Operational Policy Agenda 7-28-25

***** *Indicates policy is pending Medical Executive Committee's approval on 7/21/25.***

Title	Area	Revised?	Summary of Changes
Contra Costa Regional Medical Center Joint Conference Committee Expedited Privileges Subcommittee Charter *	Hospital & Health Centers	Revised	*Edits are not tracked due to the document being created in PolicyStat for the 1st time.* Expedited Privileges. A subcommittee of JCC for the purpose of reviewing and approving off-cycle candidates with Category 1 applications (no concerns).The process of granting privileges outside the standard schedule due to various circumstances such as recruitment needs, changes in service demand, or urgent staffing requirements.
Contra Costa Regional Medical Center & Health Centers Medical Staff Rules and Regulations	Hospital & Health Centers	Unchanged	N/A
Policy for Escalation	Hospital & Health Centers	Revised	Updated language to indicate both clinical and safety concerns with the escalation pathways. Updated language to include both hospital and clinics. Reformatted for ease of understanding.
Policy for Code of Conduct	Ambulatory Care	Revised	Added "designated MOU" and provided clarification regarding break times, removed P&P numbering, and minor rewording and reformatting.

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Owner	Heather Cedermaz: Family Nurse Practitioner
Area	Hospital & Health Centers

Contra Costa Regional Medical Center Joint Conference Committee Expedited Privileges Subcommittee Charter

Purpose

The Contra Costa Regional Medical Center (CCRMC) Joint Conference Committee (JCC) establishes this charter for the review and approval of expedited credentialing of medical staff members for Category 1 applications by a JCC Expedited Credentialling Subcommittee. It outlines the roles, responsibilities, and processes for the Subcommittee to ensure compliance with regulatory standards and to maintain high-quality patient care.

Scope

This charter applies to all CCRMC and Clinics medical staff members and applicants with a Category I initial and reappointment application who are seeking credentials in an expedited procedure via the use of the Subcommittee.

Definitions

A. **Category I applications must be complete and have no issues on record that would cause them to have a category II application as outlined in the Medical Staff Bylaws.**

B. **On-Cycle Credentialing**: The regular monthly process of credentialing files via Medical Staff Office (MSO), the Credentials Committee (CC), and the Medical Executive Committee (MEC) meetings.

C. **Off-Cycle Credentialing**: The process of granting privileges outside the standard schedule due to various circumstances such as recruitment needs, changes in service demand, or urgent staffing requirements.

Membership

A. The Expedited Credentialing Subcommittee will consist of three members, two of whom must be voting members of the CCRMC JCC.

B. Members of the Subcommittee will be appointed by the CCRMC JCC for two-year terms every 2 years. Vacancies on the Subcommittee will be filled by appointment of the Chair of the CCRMC JCC to complete the remaining term of the vacant seat.

C. **Composition**: The Subcommittee shall consist of three members:

    1. CCRMC Chief Medical Officer (CMO) or Chief Executive Officer (CEO); and
    2. 2 members who are voting members of the CCRMC JCC.

Procedure

A. Medical Staff Office (MSO) staff will determine if expedited credentialing is warranted based on the following criteria:

    1. There is a staffing need, and
    2. Completed application for initial appointment, reappointment or request for additional privileges is turned into the MSO timely and before JCC convenes, and it is identified as a category 1 application. Application processing includes the following guidelines:
        a. On-cycle: staff is not needed until after MEC
        b. Off-cycle: Completed application is turned into MSO at a time when it cannot be processed through the regular committee cycle;
    3. If application is off cycle:
        a. Department Chair and Credentials Committee Chair meet on behalf of the Credentials Committee for approval;
        b. Special MEC meeting called for approval of application(s); and
        c. JCC Expedited Credentialling Subcommittee reviews application for approval on behalf of JCC and Board Of Supervisors.

B. **Review Applications**:

    1. To qualify for expedited credentialing, all applications for both on-cycle and off-cycle must be considered Category 1 as defined above.
    2. Applications will not be considered for expedited credentialling if the applicant has submitted an incomplete application or if the Medical Executive Committee makes a final recommendation that is adverse or has limitations.
    3. The following situations will be evaluated on a case-by-case basis and usually result in ineligibility for the expedited process:
        a. There is a current challenge or a previously successful challenge to licensure or registration,
        b. The applicant has received an involuntary termination of medical staff membership at another hospital,

c. The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

d. There has been either an unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment against the applicant.

C. **Decision Making**:

1. If any group (Credentials Committee, MEC, JCC Subcommittee) believes that an application is not category I, they will **not** proceed with expedited credentialing and the file will go through the non-expedited credentialling approval process.
2. If expedited credentialing occurs, the governing body (JCC) must still review the expedited files at the next regularly scheduled meeting.
3. A unanimous decision by the Subcommittee is required for approval of all applications considered under the Expedited Credentialing process.

D. **Monitoring and Quality Assurance**:

1. The JCC Expedited Credentialing Subcommittee will produce meeting minutes for review in regular JCC meetings.
2. All approved files will be included in subsequent BoS credential procedures.
3. MSO will report out to MEC every year about the number of expedited credentials completed, both on- and off-cycle.

Meeting Frequency

A. The subcommittee shall meet twice monthly as needed: once following each MEC meeting to address on-cycle requests and once during the first half of month to address any off-cycle requests.

Review and Amendments

A. This Charter shall be reviewed annually and amended as necessary to reflect changes in regulations, best practices, and institutional policies.

B. Any proposed amendments to this Charter must be approved by the CCRMC Joint Conference Committee.

Confidentiality

A. All personnel documents pertaining to credentialing decisions are confidential and shall be treated as such in accordance with applicable laws and institutional policies during the committee.

Compliance

A. This Charter will comply with all relevant federal, state, and local laws, as well as accreditation standards set forth by regulatory bodies.

References

A. CMS section 482.12

B. The Joint Commission Standard MSO 06.01.11 EP01

Approval Signatures

Step Description	Approver	Date
Medical Executive Committee	Sarah E. Mcneil	Pending
Credentialing Committee	Heather Cedermaz: Family Nurse Practitioner	07/2025
	Heather Cedermaz: Family Nurse Practitioner	07/2025

Standards

No standards are associated with this document

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

Contra Costa Regional Medical Center & Health Centers Medical Staff Rules and Regulations

Medical Executive Committee Approved: June 2025

Adoption Date (approved by Board):

Amendment Date(s) (approved by Board)

Table of Contents

ARTICLE I. INTRODUCTION

1.1 INTRODUCTION

These Rules and Regulations are adopted by the Medical Executive Committee and approved by the County Board of Supervisors of Contra Costa Medical Center & Health Centers (collectively referred to as Contra Costa Health or "CCH") to further define the general policies contained in the Contra Costa Medical Center & Health Centers Medical Staff Bylaws ("Bylaws"), and to govern the discharge of professional services within the Hospital. These Rules and Regulations are binding on all Medical Staff appointees and other individuals exercising clinical privileges (collectively referred to as "Practitioners" as defined within the Bylaws). Hospital policies concerning the delivery of health care may not conflict with these Rules and Regulations, and these Rules and Regulations shall prevail in any area of conflict. These Rules and Regulations of the Medical Staff may be adopted, amended, or repealed only by the mechanism provided in the Bylaws. This article supersedes and replaces all other Medical Staff rules and regulations, or policies and procedures, pertaining to the subject matter thereof.

ARTICLE II. ADMISSION AND DISCHARGE

2.1 ADMISSIONS

2.1.1 General

Patients are admitted to the hospital only on the decision of a licensed practitioner permitted by the state of California to admit patients to a hospital.

a. **Admitting Privileges:** A patient may be admitted to the hospital only by a practitioner on the Medical Staff with admitting privileges.

b. **Admitting Diagnosis:** Except in an emergency, no patient will be admitted to the hospital until a provisional diagnosis or valid reason for admission has been written in the medical record. In the case of emergency, the admitting diagnosis will be recorded as soon as possible.

c. **Admission Priority and Procedure:** The Hospital "Policy for Admission, Unit Transfer, and Discharge" shall be followed.

2.1.2 Inpatient Psychiatric Services

a. The hospital policies for admission shall be followed for admission to the inpatient psychiatric unit, including specific psychiatry "Policy for Admission Criteria to Inpatient Psychiatry," "Inpatient Psychiatry – Medical/Physical Care of Patients," and "Procedure for Admission Process to Inpatient Psychiatric Service from Psychiatric Emergency Services (PES)."

2.2 EMERGENCY PATIENTS

The Emergency Medical Treatment and Active Labor Act (EMTALA) requires that for all patients who present to the Emergency Department, the Hospital must, at a minimum, provide for an appropriate medical screening examination within the capability of the hospital's emergency department, including ancillary services routinely available to the emergency department, to determine whether or not an emergency medical condition exists. Practitioners should follow the hospital Policy for EMTALA.

