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## APPLICATION FORM

- 1.1** Pursuant to the Medical Staff Bylaws Procedures for Appointment and Reappointment Article, the content of the application for appointment and privileges shall include, but need not be limited to, the following:
- 1.1.1** An agreement that the applicant will abide by the Governing Documents.
- 1.1.2** A request for information pertinent to the applicant's qualifications, including, but not limited to, information regarding the applicant's:
- a. Licensing,
  - b. Education (including participation in continuing medical education),
  - c. Specialty training,
  - d. Experience,
  - e. Abilities and current competencies,
  - f. Professional affiliations,
  - g. Proffered references (including the names and addresses of professional peers — when possible from the same professional discipline as the applicant — who will be able to attest in writing to the applicant's relevant qualifications, experience, abilities and current competencies), and
  - h. Relevant health status.
- 1.1.3** A request for information regarding professional liability, licensing, and related matters, including involvement in professional liability actions; the requested information shall include, but not be limited to:
- a. All pending professional liability actions and all professional liability final judgments or settlements involving the applicant;
  - b. Previously completed or currently pending challenges involving professional licensure, certification or registration (state or district, Drug Enforcement Administration), or the voluntary relinquishment of licensure, certification or registration;
  - c. Voluntary or involuntary termination, limitation, reduction or loss of Medical Staff or medical group membership and/or clinical privileges at any other hospital or health facility or entity;
  - d. Any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and

- e. Any prior or pending government agency or third-party payor investigation, proceeding or litigation challenging or sanctioning the Practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including, but not limited to, Medicare or Medi-Cal fraud and abuse proceedings or convictions.

**1.1.4** A statement releasing, at a minimum, all persons and entities from any liability that might arise from their evaluating and/or acting on the application.

**1.2** The Medical Staff may require applicants to consent to a criminal background check and may perform a criminal background check as part of application process. An applicant's failure to consent to a criminal background check will be considered a voluntary withdrawal of the application, and the application will not be processed further.

## **RULE 2**

### **DEPARTMENTS**

As referenced in the Departments/Services Article of the Medical Staff Bylaws, the Hospital has the following Departments:

Psychiatry

Radiology

Med Surg

Laboratory

Pharmacy

Surgery

Intensive Care Unit

## RULE 3

### STANDARDS OF CONDUCT

#### 3.1 Purpose

The Medical Staff adopts these Standards of Conduct in order to form a cohesive, harmonious, and professional environment that respects the entire care team and supports a high level of patient care. These Standards represent the expectations necessary to achieve the desired care environment, which requires teamwork, mutual respect, and the Medical Staff and Allied Health Staff members' personal commitment to the behavior expectations contained in these Standards.

The behavior requirements set forth in these Standards do not exceed any Bylaws' requirements. They also do not exceed the generally-recognized expectations for professional behavior by health care professionals. In addressing incidents of inappropriate conduct, the primary concern is the protection of patients, employees, Practitioners, AHPs, and other persons at the Hospital. In addition, the wellbeing of a Practitioner or AHP whose conduct is in question is also of concern, as is the orderly operation of the Hospital.

Practitioners and AHPs are also expected to comply with the Hospital's Code of Conduct.

#### 3.2 Definitions

**3.2.1 Appropriate behavior:** behavior that includes any reasonable conduct to advocate for patients; to recommend improvements in patient care; to participate in Medical Staff operations, leadership or activities; or to engage in professional practice, including practice that may compete with the Hospital. Appropriate behavior is not subject to discipline.

**3.2.2 Unacceptable and inappropriate conduct (sometimes referred to only as "inappropriate conduct" or "inappropriate behavior"):** conduct or behavior that is inconsistent with appropriate behavior or is unprofessional, disruptive, harassing, demeaning, or offensive. A non-exhaustive list of examples of unacceptable and inappropriate conduct is included in the Examples of Inappropriate Conduct, below.

**3.2.3 Harassment:** conduct toward others based on, but not limited to, their sex, gender identity and gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status that has the purpose or direct effect of unreasonably interfering with a person's work performance, or which creates an offensive, intimidating, or otherwise hostile work environment.

**3.2.4 Sexual harassment:** unwelcome sexual advances, requests for sexual favors, or other verbal, visual, or physical conduct of a sexual nature where:

- a. Submission to, or rejection of, such conduct is made either explicitly or implicitly a term or condition of instruction, employment, or participation in Hospital or Medical Staff activities; or

- b. Submission to, or rejection of, such conduct by an individual impacts the evaluation of the individual's professional competence or job performance; or
- c. Such conduct reasonably interferes with an individual's performance or creates an intimidating, hostile, or offensive work environment.

### 3.3 Examples of Inappropriate Conduct

Examples of common inappropriate conduct include, but are not limited to, the following (examples are designed to generally discuss and illustrate common problems; they are not exhaustive):

- 3.3.1 Verbal abuse:** Verbal abuse includes, but is not limited to, vulgar, profane, or demeaning language, or shouting, sarcasm, or criticism directed at an individual that has the intent or effect of lowering the recipient's reputation or self-esteem. It is often intimidating to the recipient and can cause the recipient or others around him or her to become ineffective in performing their responsibilities (e.g., the individuals become afraid or unwilling to question or to communicate concerns, or to notify or involve either the involved Practitioner or others when problems occur). While constructive criticism is valued and appreciated, the kind of conduct described in this paragraph is disruptive when it reaches beyond the bounds of fair professional comment or negatively impacts staff morale.
- 3.3.2 Noncommunication:** Noncommunication includes refusal or failure to communicate with others where that refusal or failure adversely impacts the provision of care to patients or Medical Staff or Hospital operations. Noncommunication may cause important information to not be clearly communicated and may take the form of incomplete or ambiguous communication that requires others to divert patient care resources to obtain follow-up clarification. Specific forms of noncommunication include, but are not limited to, failing or refusing to take or return phone calls, pages, texts, or other communications related to patient care; repeatedly or intentionally providing ambiguous orders and/or failing to clarify orders; failing to respond to requests from the Medical Staff for information; and refusing or failing to participate in peer review and/or quality improvement.
- 3.3.3 Inappropriate communication:** Inappropriate communication includes using medical records or other inappropriate venues to criticize the Hospital or its employees, Medical Staff members, or AHPs; or making false statements regarding the Hospital or Medical Staff, or about patient care, to patients, visitors, other Practitioners, or members of the public. The Hospital and Medical Staff provide internal mechanisms for relaying concerns regarding patient care matters; Medical Staff members and AHPs are encouraged to use those when patient care or other concerns are identified. Notwithstanding the above, reports to government agencies with oversight over the Hospital or to entities that accredit the Hospital do not constitute inappropriate communication.
- 3.3.4 Failure to comply:** Failure to comply includes willfully or negligently failing to comply with the Governing Documents. Failure to comply places the Medical Staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying

with other applicable laws, or meeting other specific obligations to patients, potential patients, and facility staff. Specific examples include:

- a. Failing to cooperate in the peer review process (e.g., failing to meet with committee members, to answer reasonable questions relevant to the evaluation of patient care, or to provide information relevant to the evaluation of patient care).
- b. Failing to provide information necessary to process the facility's or a patient's paperwork. The facility, its patients, and their families have a right to expect timely and thorough compliance with all requirements of the facility, third-party payors, regulators, etc., as necessary to assure smooth functioning of the facility and that patients receive the benefits to which they are entitled.
- c. Violating confidentiality rules, including disclosing confidential peer review information outside the confines of the formal peer review process. If Practitioners are concerned about the quality of care provided by a Practitioner or by the facility, they should report it using the internal reporting mechanisms or by elevating the report up the chain of command within the institution. Notwithstanding the above, reports to government agencies with oversight over the Hospital or to entities that accredit the Hospital do not constitute a failure to comply.
- d. Refusing to comply with established protocols and standards, including, but not limited to, utilization review standards. Where deviation from established protocols and standards is necessary in the best interests of the patient, the Practitioner or AHP should be able to account for the deviation and, in appropriate circumstances, work cooperatively and constructively toward any necessary refinements of protocol or standards.
- e. Failing to participate in, or meet, Medical Staff obligations when doing so obstructs or significantly impairs the ability of the Medical Staff to perform its delegated responsibilities.
- f. Repeatedly abusing or ignoring scheduling policies or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary delays in, or hurrying of, patient care services being rendered to any patient of the facility.

**3.3.5 Physical abuse:** Physical abuse includes, but is not limited to, offensive or nonconsensual physical contact with any person, intentionally causing damage to facility premises or equipment, or vandalism of any person's property on facility premises.

**3.3.6 Threatening behavior:** Threatening behavior includes, but is not limited to, physical behavior, such as cornering, blocking, or throwing things in anger or frustration, and verbal behavior that threatens another's physical or emotional safety or property, that threatens to adversely affect another's employment or position, or that is otherwise reasonably perceived as intimidating others from performing their designated responsibilities or interfering with their wellbeing. This includes threats of litigation

against peer review participants or against persons who report concerns in accordance with established reporting channels.

- 3.3.7 Combative behavior:** Combative behavior includes, but is not limited to, behavior that repeatedly verbally or physically challenges legitimate and generally-recognized authority or generally-recognized lines of professional interaction and communications, or behavior that reflects an inability to acknowledge or to deliver constructive comments and criticism. Combative behavior does not include challenges to authority that are presented in a professional and constructive manner.
- 3.3.8 Dishonesty:** Dishonesty includes, but is not limited to, intentionally recording false information in medical records or inappropriately back-dating medical record entries; providing false information to peer reviewers or Medical Staff Leaders; submitting knowingly false grievances, complaints, or reports; and making knowingly false allegations against a staff member, Medical Staff member, other professional, or Hospital administration or administrators.
- 3.3.9 Abusive use of media, including social media:** Abusive use of media, including social media, includes, but is not limited to, using media or social media platforms to intimidate or harass any person affiliated with the Hospital, including patients and their families; to falsely and maliciously discredit Hospital employees, contractors, or Medical Staff members; to post confidential health care information about patients; to share confidential or peer review information about the Hospital, its employees or contractors, or Medical Staff members; or to post inaccurate information about the Hospital or its Governing Body members, administration, administrators, employees, contractors, Medical Staff members, or AHPs.
- 3.3.10 Harassment and sexual harassment:** Harassment and sexual harassment includes conduct as defined in this Rule.

