE) will be worn by personnel when using transport gel, cleansers and disinfectants.

~~PROCEDURE:~~

GUIDELINES:

Ambulatory Care

A. After procedure, gel hands and don gloves
B. Discard any disposable supplies into appropriate container.
    1. Gauze or gloves into appropriate container.
    2. Sharps should be discarded into sharps disposal box.

3. Any vials or ampules containing medication should be discarded in appropriate container.

C. Place the instruments in the transport rigid container marked with the Biohazard symbol for transport to the soiled utility room.

D. Remove and discard gloves and perform hand hygiene.

E. After hand hygiene has been performed, don gloves and wipe down the countertop/mayo stand and transport container with Super Sani-wipe (Purple Top), or if unavailable, the AF3 wipe (Gray top) is also acceptable.

F. Doff gloves, perform hand hygiene, and transport container to soiled utility room.

G. Once in the soiled utility room, Don PPE (gown, mask, eye protection and gloves), open transport container and before placing the instruments in the SPD pick-up container follow the steps below:

1. Rinse and wipe the instruments to remove any obvious debris
2. Vaginal speculums should be rinsed and disassembled
3. Open all hinged instruments

H. While still wearing PPE , spray all of the instruments with PreKlenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.

I. Replace cover on the biohazard container. Remove PPE and perform hand hygiene.

J. The soiled utility room container will be picked up on a regular basis by Sterile Processing Department technician.

K. The transport container may be rinsed, wiped dry and then wiped with either the Super Sani Wipe (Purple top) or the AF3 wipe (gray top). Observe recommended dwell time before it is re-used.

L. Follow the steps listed above whenever adding instruments to the SPD pick-up container.

Special Procedures Room -3rd floor Diagnostic Imaging

A. After the procedure, gel hands and don gloves and discard disposable supplies into appropriate trash container.

1. Sharps should be discarded into sharps disposal box
2. Any vials or ampules containing medication into appropriate container
3. Discard disposable instruments in appropriate container
4. Dispose of any residual liquids in cups.

B. At the end of the procedure, re-usable instruments will be placed in a covered rigid container with Biohazard label on the lid.

1. Open all hinged instruments
2. Spray the instruments with PreKlenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.

3. Contact SPD to pick-up the instruments.

Hospital Nursing Units and ED

A. After procedure, gel hands and don gloves, and wipe down the countertop/mayo stand with Super Sani-wipe (Purple Top) -if unavailable, the AF3 wipe (Gray top) is also acceptable~~)~~.

B. Bring the clean rigid transport container marked with the Biohazard symbol into the room. Place the used instruments in the container and transport them to the soiled utility room.

C. Once in the soiled utility room Don PPE (gown,mask,eye protection and gloves), open the container and follow steps below:

    1. Remove gross soil by wiping with paper towel or gauze moistened with water.
    2. Vaginal Speculums should be rinsed and disassembled.
    3. Open all hinged instruments

D. Place the opened/disassembled instrument(s) into the bio-hazard container.

E. While still wearing the PPE, spray the instrument(s) with Pre-Klenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist.

F. Replace cover on the rigid biohazard container. Remove PPE and gloves, gel hands.

G. Container will be picked up on a regular basis by Sterile Processing Department technician.

H. The Sterile Processing Technician will place a clean rigid biohazard container in the clean utility room or other designated location on the Medical/Surgical, Critical Care, IMCU and ED units.

I. Procedures are not routinely performed on Inpatient Psychiatry or Psychiatric Emergency (PES) units. If a procedure is planned, ~~if a procedure is planned~~ the transport container may be picked up in the SPD on the 2nd floor.

Perinatal Labor and Delivery

A. At the end of the delivery, place the instruments in a rigid transport container marked with the Biohazard symbol and transport to the soiled utility room.

B. Once in the soiled utility room Don PPE (gown,mask,eye protection and gloves), open the container and follow steps below:

    1. Remove gross soil by wiping with paper towel or gauze moistened with water.
    2. Vaginal Speculums should be rinsed and disassembled.
    3. Open all hinged instruments

C. Place the opened/disassembled instrument(s) into the bio-hazard SPD pick-up container.

D. While still wearing the PPE, spray the instrument(s) with Pre-Klenz. Be sure to cover the instrument completely. The spray will initially appear foam-like; it will then form a gel to keep the instruments moist. Replace cover on the rigid biohazard container.

E. Repeat steps above each time instruments are added to the Biohazard SPD pick-up container.

F. Don clean gloves and manage the transport container as follows:

1. Wipe the counter top with either a Purple top (Super SanipCloth) or Gray top (AF3) observe contact time.
2. Wipe the transport container inside and outside with either Purple Top or Gray Top wipes, observe contact time.
3. Bring the cleaned transport bin to the clean utility/LDRP room

G. The SPD pick-up container in the soiled utility will be picked up by the SPD department on a regular basis. The SPD tech will place a new empty biohazard pick-up container in the soiled utility room.

H. Should the container become full prior to regular rounds by the SPD staff, call x5360 to arrange ~~to have the~~for instruments to be picked up.