2.2.1 Emergency Department Call Coverage

a. **Call Schedule:** The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. The Department/Division Chairs shall provide the hospital with a list of physicians who are scheduled to provide call coverage to respond to medical emergencies.

b. **Response Time:**

   i. It is the responsibility of the on-call physician, or designee, to respond in an appropriate time frame.

   ii. The on-call physician, or designee, should respond to calls from the Emergency Department no longer than twenty (20) minutes by telephone, unless a shorter time is required by contract or accrediting body. The on-call physician or designee must arrive at the Hospital, if requested to see the patient, in a timeframe based on the communication between the ED practitioner and the on-call physician. Specialties that provide telemedicine coverage shall see the patient based on the timeframes defined by contract and/or agreed upon between the ED practitioner and the on-call

telemedicine physician.

iii. In areas of dispute, the ED physician decision rules. If there is disagreement on the timeframe, the ED practitioner shall define the timeframe.

iv. If the on-call physician does not respond to being called or paged, the physician's documented designee shall be contacted. If the physician's designee does not respond to being called or paged, the Administrative Director should be contacted. Any violations of EMTALA will be reported in compliance with the policy.

v. Teaching services are expected to respond in the same timeframes or sooner in lieu of the on-call physician when appropriate.

c. **Substitute Coverage:** It is the on-call physician's responsibility to change the online call schedule through communication with the Department or Division leadership when there is enough time to do so as determined by the hospital. Short timeframes require the on-call physician to arrange for coverage and notify the Emergency Department if they are unavailable to take call when assigned. Failure to notify the Emergency Department of alternate call coverage may result in the initiation of disciplinary action.

2.2.2 Patients Not Requiring Admission

In cases where the Emergency Department consults with the on-call physician and no admission is deemed medically necessary, the Emergency Department physician shall implement the appropriate care/treatment and discharge the patient with arrangements made for appropriate follow-up care. If the Emergency Department physician and the consultant agree that the outpatient visit can serve in lieu of the consultant coming into the Emergency Department, an appropriate outpatient follow-up care plan shall be developed.

If the consultant, in disagreement with the emergency physician, feels 1) that inpatient admission is not warranted, or 2) the patient requires transfer to another facility, then the consultant, at the request of the emergency physician, is required to assess the patient and make appropriate arrangements and document their decision.

2.2.3 Patient Follow-up After Discharge from the ED

The ED will coordinate or provide information about follow-up care with an appropriate practitioner at CCHS or an external provider as appropriate.

2.2.4 Guidelines for Call Coverage

The following rules should be used in developing service policies regarding call coverage obligations:

a. The hospital shall have physician coverage to comply with basic emergency medical service capability requirements.[1]

b. Call duties, to supply basic stabilization and disposition of the patient, should be based on the practitioner's core privileges and training.

[1] Title 22, § 70413. Basic Emergency Medical Service, Physician on Duty, General Requirements.

c. The Medical Executive Committee in consultation with Administration shall determine which specialties are required to have call schedules (in addition to the basic medical service capability requirements),
d. Emergency duties may be divided by specialty or subspecialty.
e. Call is assigned by the Department or Division Leadership.
f. Call coverage is documented in an electronic call roster (e.g., Amion).
g. If a physician is on-call at more than one hospital simultaneously, they must have an agreed upon back-up physician named to provide coverage in case of emergencies.
h. Physicians must be listed by name on the call roster (they cannot be listed by group).
i. Departments or specialties that do not provide 24/7/365 call coverage shall work with Administration to communicate the coverage schedule to the Emergency Department and develop a back-up plan when coverage is not available.[2]

2.2.5 Failure to Meet Call Obligations

All failures to meet call responsibilities shall be reported to the Department Chair and the Medical Executive Committee. Recurrent failure to meet call obligations may result in corrective action per the Medical Staff Bylaws.

2.2.6 Qualified Medical Personnel for Screening Examinations

Only physicians are deemed to be Qualified Medical Personnel (QMP) for purposes of (1) performing an appropriate medical screening examination of an individual presenting to CCH to determine whether the individual suffers from an emergency medical condition, and (2) completing the required physician certification for transfer of a patient with an emergency medical condition including active labor who has not been stabilized to another facility for treatment at the direction of the Responsible Physician.

2.3 TRANSFERS

2.3.1 Transfers To and From Other Acute Care Facilities

Patients who are transferred to or from another hospital must follow the Hospital policies including "Policy for Patient Transfers to Other Facilities" and "Policy for Accepting Patient Transfers from Outside Facilities and Referrals from Contra Costa Health Centers," and ensure EMTALA compliance.

2.3.2 Transfers Within the Hospital

Patients may be transferred from one patient care unit to another in accordance with the priority established by the Hospital. All practitioners actively providing care to the patient will be notified of all transfers. Hospital policies must be followed including "Policy for Admission, Unit Transfer, and Discharge."

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[2] §489.24(j) - Availability of On-call Physicians In accordance with the on-call requirements specified in §489.20(r)(2), a hospital must have written policies and procedures in place: (1) To respond to situations in which a particular specialty is not available or the on-call physician cannot respond because of circumstances beyond the physician's control.

2.4 PATIENTS WHO ARE A DANGER TO THEMSELVES AND OTHERS

The attending physician, or designee, is responsible for providing the Hospital with necessary information to assure the protection of the patient from self-harm and to assure the protection of others. Practitioners caring for patients who are a danger to themselves and/or others should follow "Procedure for Assault Precautions" policy and "Suicide Risk Screening, Evaluation, and Precautions in Psychiatric Units" policy.

2.5 DISCHARGE ORDERS AND INSTRUCTIONS

Patients will be discharged or transferred only upon the authenticated order of the attending physician, or designee, who shall provide, or assist Hospital personnel in providing, written discharge instruction in a form that can be understood by all individuals and organizations responsible for the patient's care. See Section 3 for the elements of the Discharge Summary. The discharge instructions should include, if appropriate based on age and condition:

a. A list of all medications the patient is to take post-discharge
b. Dietary instructions and modifications
c. Medical equipment and supplies
d. Instructions for pain management
e. Any restrictions or modification of activity
f. Follow up appointments and continuing care instructions
g. Referrals to rehabilitation, physical therapy, and home health services, and
h. Recommended lifestyle changes, such as smoking cessation.

2.6 DISCHARGE AGAINST MEDICAL ADVICE

Should a patient or a patient and their legally authorized representative leave the hospital against the advice of the attending physician, or without a discharge order, hospital policies "Procedure for Patient Leaving Against Medical Advice (AMA)," "Absent Without Leave (AWOL)" and "Access to Outdoors" shall be followed. The attending physician shall be notified that the patient has left against medical advice.

2.7 DISCHARGE PLANNING

Discharge planning is a formalized process through which follow-up care is planned and carried out for each patient. Discharge planning is undertaken to ensure that a patient remains in the hospital only for as long as medically necessary. All practitioners are expected to participate in the discharge planning activities established by the Hospital and approved by the Medical Executive Committee.

2.8 DISCHARGING FROM THE PSYCHIATRIC UNIT

The patient, patient's family, physicians, other licensed practitioners, clinical psychologists, and staff involved in the patient's care, treatment, and services shall participate in planning the patient's discharge or transfer. Psychiatry policies "Policy for Discharge Planning / After-Care Plan for Inpatient Psychiatry" and "PES Discharge Process and After Visit Summary" should be followed.

ARTICLE III. MEDICAL RECORDS

3.1 GENERAL REQUIREMENTS

The attending physician is responsible for the preparation of the physician components of the medical record to ensure a complete and legible medical record for each patient.

All practitioners with privileges are required to utilize the electronic health record (EHR), unless a "rare user" exception has been granted, to meet regulatory requirements and provide efficiencies in delivering healthcare to the community. All practitioners will complete EHR training, and comply with security guidelines, per the hospital's policy on use of the EHR.

The medical record must be complete within thirty (30) days after the patient's discharge unless a shorter timeframe is defined by policy.[3] Hospital policies on medical record documentation shall be followed, including "Authority to Make Medical Record Entries", and "Procedure for Medical Record Content."

3.2 AUTHENTICATION

All clinical entries in the patient's medical record will be accurately dated, timed, and authenticated (signed) with the practitioner's legible signature or by approved electronic means.[4]

3.3 CLARITY, LEGIBILITY, AND COMPLETENESS

All handwritten entries in the paper medical record shall be made in ink and shall be clear, complete, and legible. Orders which are, in the opinion of the authorized individual responsible for executing the order, illegible, unclear, incomplete, or improperly documented (such as those containing prohibited abbreviation and symbols) will not be implemented. Improper orders shall be called to the attention of the ordering practitioner immediately.