### 3.4 Conduct Expectations

- 3.4.1** All Practitioners and AHPs are expected to engage in appropriate behavior and to refrain from unacceptable and inappropriate conduct. Practitioners and Allied Health Staff members must address any concerns or complaints about Hospital-related matters, including those listed below, in a professional manner to the appropriate Medical Staff Leader, Department manager, nursing/staff supervisor, administrator, or Governing Body representative:
  - a. Patient care;
  - b. Medical Staff member, Allied Health Staff member, or employee performance or behavior;
  - c. Hospital facilities, operations, policies, governance, administration, or action; or
  - d. Medical Staff operations, governance, Governing Documents, processes, or action.

- 3.4.2** If a Practitioner or AHP engages in inappropriate conduct in a manner that (a) is disruptive to Hospital operations, (b) negatively impacts, or potentially could negatively impact, patient health and wellbeing, or (c) suggests that the Practitioner or AHP no longer meets the qualifications or responsibilities of membership or privileges, the Practitioner or AHP may be subject to action under this rule and/or corrective action under the Bylaws, including, but not limited to, summary action or termination.
- 3.4.3** The Medical Staff recognizes that, on occasion, there may be instances where a Practitioner or AHP's conduct falls outside the literal description of expected behavior but is not disruptive. There also are circumstances where the exigencies of a situation may result in crossing over the lines of acceptable behavior. In most instances involving isolated events, corrective action may not be called for. However, repeated or egregious incidents, as judged by the Medical Staff, is subject to such corrective action as deemed necessary to effectively address the particular circumstances, up to and including termination.

### **3.5 Procedures**

**3.5.1 Reporting:** Any person may report potential violations of the conduct expectations. Anyone who receives such a report shall document it in writing and submit it to the Chief of Staff and Chief Executive Officer for evaluation. The Chief of Staff and Chief Executive Officer may delegate the evaluation to an appropriate officer or committee, including the Professional Conduct Committee (known as the "evaluating body"). Requests by a reporting party that "nothing should be done" about an event or that the report is for "information only" will not be granted. The Chief of Staff and Chief Executive Officer may consult with the Hospital's Human Resources department or other consultant as appropriate.

#### **3.5.2 Evaluation**

- a. The evaluating body shall seek appropriate documentation of each incident of alleged inappropriate conduct. Such documentation should include:
1. Date, time, and location of the reported behavior.
  2. A factual description of the behavior.
  3. The circumstances that precipitated the event.
  4. The name and medical record number of any patient or patient's family member who was involved in or witnessed the event.
  5. The names of other witnesses to the event.
  6. The consequences, if any, of the behavior as it relates to patient care or safety, or Hospital personnel or operations.
  7. Any action taken to intervene in or remedy the event, including the names of those intervening.

8. A record of any action taken to address the situation prior to the Medical Staff's evaluation, including the date, time, place, action and name(s) of those taking such an action.
- b. The evaluating body will seek information regarding the alleged incident from the Practitioner or AHP at issue. That input can be in the form of a written statement or an oral statement obtained and documented by the evaluating body.
- c. The evaluating body will evaluate anonymous reports to the degree possible.
- d. The evaluation shall take place within 14 calendar days from receipt of a report of inappropriate conduct.

### 3.5.3 Action

- a. **Unfounded/Unconfirmed Report:** If the evaluating body determines the report is unfounded or is unable to be confirmed, it shall include a statement regarding this finding with the report. The report shall be maintained in the Medical Staff member's file with the original complaint. The evaluating body will notify the individual who initiated the report of the decision.
- b. **Confirmed Report:** If the evaluating body confirms the report, it shall refer it to the Medical Executive Committee or to the Professional Conduct Committee (the "designated committee") to determine what, if any, actions should be taken. Any actions will depend on a number of variables, including, but not limited to:
  1. Degree of disruptiveness,
  2. Number of incidents (i.e., pattern of disruptive behavior over time), and
  3. Length of time between incidents of disruptive behavior, if multiple incidents have occurred.
- c. **Plan for Addressing Disruptive Behavior:** The designated committee will develop a plan for addressing the inappropriate behavior, which will be included in the individual's credentials file. The plan shall include item (1) below, and may include any portion or all of items (2) and (3) below:
  1. The designated committee shall send a letter to the individual that describes the inappropriate conduct, explains that the behavior is in violation of the Standards of Conduct, notes any patient care or Hospital operations implications, explains why the behavior in question is inappropriate, directs the individual to comply with the Standards of Conduct in the future, invites the individual to respond, and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds for further disciplinary action. A copy of this Rule shall be included with the letter. Documentation of both the letter and the individual's response, if any, shall be included in the individual's file.

2. The Chief of Staff, Chief Executive Officer, or the designated committee, and any other number of appropriate participants from the Medical Staff and Governing Body, shall schedule a meeting with the individual to discuss the inappropriateness of his or her behavior and require that such behavior cease. During the meeting, the individual will be advised that he or she is required to comply with the Bylaws and the Standards of Conduct. A follow-up letter documenting the content of the discussion and any specific actions the offending individual has agreed to perform shall be sent to the individual. The individual will be invited to respond. This letter and any response will be included in the individual's file.
  
3. The plan may incorporate additional components, including, but not limited to:
  - i. Warning the individual that failure to abide by the terms of the Standards of Conduct shall be grounds for disciplinary action including, but not limited to, suspension and/or termination of Medical Staff membership.
  
  - ii. Requiring the individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait, or requiring the individual to sign a behavior modification contract. The Chief of Staff, Chief Executive Officer or designated committee shall document any corrective action and require the individual to sign his or her acceptance of this plan. The plan may clearly delineate the consequences for the individual not successfully completing the agreed upon corrective action.
  
  - iii. In appropriate circumstances, the plan may provide for immediate suspension and/or action to terminate Medical Staff membership without need of further warning or counseling.

**3.5.4 Final Warning:** If the Chief of Staff, Chief Executive Officer, or designated committee determines that the plan has been unsuccessful, the Medical Executive Committee shall be informed and advised to proceed with a final warning. If the Medical Executive Committee determines that the individual deserves a final warning, it shall meet with and advise the individual that the disruptive behavior in question is intolerable and must stop. The Medical Executive Committee will inform the individual that a single recurrence of disruptive behavior shall be sufficient cause to result in his/her suspension and/or termination of Medical Staff membership. The individual will also receive a follow-up letter reiterating the final warning and the consequence of suspension and possible termination of Medical Staff membership and privileges.

**3.5.5 Suspension:** At any time, a Practitioner or AHP may be summarily suspended as a result of inappropriate conduct if the standards for summary suspension as described in the Medical Staff Bylaws or the AHP Rule are met.

**3.5.6 Consequences of a Member’s Failure to Comply with the Standards of Conduct:**

Depending on the factors involved and whether or not the recommendation or action is one that is identified as “Grounds for Hearing,” the Practitioner or AHP may be entitled to the hearing rights found in the Hearing and Appeals Article of the Medical Staff Bylaws, the Administrative Hearings Rule in these Rules, or the Allied Health Practitioner Rule in these Rules.

## **RULE 4**

### **IMMUNIZATION AND COMMUNICABLE DISEASES**

Medical Staff members and AHPs are expected to know their own health status, to take such precautionary measures as may be warranted under the circumstances to protect patients and others at the Hospital, and to comply with all reasonable precautions established by Hospital and/or Medical Staff policy respecting safe provision of care and services in the Hospital. Additionally, Medical Staff members and AHPs are expected to comply with Hospital policies regarding the testing for communicable diseases and regarding immunizations.

## RULE 5

### WAIVERS TO BOARD CERTIFICATION

The Medical Staff has determined that board certification, as defined and described in the Medical Staff Bylaws, is a minimum qualification for Medical Staff membership and/or privileges and expects every Practitioner to meet that qualification. However, under the limited circumstances described below, a Practitioner may receive a limited exemption from the board certification requirement. Receiving an exemption from the board certification requirement does not mean that appointment or privileges will be granted, but only that processing of the application can begin.

#### 5.1 Time Limited Exemptions

Practitioners who fall within the following categories may receive a time-limited exemption from the board certification requirement as long as they are: (i) eligible to take the board certification exam or are working toward eligibility to take the board certification exam, and (ii) can demonstrate current clinical knowledge and competency to the satisfaction of the Medical Executive Committee and the Governing Body.

- 5.1.1 A Practitioner who has taken the board certification exam but has not yet been informed of the results. In such cases, the exemption expires no more than three months after the Practitioner has taken the exam.
- 5.1.2 A Practitioner who has graduated from his or her residency or fellowship program within 12 months of applying for membership and/or privileges. In such cases, the exemption expires no more than 12-months after the Practitioner has graduated.
- 5.1.3 A Practitioner whose specialty board requires a minimum number of years of practice before eligibility to take the examination. In such cases, the exemption expires no more than 15 months after the Practitioner becomes eligible to take the exam, or no later than seven years after the Practitioner has completed his or her relevant residency or fellowship program, whichever comes first.
- 5.1.4 A Practitioner who, as determined by the Medical Executive Committee, has experienced extraordinary circumstances in the 18-month period prior to the board certification deadline or the date of the board certification examination or renewal examination. In such cases, the exemption shall expire no more than 15 months after the board certification deadline or expected examination date. Examples of “extraordinary circumstances” include the death of a close family member (spouse, child, parent, or sibling); divorce and/or custody proceedings; and serious illness or disability requiring significant treatment or hospitalization, as documented by a California-licensed physician. “Extraordinary circumstances” do not include, among other things, prior board examination failure or relocation of practice. The Medical Executive Committee’s decision that the extraordinary circumstances exception does not apply is not subject to the hearing and appeal rights in the Governing Documents.

#### 5.2 Permanent Exemptions

Practitioners who fall within the following categories may receive permanent exemptions from the board certification requirements, as long as the Practitioners can demonstrate current clinical

knowledge and competency to the Medical Executive Committee's and Governing Body's satisfaction.

- 5.2.1** A member who has been continuously on staff since \_\_\_\_\_ and was not board certified at the time this Rule was adopted.
- 5.2.2** Practitioners whose sub-specialty did not, at the time of their training, have a sub-specialty board or formal residency programs, and therefore, the Practitioners have never been eligible to sit for the sub-specialty board certification examinations. In such cases, the Practitioner may be exempted from the sub-specialty certification requirement but must still be certified in their original specialty.
- 5.2.3** Practitioners who are ineligible for board certification due to graduation from a foreign training program.