Operating Room/Procedure Room

A. During the operation/procedure, instruments will be managed according to accepted OR practice.

B. At the end of the case, instruments will be placed in the appropriate tray with lid for transport to sterile processing. A blue towel moistened with sterile water will be placed over the instruments before they are transported to the decontamination room in the Sterile Processing Department (SPD).

C.

RELATED LINKS:

Steris Label
Pre-Klenz Safety Data Sheet
Procedure for the Management of Dental Instruments Prior to Return to Sterile Processing

REFERENCES:

A. Association for the Advancement of Medical Instrumentation (AAMI) ST79 A1, A2, A3 and A4, 2013

B. CalOSHA Bloodborne Pathogen Standard (8CCR 5193)

C. Steris, "Pre-Klenz" Instructions for Use

APPROVALS:

Infection Prevention & Control Committee: 11/16, 9/22, 12/24
Patient Care Policy & Evaluation Committee: 10/22, 1/25
Medical Ethics Committee: 10/22

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	10/2025
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	10/2025
Infection Prevention & Control Committee	Kathy Ferris: Infection Control Coord	09/2025
	Kathy Ferris: Infection Control Coord	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18853578**

Origination	03/2006	Owner	Kathy Ferris: Infection Control Coord
Last Approved	N/A	Area	Infection Control
Effective	Upon Approval		
Last Revised	09/2025		
Next Review	3 years after approval		

Policy on Reporting Reportable Diseases

POLICY STATEMENT:

This document is to provide guidelines for reporting of communicable disease to the Public Health Department. To comply with the regulations of California State Department of Health Services all health care provider at CCRMC and Health Centers, Contra Costa Public Health and Infection Prevention and Control Program who has knowledge and or involved in a case or suspected case of any of the diseases or condition listed in the attached form (CMR- Confidential Morbidity Report) will report to the local public health officer for the jurisdiction where the patient resides.

GUIDELINES:

A. The reporting is via the Confidential Morbidity Report (CMR) form. The instructions are on the form and the list of reportable diseases and conditions is located on the back of the form

B. Disposition of Completed forms:
    1. Faxes should be sent to Public Health at 925-313-6465
    2. Mail is directed to Public Health at 597 Center Ave Suite 200 A (transmittal envelope may be used.)

C. Documentation of notification should be made on the Patient's Problem List

D. Occasionally, local, state, or federal government may add a disease to the list of reportable illness. The Infection Prevention and Control Program will report these illnesses as directed.

E. Some diseases may require immediate reporting via telephone. In this situation the physician and or resident should phone the Communicable Disease Program of Public Health at 925-313-6740.

F. During after-hours and weekend the sheriff dispatcher will answer the call and will notify the Public Health officer on duty.

G. Assistance in reporting may be obtained from the Infection Prevention and Control Program manager by paging 925-346-4122

H. When unusual illness or clusters of illness are identified, the Infection Prevention and Control Program manager will also notify the California State Department of Health Services

I. Notify Infection Prevention and Control Program manager at pager 925-346-4122 with **all suspected or confirmed cases of Tuberculosis. Under the Gotch Bill, there are additional reporting forms required**

J. The Infection Prevention and Control Program manager should also be contacted if the disease is communicable and there is the possibility that staff may have been exposed to the illness/disease prior to diagnosis and/or institution of appropriate isolation measures.

RELATED LINKS:

Confidential Morbidity Report (PM 110)
Confidential Morbidity Report- CDPH 110A
Confidential Morbidity Report- CDPH 110B

REFERENCES:

A. Title 17, California Code of Regulations Reportable Diseases and Conditions, revised ~~May 24, 2007.~~June 2025

B. TJC, Comprehensive Accreditation Manual for Hospitals

C. (n.d.). Communicable Disease Control Forms. California Department of Public Health. https://www.cdph.ca.gov/Programs/PSB/Pages/CommunicableDiseaseControl.aspx

APPROVALS:

Infection Prevention & Control Committee:
Patient Care Policy & Evaluation Committee: 3/24
Medical Executive Committee:

Attachments

ReportableDiseases_June2025.pdf

Approval Signatures

Step Description	Approver	Date

Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	10/2025
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	10/2025
Infection Prevention & Control Committee	Kathy Ferris: Infection Control Coord	09/2025
	Kathy Ferris: Infection Control Coord	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19162658**

Origination	08/2010	Owner	Kathy Ferris: Infection Control Coord
Last Approved	N/A	Area	Infection Control
Effective	Upon Approval		
Last Revised	02/2022		
Next Review	3 years after approval		

Policy for Controlled Air Purifying Respirator (CAPR)

POLICY STATEMENT:

CCRMC and Health Center employees who may be exposed to patients with a suspected or confirmed Aerosol Transmissible Disease (ATD) will be provided higher level of protection using NIOSH approved respirators. When an employee cannot use a N95 respirator, they will be provided with a Controlled Air Purifying Respirator (CAPR).

GUIDELINES:

A. Employees who have facial hair in the mask fit area may not use a N95 respirator and must use a CAPR when providing care to patients in Airborne Precautions.

B. Employees who cannot be fit tested or achieve an appropriate fit with the N95 respirator will also be required to use a CAPR when providing care to patients in Airborne Precautions.