3.4 ABBREVIATIONS AND SYMBOLS

The use of abbreviations can be confusing and may be a source of medical errors. However, the Medical Staff recognizes that abbreviations may be acceptable to avoid repetition of words and phrases in written documents. The use of abbreviations and symbols in the medical record must be consistent with the following rules:

3.4.1 Prohibited Abbreviations, Acronyms, and Symbols

The Medical Executive Committee shall adopt a list of prohibited abbreviations and symbols that may not be used in medical record entries or orders; these are noted in the policy on prohibited abbreviations, Pharmacy Policy Unacceptable Abbreviations and Symbols List.[5]

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[3] TJC RC.01.03.01-01: The hospital defines the time frame for completion of the medical record, which does not exceed 30 days after the patient's discharge.
[4] TJC RC.01.02.01: Entries in the medical record are authenticated.
[5] TJC IM.02.02.01-03: The hospital follows its list of prohibited abbreviations, acronyms, symbols, and

dose designations, which includes those listed in this document.

At a minimum, the following abbreviations, acronyms, symbols, and dose designations are prohibited:

- U,u
- IU
- Q.D., QD, q.d., qd
- Q.O.D., QOD, q.o.d, qod
- Trailing zero (X.0 mg)
- Lack of leading zero (.X mg)
- MS
- MSO4
- MgSO4

3.4.2 Situations Where Abbreviations Are Not Allowed

Abbreviations, acronyms, and symbols may not be used on informed consents.

3.5 ADMISSION HISTORY AND PHYSICAL EXAMINATION

3.5.1 Time Limits

Time limits for performance of the medical history and physical examination are noted in Part I, Section 2 of the medical staff bylaws. For the inpatient psychiatric unit, a psychiatric evaluation must be completed within sixty (60) hours of admission or registration.[6]

3.5.2 Who May Perform and Document the Admission History and Physical Examination

All medical staff with H&P privileges are allowed to perform admitting and outpatient history and physical examinations regardless of specialty.

b. Advanced Practice Providers (e.g., CRNA, NP, PA) may also complete the required history and physical examination if they possess the necessary privileges.[7]

c. For residents and practitioners requiring supervision or collaboration, a physician with privileges shall review and countersign the history and physical examination record within twenty-four (24) hours.[8]

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[6] TJC PC.01.02.13-07: Each patient receives a psychiatric evaluation completed within sixty (60) hours of admission.
[7] TJC MS.03.01.01-08: The medical staff requires that a physician or other licensed practitioner who has been granted privileges by the hospital to do so perform a patient's medical history and physical examination and required updates.
[8] TJC MS.03.01.01-10: The organized medical staff defines when a medical history and physical examination must be validated and countersigned by a physician with appropriate privileges.

d. **Examinations by Practitioners without Privileges:** The hospital may accept a history and physical examination performed within thirty (30) days prior to admission by a practitioner without current hospital membership or privileges as long as a practitioner with current hospital membership or privileges endorses the findings and enters an interval note within twenty-four (24) hours after admission and prior to any operative or other invasive procedure involving general or major regional anesthesia.

3.5.3 Compliance with Documentation Guidelines

a. The documentation of the admission history and physical examination shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority.

b. **Complete History and Physical Exam:** A complete history and physical examination is required for all admissions, all operative or invasive procedures requiring anesthesia (general, regional, MAC, or deep/moderate sedation), and all observation patients. A complete history and physical examination report must include the following information, as age appropriate and based on the patient's condition:

i. Chief complaint or reason for the admission or procedure
ii. A description of the present illness
iii. Past medical history, including current medications, allergies, past and present diagnoses, illnesses, operations, injuries, treatment, and health risk factors;
iv. An age-appropriate social history;
v. A pertinent family history;
vi. A review of systems;
vii. Physical examination and relevant physical findings; and
viii. Diagnosis or problem list with a plan of care.

c. Behavioral and Emotional Assessment[9]

Based on the patient's age and needs, the assessment for patients who receive treatment for emotional and behavioral disorders includes the following:

i. A psychiatric evaluation
ii. Psychological assessments, including intellectual, projective, neuropsychological, and personality testing
iii. Complete neurological examination at the time of the admission physical examination, when indicated

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[9] TJC PC.01.02.13-06

d. Focused History and Physical Examination/Outpatient Assessment: A focused history and physical examination or outpatient assessment, is used for those outpatients who are undergoing invasive procedures under local anesthesia or conscious sedation should include, as age appropriate and based on the patient's condition:[10]

i. Elements that are immediately pertinent to the chief complaint or presenting problem, including a physical examination of the area of interest for the planned procedure and surrounding structures, if applicable,

ii. Medications and known allergies,

iii. An examination of the heart, lungs, and neurological status, and

iv. Additional assessment as deemed necessary for the safe and effective treatment of the patient.

A brief history and physical may be appropriate in lieu of a comprehensive history and physical, in the following types of care environments: radiology, endoscopy, emergency medicine, and oncology services. The decision must be documented and based on the patient's age, diagnosis, type and number of procedures to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure.[11]

e. **Exceptions:**

i. A clinically pertinent note may be substituted for a history and physical for the purpose of emergency surgery or prior to other urgent interventions involving general or major regional anesthesia.

ii. A patient's prenatal records may serve as the history and physical examination for vaginal deliveries as long as there is a documented visit within the thirty (30) days prior to admission. However, an update note should be added to the prenatal record after admission and prior to any procedure requiring general or major regional anesthesia.

iii. An assessment may be substituted for a pre-surgical history and physical examination to the extent allowed for low-risk patients and procedures.

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[10] TJC MS.03.01.01-11: The organized medical staff defines the scope of the medical history and physical examination when required for non-inpatient services.
[11] TJC MS.03.01.01-19: If the medical staff chooses to develop and maintain a policy for the identification of specific patients to whom the assessment requirements would apply, in lieu of a comprehensive medical history and physical examination, the policy is based on the following: patient age, diagnosis, the type and number of surgeries and procedures scheduled to be performed, comorbidities, and the level of anesthesia required for the surgery or procedure. Nationally recognized guidelines and standards of practice for assessment of particular types of patients prior to specific outpatient surgeries and procedures. Applicable state and local health laws.

f. **Interval Note:**

i. An update or interval note should be entered in the medical record whenever the history and physical examination was performed prior to admission or registration for surgery.

ii. Such update or interval note shall document any significant changes reported by or observed in the patient since the pre-admission / pre-registration history and physical examination.

iii. The note should be documented in the medical record within twenty-four (24) hours following admission, and prior to any operative or invasive procedure requiring general or major regional anesthesia.

iv. The interval note may be entered by any practitioner otherwise privileged to complete a history and physical examination as described above.

3.5.4 Responsibility for the Admission History and Physical Examination

The admitting practitioner entering the admission order, or designee with privileges to complete the exam, is responsible for completing the admission history and physical examination.

3.5.5 Admissions for Emotional and Behavioral Disorders[12]

The admitting practitioner is responsible for documenting the 1) reason for admission as stated by the patient and/or others involved in the patient's care, 2) onset of the patient's illness and circumstances leading to admission, and 3) inventory of the patient's strengths and disabilities (such as psychiatric, biopsychosocial problems requiring treatment/intervention) written in a descriptive manner on which to base a treatment plan.

The admitting practitioner shall also assess and document the following:

a. Current mental, emotional, and behavioral functioning

b. Maladaptive or other behaviors that create risk to the patient or others

c. Mental status examination

3.6 PREOPERATIVE DOCUMENTATION

3.6.1 Policy

Except in an emergency, a current medical history and appropriate physical examination will be documented in the medical record prior to:

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[12] TJC PC.01.02.13: The hospital assesses the needs of patients who receive treatment for emotional and behavioral disorders.

a. all invasive procedures performed in the Hospital's surgical suites;

b. certain procedures performed in the Interventional Radiology Department, and

c. certain procedures performed in other treatment areas (such as bronchoscopy, gastrointestinal endoscopy, transesophageal echocardiography, therapeutic nerve blocks, and elective electrical cardioversion).

When a history and physical examination is required prior to a procedure, and the procedure is not deemed an emergency, the procedure will be cancelled if an H&P is not completed.[13]

In cases of procedures performed by dentists, the pre-anesthesia evaluation may suffice for the update to the history and physical examination.

3.7 PROGRESS NOTES

The attending physician or designee shall see the patient and record a daily progress note, unless a more frequent requirement is documented in a unit policy. Progress notes documented by residents/fellows in training require co-signature by a supervising physician, or designee.

There should also be a progress note for each significant patient encounter, on all hospitalized patients. Progress notes must document the reason for continued hospitalization.