## **RULE 6**

### **CONFLICTS OF INTEREST**

#### **6.1 Conflicts of Interest Policy**

**6.1.1** Practitioners and AHPs shall abide by the Medical Staff Conflicts of Interest policy. At a minimum, the Conflicts of Interest policy will:

- a. Define what constitutes an actual or potential conflict of interest;
- b. Require all candidates for Medical Staff office or Department or Section office to disclose in writing, at least 20 days prior to the election, actual or potential conflicts of interest to the Medical Executive Committee and to the Chief Executive Officer;
- c. Require that the candidate disclosure statements be distributed with ballots for the election;
- d. Require all committee members to disclose in writing to the Medical Executive Committee and the Chief Executive Officer actual or potential conflicts of interest prior to appointment;
- e. Require Medical Staff Leaders and committee members to update their written disclosure whenever the information changes while they are in office or serving on a committee;
- f. Require Medical Staff Leaders and committee members to recuse themselves from decisions for which they have an actual conflict of interest; and
- g. Include provisions addressing how disagreements regarding whether or not a Medical Staff Leader or committee member should be recused shall be resolved.

**6.1.2** Failure to comply with the Medical Staff's Conflict of Interest policy may result in corrective action and may be grounds for recall or removal.

#### **6.2 Disclosure of Interest Form**

The Medical Staff may develop a Disclosure of Interest form to facilitate the written disclosures.

## **RULE 7**

### **CONFLICT MANAGEMENT PROCESSES**

#### **7.1 Medical Staff Disputes**

- 7.1.1** In the event of conflict between the Medical Executive Committee and the Medical Staff regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the Medical Staff can submit a petition requesting initiation of the conflict management process signed by at least [insert percentage] of members eligible to vote. The petition must identify up to [five] Medical Staff members eligible to vote that shall serve as petitioners' representatives. Each page of the petition where signatures appear must include a description of the nature of the dispute.
- 7.1.2** Upon verification of the petition, the Chief of Staff shall convene a meeting with one or more of the petitioners' representatives and an equal number of Medical Executive Committee members. The representatives of both the Medical Executive Committee and the petitioners shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital.
- 7.1.3** Resolution of the conflict requires a majority vote of the Medical Executive Committee's representatives at the meeting, and a majority vote of the petitioner's representatives at the meeting. Unresolved differences regarding Governing Documents shall be addressed as described in the Governing Document Article of the Bylaws. All other unresolved matters shall be brought to the Medical Staff for discussion at the next Medical Staff meeting.
- 7.1.4** Nothing in this section shall limit the ability of Medical Staff members to communicate with the Governing Body on a rule, regulation, or policy adopted by the Medical Staff or the Medical Executive Committee. The Governing Body determines the method of communication.

#### **7.2 Disputes with the Governing Body**

In the event of a dispute between the Medical Staff and the Governing Body relating either to the independent rights of the Medical Staff or to a matter that could adversely affect patient safety or quality of care, the Medical Staff and Governing Body shall meet and confer as follows

- 7.2.1** Either the Medical Executive Committee or the Governing Body may invoke the meet and confer process, or the process may be invoked by a written petition signed by at least 50 percent of Medical Staff members eligible to vote. The purpose of the petition must be included on every page where signatures appear.
- 7.2.2** The matter may be referred to the Joint Conference Committee described in the Medical Staff Rules, or, upon request of at least two thirds of members of the Medical Executive Committee or two thirds of members of the Governing Body, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body.

- 7.2.3** A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon the request of:
- a. At least a majority of the Medical Executive Committee plus two members of the Governing Body; or
  - b. At least a majority of the Governing Body plus two members of the Medical Executive Committee.

The cost of the neutral mediator shall be split evenly between the Medical Staff and the Governing Body, or the Governing Body may elect to bear the full cost.

- 7.2.4** The parties' representatives shall convene as early as possible; shall gather and share relevant information; and shall work in good faith to manage and, if possible, resolve the conflict. If the parties are unable to resolve the dispute, the Governing Body shall make its final determination, giving great weight to the actions and recommendations of the Medical Executive Committee. The Governing Body's determination shall not be arbitrary or capricious and shall be in keeping with its legal responsibilities, including its responsibilities to protect the quality of medical care provided at the Hospital, to ensure the competency of the Medical Staff, and to ensure the responsible governance of the Hospital.

## **RULE 8**

### **AUTHORIZATIONS, RELEASES, IMMUNITY, CONFIDENTIALITY, AND INDEMNITY**

#### **8.1 Duration of Application**

- 8.1.1** Applicants, members, Practitioners, and AHPs, by applying for or accepting Medical Staff membership, Allied Health Staff status, clinical privileges, or other practice prerogatives, authorize and agree that the provisions set forth in this Rule commence when an individual requests an application and that these provisions apply and remain in effect for all time, whether or not an application for membership or privileges is provided or considered, and whether or not membership or any privileges are granted, denied, suspended, limited, or terminated, for any reason.
- 8.1.2** For the purposes of this Rule only, references to “members” and to AHPs includes persons who had Medical Staff membership or Allied Health Staff status at any time, regardless of whether or not they continue to be Medical Staff members or hold Allied Health Staff status.
- 8.1.3** The authorizations, immunities, indemnity, releases, and confidentiality provisions in this Article apply to all actions taken or declined pursuant to the Governing Documents. “Action” for the purpose of this article includes, without limitation, any act of communication, consideration, report, recommendation, disclosure, rule-making, or adjudication taken, or declined to be taken, pursuant to the Medical Staff Governing Documents or otherwise in furtherance of the Hospital’s or Medical Staff’s responsibilities, duties, and obligations.

#### **8.2 Authorizations**

Applicants, members, and AHPs, by applying for or accepting Medical Staff membership, Allied Health Staff status, clinical privileges, or other practice prerogatives, authorize and agree to the following:

- 8.2.1** The Hospital and Medical Staff may solicit from any person or entity any information that may be relevant to the Practitioner’s or AHP’s qualifications, fitness, character, or ability to meet the standards of the Medical Staff.
- 8.2.2** The Hospital and Medical Staff may provide to any health care organization (including, but not limited to, any medical group, hospital, medical foundation, training facility, professional school, or health care payor) or licensing agency information that may be relevant to the Practitioner’s or AHP’s professional qualifications, fitness, character, or ability to meet the standards of that organization.

#### **8.3 Confidentiality and Sharing of Information**

##### **8.3.1 General Rule of Confidentiality**

- a. Effective Hospital and Medical Staff operations, including credentialing, quality improvement, and peer review, depend on confidentiality to facilitate free and candid discussions. Practitioners and others participate in Medical Staff

operations with the reasonable expectations that this confidentiality will be preserved and maintained, except as expressly required by law or as otherwise provided in the Governing Documents.

- b. Therefore, all Medical Staff records and information, including, but not limited to the following, shall, to the fullest extent permitted by law, be confidential, regardless of the source of the information: department, section, and committee records, minutes, and files; applications and privileging forms and the evaluations of those forms; internal policies; information learned during any Medical Staff, department, section, or committee meeting; and other records. These documents, in whatever form, shall be maintained as Medical Staff committee records and not become part of a patient medical record or Hospital record. Access to, use of, and dissemination of confidential information and records shall be made only where expressly required by law or as otherwise provided in the Governing Documents.
- c. Committee members and persons attending any Medical Staff meeting may be required, as a condition or service or attendance, to sign a statement regarding their obligations to keep records and information confidential. Regardless of whether such a statement is required, the confidentiality provisions in the Governing Documents apply.

### **8.3.2 Permitted Use and Disclosure of Confidential Information**

Medical Staff records, as described above, may be used and disclosed as follows:

- a. As permitted or required by Hospital or Medical Staff Governing Documents;
- b. As needed to fulfill the obligations of the Hospital or Medical Staff, as determined by those individuals charged with overseeing those obligations;
- c. Upon approval of the Chief of Staff, to respond to requests for information from other peer review bodies or health care entities;
- d. In compliance with an information sharing agreement with another health care entity;
- e. To share with System Members to facilitate the review of an applicant or member of the affiliated entity's Medical Staff or Allied Health Staff, or to facilitate systemwide performance improvement and quality assurance activities;
- f. For any other purpose designed to assist the Hospital or Medical Staff in either of their functions, either upon approval of the Chief of Staff or upon approval of the Chief Executive Officer, after the Chief Executive Officer provides notice to the Chief of Staff explaining the reasons for the use or disclosure;
- g. As required by law (including court order) or accreditation requirement, as determined by the Medical Executive Committee, the Chief Executive Officer, or the Governing Body.

### **8.3.3** Individuals Who May Access Information

Medical Staff records, as described above, may be accessed by the following individuals and their representatives, but only for the use and disclosure purposes described above.

- a. Medical Staff Officers, for the purpose of fulfilling any of their duties;
- b. Committee members, for the purposes of conducting their specific committee functions;
- c. The Chief Executive Officer, Chief Medical Officer, and the Governing Body;
- d. The Medical Staff Services Administration personnel;
- e. Risk Management and Quality Improvement department personnel, so long as such access is both necessary and consistent with their administrative functions;
- f. Other persons designated by the Chief of Staff as needing access to ensure the fulfillment of the Medical Staff's and the Hospital's obligations.

### **8.3.4** Sharing Peer Review Information With Other Peer Review Bodies

- a. Whenever the Medical Staff receives a request from a peer review body for information regarding an individual who was subject to corrective action under the Bylaws for a medical disciplinary cause or reason, the Medical Staff will, subject to the conditions in paragraph (b), provide the peer review body with a written summary of the relevant peer review information or with the peer review records.
- b. The Medical Staff may, within its discretion and on a case-by-case basis, condition its release of any peer review information on first receiving: (i) a release from the individual that is acceptable to the Medical Staff, and/or (ii) a peer review sharing agreement agreeable to the Medical Staff and signed by the requesting peer review body, and that includes an indemnification provision.
- c. "Relevant peer review information" or "peer review record" includes, but is not limited to, allegations and findings, explanatory or exculpatory information submitted by the individual, any conclusions made, any actions taken, and the reasons for those actions, to the extent not otherwise prohibited by applicable federal or state law. The information shall not identify any person except the individual identified in the request.
- d. This section does not limit the Medical Staff's ability to share and disclose peer review information to any entity or person, as long as it is done in a manner consistent with the other Confidentiality and Sharing of Information provisions in the Governing Documents.

### **8.3.5** Peer Review Information Sharing Agreements

The Hospital may execute information sharing agreements with other health care entities to facilitate the sharing of information. Notwithstanding any other provision in the

Governing Documents, except for provisions regarding the protection of Wellbeing Committee information and substance abuse treatment information, Medical Staff records may be shared pursuant to the terms of an information sharing agreement so long as the agreement includes provisions to promote the protection of the shared Medical Staff records and the agreement has been approved by the Medical Executive Committee and the Chief Executive Officer.