C. When an Aerosol Transmissible Disease is suspected, all persons in the room where an aerosol-generating procedure (e.g., bronchoscopy, etc.) is being performed will wear a Controlled Air Purifying Respirator (CAPR).

D. When supplies of N95 respirators are low, the hospital may move to expand the use of CAPRs to patient care areas. Additionally, in any situation where a higher level of respiratory protection is needed, hospital administration may elect to move to the use of a Controlled Air Purifying Respirator (CAPR). In an emergency, Powered Air Purifying Respirators (PAPR) may be used in addition to CAPRs.

E. No fit testing is required to use a CAPR. Employees will be educated and trained in its used.

RELATED LINKS:

Procedure for Controlled Air Purifying Respirator (CAPR)
Disease/Pathogens Requiring Airborne Infection Isolation

REFERENCES:

A. CAL OSHA, Title 8 Section 5199, Aerosol Transmissible Diseases July 2009
B. Hospital Infection Control Practices Advisory Committee (HICPAC), Centers for Disease Prevention and Control, "Guidelines for Isolation Precautions in Healthcare Settings, June 2007. (Downloaded 7/5/07)
C. Department of Health and Human Services, Centers for Disease Control and Prevention, "Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Health Care Settings", MMWR, December 30, 2005, Vol. 54 No. RR-17
D. Maxair, CAPR Owner's Manual, training DVD.

APPROVALS:

Infection Prevention and Control Committee: 2/22
Patient Care Policy & Evaluation Committee: 3/22
Medical Ethics Committee 4/22

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Infection Prevention & Control Committee	Kathy Ferris: Infection Control Coord	10/2025
	Kathy Ferris: Infection Control Coord	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18825060**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	3 years after approval
Owner	Ira-Beda Sabio: Director, Inpatient Nursing OP
Area	Nursing

Policy For Nursing Documentation

POLICY FOR NURSING DOCUMENTATION

POLICY STATEMENT:

To provide guidelines for effective electronic records of care, and to facilitate care by the entire health care team.

GUIDELINES:

A. Nursing documentation will be completed in the patient's EHR (Electronic Health Record) every shift by nursing personnel, to provide written evidence of the care provided. The nursing process of assessment, planning, interventions, and evaluation (APIE) will be utilized. The Patient Classification System tool will be used to record care, assessments, plans, acuity of the patient, and evaluation of the care provided.

B. Gather information regarding the patient, identify the patient's needs and collect data.

C. Information identified and gathered during the initial shift assessment will be recorded in the patient EHR, including but not limited to:

   1. A comprehensive assessment upon admission and focus assessment every shift based on the patient's needs and unit requirements (ie. Physical and psychosocial assessments, vital signs, height, weight, and general medical inventory).
   2. Patient preferences during hospitalization
   3. Anticipated needs for discharge (ie. DME (Durable Medical Equipment), transportation, referrals).

D. Document an individualized plan of care, including interventions, education, and outcomes.

E. Document and report all abnormal findings, changes in patient status and information significant to patient diagnosis.

F. Document interdisciplinary communications and handoffs.

G. Refer to Nursing Policy for Medication Administration and Documentation.

H. Use universal time for time documentation. Document the actual time intervention was performed. Time range is not acceptable. Narratives of an event (i.e.. emergency codes) not documented in the flowsheet will be documented in the nurse's notes with the date and time of event. Any late entry will be documented as an "Addendum."

REFERENCES:

A. California Title 22: Section 70213.

B. CCRMC

C. CCRMC Nursing Policy #701, "Medication Administration and Documentation."

D. TJC 2023 Standard IM.02.01.03, "The hospital maintains the security and integrity of health information."

E. Smith, Duell & Martin. **Clinical Nursing Skills.** 9th Edition, 2017. "Managing Client Care: Documentation and Delegation." p. 34 – 57.

APPROVALS:

Clinical Practice Committee: 1/2023

Patient Care Policy and Evaluation Committee: 1/2023

Medical Executive Committee: 1/2023

Joint Conference Committee: 3/2023

Reviewed

1/2004 (new), 6/2006, 6/2009, 1/2017, 1/2020, 1/2023, 3/2023

Revised:

9/2008, 6/2012, 11/2014

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [SP]	10/2025

Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	10/2025
Clinical Practice Committee	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	09/2025
	Ira-Beda Sabio: Director, Inpatient Nursing OP [LS]	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18940773**

Origination	01/2024	Owner	Shideh Ataii: Director Of Pharmacy Svcs
Last Approved	N/A	Area	Pharmacy
Effective	Upon Approval		
Last Revised	09/2025		
Next Review	3 years after approval		

Policy for Teclistamab-cqyv (TECVAYLI®) and Talquetamab-tgvs (TALVEY®)

POLICY STATEMENT:

This policy outlines the requirements for dispensing and administration of teclistamab-cqyv (TECVAYLI®) and talquetamab-tgvs (TALVEY®).

GUIDELINES:

TECVAYLI® is a bispecific B-cell maturation antigen (BCMA)-directed CD3 T-cell engager and TALVEY® is a bispecific GPRC5D-directed CD3 T cell engager. Both are indicated for the treatment of adult patients with relapsed or refractory multiple myeloma who have received at least four prior lines of therapy, including a proteasome inhibitor, an immunomodulatory agent and an anti-CD38 monoclonal antibody.