In the Inpatient Psychiatric Unit, progress notes shall be documented at least weekly for the first two (2) months and at least once a month thereafter, and must contain recommendations for revisions in the treatment plan as indicated as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.[14]

3.8 OPERATIVE / PROCEDURE REPORTS

Operative reports will be written or dictated immediately after surgery,[15] and prior to transferring the patient to the next level of care. Operative/procedure reports will include:[16]

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[13] TJC RC.02.01.03-03: The patient's medical history and physical examination are recorded in the medical record before an operative or other high-risk procedure is performed. See also PC.01.02.03-04 and 05.
[14] TJC RC.02.01.01-07
[15] TJC RC.02.01.03-05: An operative or other high-risk procedure report is written or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.
[16] TJC RC.02.01.03-06 includes the list of required information in the operative report.

a. Names of the physician or other licensed practitioner(s) who performed the procedure and his or her assistant(s)

b. The name of the procedure performed

c. A description of the procedure

d. Any estimated blood loss

e. Any specimen(s) removed

f. The postoperative diagnosis

3.9 IMMEDIATE POST-OPERATIVE / PROCEDURE NOTES

If there is a delay in getting the operative/procedure report in the medical record due to an unforeseen emergency, a brief operative/procedure note is recorded in the medical record, prior to transfer to the next level of care, outlining the procedure performed. Operative/procedure notes will include:[17]

a. Names of the physician or other licensed practitioner(s) who performed the procedure and his or her assistant(s)

b. The name of the procedure performed

c. A description of each procedure finding

d. Any estimated blood loss

e. Any specimen(s) removed

f. The post-operative diagnoses

3.10 PRE-ANESTHESIA NOTES AND PRE-SEDATION ASSESSMENTS[18]

3.10.1 Pre-anesthesia notes

a. Anesthesia consists of general anesthesia and spinal or major regional anesthesia, does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuro-muscular function. Cardiovascular function may be impaired.

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[17] TJC RC.02.01.03-07 addresses the requirements of the post-operative progress note.
[18] TJC PC.03.01.03-01: Before operative or other high-risk procedures are initiated, or before moderate or deep sedation or anesthesia is administered the hospital conducts a pre-sedation or pre-anesthesia patient assessment.

b. Moderate sedation is a drug-induced depression of consciousness during which patients respond to purposefully to verbal commands, either alone or accompanied by light tactile stimulation. Reflex withdrawal from a pain stimulus is not considered a purposeful response. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

c. Deep sedation is a drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance and maintaining a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

d. The pre-anesthesia evaluation must be completed and documented within forty-eight (48) hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia, or moderate/deep sedation services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia, as defined above, marks the end of the forty-eight (48) hour time frame. [19]

In accordance with current standards of anesthesia care, some of the individual elements contributing to the pre-anesthesia evaluation may be performed prior to the forty-eight (48) hour timeframe. However, under no circumstances may these elements[20] be performed more than thirty (30) days prior to surgery or a procedure requiring anesthesia services. A review of these elements must be conducted, and any appropriate updates documented, within the forty-eight (48) hour timeframe.

3.10.2 Pre-sedation assessments

Pre-sedation assessments should comply with the Hospital policy, including "Procedure for Moderate Sedation Administration by Non-Anesthesiologists."

3.11 ANESTHESIA RECORD

A record of anesthesia that conforms to the policies and procedures developed by the Department of Anesthesia shall be made for each patient receiving sedation or anesthesia at any anesthetizing location.

3.12 POST-ANESTHESIA NOTES AND POST-SEDATION NOTES[21]

Post-anesthesia and post-sedation notes shall be placed in the record within twenty-four (24) hours after the completion of a procedure involving anesthesia or sedation. The note shall contain the requirements in the appropriate hospital policy.

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[19] TJC PC.03.01.03-18: A pre-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia within 48 hours prior to surgery or a procedure requiring anesthesia services.
[20] 482.52(b)(1): Interpretive Guidelines - Elements that must be performed within 48-hours are medical history, drug and allergy history, medical interview, and exam.

3.13 CONSULTATION REPORTS

a. Consultation orders shall be entered into the EHR.

b. The documentation in the consultation report shall be consistent with the current guidelines for the documentation of evaluation and management services as promulgated by the Centers for Medicare and Medicaid Services or comparable regulatory authority. Consultation reports will demonstrate evidence of review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion, and recommendations. This report will be made part of the patient's record.

c. The consultation report should be completed and entered in the patient's chart no later than twenty-four (24) hours after receipt of notification of the consult request, unless a later timeframe is agreed upon and documented in the medical record.

d. If a consultation is performed by an APP who cannot practice independently in the state of California or a resident/fellow in training, the supervising physician should review and add an addendum with their assessment and recommendations in a timely manner and not more than twenty-four (24) hours after the consult is completed.

e. If a full consultation report is not immediately available after the consultation, a note should be documented in the record containing the consultant's assessment and plan for the care of the patient. When operative procedures are involved, the consultation report, except in emergency situations so verified on the record, will be recorded prior to the operation/procedure.

3.14 INPATIENT PSYCHIATRIC UNIT CARE PLANS

The written plan of care shall be based on the patient's short and long-term goals and the time frames, settings, and services required to meet the goals. The written care plan includes the responsibilities of each team member[22] and the following:

a. A substantiated diagnosis
b. Documentation to justify the diagnosis and the treatment and rehabilitation activities carried out
c. Documentation that demonstrates all active therapeutic efforts
d. The specific treatment modalities used to treat the patient

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[21] TJC PC.03.01.07-07: A post-anesthesia evaluation is completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. TJC PC.03.01.07-08: The post-anesthesia evaluation for anesthesia recovery is completed in accordance with law and regulation and policies and procedures that have been approved by the medical staff.
[22] TJC PC.01.03.01-05/06/43

3.15 FINAL DIAGNOSES

The final diagnoses will be recorded in full, dated and signed by the discharging practitioner in the discharge summary, transfer note, or death summary of the patient. If pertinent diagnostic information has not been received at the time the patient is discharged, the discharging practitioner will be required to document such in the patient's record.

3.16 DISCHARGE SUMMARIES

At the time of the patient's discharge or transfer, the patient or their representative shall be informed about the care, treatment, and services provided to the patient.[23] The content of the medical record will be sufficient to justify the diagnosis, treatment, and outcome. All discharge summaries, including the Death Summary, are the responsibility of the discharging physician, or designee. Documentation should be completed within twenty-four (24) hours of discharge All discharge summaries completed by APPs who are not permitted to practice independently in California and residents/fellows in training must be cosigned.

a. Content: Information for service providers shall include:[24]

i. The reason for the patient's discharge or transfer
ii. The patient's physical and psychosocial status
iii. A summary of care, treatment, and services provided
iv. The patient's progress toward goals
v. A list of community resources or referrals made or provided
vi. The patient's treatment preferences

b. Content: The discharge summary shall contain[25]

i. The reason for hospitalization
ii. The procedures performed
iii. The care, treatment, and services provided
iv. The patient's condition and disposition at discharge
v. Information provided to the patient and family
vi. Provisions for follow-up care

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[23] TJC PC.04.02.01
[24] TJC PC.04.02.01-01: At the time of the patient's discharge or transfer, the hospital informs other service providers who will provide care, treatment, and services to the patient about the elements noted.
[25] TJC RC.02.04.01-03: In order to provide information to other caregivers and facilitate the patient's continuity of care, the medical record contains a concise discharge summary that includes the elements noted.

c. Death Summary: A discharge summary is required on all inpatients who have expired and will include:

i. Reason for admission,
ii. Summary of hospital course,
iii. Cause of death, and
iv. Final diagnoses.

3.17 CLINIC DOCUMENTATION AND IN-BASKET MANAGEMENT

3.17.1 See Appendix A.

3.18 STUDENTS, RESIDENTS, AND FELLOWS IN TRAINING

3.18.1 Residents shall be permitted to function clinically only in accordance with the written training protocols developed by the Graduate Medical Education Committee (GMEC) and the Medical Executive Committee (MEC).

3.18.2 The post-graduate education program director or committee must communicate periodically with the MEC.[26]

3.19 ACCESS AND CONFIDENTIALITY

A patient's medical record is the property of the Hospital. If requested, protected health information (PHI) contained in the record will be made available to any privileged practitioner attending the patient, to practitioners at other hospitals, and to others in accordance with the Health Insurance Portability and Accountability Act (HIPAA), Health Information Technology for Economic and Clinical Health Act (HITECH) and state information privacy and security laws. See hospital policies on confidentiality and protected health information.

3.20 INCOMPLETE/DELINQUENT MEDICAL RECORDS

Penalties for noncompliance with medical record completion requirements are outlined in "CCHS Provider Notification and Suspension of Privileges Process" (see Appendix A).

3.21 COPY AND PASTE FUNCTIONALITY

Previously documented information that is carried forward, imported, or supplied by use of a template must be reviewed and edited to accurately reflect the services provided during the current encounter.

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[26] TJC MS.04.01.01-05: There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body.