### **8.3.6 Wellbeing Committee and Substance Abuse Treatment Information**

- a. Notwithstanding any other provision in this Rule, information regarding a Practitioner or AHP maintained by the Wellbeing Committee shall not be shared unless: (i) required by law, (ii) the Practitioner or AHP provides written permission to share the information maintained by the Wellbeing Committee, or (iii) the Medical Executive Committee votes to disclose the information.
- b. Prior to sharing any mental health records or substance abuse treatment records, the Medical Staff shall consult with legal counsel to determine the manner in which the information may be provided to third parties.

### **8.3.7 Breach of Confidentiality and Misuse of Information**

Applicants, Practitioners, and AHPs, by applying for or accepting Medical Staff membership, clinical privileges, or other permissions to practice, acknowledge that compliance with the confidentiality provisions of the Governing Documents, including the use and disclosure provisions, is a condition of appointment to, and continued membership on, the Medical Staff. Breach of these provisions violates the Bylaws, is *per se* disruptive to Hospital operations, and may result in corrective action.

If corrective action results from the breach of confidentiality or misuse of information, and if such action entitles the Practitioner to a hearing and appeal right under the Bylaws or this Rule, then the only issues before the Trier of Fact shall be: (a) whether the breach occurred, and (b) if the breach occurred, whether the corrective action taken or recommended is reasonable and warranted.

### **8.3.8 Practitioner and Allied Health Staff Access and Correction**

- a. A Practitioner or Allied Health Staff member shall be granted access to his or her own credentials file, subject to the following provisions:
  1. The Practitioner or AHP shall give notice of a request to review the file to the Chief of Staff (or his or her designee) at least five business days before the requested date for review.
  2. The Medical Staff may require the Practitioner or AHP to sign a statement prior to having access to the credentials file confirming that the information reviewed is confidential and may not be disclosed outside of the peer review process, that the Practitioner understands that retaliation against any individual who provided information to the Medical Staff is strictly prohibited, and that any retaliation will be grounds for corrective action.

3. The Practitioner or AHP may review and receive a copy of only those documents provided by or addressed personally to the Practitioner or AHP. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, and complaints, shall be made available to the Practitioner and AHP, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized. A copy of the summary shall be kept in the credentials file.
  4. Per federal restrictions, National Practitioner Data Bank reports will not be provided. Practitioners may perform their own query for information from the National Practitioner Data Bank.
  5. The Practitioner or AHP's review of the information and summary shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Chief of Staff present.
  6. In the event the Hearings and Appeals provisions of the Bylaws are invoked, the Practitioner shall have access to his or her credentials file in a manner consistent with Hearings and Appeals Article.
- b. A Practitioner or Allied Health Staff member may be permitted to request correction of information as follows:
1. After review of his or her file, a Practitioner or AHP may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.
  2. The Chief of Staff shall review the request within 30 days and shall recommend to the Medical Executive Committee whether to make the correction as requested. The Medical Executive Committee shall make the final determination of whether to make the correction.
  3. Good cause for correction exists only if the information is demonstrably factually inaccurate or has been placed in the wrong file. Good cause does not exist if the Practitioner or AHP simply disagrees with the information, or the information is old, or the Medical Staff was unable to validate the information. In instances where the Medical Staff evaluated a complaint or report regarding a Practitioner or AHP but was unable to substantiate it or found it to be unsubstantiated, the Medical Staff shall attach a statement to the complaint or report reflecting the findings of the evaluation. The original complaint or report shall not be deleted from the Practitioner's or AHP's file.
  4. The Practitioner or AHP shall be notified within seven days, in writing, of the Medical Executive Committee's decision.

5. Regardless of whether a correction is requested or made, a Practitioner or AHP shall have the right to add to his or her credentials file a statement responding to any information contained in the file. Any written statement shall be addressed to the Medical Executive Committee and shall be placed in the credentials file immediately following review by the Medical Executive Committee.

## **8.4 Immunity and Releases**

- 8.4.1** Applicants, Practitioners, and AHPs, by applying for, or accepting, Medical Staff membership, Allied Health Staff status, clinical privileges, or other permissions to practice, acknowledge and agree that the Hospital, the Medical Staff, each Medical Staff member, any representative of the Hospital or Medical Staff, and all third parties are exempt from liability to a Practitioner or AHP for damages or other relief for any action taken or declined, as described in the Rules, or for providing information to the Hospital or Medical Staff. This immunity shall also apply to actions taken or declined that occur after an application is denied or is withdrawn, or after the individual no longer holds membership or Allied Health Staff status. Nothing in the Governing Documents shall be deemed to waive or limit any immunity provided by federal or state law.
- 8.4.2** Applicants, Practitioners, and AHPs, by applying for, or accepting, Medical Staff membership, Allied Health Staff status, clinical privileges, or other permissions to practice, release from liability to the fullest extent under the law the Hospital, the Medical Staff, each Medical Staff member, and any representative of the Hospital or Medical Staff for any action taken or declined, as described in the Rules. This release of liability shall remain in effect for all time and shall also apply to actions taken or declined that occur after an application is denied or withdrawn, or after the individual no longer holds membership or Allied Health Staff status.
- 8.4.3** As a condition of continued membership or privileges, or of continued processing of an application, an individual applicant, Practitioner, or AHP must, when requested by a Medical Staff Committee or Officer, execute any general or specific releases that may be required by any entity for the purpose of obtaining additional information regarding the Practitioner's qualifications, fitness, character, or ability to meet the standards of the Medical Staff. Failure to execute such a release within 14 days after requested to do so shall result in an automatic suspension of Medical Staff membership (as detailed further in the Automatic Suspension, Termination, and Limitation provisions of the Corrective Action Article of the Bylaws) or a finding that the applicant's application is incomplete and deemed voluntarily withdrawn.

## **8.5 Indemnity**

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

- a. As a member of, or witness for, a Medical Staff, Department, committee, or hearing committee;
- b. As a member of, or witness for, the Hospital Governing Body or any Hospital task force, group or committee; and
- c. As a person providing information to any Medical Staff or Hospital group, officer, Governing Body member, or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

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

**8.5.3** Nothing in this Rule shall be construed as obligating the Hospital to compensate any individual or the Medical Staff as a whole for any: (a) time spent participating in, (b) opportunity cost incurred from, or (c) lost income resulting from any peer review activity or in the defense of any threatened, pending, or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment activities.

## RULE 9

### ADMINISTRATIVE HEARINGS

#### 9.1 Eligibility

If a Practitioner's membership or privileges are involuntarily denied, restricted, reduced, or terminated, and the Practitioner is not entitled to a hearing under the Hearing and Appeals Article of the Medical Staff Bylaws, the Medical Executive Committee or the Governing Body, in their discretion, may nonetheless offer the Practitioner an administrative hearing if the denial, restriction, reduction, or termination:

- 9.1.1 Does not require the Hospital to file a report with the licensing body pursuant to Business and Professions Code Section 805 or with the National Practitioner Data Bank;
- 9.1.2 Is not based on the Practitioner's failure to meet a minimum qualification for membership or a qualification for specific privileges;
- 9.1.3 Does not result from the "Automatic Suspension, Termination, and Limitation" section of the Corrective Action Article of the Medical Staff Bylaws; and
- 9.1.4 Is not based on any ground that the Medical Staff Bylaws declares does not give rise to a hearing.

#### 9.2 Administrative Hearing Procedure

For ease of use, the terms of this Rule generally reference hearing rights that arise from actions and recommendations by the Medical Executive Committee. If the Governing Body takes an action without first receiving a corrective action recommendation from the Medical Executive Committee, and that action is grounds for a hearing under this Article, any reference in this Article to the "Medical Executive Committee" or "Chief of Staff" will be interpreted as a reference to the "Governing Body" or "Governing Body designee," respectively, and the Governing Body or its designee will have the responsibilities otherwise granted to the Medical Executive Committee or Chief of Staff.

- 9.2.1 Administrative Hearings need not follow the Hearing and Appeal Article of the Medical Staff Bylaws and instead shall comply with the process described in this Rule; however, the Medical Staff may, but is not required to, use the following sections and provisions in the Hearing and Appeals Article of the Medical Staff Bylaws to guide Administrative Hearings:
  - a. Scope of Article,
  - b. Mediation,
  - c. Arbitrator,
  - d. Prehearing Process,
  - e. The Hearing,
  - f. Appeal Procedure,
  - g. Additional Provisions, and Joint Hearing

- 9.2.2** The Medical Staff shall provide the Practitioner with notice of the action or recommendation. The notice shall also inform the Practitioner that he or she has 30 days in which to request an Administrative Hearing. The notice shall include a copy of this Rule and the sections of the Hearing and Appeals Article described above.
- 9.2.3** The Practitioner must submit any request for hearing in writing, addressed to the Medical Executive Committee with a copy to the Chief Executive Officer or his/her designee. The request must be received by the Medical Staff Services Administration within the deadline. The Practitioner shall state, in writing within the request, his or her intentions with respect to attorney representation.
- 9.2.4** In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. In such cases, the Medical Staff's recommendation or action shall be considered by the Governing Body at its next meeting. The Governing Body shall give the recommendation great weight, but may exercise its independent judgment in determining whether or not to adopt the recommendation or action.
- 9.2.5** If the Practitioner requests a hearing within the time and in the manner described, the Medical Executive Committee will provide him or her with a notice of the reasons that form the basis for the action or recommendation within 60 days after receiving the request for hearing. The notice may be supplemented or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the Practitioner's qualifications and the Practitioner has a sufficient opportunity (at a minimum, 30 days) to review and respond with additional information.
- 9.2.6** The Medical Executive Committee shall endeavor to schedule the hearing to begin within 90 days after receiving the request for hearing, but no sooner than 30 days after sending the Notice of Reasons. The Medical Executive Committee will send the Practitioner notice of the time, date, and location of the hearing at least 30 days prior to the hearing date.
- 9.2.7** The administrative hearing shall be held in front of an arbitrator selected in the manner described in the "Arbitrators" section in the Hearing and Appeals Article of the Medical Staff Bylaws.
- 9.2.8** Failure of the Practitioner to attend any hearing session shall be deemed a waiver of his or her hearing rights, unless the Practitioner can prove to the satisfaction of the arbitrator that an unforeseen and unanticipated emergency prevented him or her from attending.

## **RULE 10**

### **MEDIATION**

As described in the Medical Staff Bylaws Hearing and Appeals Article, at any time before or after making a corrective action recommendation, the Medical Staff may offer the Practitioner the opportunity to mediate the dispute. The mediation shall be conducted in the manner described below.

