Contra Costa Regional Medical Center & Health Centers
Medical Staff Bylaws

MEDICAL STAFF BYLAWS

Part I: Governance

Board Approval Date

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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.

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 of Medical Staff Membership

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, and podiatrists who continuously meet the qualifications, standards, and requirements set forth in these bylaws and associated rules, 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 Section 3 of these bylaws (Categories of Medical Staff). The qualifications for privileges are delineated in Part III of these bylaws (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.

2.5.1

2.5 Responsibilities

Each member shall:

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.

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

2.5.2 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.

2.5.3

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.

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.

2.6.5 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

Qualifications

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

3.1.1

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.

Prerogatives

3.1.2

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 staff or Hospital and Health Centers education programs
c. Hold Medical Staff office
d. 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

Members 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

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).

3.2.1 Prerogatives

Members of this category may:

3.2.2
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 Responsibilities

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

President

President-Elect

Immediate Past-President

4.2 Qualifications of Officers

4.1.1

4.1.2 Each Officer must be:

4.1.3

An MD, DO, DDS, DMD, or DPM

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

4.2.2 A member of the Active Category

4.2.3 Board certified

4.2.4 Willing to faithfully discharge the duties of the office, and exercise the authority
4.2.5 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
4.3.2 shall offer at least one nominee for the office of President-Elect. Nominations can be suggested by Department Chairs and vetted by the MEC.

4.3.3 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
4.3.4 election.

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

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.

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.

4.3.5 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 4.3.6 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

An 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 Meetings:

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 Committees 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.

Contra Costa Medical Center & Health Centers
Medical Staff Bylaws

MEDICAL STAFF BYLAWS

Part II: Investigations, Corrective Actions, Hearing and Appeal Plan

BOARD APPROVAL DATE

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.

MEDICAL STAFF BYLAWS

PART III: CREDENTIALS PROCEDURES MANUAL

BOARD APPROVAL DATE

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.