ARTICLE IV. STANDARDS OF PRACTICE

4.1 ORDERS

4.1.1 Verbal/Telephone Orders

Verbal/telephone orders are discouraged and should be reserved for those situations when it is impossible or impractical for the practitioner to write the order or enter it in the EHR. Verbal orders are given directly from the ordering practitioner to the recipient hospital staff; telephone orders are given directly from the ordering practitioner to the recipient hospital staff via telephonic communication means. Verbal/telephone orders must be given to an authorized individual[27] and comply with Hospital Pharmacy "Policy for Telephone, Verbal, and Written Orders for Medication," "Policy for Verbal and Written Orders," and "Policy for Medication Preparation."

4.1.2 Orders from sources other than the Electronic Health Record

Orders should be entered in the EHR except in cases when the EHR is not available including during downtime. In this case, the Hospital downtime policies should be followed. Orders transmitted by facsimile, written/printed on paper, or other forms of transmittal other than the electronic health record shall be considered properly authenticated and executable provided that:

a. The order is legible, clear, and complete

b. The identity of the patient is clearly documented

c. The order contains the name of the ordering practitioner, address and a telephone number for verbal confirmation, the time and date of transmission, and the name of the intended recipient of the order, as well as any other information required by federal or state law, and

d. The order contains the practitioner's signature.

e. The order may be executed by hospital policy or by a privileged practitioner.

4.1.3 Medication Reconciliation

Medication reconciliation is performed when the patient:

a. is admitted,

b. following surgery (OR/PACU to the unit),

c. is transferred to or from a unit,

d. is transferred to, and readmitted from, another hospital or health care facility, or

e. is discharged.

New orders shall be specifically written following surgery or the transfers noted above.

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[27] RC.02.03.07-01: The hospital identifies, in writing, the staff who are authorized to receive and record verbal orders, in accordance with law and regulation. RC.02.03.07-02: Only authorized staff receive and

record verbal orders.

4.1.4 Drugs and Medications

Orders for drugs and medications must follow "Hospital Pharmacy Policy for Prescribing & Ordering", "Policy for Verbal and Written Orders", and "Policy for Telephone, Verbal, and Written Orders for Medications".

4.2 CONSULTATIONS

4.2.1 The following circumstances may prompt consultation or management by a physician or other licensed practitioner:[28]

a. Treatments needs are outside of the scope of privileges of the attending physician,

b. Doubt exists as to the diagnosis or choice of therapeutic measures to be utilized,

c. In unusually complicated situations where specific skills of other practitioners may be needed, and

d. When requested by a patient or their representative and deemed appropriate by the attending physician.

4.2.2 Any qualified practitioner with clinical privileges may be requested for consultation within their area of expertise. The attending physician, or designee, will provide written authorization in the EMR requesting the consultation, permitting the consulting practitioner to attend or examine their patient. The referring practitioner can determine if the consulting physician, or their designee, is necessary to perform the consultation.

a. Every consultation request should contain the reason for the consultation and the urgency of the consultation; the following timeframes should be followed:

i. Routine consultation – within twenty-four (24) hours,

ii. Urgent/STAT consultation – based on the conversation between the referring and consulting practitioners

b. Practitioner-to-practitioner communication is required for all non-routine consultations (i.e. Urgent or STAT priority).

c. Consultations may be done in timeframes longer than twenty-four (24) hours if appropriate for the patient and their medical condition.

d. Consultants are not required to perform daily visits, unless the patient's condition warrants it.

e. APPs may perform the consultation, including ordering diagnostics or therapeutics.

f. Residents may perform the consultation, including ordering diagnostics or therapeutics. The supervising physician will cosign the resident consultation note.

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[28] TJC MS.03.01.03-04: The organized medical staff, through its designated mechanism, determines the circumstances under which consultation or management by a Doctor of Medicine or Osteopathy, or other licensed practitioner, is required.

4.3 DEATH IN HOSPITAL

4.3.1 Pronouncing and Certifying the Cause of Death

In the event of a Hospital death, the deceased shall be pronounced dead by a physician within a reasonable time. For inpatients, the attending physician is responsible for certifying the cause of death and completing the Death Certificate within fifteen (15) hours and prior to release of the body from the Hospital, in accordance with law.[29] The "Hospital Procedure for Patient Expiration" must be followed. In cases of fetal demise or neonatal death, the "Hospital Policy for Fetal Demise/Neonatal Death" must be followed.

4.3.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable. "Hospital Policy for Anatomical Donations for Tissue and Organ Transplantation" should be followed.

4.4 AUTOPSY

Unless the Medical Examiner exercises jurisdiction, it is the responsibility of the attending physician to consider and order autopsies. It is the responsibility of the attending physician to consider an autopsy in all cases of unusual deaths, in cases of medico-legal, or of special educational interest. A provisional diagnosis and the complete autopsy report will be completed as soon as possible. See "Policy for Patient Expiration" and "Policy for Autopsy Protocol".

4.5 ADVANCED PRACTICE PROVIDERS

4.5.1 Overview

Advanced Practice Providers (APPs) are defined in the Medical Staff Bylaws.

4.5.2 Guidelines for Advanced Practice Providers (APP)

a. Health care services delivered by APPs to patients under their care must be within the scope of each practitioner's authorized practice, as defined by state law.

b. The APP is responsible for coordinating and managing the care of their patients, in collaboration with specialists and other qualified medical professionals, and ensuring the quality of health care provided to patients.

c. The role of the APP in the delivery of care shall be defined through mutually agreed upon Scope of Practice Guidelines that are developed by the Interdisciplinary Practice Committee and approved by the Medical Executive Committee.

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[29] Cal. Health & Saf. Code § 102800: Attending to complete the death certificate within fifteen (15) hours.

d. Consultation, either in person or through telecommunication systems or other means, shall be available at all times.

e. Patients should be made aware whether they are being cared for by a physician or APP.

f. Ongoing Professional Performance Evaluations will be completed on schedule for the APP with the supervising physician or department/division chair as established by MEC policy. The supervising or specialty physician is responsible for clarifying and familiarizing the APP with supervision methods and style of delegating patient care.

g. A record of all supervising or delegating physicians is kept on file by the Medical Staff office, as applicable, and reviewed regularly through the credentialing process.

4.5.3 Supervising/Delegating Practice Agreements

Advanced Practice Providers that require supervision or collaboration must have a written Supervision/ Collaboration Agreement on file in the Medical Staff Office that describes health care-related tasks which may be performed by the APP. This document must be signed by the APP and the supervising/ collaborating physician. Changes to the APP's supervising/collaborating physician will be updated through the credentials process.

4.5.4 Supervising/Delegating Physician

a. A physician may not supervise more APPs than is allowed by state law.

b. A physician who fails to fulfill the responsibilities defined in this section and/or in a sponsorship agreement for the supervision of, or collaboration with, an APP shall be subject to appropriate corrective action as provided in the Medical Staff Bylaws.

4.5.5 Medical Record Documentation

Advanced Practice Provider medical record documentation is addressed in Section 3, and in policies "Authority to Make Medical Record Entries" and "Procedure for Medical Record Content".

4.6 INFECTION PREVENTION AND CONTROL

All practitioners are responsible for complying with "Infection Prevention" policies and procedures in the performance of their duties, including hand hygiene.

ARTICLE V. PATIENT RIGHTS

5.1 PATIENT RIGHTS

All practitioners shall respect the patient rights as delineated in "Hospital Policy for Patients' Rights."

5.2 INFORMED CONSENT

The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice. The patient should make their own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical and legal obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow the "Hospital Policy for Consent to Medical Treatment."

5.3 ADVANCE DIRECTIVES AND DO NOT ATTEMPT RESUSCITATION

Hospital policies delineate the responsibilities, procedure, and documentation that must occur regarding Advance Directives, when withdrawing or withholding life-sustaining treatment, and when initiating or cancelling a Do Not Resuscitate order. See "Policy for Do Not Resuscitate (DNR)," "Policy for Advance Health Care Directive (Patient Self-Determination Act)," and "Policy for Pre-Hospital Do Not Resuscitate Orders."

5.4 DISCLOSURE AND REPORTING OF UNANTICIPATED OUTCOMES

Hospital policies delineate the responsibilities, procedure, and documentation that must occur when an unanticipated outcome does occur. See policy "Adverse Event Reporting."

5.5 RESTRAINTS AND SECLUSION

The Hospital policy "Procedure for Denial of Patient Rights" delineates the responsibilities, procedure, and documentation that must occur when ordering restraints or seclusion.

5.6 INVESTIGATIONAL STUDIES

Investigational studies and clinical trials conducted at the Hospital must be approved in advance by the Institutional Review Board. When patients are asked to participate in investigational studies, Hospital policy should be followed.

ARTICLE VI. SURGICAL CARE

6.1 TISSUE SPECIMENS

Specimens removed during the operation will be sent to the Hospital pathologist who will make such examination as may be considered necessary to obtain a tissue diagnosis. Certain specimens are exempt from pathology examination, as defined in "Policy for Specimen Exempted from Submission for Pathology Examination and Specimens not Routinely Examined Histologically." The pathologist's report will be made a part of the patient's medical record.[30]

6.2 VERIFICATION OF CORRECT PATIENT, SITE, AND PROCEDURE[31]

The physician/surgeon has the primary responsibility for verification of the patient, surgical site, and procedure to be performed. Patients requiring a procedure or surgical intervention will be identified by an ID with the patient's name and a second identifier as chosen by the hospital. Hospital policy "Universal Protocol Procedure", shall be followed.