The Federal and Drug Administration (FDA) has determined that a Risk Evaluation and Mitigation Strategy (REMS) program is necessary to ensure that the benefits of TECVAYLI® outweighs the risks of cytokine release syndrome (CRS), neurologic toxicity, and immune effector cell-associated neurotoxicity (ICANS).

Prescribers must be certified in the TECVAYLI® and TALVEY™® REMS to treat patients with TECVAYLI® or TALVEY™®.

Pharmacies and Healthcare Settings must be enrolled in the TECVAYLI® and TALVEY™® REMS to dispense TECVAYLI® or TALVEY™® to patients.

~~This policy does not address the dispensing and administration of TALVEY™, which has a combined REMS program with TECVAYLI®.~~

RELATED LINKS:

Procedure for ~~Teclistamab-cqyv (~~TECVAYLI®~~)~~ and TALVEY® REMS

REFERENCES:

A. https://tec-talrems.com/#Main

B. https://www.accessdata.fda.gov/drugsatfda_docs/label/2022/761291s000lbl.pdf

~~APPROVALS:~~

~~Patient Care Policy and Evaluation Committee: 1/2024~~
~~Medical Executive Committee:~~
~~Joint Conference Committee:~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy and Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
	Shideh Ataii: Director Of Pharmacy Svcs	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19027584**

Origination	N/A
Last Approved	N/A
Effective	Upon Approval
Last Revised	N/A
Next Review	2 years after approval
Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Respiratory Care Practitioner Response to Emergency Events

Policy Statement:

All licensed Respiratory Care Practitioners (RCPs) shall respond to designated emergency events within the facility. The Primary RCP assigned to the shift is required to respond and assume lead respiratory responsibilities. All available RCPs must support emergency response efforts as needed.

This policy supports and complements existing policies and procedures for each emergency event, including Code Blue, Rapid Response Team (RRT), Massive Transfusion Protocol (MTP), Malignant Hyperthermia (MH), Obstetric (OB) Emergency Response, and other emergent clinical scenarios requiring respiratory care intervention.

Guidelines:

A. **Responsibilities of Respiratory Care Practitioners**

1. Upon activation of any emergency code or alert, RCPs are expected to:
    a. Respond immediately with appropriate respiratory equipment
    b. Assess airway patency, breathing effort, and oxygenation status
    c. Provide manual ventilation and assist with intubation as needed
    d. Initiate and manage mechanical or non-invasive ventilation
    e. Administer aerosolized medications and oxygen therapy
        i. Monitor respiratory parameters including:

ii. Oxygen saturation (SpO_2)

iii. Respiratory rate and effort

iv. End-tidal CO_2 ($EtCO_2$) via non-invasive and/or invasive capnography

f. Collaborate with interdisciplinary teams to ensure coordinated care

g. Document all assessments, interventions, and outcomes in the patient's electronic medical record

B. **Equipment and Readiness**

1. RCPs must ensure the following equipment is available, functional, and ready for use at all times:

a. Emergency airway cart

b. Bag-valve-mask devices (adult, pediatric, neonatal)

c. ~~ntubation~~Intubation supplies

d. Mechanical ventilators

e. Oxygen delivery systems

f. Nebulizers and aerosol therapy kits

g. Capnography monitors (for $EtCO_2$ monitoring)

C. **Documentation Requirements**

1. All emergency interventions must be documented in the patient's electronic medical record, including:

a. Time of arrival and response

b. Procedures performed

c. Medications administered

d. $EtCO_2$ values and trends

e. Patient outcomes and ~~dispositio~~disposition.

References:

- American Association for Respiratory Care. (2021). *Clinical practice guideline: Capnography during mechanical ventilation*. https://www.aarc.org/resources/clinical-practice-guidelines/
- American Heart Association. (2021). *Advanced cardiovascular life support (ACLS) provider manual*. American Heart Association.
- American Academy of Pediatrics & American Heart Association. (2021). *Textbook of neonatal resuscitation (NRP) (8th ed.)*. American Academy of Pediatrics.
- Joint Commission. (2021). *Emergency management standards for hospitals*. https://www.jointcommission.org/standards/
- Institute for Healthcare Improvement. (2021). *Rapid response systems: Best practices and implementation guide*. https://www.ihi.org/resources/Pages/Tools/RapidResponseTeam.aspx

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19026703**

Origination	09/2014	Owner	Michael De Peralta: Respiratory Care Services Mgr
Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	10/2025		
Next Review	2 years after approval		

Policy for Mechanical Ventilation Management

POLICY STATEMENT:

Goal of mechanical ventilation is to augment or to assist the respiratory function of patients with ventilation or oxygenation failure. Patients requiring mechanical ventilation will receive care as outlined:

A. Mechanical ventilators should only be set-up and placed on patients by Respiratory Care Practitioner (RCP).

B. Mechanical ventilator adjustments should only be performed by a RCP.

C. A physician's order must be written for the initiation of mechanical ventilation and must include: Ventilator Mode, Set Rate, Set Tidal Volume or targeted volume (~~or~~ ml/kg), PEEP, ~~Rate,~~ FiO2.