#### **10.1 Purpose**

**10.1.1** Mediation is a confidential process in which a neutral person facilitates communication between the Medical Executive Committee and a Practitioner to assist them in reaching a mutually acceptable resolution of a peer review controversy in a manner that is consistent with the best interests of patient care.

**10.1.2** The parties are encouraged to consider mediation whenever it could be productive in resolving the dispute.

#### **10.2 Request**

If the Practitioner requests mediation in writing within 10 days of receiving a Notice of Recommendation or Action, as described in the Bylaws, the Medical Executive Committee shall participate in mediation. If the Practitioner requests mediation after that deadline, the Medical Executive Committee has the discretion of whether or not to participate in mediation, but shall make its decision regarding participation in good faith.

#### **10.3 Deadlines**

**10.3.1** If the Practitioner and the Medical Executive Committee agree to mediation, all deadlines and time frames relating to the hearing process described in the Medical Staff Bylaws Hearing and Appeals Article shall be tolled while the mediation is in process, and the Practitioner agrees that no damages accrue as the result of any delays attributable to the mediation.

**10.3.2** Mediation cannot be used by either the Medical Staff or the Practitioner as a way of unduly delaying the corrective action or hearing process. Accordingly, unless both the Medical Staff and the Practitioner agree otherwise, mediation must commence within 30 days of the Practitioner's request and must conclude within 30 days of its commencement. If the mediation does not resolve the dispute, the fair hearing process will promptly resume upon completion of the mediation.

#### **10.4 Selection and Process**

**10.4.1** The parties shall cooperate in the selection of a mediator or mediators. Mediators should be both familiar with the mediation process and knowledgeable regarding the issues in dispute. The mediator may also serve as the Hearing Officer at any subsequent hearing, subject to the agreement of the parties; such agreement may be given prior to the mediation or after, with the parties to decide when they will agree on this issue. The costs of mediation shall be shared two-thirds by the Medical Staff and one third by the Practitioner. The inability of the Medical Staff and the Practitioner to agree upon a

mediator within the required time limits shall result in the termination of the mediation process and the resumption of the fair hearing process.

- 10.4.2** Once selected, the mediator and the parties, working together, shall determine the procedures to be followed during the mediation. Each party has the right to be represented by legal counsel in the mediation process.

## **10.5 Confidentiality**

All mediation proceedings shall be confidential, and the provisions of California Evidence Code Section 1119 shall apply. Except as otherwise permitted in this Section, no other evidence of anything said at, or any writing prepared for or as the result of, the mediation shall be used in any subsequent hearing process that takes place if the mediation is not successful.

Notwithstanding the above, evidence of mediation may be introduced at a hearing as follows:

- 10.5.1** Communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented.
- 10.5.2** The fact of the mediation may be disclosed to demonstrate the good faith of the parties in their attempts to resolve the matter; however, this shall not include any points that are substantive in nature or address the issues presented.

**RULE 11**  
**COMMITTEES**

**11.1 Committees**

Unless specifically excluded in the Committee composition provision, each Committee shall include the ex officio members identified in the Medical Staff Bylaws. Ex officio members shall be nonvoting, unless otherwise provided. In addition to the Committees described in the Medical Staff Bylaws, and pursuant to the Committees Article of the Medical Staff Bylaws, the Medical Staff establishes the following committees. The rules applicable to each committee are set forth in the corresponding appendix.

*See Appendix*

- |   |     |
|---|-----|
| <input type="checkbox"/> Bioethics Committee                  | 11A |
| <input type="checkbox"/> Bylaws Committee                     | 11B |
| <input type="checkbox"/> Credentials Committee                | 11D |
| <input type="checkbox"/> Department Committees                | 11E |
| <input type="checkbox"/> Infection Prevention Committee       | 11G |
| <input type="checkbox"/> Interdisciplinary Practice Committee | 11I |
| <input type="checkbox"/> Pharmacy and Therapeutics Committee  | 11K |
| <input type="checkbox"/> Professional Conduct Committee       | 11L |
| <input type="checkbox"/> Quality Improvement Committee        | 11M |
| <input type="checkbox"/> Utilization Review Committee         | 11N |
| <input type="checkbox"/> Wellbeing Committee                  | 11O |

## **Appendix 11A**

### **Bioethics Committee**

#### **1. Composition**

The Bioethics Committee shall be composed of at least (6) six members, a majority of whom shall be Practitioners and all of whom are voting members. If possible, membership shall include a registered nurse, a clergy member, a medical social worker (or a comparable discipline), a palliative care staff member, a member of Hospital administration, a non-hospital local community member at large, and an ethicist. Additional members may be appointed by the Chief of Staff.

#### **2. Duties**

The Bioethics Committee shall strive to contribute to the quality of health care provided by the Hospital by:

- a. Providing assistance and resources for decisions which have bioethical implications. The Bioethics Committee shall not, however, be a decision maker in any case.
- b. Educating members within the Hospital community concerning bioethical issues and dilemmas.
- c. Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.
- d. Retrospectively reviewing cases to evaluate bioethical implications and providing policy and education guidance relating to such matters.
- e. Proposing guidelines for decision making in cases that have bioethical implications.

#### **3. Meetings and Reporting**

The Bioethics Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

## Appendix 11B

### Bylaws Committee

#### 1. Composition

The Bylaws Committee shall include at least 3 active staff members, including the immediate past Chief of Staff, who serves as an ex-officio member. The members shall be broadly representative of the departments and sections.

#### 2. Duties

The duties of the Bylaws Committee include:

- a. Reviewing the Medical Staff Bylaws, Rules, and forms promulgated by the Medical Staff and its departments on an as-needed basis, but at least once every two years;
- b. Evaluating suggestions for modification of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its departments;
- c. Submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and
- d. Assuring that the Bylaws and Rules comply with applicable laws, regulations, and accreditation standards, and that they adequately and accurately describe the current structure of the Medical Staff, including, but not limited to:
  - 1) Establishing and enforcing criteria and standards for Medical Staff membership and clinical privileges, as well as the mechanisms for doing so;
  - 2) Establishing and enforcing clinical criteria and standards to oversee and manage quality improvement and assessment, utilization review, and other Medical Staff activities, including procedures for meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records; as well as procedures for evaluating and revising such activities;
  - 3) The mechanism for terminating Medical Staff membership;
  - 4) The fair hearing and appeal procedures;
  - 5) Provisions for assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff and in a manner that is consistent with the Hospital's nonprofit tax-exempt purposes;
  - 6) Provisions respecting the Medical Staff's ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and
  - 7) Provisions requiring a physical examination and medical history to be completed within the time frames established by state hospital licensing regulations and federal Medicare law.

### **3. Meetings and Reporting**

The committee will meet as requested by the Bylaws Committee Chair or Chief of Staff, but at least annually, and reports to the Medical Executive Committee.

## Appendix 11D

### Credentials/IDP Committee

#### 1. Composition

The Credentials Committee shall be composed of at least one active staff member from each department. It may include representatives from the Allied Health Staff, who only have voting rights for applications relating to AHPs.

#### 2. Duties

The duties of the Credentials Committee include:

- a. Following the process described in the Medical Staff Bylaws and other standards set forth in the Governing Documents, evaluating or coordinating the evaluation of the qualifications of all applicants for Medical Staff appointment, reappointment, or changes in staff categories.
- b. When requested, providing input into questions from Departments regarding the development of privileging criteria.
- c. Receiving recommendations from the Interdisciplinary Practice Committee regarding privileges for Advanced Practice Professionals.

#### 3. Meetings and Reporting

The Credentials Committee shall meet as often as necessary, but at least 10 times a year. The Committee shall report to the Medical Executive Committee.

## Appendix 11E

### Department Committees

#### 1. **Composition**

Each department shall have a committee consisting of at least three department members. Hospital employees, AHPs, and medical staff members who are not department members may be appointed as non-voting members.

#### 2. **Duties**

The Department Committees shall assist the Department Chair to carry out the responsibilities assigned to the Departments and the Department Chair under the Governing Documents.

#### 3. **Meetings and Reporting**

Each Department Committee shall meet as often as necessary, but at least quarterly. Department Committees shall report to the Medical Executive Committee.

## Appendix 11G

### Infection Prevention Committee

#### 1. Composition

- a. The Infection Prevention Committee shall be composed of [at least five active staff members, including one representative from each department and one physician whose primary specialty is infectious disease. In addition, the infection control officer, a nurse whose responsibilities primarily involve infectious disease, and the pharmacy director shall be voting members. The employee health nurse, a representative of nursing administration, the operating room supervisor, the director of central supply, and a representative of Hospital administration shall be ex officio members without vote.]
- b. [Representatives from housekeeping, laundry, dietetic services, and engineering and maintenance shall be invited to attend on a consultative and ad hoc basis].

#### 2. Duties

The Infection Prevention Committee shall:

- a. Develop and oversee the Hospital's infection prevention and control program and the staff's treatment of infectious disease.
- b. Engage in surveillance and review activities for the clinical use of antimicrobials at the Hospital.
- c. Evaluate, approve, and monitor surveillance activities.
- d. Approve action to prevent or control infections and the infection potential among patients and Hospital personnel.
- e. Review infections originating in the Hospital and evaluate ways to prevent or reduce the risk of future occurrence.
- f. Assure that the results of infection control studies and reviews are incorporated into the Hospital's educational programs and into the Hospital's quality assessment and improvement activities.
- g. Review and approve all policies and procedures relating to infection surveillance, prevention, and control activities throughout the Hospital at least once every two years.
- h. Work with administration to ensure that any facility improvement plans include current infection control principles.
- i. Ensure that the Hospital's prevention and control program links with external support systems and with communitywide agencies as they relate to reduction of risk from the environment.

- j. Ensure that appropriate resources are available for infection control activities.
- k. Have the Chair or his or her designee be available for on-the-spot interpretation of applicable infection prevention and control policies and rules.

### **3. Meetings and Reporting**

The Infection Control Committee shall meet as frequently as necessary, and at least quarterly. The Committee reports to the Medical Executive Committee.

## Appendix 11I

### Interdisciplinary Practice Committee

#### 1. Composition

The Interdisciplinary Practice Committee (IPC) shall be composed of the Chief Nursing Officer, the Chief Executive Officer or designee, an equal number of physician members and registered nurses appointed by the Chief Nursing Officer, [one or more clinical psychologists], and representatives of the other Advanced Practice Professional categories that are granted privileges at the Hospital. Each of these members are voting members.