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[30] TJC PC.03.01.08: The medical staff approves a policy in coordination with Pathology and the Laboratory regarding specimens removed during surgical procedures.
[31] UP.01.01.01-02: Conduct a pre-procedure verification process. The expectation of this element of performance is that the standardized list is available and is used consistently during the pre-procedure verification.

ARTICLE VII. RULES OF CONDUCT

7.1 DISRUPTIVE BEHAVIOR

Practitioners are expected to conduct themselves in a professional and cooperative manner in the Hospital. Disruptive behavior is behavior that is disruptive to the operations of the Hospital or could compromise the quality of patient care, either directly or by disrupting the ability of other professionals to provide quality patient care. "Policy for Appropriate Workplace Behavior" shall be followed.

7.2 IMPAIRED PRACTITIONERS

Reports and self-referrals concerning possible impairment or disability due to physical, mental, emotional, or personality disorders, deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs or alcohol shall be referred to the Medical Staff Assistance Committee.

7.3 TREATMENT OF FAMILY MEMBERS

The following is based on the AMA *Code of Medical Ethics*' Opinion on Physicians Treating Family Members. In general, practitioners should not treat themselves or their family members. Family members are deemed to include spouses, domestic partners, parents, parents-in-law, children, stepchildren, and siblings.

In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians are discouraged to serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems. Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members.

7.4 MEDICAL RECORDS OF SELF AND FAMILY MEMBERS

Practitioners shall follow the "Confidentiality of Patient/Client Information" policy and "Confidentiality/ Security of Electronic Patient Information" policy, regarding access, use, and disclosure to protected health information of themselves or family members to maintain compliance with HIPAA and state privacy laws. Practitioners must utilize the Patient Portal or the traditional release of records process to access their own, or their family member's, medical records. See Procedure for "Removal, Retention, and Destruction of Protected Health Information" policy.

7.5 COMPLIANCE WITH HOSPITAL HEALTH REQUIREMENTS

All practitioners must comply with the Hospital's policy on testing, vaccinations, and all other infection control measures.

7.6 COMMUNICATION METHODS

All practitioners must maintain a currently accessible county e-mail address on file in the Medical Staff Office, as well as a current cell phone number.

All practitioners must use the accepted method of communication regarding clinical care as determined

by the MEC and department leadership (eg: Epic Chat, cell phone, etc).

ARTICLE VIII. FUNCTIONS OF THE MEDICAL STAFF

8.1 Description of Medical Staff Functions

The Medical Staff is responsible for the oversight of the quality of patient care, treatment, and services provided by physicians and other licensed practitioners privileged through the medical staff process.[32] In addition, the medical staff is responsible for the leadership and oversight of activities related to patient safety.[33] To ensure appropriate oversight, the Medical Staff, acting as a whole or through committees, participates in hospital committees or medical staff committees that address the following:

1) governance, 2) medical care evaluation/performance improvement/patient safety activities, 3) hospital performance improvement and patient safety programs, 4) credentials review, 5) information management, 6) emergency and disaster preparedness, 7) strategic planning, 8) bylaws review, 9) nominating process, 10) infection prevention and control, 11) pharmacy and therapeutics, 12) practitioner health, 13) utilization management 14) continuing education, and 15) collaboration with administration and nursing.

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[32] TJC MS.03.01.01
[33] TJC MS.03.01.01-04/05

ARTICLE IX. MEDICAL STAFF COMMITTEES

9.1 General

Committees, designation, substitution, meetings, special meetings, quorum, and attendance are all outlined in the Bylaws. The committees listed below report to the MEC, and address the medical staff's responsibility to oversee and participate in hospital and medical staff functions.[34]

9.2 Credentials Committee

The Credentials Committee details are documented in Part III, Section 1 of the Medical Staff Bylaws.

9.3 Peer Review Oversight Committee (PROC)

The details of this committee are documented in the Peer Review Oversight Committee Charter. (see attachments)

9.4 Administrative Affairs (Bylaws) Committee

9.4.1 Composition: Chair and at least one (1) other member of the Medical Staff.

9.4.2 Meetings: The committee shall meet at least biennially, or more often to address required or requested amendments.

9.4.3 Responsibilities: The committee shall be responsible for making recommendations relating to revisions and updating the Bylaws and Rules & Regulations; receiving all correspondence regarding any suggestions of changes or additions to the Bylaws or Rules & Regulations and acting on these suggestions; and being responsible for a comprehensive review of the Bylaws and Rules & Regulations biennially.

9.5 Ambulatory Policy Committee

9.5.1 Composition: Chair, DFAM Chair or designee, at least one Allied Health Professional, ideally one representative from Ob/Gyn, Surgery, Pediatrics, and Specialty Medicine, anyone with special expertise needed on an ad-hoc basis. Non-voting members: Ambulatory Care Medical Director, Chief Nursing Officer or designee. Regional representation (Martinez, Concord, East County, Far East County, West County, North Richmond) is strongly recommended.

9.5.2 Meetings: The committee shall ideally meet monthly, but at minimum ten (10) times per year.

9.5.3 Responsibilities: Sets Medical Staff policy in the health centers and acts as a liaison with Nursing and Administration for coordination of policies and procedures under joint Medical Staff-Administration or Medical Staff-Nursing purview. APC develops policies to resolve issues that affect more than one Medical Staff Department and focuses on policies and projects that relate to quality of care, the efficiency of the health centers and patients that relate to quality care, the regulatory compliance. APC coordinates its activities with PSPIC and receives quality assurance reports suggestive of or requiring changes in policies and procedures from individual Medical Staff Departments and from the Ambulatory Subcommittee of PSPIC.

[34] Title XXII 70703(d): the medical staff bylaws and rules shall include the following functions: executive review, credential, medical records, tissue review, utilization review, infection control, pharmacy and therapeutics, and assisting medical staff members impaired by chemical dependency and/or mental illness.

9.6 Ethics Committee

9.6.1 Composition: Chair and at least 4 members from a multidisciplinary representation of clinical services, lay members, hospital administration. The Committee is encouraged to invite other professional or community members to be utilized when discussing issues involving their particular clinical, ethnic, religious or other background.

9.6.2 Meetings: The committee will meet regularly (at least six (6) times yearly) and will also provide a mechanism for other meetings as necessary to perform case consultation functions.

9.6.3 Responsibilities: The Bioethics Committee provides a multi-disciplinary forum for the development of guidelines for consideration of cases and issues having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies regarding care and treatment in cases or issues having bioethical implications; consultation with concerned parties to facilitate and education of the hospital staff regarding bioethical matters. The committee chair will report to the Medical Executive Committee.

See "Ethics Committee Policy" for additional committee guidelines.

9.7 Continuing Medical Education Committee

9.7.1 Composition: A Chairperson appointed by the Medical Staff President, subject to MEC approval; at least two additional Medical Staff Members; and, if available, the Medical Librarian, without vote.

9.7.2 Meetings: at least twice a year, and more frequently as needed

9.7.3 Purpose: The Continuing Medical Education Committee (CMEC) directs the development of CME programs in response to quality assurance findings and needs of Medical Staff, in collaboration with nursing staff. The committee apprises the Medical Staff of outside education opportunities. The CMEC also analyzes the status and needs of, and makes recommendations regarding, the medical library services via provider journal subscriptions. The CMEC supports the provider simulation lab to help Medical Staff learn and keep up procedural skills. Simulated procedures can help providers get/maintain privileging. The CMEC Chair will coordinate with departments who will utilize the lab, and with Professional Development on upkeep and expansion.

9.8 Cancer Committee

See Committee Charter (see attachments)

9.9 Medical Staff Assistance Committee

See Committee Charter (see attachments)

9.10 Inter-Disciplinary Practice Committee

See Committee Charter (see attachments)

9.11 Patient Care Policy and Evaluation Committee (PCP&E)

See Committee Charter (see attachments)

9.12 Patient Safety and Performance Improvement Committee

9.12.1 Composition: Chair appointed by the Medical Staff President, subject to MEC Approval; Medical Staff President; CCRMC CEO; Director of Pharmacy; CMO; CNO; Ambulatory Care Medical Director; COO; CQO; past Medical Staff President; Chair of PCP&E; Patient Safety Officer; Director of Safety and Performance Improvement; Medical Director of Quality and Safety; Hospital Medical Director, Specialty Medical Director; Hospital Regulatory Compliance Officer; Quality Manager Program Coordinator; two medical staff representatives, appointed by the Medical Staff President, subject to MEC approval; one medical staff member representative from the Behavioral Health Division, appointed by the Medical Staff President, subject to MEC approval

9.12.2 Meetings: The committee shall ideally meet monthly, but at minimum 10 times per year.

9.12.3 Responsibilities: The Patient Safety and Performance Improvement Committee (PSPIC) has the authority and responsibility for implementing and directing the Quality Management Program for the Hospital. It is responsible for setting the quality management standards, determining criteria by which care will be measured, setting priorities for which aspects of care will be monitored, and analyzing the quality-of-care studies, indicators, utilization reports, grievances, survey data, and risk management information. A systematic, multi-disciplinary improvement process is followed. It develops an annual plan for performance improvement activities (Quality Management Plan).