D. Proper documentation of all ventilator assessments and parameter adjustments must be performed at the time of assessment or time of change ~~and~~ by the individual initiating the parameter change.

E. Registered Nurses may adjust FiO_2 when necessary, notifying the RCP.

F. Mechanical ventilator must be cleaned and setup when ventilator is discontinued.

GUIDELINES:

To provide guidelines and standards for the initiation, cleaning, monitoring and assessment, and documentation of mechanical ventilation.

RELATED LINKS:

Procedure for Mechanical Ventilation Management

REFERENCES:

~~A. Dean Hess, Robert Kacmarek, Essential of Mechanical Ventilation, McGraw-Hill Professional; 1st edition (March1, 1996)~~

~~B. American College of Chest Physicians Consensus Conference on Mechanical Ventilation, Chest 1993; 104:1833-59.~~

~~C. AARC Clinical Practice Guidelines- Ventilator Circuit Changes. Respiratory Care 1994; 39(8):797-802~~

~~D. AARC Clinical Practice Guidelines; Patient-Ventilator System Checks, Respiratory Care: 1992; 37:882-886~~

A. Hess, Dean, and Robert M. Kacmarek. Essentials of Mechanical Ventilation. Fourth edition., McGraw-Hill Education, 2019. (MDL reviewed on 09/2025).

B. Slutsky A. S. (1993). Mechanical ventilation. American College of Chest Physicians' Consensus Conference. Chest, 104(6), 1833–1859. https://doi.org/10.1378/chest.104.6.1833 (MDL reviewed on 09/2025).

C. Goodfellow, L. T., Miller, A. G., Varekojis, S. M., LaVita, C. J., Glogowski, J. T., & Hess, D. R. (2024). AARC Clinical Practice Guideline: Patient-Ventilator Assessment. Respiratory care, 69(8), 1042–1054. https://doi.org/10.4187/respcare.12007

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18904368**

Origination	03/2016	Owner	Michael De Peralta: Respiratory Care Services Mgr
Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	09/2025		
Next Review	2 years after approval		

Policy for Medication Administration and Documentation

POLICY STATEMENT:

Licensed Respiratory Care Practitioners (RCPs) are responsible for administering and documenting all medications within their scope of practice, as prescribed by the medical provider. They will ~~administer and document all~~monitor the effects of the medications ~~within their scope of practice as ordered by the practitioner, monitor medication effects,~~ and report any relevant findings to the medical provider ~~as needed~~when necessary.

GUIDELINES:

To provide guidelines for the administration and documentation of medications.

RELATED LINKS:

Procedure for Medication Administration and Documentation

REFERENCES:

~~A. California Licensed Respiratory Care Practitioner Scope of Practice Business and Professions Code Title 22: Section 71233:2g. TJC 2014 National Patient Safety Goal, #3, "Use medications safely."~~

~~B. Centers for Medicare and Medicaid Services (CMS) Memo to State Survey Agency Directors, March 14, 2014: "Requirements for Hospital Medication Administration, Particularly Intravenous (IV) Medications and Post-Operative Care of Patients Receiving IV Opioids."~~

~~C. Pharmacy Policy #3511, "Standard Administration Times for Medications."~~

D. ~~Contra Costa County Health Services Nursing Department Policy & Procedure Manual #701 Medication Administration and Documentation~~

A. Respiratory Care Board of California. Licensed Respiratory Care Practitioner Scope of Practice. Available at: http://rcb.ca.gov/licensees/scope_of_practice.shtml (MDL reviewed on 09/2025)

B. California Code of Regulations, Title 22, Section 51082. Responsibilities and Scope of Practice for Respiratory Care Practitioners. Available at: https://www.law.cornell.edu/regulations/california/22-CCR-51082. (MDL reviewed on 09/2025)

C. The Joint Commission. National Patient Safety Goals (2025). Available at: https://www.jointcommission.org/standards/national-patient-safety-goals/.

D. Centers for Medicare & Medicaid Services (CMS). Policy and Memos to States and CMS Locations. Available at: https://www.cms.gov/medicare/health-safety-standards/quality-safety-oversight-general-information/policy-memos/policy-memos-states-and-cms-locations (MDL reviewed on 09/2025)

E. Pharmacy Policy #3511, "Standard Administration Times for Medications." (MDL reviewed on 09/2025)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19026809**

Origination	09/2014
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2025
Next Review	2 years after approval

Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Non-Invasive Positive Pressure Ventilation

POLICY STATEMENT:

~~BiPAP~~Positive pressure ventilation therapy will be ~~performed~~administered by the Respiratory Care Practitioner (RCP) for patients receiving ~~rescue or non-rescue~~ non-invasive positive pressure ventilation (NPPV) due to rescue, acute, or chronic conditions. Initiation of NPPV requires a physician~~'~~'s order.

GUIDELINES:

To provide safe guidelines for the application of Non-Invasive Positive Pressure Ventilation and to provide safe guidelines for the use and operations of bilevel positive airway pressure devices.