#### 2. Duties

- a. Policies and Procedures. The IPC shall develop policies and procedures for the conduct of its business, including, but not limited to, the following:
  - 1) Provision for securing recommendations from the medical staff in the medical specialty or clinical field of practice under review, and from Advanced Practice Professionals who practice in the clinical field or specialty under review.
  - 2) Method for the approval of standardized procedures in accordance with statutory requirements, in which affirmative approval of the Chief Executive Officer and a majority of the physician members and a majority of the registered nurse members would be required, and that prior to such approval, consultation shall be obtained from medical staff and nurses in the medical and nursing specialties under review.
  - 3) Providing for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the medical staff for medical services in the facility.
  - 4) Intended line of approval for each recommendation of the Committee, which shall be consistent with the Governing Documents.
- b. Standardized Procedures. The IPC shall:
  - 1) Identify functions and/or procedures which require the formulation and adoption of standardized procedures under statutory law in order for them to be performed by registered nurses in the facility and initiate the preparation of such standardized procedures.
  - 2) Review and approve all such standardized procedures covering practice by registered nurses in the facility. Standardized procedures can be approved only after consultation with the relevant Medical Staff departments and by affirmative vote of the Chief Executive Officer and a majority of the physician members and a majority of the registered nurse members.
  - 3) Recommend policies and procedures for the authorization of employed registered nurses to perform the identified functions and/or procedures. These

policies and procedures may be administered by the IPC or by delegation to the Chief Nursing Officer.

c. Credentialing Allied Health Professionals. The IPC shall:

- 1) Recommend policies and procedures for expanded role privileges for registered nurses, assessing, planning and directing the patients' diagnostic and therapeutic care.
- 2) Review AHP applications and requests for privileges and forward its recommendations and the applications to the Medical Executive Committee.
- 3) Participate in AHP peer review and quality improvement. It may initiate corrective action when indicated against AHPs in accordance with these Rules or other guidelines governing AHPs.
- 4) Serve as liaison between AHPs and the Medical Staff.

d. Education

The IPC shall assure that appropriate ongoing educational programs are developed and implemented addressing issues of interest to the Allied Health Staff. It can achieve this by providing input to other committees responsible for continuing education development.

### **3. Meetings and Reporting**

The IPC shall meet as often as necessary.

## Appendix 11K

### Pharmacy and Therapeutics Committee

#### 1. Composition

The Pharmacy and Therapeutics Committee shall consist of at least one physician, the pharmacist director, the Chief Nursing Officer or designee, and the Chief Executive Officer or designee. The pharmacy director shall assume an active leadership role on the committee. Additional Medical Staff members and pharmacists may be appointed to reflect a broad range of services. All members are voting members.

#### 2. Duties

The Pharmacy and Therapeutics Committee shall:

- a. Develop written policies and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing, and use of drugs and chemicals.
- b. Develop and maintain a formulary of drugs for use throughout the Hospital to assure quality pharmaceuticals at reasonable costs.
- c. Review and, as appropriate, update the formulary as needed, and at least annually.
- d. Provide oversight for the medication management systems, including identifying risks and implementing processes to reduce risk and improve patient safety.
- e. Evaluate reports on medication errors that occur at the Hospital and make recommendations to reduce the occurrence of errors.
- f. Evaluate reports on adverse drug reactions and interactions that occur at the Hospital and make recommendations to reduce the occurrence of adverse drug reactions and interactions.
- g. Provide education to the Medical Staff and Hospital clinical staff about any changes in the formulary, medical management system, or policies and procedures, as well as on other topics determined appropriate by the Committee.

#### 3. Meetings and Reporting

The Pharmacy and Therapeutics Committee shall meet as frequently as necessary, and at least quarterly. The Committee reports to the Medical Executive Committee.

## Appendix 11L

### Professional Conduct Committee

#### 1. Composition

The Professional Conduct Committee shall consist of the Chief Medical Officer and at least three Medical Staff members (at least one whom should be a psychiatrist), and at least one additional representative of Hospital administration appointed by the Chief Executive Officer. All members are voting members.

#### 2. Duties

The Professional Conduct Committee shall:

- a. Monitor Practitioners' and AHP's compliance with the Medical Staff Standards of Conduct;
- b. Review incident reports involving Practitioner and AHP conduct;
- c. Meet with and counsel individuals who have been referred to the committee by self-referral or by referral from another committee or by a Medical Staff Leader
- d. Develop and monitor compliance with corrective action plans;
- e. Make recommendations to the Medical Executive Committee for administrative or disciplinary action whenever informal measures are insufficient or ineffective in addressing reported problems; and
- f. Perform whatever other tasks might be assigned to it by the Medical Executive Committee or in a Governing Document.

#### 3. Meetings and Reporting

The committee shall meet as often as necessary. The Committee reports to the Medical Executive Committee.

## Appendix 11M

### Quality Improvement Committee

#### 1. Composition

The Quality Improvement Committee shall consist of the Medical Staff Officers, Department Chairs, Infection Prevention Chair, Utilization Review Chair, the Director of Quality Improvement, Director of Risk Management, Director of Health Information, the Nursing Quality Improvement Liaison, and the Director of Pharmacy. All members are voting members. The Chair shall be the Vice Chief of Staff.

#### 2. Duties

The Quality Improvement Committee shall be responsible to provide leadership in measuring, assessing and improving medical care rendered in the Hospital including, but not limited to: oversight of Ongoing Professional Practice Evaluation activities to assess members' general competencies; medical assessment and treatment; use of medications; use of blood and blood components; operative and other procedures; efficiency of clinical practice patterns; monitoring significant departures from established clinical patterns; patient and family education; coordination of care with other health care professionals and Hospital personnel; the accurate, timely, legible and timely completion of patients' medical records; and compliance with developed criteria for autopsies. Subcommittees that report to the Quality Improvement Committee may be appointed as needed using the procedure described in the Medical Staff Bylaws. Additionally, on its own behalf or in concert with other Medical Staff or Department committees, the QIC can provide oversight to Focused Professional Practice Evaluations.

To meet these responsibilities, the QIC shall do the following.

##### a. Quality Improvement

- 1) Develop, review annually, and revise as needed, a quality improvement plan that is appropriate for the Hospital and Medical Staff and that meets accreditation and regulatory requirements. The quality improvement plan may include mechanisms for:
  - i. Establishing objective criteria;
  - ii. Measuring actual practice against the criteria;
  - iii. Analyzing practice variations from criteria by peers;
  - iv. Taking appropriate action to correct identified problems;
  - v. Following up on action taken; and
  - vi. Reporting the findings and results of the audit activity to the Medical Staff, the Chief Executive Officer, and the Governing Body.

- 2) Utilize at least sentinel event data and patient safety data in measuring and assessing performance improvement.
- 3) Review and act upon, on a regular basis, factors affecting the quality, appropriateness, and efficiency of patient care provided in the Hospital, including review of surgical and other invasive procedures; mortality; use of medications, including antibiotics; blood and blood components usage; admissions and continued hospitalization; and fulfillment of consultation requirements.
- 4) Coordinate the findings and results of department, committee, and staff patient care review activities; utilization review activities; continuing education activities; reviews of medical record completeness, timeliness, and clinical pertinence; and other staff activities designed to monitor patient care practices.
- 5) Submit monthly reports to the Medical Executive Committee on the overall quality, appropriateness, and efficiency of medical care provided in the Hospital, and on the department, committee, and staff patient care review, utilization review and other quality review, evaluation and monitoring activities.
- 6) Make recommendations to the committees responsible for continuing medical education for the development of appropriate educational programs.
- 7) On at least an annual basis, evaluate the coordination of patient care and formulate policy recommendations for dietary services, equipment standardization, home health, physical therapy and social services.
- 8) At least once a year, evaluate and revise as needed the Hospital-wide quality improvement program to assess the effectiveness of the monitoring and evaluation activities and recommend improvement.

**b. Surgical Case Review Duties**

Review the monthly review of all surgical cases, regardless of whether a tissue specimen was removed. All surgical cases must be reviewed, except that when surgical case review consistently supports the justification and appropriateness of surgical procedures performed by individual Practitioners, an adequate sample of cases may be reviewed. The review should address:

- 1) Selecting appropriate procedures;
- 2) Preparing the patient for the procedure;
- 3) Performing the procedure and monitoring the patient; and
- 4) Providing post-procedure care.

c. **Death and Tissue Review**

Review all cases involving deaths or removed tissue when the tissue is found to be normal or not consistent with the clinical diagnosis; develop and implement measures to correct any problems discovered.

d. **Blood and Blood Components Usage Review Duties**

- 1) Provide for at least a quarterly review of blood usage. This includes evaluating all or a sample of cases involving transfusion; all confirmed transfusion reactions; the adequacy of transfusion services in meeting patient needs; ordering practices; distributing, handling and dispensing, and administration of blood and blood components.
- 2) Review policies governing blood usage.

e. **Medical Records Function**

- 1) Provide for at least quarterly review of medical records for clinical pertinence and timely completion.
- 2) Provide for quarterly review by a multidisciplinary team (including Medical Staff members, nursing, health information management service staff and administration) of a sample of records to determine whether they reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and the condition of the patient at discharge.
- 3) Review summary reports concerning timely completion of medical records.
- 4) Approve a standardized medical record format and forms to be used in the record.
- 5) Recommend solutions for problems identified during review, and monitor effectiveness of these interventions.

**3. Meetings and Reporting**

The committee shall meet as needed, and at least quarterly. The Committee shall report to the Medical Executive Committee.

## Appendix 11N

### Utilization Review Committee

#### 1. Composition

The committee shall consist of sufficient members to afford, insofar as feasible, representation from major departments or sections. At a minimum, the committee shall include two physicians, and may include other Practitioners and health care professionals. Subcommittees may be established by the committee as it deems appropriate in a manner consistent with the Bylaws. The Director of Quality Improvement and the Utilization Review Coordinator shall serve as ex officio nonvoting members. Other committee members may be appointed, and subcommittees formed, as needed to carry out the Utilization Review Plan.

#### 2. Duties

The Utilization Review Committee shall perform the following functions:

##### a. General Duties

- 1) Reviews the Hospital's utilization review plan and acts in a manner consistent with the plan.
- 2) Oversees review of the medical necessity for admissions, duration of stays, and services furnished, including drugs and biologicals, as further described in the utilization review plan.
- 3) Addresses over-utilization, under-utilization, and inefficient scheduling and use of resources.
- 4) Follows patterns of care and recommends focused review as necessary.
- 5) Works toward maintaining proper continuity of care upon discharge.
- 6) Communicates pertinent data and results of review to the Medical Executive Committee.
- 7) Makes recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

##### b. Utilization Review Plan

The committee shall establish and follow a Utilization Review Plan, which shall be approved by the Medical Executive Committee and Governing Body and shall comply with applicable federal and state regulations.