Appendix A

CCRMC Provider Notification and Suspension of Clinical Privileges Process

Current support of In Basket management for providers:

- Medical Staff Office (MSO) can schedule Dragon voice recognition software training upon request
- MSO can help you schedule Super User sessions and cancel clinic for this
- Once you reach delinquency, Health Information Management (HIM) will automatically notify you and your dept/division chair per the attached algorithm
- A human in the MSO will call you once you are one week away from suspension
- Your department/division chair can help you navigate work-life balance, assist adjusting your schedule if possible, and make a referral to the Medical Staff Assistance Committee
- Primary care health home team will help PCPs address messages, prior authorizations, etc.
- As a reminder to PDOCC (Physicians' and Dentists' Organization of Contra Costa) members: MOU (Memorandum of Understanding) changes have helped to increase clinical admin time, and add telephone clinics, and bill for extra telephone encounters
- Future state: Superusers can set you up with AI note writing upon request

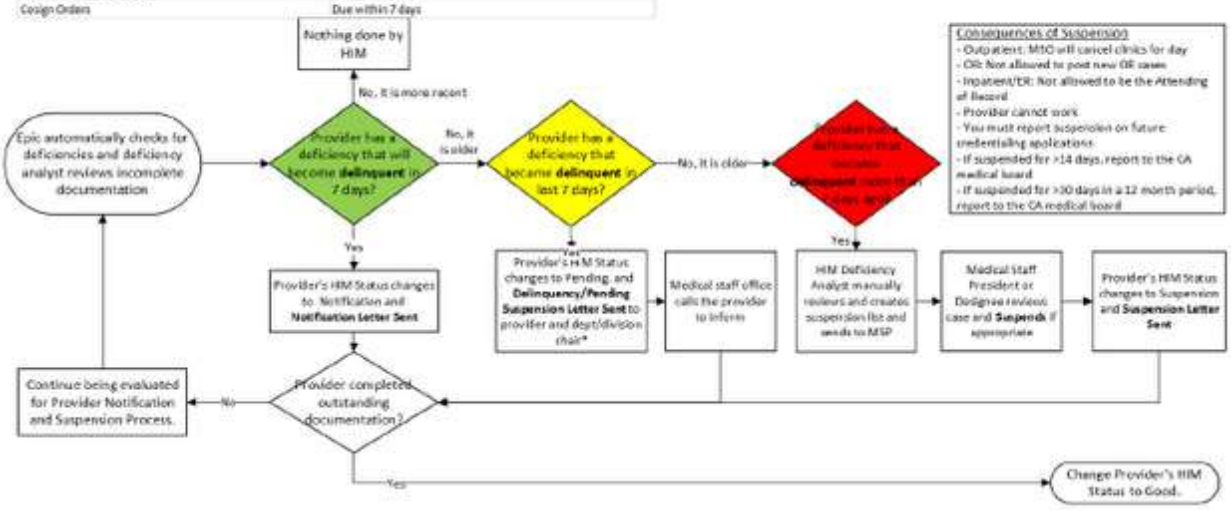
* Please remember: If you feel you are falling behind, and might be in danger of a suspension, be PROACTIVE. Call HIM and come up with a plan to get the support you need!

Resources

Your Deficiency Team

- Your Department Chair
- Medical Staff President/Designee
- HIM Deficiency Analyst
- HIM Director

Med Staff Bylaws	
Document	**Time Due**
Discharge Summary	24 hours post discharge
Inpatient History/Physical	24 hours post admission
Interval History/Physical	Less than 24 hours prior to surgery
Operative Report	Immediately after surgery
Pre-Anesthesia Evaluation	Must be completed prior to being placed under anesthesia unless extreme emergency
Post-Anesthesia Note	6 hours after conclusion of anesthesia
Verbal Orders	Authenticated by 24 hours for IV Fluid or IV drug orders; all others within 48 hours
Other inpatient documentation as required by law, including:	At hospital discharge
a) Diagnostic and therapeutic orders	
b) Clinical observations and results of therapy;	Must be signed within 13 days and are delinquent after the 14th day
c) Reports of procedures, tests, and their results;	
d) Conclusions at the termination of care	
Current Additions	**Time Due**
ED Provider Notes	Due within 24 hours of ED Admission
L&D Summary Notes	Due within 24 hours of L&D Delivery
Consult Notes	Due within 24 hours of Note/Deficiency Created
Open Clinic Encounter	Due within 24 hours of Encounter
Proposed Additions	**Time Due**
Result In Basket Messages	Due within 7 days
Cosign Orders	Due within 7 days



Attachments

- Cancer Committee Charter
- Inter-Discpilinary Practice Committee Charter
- Medical Staff Assistance Committee Charter
- Patient Care Policy and Evaluation Committee
- Peer Review Oversight Charter

Approval Signatures

Step Description	Approver	Date

Joint Conference Committee	John Gioia: Board of Supervisor	Pending
	Sarah Mcneil: OBGYN Fam Med Adv Obst Ex	06/2025

Standards

No standards are associated with this document

Status Pending PolicyStat ID 18266034

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Last Approved	N/A	Area	Hospital & Health Centers
Effective	Upon Approval		
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Next Review	3 years after approval		

Policy for Escalation

POLICY STATEMENT:

Issues that indicate the need for immediate clinical or safety intervention shall be promptly communicated to ~~a practitioner responsible for the~~the clinical care team and/or appropriate administrative leadership. Employees of Contra Costa Regional Medical Center and Health Centers have the responsibility and authority to immediately intervene to protect the safety of a patient~~'s care~~ to prevent a medical error or harm to a patient, employee, or visitor. ~~Employees of Contra Costa Regional Medical Center have the responsibility and authority to immediately intervene to protect the safety of a patient to prevent a medical error or harm to a patient.~~

(Authority to Intervene to Protect Patient Safety and to Report Safety Concerns)

GUIDELINES:

A. All hospital and health center employees, contractors, and providers are obliged to escalate any concern they have over the safety or wellbeing of any patient, staff member, or visitor, through immediate intervention or through the chain of notification.

B. Time Frames for Escalation of Concerns:

1. Critical Concerns (concerns that may represent a life-threatening situation or a situation that may lead to serious impairment or disability):

~~a. Immediate escalation / intervention should occur for critical concerns~~

~~b. The concerned team member should "Speak Up" to "Stop the Line". Phrases used to intervene may include:~~

~~i. "Stop the Line",~~

~~ii. "Stop"~~

~~iii. "This is not safe", or other phrases to obtain the immediate attention of team member(s).~~

a. Immediate escalation / intervention should occur for critical concerns:

i. Contact the immediate Supervisor and/or Nurse Program Manager, Ambulatory Care Clinical Services Manager or their designee, or Department Manager via phone or messaging of the employee involved.

a. Immediate Supervisor or Manager will escalate through either their Director or the Health Care Risk Manager to the Executive team.

ii. Submit SERS

iii. Contact the Safety Office/Deputy. For people not physically located in the hospital or clinic, contact local sheriff or police department for immediate concerns for threats or actions of physical harm including suicidal or homicidal intention.

b. The concerned team member should "Speak Up" to "Stop the Line". Phrases used to intervene may include:

i. "Stop the Line",

ii. "Stop"

iii. "This is not safe", or other phrases to obtain the immediate attention of team member(s).

c. The team members should immediately re-evaluate the safety of the situation and attempt to restore safety.

i. If all members of the care team including the Charge Nurse do not come to a resolution, leadership should be consulted (e.g., the Medical Director, the Nurse Program Manager, Medical Center Supervisor, Ambulatory Care Clinical Services Manager or their designee, Department Manager, etc.)

2. ~~The team members should immediately re-evaluate the safety of the situation and attempt to restore safety.~~Other patient, visitor or staff safety concerns should be escalated within a clinically appropriate time frame.

3. ~~If all members of the care team including the Charge Nurse do not come to a resolution~~Concerns regarding conditions that have the potential to affect safety should be escalated, ~~the Chief of the department~~and reported through the Safety Event Reporting System (SERS), ~~the Nurse Program Manager or Medical Center Supervisor should be consulted~~within a reasonable time frame appropriate to the condition reported, such as the same day the condition is discovered.