RELATED LINKS:

Procedure for Non-Invasive Positive Pressure Ventilation

REFERENCES:

~~A. Aboussousan M.D., L.S., & Ricaurte M.D., B. (2010, May). Noninvasive positive pressure ventilation: Increasing use in acute care. Cleveland Clinic Journal of Medicine, 77(5), 307-316.~~

~~B. Timothy Liesching,MD; Henry Kwok, MD,FCCP; and Nicholas S. Hill, MD, FCCP. Acute Applications of Noninvasive Positive Pressure Ventilation. Chest 2003;124:699-713.~~

~~C. RC.40.7.7 Procedure for Non-Invasive Positive Pressure Ventilation~~

A. Munshi, L., Mancebo, J., & Brochard, L. J. (2022). Noninvasive respiratory support for adults with acute respiratory failure. New England Journal of Medicine, 387(17), 1688–1698

B. Abe, T., Takagi, T. & Fujii, T. Update on the management of acute respiratory failure using non-invasive ventilation and pulse oximetry. Crit Care 27, 92 (2023).

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18904696**

Origination	09/2014
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2025
Next Review	2 years after approval
Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Patient Assessment and Documentation

POLICY STATEMENT:

To ~~insure~~ensure the provision of appropriate and effective ~~of~~ respiratory therapy, ~~The~~the Respiratory Care ~~Practioner~~Practitioner (RCP) will ~~perform~~conduct ongoing patient assessments ~~to~~. These assessments will confirm the appropriateness of therapy, ~~to assess~~evaluate the patient~~'~~'s previous and current respiratory status, ~~to evaluate~~monitor the patient~~'~~'s response to therapy, ~~to~~ prioritize patient care ~~and to~~, and prepare or recommend ~~changes to~~modifications to the patient care ~~plans~~plan.

GUIDELINES:

To ~~provide guidelines for the standardization of~~establish standardized procedures for initial and ~~subsequent~~follow-up patient assessments, ~~assessments~~the evaluation of patient outcomes ~~of~~following therapeutic ~~intervention~~interventions, and the accurate documentation of ~~such~~these assessments.

RELATED LINKS:

Procedure for Patient Assessments and Documentation.

REFERENCES:

A. Joint Commission Standards: P, E 1.7, P.E. 2.0, P.F.1, and P.F. ~~2.~~22 (Reviewed on 09/2025)

B. ~~Kacmmarek~~Kacmarek, Robert M. The Essentials of Respiratory Care ~~(~~, 4th ~~edition)~~ed., Elsevier Mosby Publishing, ~~2005.~~2019 (Reviewed on 09/2025)

C. Egan, Donald F. ~~Fundamental~~Fundamentals of Respiratory Care, 13th ed., Mosby Publishing, ~~1999~~2024

~~APPROVALS:~~

~~PCP&E Approval: 9/7/2022~~
~~Med Committee Approval: 9/19/2022~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18912447**

Origination	09/2014	Owner	Michael De Peralta: Respiratory Care Services Mgr
Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	09/2025		
Next Review	2 years after approval		

Policy for Pulse Oximetry

POLICY STATEMENT:

~~Pulse oximetry provides estimates of arterial oxyhemoglobin saturation (SaO2) to noninvasively determine the saturation of oxyhemoglobin (SpO2) for the purposes of monitoring the cardiopulmonary status of patients.~~

Pulse oximetry is a noninvasive, real-time method for estimating arterial oxyhemoglobin saturation (SpO_2). This policy provides standardized guidelines for respiratory therapists to ensure safe, accurate, and effective use of pulse oximeters in assessing and monitoring patients' cardiopulmonary status across all clinical settings.

GUIDELINES:

~~To provide a method for monitoring (on an intermittent or continual basis) oxygen saturation in a noninvasive manner.~~

Monitoring Protocol

A. Use pulse oximetry for continuous or intermittent monitoring based on clinical indication.
B. Apply continuous monitoring for patients with unstable respiratory status, oxygen therapy, or during procedures affecting ventilation.
C. Intermittent checks may be appropriate for stable patients or routine assessments.

2. Device Calibration & Maintenance

A. Verify that pulse oximeters are calibrated and maintained per manufacturer specifications.

B. Perform routine checks to ensure functionality and accuracy.

C. Report and replace malfunctioning devices promptly.

3. Sensor Placement

A. Preferred sites: fingertip, earlobe, or toe with adequate perfusion.

B. Ensure the site is clean, dry, and free of nail polish, artificial nails, or skin adhesives.

C. Rotate sensor sites periodically to prevent skin breakdown.

4. Accuracy Considerations

A. Recognize factors that may affect readings:

- Poor peripheral perfusion (e.g., hypotension, hypothermia)
- Skin pigmentation or thickness
- Patient movement or tremors
- Bright ambient light or external interference

B. Confirm abnormal readings with clinical assessment or arterial blood gas analysis when necessary.

5. Alarm Settings

A. Set SpO_2 alarm thresholds according to institutional protocols and patient-specific needs.

- Example: SpO_2 < 90% may trigger an alert in most adult patients.