##### c. Education

The committee shall assure that the overall results of utilization review activities are used to guide educational programs throughout the Hospital.

### **3. Meetings and Reporting**

The committee shall meet regularly, and at least as often as directed in the Utilization Review Plan. The Committee shall report to the Medical Executive Committee, and shall also report matters pertaining to quality improvement to the Quality Improvement Committee.

## Appendix 11O

### Well-Being Committee

#### 1. Composition

The Well-Being Committee shall be composed of no fewer than three active Medical Staff members, a majority of whom, including the Chair, shall be physicians, and one of whom should be a psychiatrist whenever possible. The committee also can include Advanced Practice Professionals (APPs) or registered nurses with insight or interest in wellbeing matters. Insofar as possible, members of this committee shall not actively participate on other peer review or Quality Improvement Committees while serving on this committee. The Chief of Staff, Chief Executive Officer, and the Chief Medical Officer shall not serve on the Wellbeing Committee.

#### 2. Duties

- a. The Well-Being Committee shall develop processes to educate Medical Staff Members and AHPs about Practitioner and APP health; to address prevention of physical, psychiatric, or emotional illness; and to facilitate confidential diagnosis, treatment and rehabilitation of Practitioners and APPs who suffer from a potentially impairing condition. At a minimum, these processes should include mechanisms for the following:
  - 1) Educating the Medical Staff and Hospital staff about illness and impairment recognition issues specific to health care professionals.
  - 2) Self-referral by a Practitioner or APP, as well as referral by others while maintaining informant confidentiality.
  - 3) Referral of the Practitioner or APP to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.
  - 4) Maintenance of confidentiality of the Practitioner or APP seeking referral or referred for assistance, except as limited by applicable law or ethical obligations, or when the health and safety of a patient is threatened.
  - 5) Evaluation of the credibility of a complaint, allegation, or concern.
  - 6) Monitoring the Practitioner or APP until the rehabilitation is complete and periodically thereafter, if warranted.
  - 7) Reporting to the Medical Executive Committee instances in which the Wellbeing Committee has concern that a Practitioner or APP cannot practice safely.
  - 8) Initiating appropriate actions, which may include reporting to the Medical Executive Committee, when a Practitioner or APP fails to complete the required rehabilitation program.
- b. The Well-Being Committee may be asked to review the responses from applicants concerning disabilities and recommend what, if any, reasonable accommodations may be

indicated in order to assure that the Practitioner or APP will provide care in accordance with the Hospital and Medical Staff's standard of care.

- c. The Well-Being Committee shall perform such other functions assigned by the Medical Executive Committee.

### **3. Meetings, Reporting and Minutes**

The committee shall meet as often as necessary, but at least quarterly. It shall maintain sufficient records of its proceedings to fulfill its responsibilities; it shall also evaluate and implement the measures necessary to assure appropriate confidentiality. The Committee shall report on its activities to the Medical Executive Committee but shall, with the Medical Executive Committee, develop standards regarding the circumstances under which information about individual Practitioners or APPs is reported.

## RULE 13

### ALLIED HEALTH PRACTITIONERS

#### 12.1 Definitions

The definitions of Allied Health Practitioner, Allied Health Staff, and Advanced Practice Professional, as found in the Medical Staff Bylaws, apply to this Rule. Those definitions are reproduced here; to the extent the reproduced definitions differ from the Medical Staff Bylaws definitions, the definitions in the Medical Staff Bylaws shall control.

**12.1.1** ALLIED HEALTH PRACTITIONER (“AHP”) means a health care professional, other than a physician, dentist, [clinical psychologist] or podiatrist, who holds a license or other legal credential, as required by California law, that: (a) permits the professional to provide health care services, and (b) has been designated by the Governing Body as a profession that is eligible for Allied Health Status. Allied Health Practitioners are ineligible for Medical Staff membership but are eligible for privileges if they are Advanced Practice Professionals, and for practice prerogatives if they are not Advanced Practice Professionals.

**12.1.2** ADVANCED PRACTICE PROFESSIONAL (“APP”) means an Allied Health Practitioner whose license or other legal credential permits the professional to provide health care services at a medical level of care, whether independently or under the supervision or order of a physician, podiatrist, dentist, or clinical psychologist. Advanced Practice Professionals are ineligible for Medical Staff membership, but are eligible for privileges.

**12.1.3** ALLIED HEALTH STAFF means: (a) those Allied Health Practitioners who are not employees of the Hospital, but have been granted privileges or practice prerogatives to provide certain clinical services, and (b) all Advanced Practice Professionals, whether employed by the Hospital or not, who have been granted privileges to provide certain clinical services. Allied Health Staff that are credentialed under this Rule are considered to hold “Allied Health Status.”

#### 12.2 Designation of Allied Health Practitioners

**12.2.1** The Governing Body shall designate which categories of professionals may practice at the Hospital as AHPs, and those categories shall be identified in this Rule.

**12.2.2** Any individual may request that a new category of professional be included in the AHP designation. At a minimum, the State of California must recognize the profession through a system of licensure, certification, or registration (as applicable) or, if California law does not require professionals in the profession to possess a license, a private certifying body of solid national reputation must provide a certification or accreditation.

**12.2.3** The request shall be submitted to the Medical Executive Committee, which may refer it to the Interdisciplinary Practice Committee for consideration. The Medical Executive Committee shall make a recommendation to the Governing Body regarding whether the category of professional should be included in the Allied Health Staff.

- 12.2.4** At a minimum, the Medical Executive Committee and the Governing Body shall consider the following:
- a. Any applicable statutory licensing provisions delineating the scope of practice and prescribed mechanisms for governmental oversight (e.g. California Business and Professions Code; California Code of Regulations), or, if California law does not require professionals in the profession to possess a license, a copy of the standards of the private certifying body of solid national reputation.
  - b. Evidence that the new category will improve access to, or quality of care at, the Hospital.
  - c. The effect of the professional on patient charges.
  - d. Whether the Hospital and Medical Staff can provide necessary oversight and supervision.
- 12.2.5** The following categories of professionals have been designated as Advanced Practice Professionals eligible for Allied Health Status and privileges:
- a.
  - b.
- 12.2.6** The following categories of non-APP professionals have been designated as eligible for Allied Health Status and privileges, but do not include those persons who are employed by the Hospital:
- a. Nurse Anesthetists
  - b. Nurse Practitioners
  - c. Physician Assistants

### **12.3 Supervising Practitioner**

- 12.3.1** Except for clinical psychologists, all AHPs who apply for Allied Health Status must identify a Medical Staff member as a supervising practitioner. The supervising practitioner either must be the AHP's employer; have a contractual agreement with the AHP or the AHP's employer for supervision of the AHP's clinical tasks or functions; or work for the same medical corporation or licensed entity as the AHP, and supervision of the AHP is part of the Practitioner's job duties.
- 12.3.2** A supervising practitioner or group which employs or contracts with the AHP agrees to indemnify the Hospital against any expense, loss, or adverse judgment it may incur either as a result of allowing an AHP to practice at the Hospital, or as a result of denying or terminating the AHP's privileges.

- 12.3.3 The supervising practitioner shall assure that the AHP complies with the Governing Documents.
- 12.3.4 Supervising practitioners and the AHPs they supervise are responsible for ensuring that the AHP complies with the direction and/or supervision requirements detailed in the standardized procedures, delegation of services agreement, practice protocols, and/or Governing Documents, as applicable.
- 12.3.5 A supervising practitioner's failure to supervise an AHP in a manner consistent with the standardized procedures, practice agreement, practice protocols, or Governing Documents, as applicable, shall be grounds for corrective action against the supervising practitioner.

## 12.4 Credentialing Required

- 12.4.1 All AHPs who (a) are not employees of, or contractors with, the Hospital, but have been granted privileges or practice prerogatives to provide certain clinical services, and (b) are Advanced Practice Professionals, whether employed by the Hospital or not, and have been granted privileges to provide certain clinical services as defined in the Medical Staff Bylaws, must be credentialed through the process described in this Rule, appointed to the Allied Health Staff, and granted privileges or practice prerogatives by the Governing Body before they can practice at the Hospital. These AHPs may only practice those privileges or practice prerogatives granted by the Governing Body pursuant to this Rule.
- 12.4.2 The Medical Staff Bylaws provisions regarding "General Qualifications," "Additional Qualifications," "General Responsibilities," and "Conduct Expectations," as well as each of the Rules in this document, apply to all AHPs who apply to the Allied Health Staff and/or who are granted privileges or practice prerogatives, as those provisions and Rules might reasonably be applied to AHPs.
- 12.4.3 The Medical Staff shall develop an application form that, at a minimum, will include the content included in the application for Medical Staff Membership and Privileges.
- 12.4.4 Each Department shall develop appropriate forms delineating the criteria required for privileges and practice prerogatives for the AHPs who practice in their Departments. For criteria that apply to advanced practice nurses, the Departments shall work with the Interdisciplinary Practice Committee in developing these criteria. All criteria shall be subject to approval by the Medical Executive Committee and the Governing Body.
- 12.4.5 Unless the AHP is an employee of the Hospital:
  - a. An AHP is not an agent of the Hospital or Medical Staff, and neither the AHP, nor the AHP's supervising practitioner, shall claim that the AHP is the Hospital's agent.
  - b. The Hospital shall have no obligation to, or responsibility for, paying an AHP or for complying with any relevant employment laws, including federal and state income tax withholding laws, overtime laws, and workers' compensation insurance coverage laws.

## **12.5 Credentialing Process**

**12.5.1** Except as otherwise provided in these Rules, all the provisions in the Procedures for Appointment and Reappointment Article and the Privilege Delineation Article of the Medical Staff Bylaws apply to AHPs, to the extent that such processes reasonably apply to AHPs, including, but not limited to, provisions regarding “Burdens of Applicants,” “Waiting Periods,” “System Credentialing,” “Processing of Telemedicine Privileges,” “Effect of Contracted Services,” “Temporary Privileges,” “Disaster Privileges,” and “Emergency Privileges.”

**12.5.2** AHPs shall be credentialed in the manner described in the Procedures for Appointment and Reappointment Article and the Privilege Delineation Article of the Medical Staff Bylaws, to the extent that such processes reasonably apply to AHPs, except that the Interdisciplinary Practice Committee shall perform the role of the Credentials Committee [for certified registered nurse anesthetists, certified registered nurse midwives, nurse practitioners, and registered nurse first assistants], and shall make a recommendation to the Medical Executive Committee.