~~a. Other patient, visitor or staff safety concerns should be escalated within a clinically appropriate time frame.~~

~~b. Concerns regarding conditions that have the potential to affect safety should be escalated, and reported through the event reporting system, within a reasonable time frame appropriate to the condition reported, such as the same day the condition is discovered.~~

4. When an employee is aware of or is the recipient of inappropriate behavior by a patient/family member(s)/significant other which contributes to an "incident," that employee should document the incident in the SERS, within a reasonable time frame appropriate to the incident reported, such as the same day the incident occurs, and notify their Supervisor/Manager as well as the Safety Office/Deputy, if appropriate.

C. Physician Response to Immediate Clinical Concerns: Physicians are expected to respond to concerns (by telephone or in person):
   a. Within 15 minutes of a STAT or EMERGENT request
   b. Within a clinically appropriate time frame for other requests

D. General Chain of Notification:
   1. Safety concerns should be escalated until resolved to the satisfaction of the team member through the following steps (when applicable):
      a. Patient Care Concerns:
         i. The Nurse with immediate responsibility for the care of the patient
         ii. The Physician responsible for the care of the patient
         iii. The Medical Center Supervisor
   2. The team member with the concern should also inform and seek the assistance of appropriate supervisory and support personnel, such as the Charge Nurse, Nurse Program Manager, or Rapid Response Team. Use of the chain of notification does not exclude collaboration with other team members as appropriate.
      a. Environment / Equipment Concerns:
         i. The department supervisor or manager
         ii. The Medical Center Supervisor
         iii. The Director or Chief of the Service / Area

E. Event Reporting: Event reports are used to improve systems and processes in order to reduce the chance of error or to address conditions that can impact safety. An event report should be completed whenever an unresolved concern exists, ~~such as~~including but not limited to:
   1. An error has occurred
   2. A high potential for error exists
   3. An unsafe condition exists
   4. Safety procedures cannot be followed
   5. A condition exists that interferes with the ability to provide care
   6. An attempt to resolve an immediate concern is unsuccessful at any level (e.g. unable

to contact the physician for a critical concern within 15 minutes)

7. Patient, employee, or visitor harm has occurred
8. Adverse and Sentinel Events

RELATED LINKS:

SERS (Safety Event Reporting System) Event / Incident Reporting System: Login

APPROVALS:

Clinical Practice Committee: 2/2016
Patient Care Policy & Evaluation Committee: 3/2016
Medical Executive Committee: 4/2016

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
CCRMC Chiefs	David Culberson: County Hosp Exec Dir-Exem	06/2025
	Leah Carlon: Health Care Risk Manager	05/2025

Standards

No standards are associated with this document

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Last Approved	N/A	Area	Ambulatory Care
Effective	Upon Approval		
Last Revised	05/2025		
Next Review	3 years after approval		

Policy for Code of Conduct

POLICY STATEMENT:

Ambulatory Care staff are expected to adhere to the following guidelines as delineated in this policy:

Staff should maintain a professional, customer (internal and external) focus and demeanor ~~at all times~~always. Staff are expected to adhere to the Ambulatory Care ~~"~~"Service Excellence Principles~~"~~" and Communication Guidelines. Staff are expected to take~~"~~", upon hire, "Customer Service Class & Communication Class~~"~~" or as directed by the Ambulatory Care Clinical Supervisor, through HSD Personnel. Lack of adherence may lead to disciplinary action.

GUIDELINES:

A. Compliance with established policies, including, but not limited to those of:
   1. County
   2. Health Services Department
   3. Hospital and Health Centers Division
   4. Ambulatory Care
   5. Laws and Regulations governing Ambulatory Care and Healthcare.

B. Ambulatory Care staff are expected to:
   1. Inform patients of, and advocate for the rights of patients.
   2. Assist peers in caring for our patients.
   3. Participate in quality and performance improvement efforts.

4. Hold themselves **accountable** for doing the work of Ambulatory Care.
5. Take responsibility for keeping him/~~herself~~her updated on department meeting minutes, communication book entries, postings, newsletter, memos, email and other management disseminated information. Attend all mandatory clinical classes, Human Resource training classes and complete all assigned all eLearning modules that are assigned.
6. Conduct personal business on own time.
7. Avoid using the Internet for non-job-related functions and personal use. Sign an Internet Policy agreement yearly to comply with this adherence. Use of all county devices including but limited to secure chat, tiger text, email to only be use for county related business.
8. Be at assigned workstation and ready to begin work at the start of shift and after designated breaks and lunch times.
9. If you have not received pre-approval for time off or away from workstation, you are then expected to be at your workstation at the start of your shift.
10. Limit break times to that time that is recognized according with your position and union.
    a. Take one break during the first 4 hours of shift and one break during second 4 hours of shift according to your designated MOU. There is no combining breaks and lunch. For breaks that were missed the manager or designees must be notified in at least one hour advance.
    b. Breaks must be coordinated with teammates to ensure adequate provider coverage and always provide ~~for~~ patient safety ~~at all times~~.
    c. ~~**Hosp Policy 508, "Hand-Off Communication**~~"Hospital Policy for Hand-Off Communication shall be followed (relevant patient information must be communicated prior to leaving for break and on return).
11. Always obtain permission from the Clinical Services Manager or designee if it is necessary to leave work prior to the end of the shift, or any other time~~;~~. such as a pre-approved physician appointment. If you are an employee with a personal medical appointment, that has been granted pre-approval time off, please follow the appropriate process of registering and fulfilling your appointment as all patients of our health system.
12. To ensure the safety and health of all our employees, there should be no food or beverages in any clinical areas with a reasonable risk of patient contamination.
13. Adhere to the established dress code, including:
    a. ~~Wearing name tag at all times.~~Always wear your county issued name tag.
    b. Avoid wearing excessive jewelry or personal effects that may become a hazard in the performance of duties.
    c. Avoid excessive use of perfumes and/or ~~colognes~~cologne.
    d. No open-toed shoes in clinical areas or areas in which clinical operations may occur at any time.

e. Adhering to Infection Control hand hygiene policy regarding fake nails and nail polish in clinical areas~~.~~

f. Professional attire (i.e., clothing that is not provocative or excessively revealing).

14. Comply with policy regarding notification of unplanned absences (See ~~AC Policy #2006, "Unplanned Absences~~Ambulatory Care's Policy for Unplanned Absences,~~"~~" for specific details.)

15. ~~Be responsible for~~It is the employees responsibility for always having a ~~current~~current license ~~(if applicable) on file with the Clinical Service Manager at all times~~, for staff that require a license, and an active BLS.

    a. All licenses must be presented to the Clinical Services Manager who will ~~in~~ turn forward to the ~~ANSOS/Staffing Coordinator~~Staffer to enter update in Shift Select.

    b. Failure to have a current license on file will prohibit you from working and could result in disciplinary action.

16. ~~Remain~~Always remain productive ~~at all times~~.

    a. When workload and usual tasks are completed, it is expected that you will support other colleagues or notify your immediate supervisor for additional job-related assignments. Keep all personal conversations out of workstation to maintain HIPPA compliance.

C. Code of Conduct

1. Ambulatory Care staff are expected to:

    a. Maintain a professional~~,~~ customer (internal and external) focus and demeanor ~~at all times~~always.

    b. Treat patients, co-workers, Health Center staff and the public with courtesy, respect and responsiveness.

    c. Maintain sensitivity and respect for the differences of co-workers and patients in the work environment, including but not limited to culture, gender, sexual preferences, religious or spiritual beliefs or lack thereof, race, ethnicity, age and national origin & demonstrate cultural humility.

    d. ~~Demonstrate cultural humility.~~

    e. Demonstrate zero-tolerance for boisterous, suggestive or profane language. (These are absolutely prohibited.) Be respectful of unnecessary noise and avoid having loud conversations not related to patient care, in all patient care areas.

    f. Be familiar with and adhere to Ambulatory Care~~'~~s ~~"~~"Service Excellence Principles~~"~~" in all customer encounters (both internal and external).

RELATED LINKS:

CCHSD Policy #117-A, "Service Excellence."

CCHSD Policy #223, "Violence in the Workplace Policy."

CCHSD Policy #271, "Appropriate Workplace Behavior Policy."

CCHSD Policy #271A, "Co-Worker Code of Conduct Guidelines."

APPROVALS:

Ambulatory Clinical Practice Committee: 6/19/2017, 2/2018

Ambulatory Policy Committee: 7/2017, 11/2018, 6/2022

/Medical Executive Committee: 8/2017, 11/2018, 7/2022

Joint Conference Committee

Approval Signatures

Step Description	Approver	Date
Joint Conference Committee	John Gioia: Board of Supervisor	Pending
Medical Executive Committee	Sarah E. Mcneil [TT]	06/2025
Ambulatory Policy Committee	Laura R. Colebourn [LC]	05/2025
Ambulatory Clinical Practice Committee	Helena Martey	05/2025
	Kelley Taylor	05/2025

Standards

No standards are associated with this document