B. Ensure alarms are audible and responded to promptly.

6. Documentation

A. Record SpO_2 values in the patient's medical record, including:

- Time of reading
- Sensor site
- Oxygen delivery method (e.g., nasal cannula, mask)
- Any factors affecting accuracy

7. Staff Training

A. All respiratory therapists and relevant clinical staff must be trained in:

- Proper use of pulse oximeters
- Interpretation of SpO_2 readings
- Troubleshooting device or sensor issues

B. Training should be reviewed annually or as new equipment is introduced.

RELATED LINKS:

Procedure for Pulse Oximetry

REFERENCE:

~~A. AARC Clinical Practice Guideline: Pulse Oximetry Resp Care 1991;36:1406-1409~~

~~B. Oximax N-595 Pulse Oximeter Operator's Manual~~

~~C. Welch-Allen Operator's Manual~~

A. American Association for Respiratory Care. (2022). AARC clinical practice guideline: Management of adult patients with oxygen in the acute care setting. Respiratory Care, 67(1), 115–128. Retrieved from https://www.aarc.org/wp-content/uploads/2022/10/cpg-clinical-mangement-adult-o2-acute-settings.pdf

B. Nellcor Puritan Bennett Inc. (n.d.). OxiMax N-595 pulse oximeter operator's manual. Retrieved from https://www.manualslib.com/manual/1390082/Nellcor-Oximax-N-595.html

C. Welch Allyn. (2020). Vital Signs Monitor operator's manual. Retrieved from https://archive.org/details/manual_Welch_Allyn_Vital_Signs_Operators_Manual (MDL Reviewed on 09/2025)

D. Masimo Corporation. (2020). Radical-7 pulse CO-oximeter operator's manual. Retrieved from https://techdocs.masimo.com/globalassets/techdocs/pdf/lab-5475j_master.pdf (MDL reviewed on 09/2025)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18889112**

Origination	10/2010
Last Approved	N/A
Effective	Upon Approval
Last Revised	09/2025
Next Review	2 years after approval
Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Respiratory Care Equipment Management

POLICY STATEMENT:

~~The Equipment Management Department Shall provide and oversee both Technical and clinical support of medical equipment used in the provision of care to patients. The Equipment Management Department will maintain all documentation of support.~~

The Biomedical Engineering Department, in partnership with Respiratory Care Services staff and management, shall provide comprehensive technical and clinical support for all medical equipment utilized in patient care. This collaborative approach ensures that equipment is properly maintained, safely operated, and consistently available to support high-quality healthcare delivery. The department is responsible for maintaining accurate documentation of equipment service, repair, and oversight to meet both clinical needs and regulatory requirements

GUIDELINES:

Contra Costa Regional Medical Center ~~has~~maintains an Equipment Management Program ~~designed to optimize~~aimed at optimizing the safety, effectiveness, and ~~economy~~cost-efficiency of diagnostic~~,~~ and therapeutic medical equipment. ~~Medical equipment~~For the purposes of this policy, *medical equipment* is ~~generally~~ defined as fixed or portable electrical ~~equipment used~~devices utilized in the diagnosis, treatment, and ~~general~~ongoing care of patients ~~served.~~

RELATED LINKS:

Procedure for Respiratory Care Equipment Management

Policy for Equipment Management Program

REFERENCES:

A. TJC EC1.2.6 (MDL reviewed on 09/2025)

B. Contra Costa Regional Medical Center Policy #348, Equipment Management Program (MDL reviewed on 09/2025)

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	09/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19026657**

Origination	08/2014	Owner	Michael De Peralta: Respiratory Care Services Mgr
Last Approved	N/A	Area	Respiratory
Effective	Upon Approval		
Last Revised	10/2025		
Next Review	2 years after approval		

Policy for Respiratory Care Services Department Disaster Plan

POLICY STATEMENT:

In the event of an emergency/disaster, the respiratory care service of the Respiratory Care Services Department will provide respiratory services, including but not limited to; mechanical ventilation, ~~arterial~~ blood gas analysis, medical gas therapy, and other life-supportive services.

GUIDELINES:

To provide guidelines for a response plan for departmental operations during an emergency/disaster event.

RELATED LINKS:

Procedure for Respiratory Care Services Department Disaster Plan

REFERENCES:

A. CCRMC Disaster Preparedness and Evacuation Plan.
B. Hospital Emergency Incident Command System (HEICS), P&P Manual

~~APPROVALS:~~

~~PCP&E: 9/7/2022~~
~~MEC: 9/19/2022~~

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **19026892**

Origination	10/2010
Last Approved	N/A
Effective	Upon Approval
Last Revised	10/2025
Next Review	2 years after approval
Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Sputum Induction

POLICY STATEMENT:

The patient should generate a cough for routine specimens for cultures, AFB smears, and cytology without induction, if possible. Pneumocystis carinii confirmation requires an induction, with three samples collected. The Respiratory Care Practitioner will obtain sputum samples from the patient inside the Emerson Treatment Chamber or by using isolation techniques listed in the Infection Control Standards. The RCP will adhere to standard precautions and isolation precautions as appropriate.

GUIDELINES:

To provide guidelines for Respiratory Care Practitioners (RCP) to safely obtain specimens for cytology, acid-fact bacilli smear and culture (AFB), gram staining, pneumocystis carinii confirmation, and fungal culture.