## **12.6 Nature of Allied Health Staff Membership**

**12.6.1** All AHPs initially shall be appointed to a provisional status for at least 12 months. Advancement from the provisional status is based on whether the AHP fulfills any applicable focused professional practice evaluation requirements or, if no focused professional practice evaluation requirements exist, as determined by the department in which the AHP is assigned, the Interdisciplinary Practice Committee (when its review is necessary for the privileges), the Medical Executive Committee, and the Governing Body.

**12.6.2** Appointments, reappointments, and the grant of clinical privileges or practice prerogatives shall be for a maximum of two years and shall not be extended beyond two years. No AHP has the right to a two-year appointment, and appointments may be for periods less than two years.

**12.6.3** The Medical Executive Committee may assess dues for AHPs. Those dues shall be considered Medical Staff funds.

**12.6.4** AHPs may be appointed to Medical Staff Committees in the manner described in the Medical Staff Bylaws or as detailed in these Rules.

## **12.7 Performance Evaluations, Investigations, and Corrective Action**

### **12.7.1 Employed APPs**

Employed APPs are subject both to the processes described below in this Rule, and to the Hospital’s employment policies and disciplinary procedures, separate and apart from any Medical Staff process.

### **12.7.2 Performance Evaluations**

APPs shall be subject to the Practitioner Performance Evaluations Article of the Medical Staff Bylaws. All other AHPs shall be subject to performance evaluation processes developed by their respective Departments and approved by the Medical Executive Committee and the Governing Body.

### 12.7.3 Investigations

- a. APPs shall be subject to the Investigation Article of the Medical Staff Bylaws.
- b. Non-APP AHPs may be investigated on the same grounds as described in the Investigation Article of the Medical Staff Bylaws; however, the investigation may be authorized by the Department, the Interdisciplinary Practice Committee, or the Medical Executive Committee. The committee that authorizes the investigation shall use the Investigation Article of the Medical Staff Bylaws as a guide for performing a fair and thorough investigation but is not bound by that process. The investigatory body shall, at a minimum:
  1. Provide the AHP the opportunity to provide information to the body in a manner that the investigatory body determines appropriate.
  2. Report its findings to the Medical Executive Committee.

### 12.7.4 Corrective Action

- a. By accepting Allied Health Staff status and/or privileges or other practice prerogatives, the AHP accepts the Medical Staff's authority to recommend and/or impose corrective action pursuant to this Rule. Each AHP agrees that he or she will comply with any requirements imposed on the AHP as corrective action once that action is considered a final action or if the action is a summary action. Failure to comply with the requirements of corrective final actions or summary actions shall, in and of itself, be grounds for additional corrective action, including termination of Allied Health Staff status and/or privileges or other practice prerogatives. Invoking the processes in this Rule to challenge corrective actions shall not be considered a failure to comply with any corrective action requirement, and no AHP shall be penalized for asserting those rights.
- b. The Medical Executive Committee; the Chief of Staff, the Chair of the AHP's Department, the Chair of the Interdisciplinary Practice Committee, the Chief Executive Officer, or the Governing Body may impose non-summary corrective action on an AHP on the grounds that the AHP has done something that is reasonable likely to have been, or to be:
  1. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;
  2. Unethical or illegal;
  3. Contrary to the Medical Staff Governing Documents;

4. Intimidating or harassing to staff, colleagues, patients, or other persons at the Hospital;
  5. Below applicable professional standards;
  6. Disruptive of Medical Staff or Hospital operations; or
  7. An improper use of Hospital resources.
- c. AHPs shall be given notice of the corrective action and a brief description of the reasons for the action.
  - d. Non-restrictive corrective actions are effective upon imposition; restrictive corrective actions are effective upon approval by the Governing Body. Except as applies to clinical psychologists, marriage and family therapists, and clinical social workers, the Governing Body may consider and act upon a corrective action recommendation prior to the exhaustion of any hearing rights.
  - e. AHPs are subject to the “Automatic Suspension, Termination, and Limitation” provisions of the Corrective Action Article of the Medical Staff Bylaws. Additionally, AHPs shall be subject to an automatic suspension if the supervising practitioner’s Medical Staff membership or privileges terminate or are suspended, or if the supervising practitioner declines to continue supervision. In such cases, the AHP shall remain on suspension until the supervising practitioner is no longer subject to suspension, until another supervising practitioner is identified, or until the AHP accumulates sufficient suspension days to result in an automatic termination, whichever occurs first.
  - f. The Medical Executive Committee, the Chief of Staff, the Chair of the AHP’s Department, the Chair of the Interdisciplinary Practice Committee, the Chief Executive Officer, the Chief Medical Officer, or any officer of the Governing Body may impose a summary restriction or suspension on any AHP, other than a clinical psychologist, marriage and family therapist, or clinical social worker, whenever any of those individuals or bodies determine that such action is necessary.
  - g. Summary action may be imposed on a clinical psychologist, marriage and family therapist, or clinical social worker only in compliance with the standards described in the Summary Action provisions of the Corrective Action Article of the Medical Staff Bylaws.

## 12.8 Challenging Corrective Actions

### 12.8.1 General Rules

- a. If a process to challenge a corrective action is available, the AHP must exhaust that process before resorting to legal action.
- b. Technical, non-prejudicial, or insubstantial deviations from the procedures set forth in this Rule shall not be grounds for invalidating the action taken.

- c. No AHP is entitled to the hearing and appeals provisions found in the Hearings and Appeals Article of the Medical Staff Bylaws, except as provided below.
- d. An employed APP who is disciplined through the Hospital's employment processes, including, but not limited to, termination, is not entitled to challenge that action through the hearing processes described in this Rule. This includes actions the Hospital takes that would, if taken by the Medical Staff, entitle the APP to the hearing process in this Rule.

#### 12.8.2 Advanced Practice Professional

- a. Clinical psychologists, marriage and family therapists, and clinical social workers are subject to the Hearings and Appeals Article of the Medical Staff Bylaws.
- b. All other APPs are entitled to the following limited hearing process:
  - 1. Only adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges are grounds for a limited hearing, and only if those decisions (a) involve a medical disciplinary cause or reason, and (b) would affect the APP's privileges for more than 30 days.
  - 2. The body that imposes the corrective action shall provide notice to the APP of the action and a brief description of the reasons for the action. The notice shall inform the APP that he or she may request a limited hearing under this Rule and that such request must be received by the Medical Staff Services Administration within 15 days of the notice. A copy of this Rule shall be included.
  - 3. If the APP timely requests a limited hearing, the Chief of Staff shall create an ad hoc committee consisting of at least three members in good standing of the Medical Staff or Allied Health Staff, at least one of which shall, if feasible, have the same licensure as the APP who requested the hearing. If it is not feasible to appoint ad hoc committee members from within the staff, the Chief of Staff may select Practitioners or AHPs from outside the Hospital as long as they sign confidentiality and business associate agreements and the Hospital's legal counsel is informed. The members of the ad hoc committee shall be impartial and not have participated in the process that led to the corrective action. Knowledge of the action does not disqualify anyone from serving on the ad hoc committee. The Chief of Staff also shall appoint a hearing officer, which may, but is not required to, meet the qualifications of a Hearing Officer under the Hearings and Appeals Article of the Medical Staff Bylaws.
  - 4. At least 45 days prior to the limited hearing, the Chief of Staff shall provide the APP with the following:
    - i. Notice of the date, time, and place for the limited hearing;
    - ii. The names of the ad hoc committee members;

- iii. A brief description of the acts and omissions that led to the corrective action, including a list of medical records, if applicable; and
    - iv. A copy of any witness statements or other documents the Medical Staff intends to rely on at the limited hearing (except for any documents that may be used for rebuttal).
  5. At least 30 days prior to the limited hearing, the APP must provide the Medical Staff with a copy of any witness statements or other documents the APP intends to rely on at the limited hearing. Failure to do so shall give the Medical Staff the right to move to exclude such statements or documents from the limited hearing.
  6. The following hearing procedures shall be followed:
    - i. Neither party shall be represented by an attorney at the limited hearing; however, each party may be represented by a Medical Staff member or Allied Health Staff member of his or her choosing.
    - ii. Both parties may submit a written statement to the ad hoc committee prior to the limited hearing, subject to any limits that the ad hoc committee may impose. Such statements must be submitted at least 10 days before the hearing, with a copy to the other party.
    - iii. No witnesses shall be presented at the limited hearing. The APP and a representative of the Medical Staff are entitled to make oral statements to the ad hoc committee, subject to any limits the ad hoc committee may impose. All other information provided to the ad hoc committee shall be in the form of documents or written witness statements. The ad hoc committee may question the APP and the Medical Staff representative.
    - iv. The limited hearing shall be recorded by a court reporter or by minutes, as determined by the Medical Staff. The cost of any court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the requesting party. The APP is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record.
    - v. The APP shall have the burden of demonstrating to the ad hoc committee by a preponderance of the evidence that the corrective action is not reasonable and warranted.
    - vi. After the limited hearing with the ad hoc committee, the committee shall determine whether or not the APP met his or her burden. Within 15 days after the limited hearing, the ad hoc committee shall issue a report stating, at a minimum, its factual

findings and its conclusion. The ad hoc committee shall submit its report to the Medical Executive Committee and the APP.

- vii. Either party may appeal the decision to the Governing Body within 15 days after receiving the ad hoc committee's report. The appeal will be through written statements; the Governing Body may, in its discretion, permit the parties to present oral statements in front of the Governing Body as well. All presentations, written and oral, shall be subject to the limits and deadlines the Governing Body sets. Giving great weight to the ad hoc committee's report, the Governing Body shall exercise its independent judgment in making a final decision. The Governing Body's decision on the appeal shall be final.
- viii. If no party appeals, the Governing Body, giving great weight to the ad hoc committee's report, shall exercise its independent judgment in making a final decision.

### 12.8.3 All Other AHPs

AHPs that are not APPs are not entitled to any form of hearing. They shall, however, be entitled to present a written statement to the Governing Body, care of the Chief Executive Officer, challenging a corrective action that restricts practice prerogatives for more than 30 days, other than automatic restrictions and terminations. The statement must be received within 30 days of the AHP receiving notice of the action. The AHP must send a copy of the written statement to the Chief of Staff at the same time it submits the statement to the Governing Body. The Medical Staff may respond in writing by submitting its own statement to the Governing Body, with a copy to the AHP, within 30 days of receiving the AHP's statement. The Governing Body may elect, at its discretion, to interview the AHP and a Medical Staff representative. The Governing Body's decision on the corrective action is final.