RELATED LINKS:

Procedure for Sputum Induction

REFERENCES:

~~A. The Centers for Disease Control and Prevention. (n.d.). CDC.gov. Retrieved from http://www.cdc.gov/tb/education/corecurr/pdf/chapter4.pdf~~

~~B. CCHS Intranet, Infection Control Policy & Procedure Manual. (2007). Retrieved from http://isite3/SitePages/Policies.aspx?InteriorNavPage=Policies~~

A. Centers for Disease Control and Prevention. (2024). Core infection prevention and control

practices for safe healthcare delivery in all settings. Retrieved from https://www.cdc.gov/infection-control/hcp/core-practices/index.html

B. Contra Costa Health Services (CCHS). (2007). Infection control policy & procedure manual. Retrieved from http://isite3/SitePages/Policies.aspx?InteriorNavPage=Policies (MDL reviewed on 09/2025).

C. The Joint Commission. (2025). Updated infection prevention and control requirements. Retrieved from https://www.jointcommission.org/-/media/tjc/documents/standards/prepublications/2025/obs_ic_requirements_july2025_prepub_accessibl.pdf

D. Thoracic Society of Australia and New Zealand. (2024). Position statement on safe sputum induction. Insight+ Medical Journal. Retrieved from https://insightplus.mja.com.au/2024/25/keeping-sputum-induction-safe-with-new-position-statement/

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	10/2025

Standards

No standards are associated with this document

Status **Pending** PolicyStat ID **18888833**

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Next Review	2 years after approval

Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for the Administration of Therapeutic Oxygen

POLICY STATEMENT:

~~A physician's order is required to initiate oxygen therapy, except in an emergency situation. The Respiratory Care Practitioner will administer therapeutic oxygen as ordered and as indicated for symptoms of hypoxia.~~

Therapeutic oxygen shall be administered by a licensed Respiratory Care Practitioner (RCP) only upon receipt of a valid physician's order, except in emergency situations where immediate intervention is required to prevent or treat hypoxia

GUIDELINES:

~~To provide guidelines for the safe administration of therapeutic oxygen to treat and prevent hypoxia, in Adults and Pediatrics.~~

To establish safe and effective guidelines for the administration of therapeutic oxygen in adult and pediatric patients, in accordance with current clinical standards and regulatory requirements

RELATED LINKS:

Procedure for Administration of Therapeutic Oxygen

REFERENCES:

~~A. AARC Clinical Practice Guidelines- Oxygen Therapy in Acute Care Hospital; Respiratory Care 1991;36:1410 -1413~~

~~B. American Thoracic Society. (2014). Thoracic.org. Retrieved from http://www.thoracic.org/clinical/copd-guidelines/for -health-professionals/exacerbation/inpatient-oxygen-therapy/oxygen-delivery-methods.php~~

~~C. Oxygen Therapy for Adults in the Acute Care Facility. (2002, June). Respiratory Care Journal, 47(6), 717-720. Retrieved from http://www.rcjournal.com/cpgs/~~

A. AARC Clinical Practice Guidelines: Management of Adult Patients With Oxygen in the Acute Care Setting. Respiratory Care, 2022. Retrieved from AARC Clinical Practice Guidelines.

B. American Thoracic Society (ATS): Clinical Practice Guidelines for Oxygen Therapy. Thoracic.org, 2022. Retrieved from ATS Guidelines.

C. Pisani, M. A., & Murphy, T. E. (2025). A person-centered approach to supplemental oxygen therapy in the modern era. *JAMA Internal Medicine*

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	09/2025

Standards

No standards are associated with this document

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Owner	Michael De Peralta: Respiratory Care Services Mgr
Area	Respiratory

Policy for Small Volume Nebulizer Treatment (Hand-Held)

POLICY STATEMENT:

Respiratory Care Services will provide hand-held nebulizer therapy to patients requiring the aerosolization of pharmacological agents to maintain airway patency and assist with clearance of retained secretions.

GUIDELINES:

To provide guidelines for the delivery of aerosol therapy, via small volume nebulizer, for medication delivery, airway patency, and airway clearance.

RELATED LINKS

Procedure for Small Volume Nebulizer Treatment (Hand-Held)

REFERENCES:

A. Hess DR. Aerosol Therapy. In: Dantzker DR, MacIntyre NR, Bakow ED, Eds. Comprehensive Respiratory Care. 2nd ed. Philadelphia: WB Saunders; 2023.

B. Kendrick AH, Smith EC, Wilson RS. Selecting and using nebulizer equipment. Thorax. 2023; 78 Suppl 2:S92-101.
AARC Clinical Guidelines: Assessing Response to Bronchodilator Therapy at Point of Care. Respiratory Care. 2023; 68(12): 1300-1307.

C. AARC Clinical Practice Guidelines: Selection of aerosol delivery device. Respiratory Care. 2022; 67:891-897.

D. AARC Clinical Practice Guidelines: Selection of a device for the delivery of aerosols to the lung parenchyma. Respiratory Care. 2023; 69:647-653.

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Patient Care Policy & Evaluation Committee	Vijay K. Bhandari [SP]	11/2025
Medical Director	Initha Elangovan: Exempt Med Stf Physician	10/2025
	Michael De Peralta: Respiratory Care Services Mgr	09/2025

Standards

No standards are associated with this document