EL CENTRO REGIONAL MEDICAL CENTER
BOARD OF TRUSTEES – REGULAR MEETING

MONDAY, January 26, 2026
5:30 PM

MOB CONFERENCE ROOM 1&2
1271 ROSS AVENUE, EL CENTRO, CA
&

TELECONFERENCE LOCATION *NOTE: Pursuant to Government Code Section 54953(b) Trustee Patty Maysent- CEO, UCSD Health will be attending the Regular Meeting via teleconference from:*

JACOBS MEDICAL CENTER, Suite 1-620
9300 CAMPUS POINT DR.
SAN DIEGO, CA 92037

ACTING-PRESIDENT: Sylvia Marroquin
MEMBERS: Sonia Carter; Claudia Camarena; Marty Ellett; Michael Crankshaw; Patty Maysent-CEO, UCSD Health; Christian Tomaszewski-M.D.-CMO, UCSD; Pablo Velez-CEO ECRMC

***CLERK**: Belen Gonzalez* ***ATTORNEY**: Douglas Habig, ECRMC Attorney*

This is a public meeting. If you are attending in person, and there is an item on the agenda on which you wish to be heard, please come forward to the microphone. Address yourself to the president. You may be asked to complete a speaker slip; while persons wishing to address the Board are not required to identify themselves (Gov't. Code § 54953.3), this information assists the Board by ensuring that all persons wishing to address the Board are recognized and it assists the Board Executive Secretary in preparing the Board meeting minutes. The president reserves the right to place a time limit on each person asking to be heard. If you wish to address the board concerning any other matter within the board's jurisdiction, you may do so during the public comment portion of the agenda.

BOARD MEMBERS, STAFF AND THE PUBLIC MAY ATTEND VIA ZOOM.
To participate and make a public comment in person, via Zoom or telephone, please raise your hand, speak up and introduce yourself.

Join Zoom Meeting: https://ecrmc.zoom.us/j/89867392545?pwd=aJVPdYjbdbe97ii2Tzt7SOiXXanOzR.1
Optional dial-in number: (669) 444-9171
Meeting ID: 898 6739 2545 **Passcode:** 347853

Public comments via zoom are subject to the same time limits as those in person.

OPEN SESSION AGENDA

ROLL CALL:

PLEDGE OF ALLEGIANCE:

PUBLIC COMMENTS: Any member of the public wishing to address the Board concerning matters within its jurisdiction may do so at this time. Three minutes is allowed per speaker with a cumulative total of 15 minutes per group, which time may be extended by the President. Additional information regarding the format for public comments may be provided at the meeting.

BOARD MEMBER COMMENTS:

CONSENT AGENDA: *(Items 1)*
All items appearing here will be acted upon for approval by one motion, without discussion. Should any Board member or other person request that any item be considered separately, that item will be taken up at a time as determined by the President.

1. Review and Approval of Board of Trustees Minutes of Regular Meeting of December 18, 2025

CHIEF EXECUTIVE OFFICER UPDATE

2. Verbal Report from the CEO to the Board of Trustees—**Informational**

3. Manager Update—Patty Maysent—**Informational**

NEW BUSINESS

4. Review and Approval of the IVHD Medical Staff Bylaws.

5. Review and Approval of the Medical Staff General Rules and Regulations Amendments.

FINANCE and OPERATIONAL UPDATE

6. Review and Approval of the Financial Statements for Month and Year-to-Date as of December 2025.

RECESS TO CLOSED SESSION – BOARD PRESIDENT

A. HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES. The Hospital Board will recess to closed session pursuant to Government Code Section 37624.3 for a hearing and/or deliberations concerning reports of the ___ hospital medical audit committee, or _X_ quality assurance committees, or _X_ staff privileges.

B. **TRADE SECRETS.** The Hospital Board will recess to closed session pursuant to Govt. Code Section 37606(b) for the purpose of discussion and/or deliberation of reports involving hospital trade secret(s) as defined in subdivision (d) of Section 3426.1 of the Civil Code and which is necessary, and would, if prematurely disclosed create a substantial probability of depriving the hospital of a substantial economic benefit:

Discussion of:	Number of Items:
_X_ hospital service;	1
_X_ program;	1
_X_ hospital facility	1

C. CONFERENCE WITH LEGAL COUNSEL. The Hospital Board will recess to closed session pursuant to Government Code Section 54956.9 (d)(1).

RECONVENE TO OPEN SESSION – BOARD PRESIDENT

ANNOUNCEMENT OF CLOSED SESSION ACTIONS, IF ANY – GENERAL COUNSEL

7. Approval of Report of Medical Executive Committee's Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff *(Approved in Closed Session)*

ADJOURNMENT: Adjourn. (Time:) Subject to additions, deletions, or changes.

El Centro Regional Medical Center
BOARD OF TRUSTEES – REGULAR MINUTES
OPEN SESSION MINUTES
MOB CONFERENCE ROOMS 1 & 2
1271 Ross Avenue, El Centro, CA 92243
Zoom Meeting link: https://ecrmc.zoom.us/j/89424719823?pwd=UUC3kyF1uAVxqhEQoY2r4cbCQ4RbQ4.1

Thursday, December 18, 2025

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
ROLL CALL	**PRESENT**: Marroquin; Carter; Ellett; Crankshaw;); Chief Executive Officer Pablo Velez; and Executive Board Secretary Belen Gonzalez **ABSENT:** Camarena; Tomaszewski; **VIA Zoom:** Maysent; City of El Centro Attorney Elizabeth Martyn; UCSD Tammy Morita; Chief of Staff Andrew Lafree, MD *(left @5:55pm*); **ALSO PRESENT:** ECRMC Attorney Douglas Habig; ECRMC **Hospital Administrative Staff:** David Momberg-CFO; Seung Gwon, MD-CMO	
CALL TO ORDER		The Board of Trustees convened in open session at 5:37 p.m. Acting Board President Marroquin called the meeting to order.
OPENING CEREMONY	The Pledge of Allegiance was recited in unison.	None

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
NOTICE OF MEETING	Notice of meeting was posted and mailed consistent with legal requirements.	None
PUBLIC COMMENTS	None	None
BOARD MEMBER COMMENTS	None	None
CONSENT AGENDA *(Item 1)* **Item 1. Review and Approval of Board of Trustees Minutes of Regular Meeting of November 24, 2025**	All items appearing here were acted upon for approval by one motion (or as to information reports, acknowledged receipt by the Board and directed to be appropriately filed) without discussion.	MOTION: by, Carter, second by Ellett and carried to approve the Consent Agenda. All present in favor; none opposed.
CHIEF EXECUTIVE OFFICER UPDATE **Item 2. Verbal Report from the CEO to the Board of Trustees—Informational**	Item to be discussed in Closed Session	Informational
Item 3. Manager Update—Patty Maysent—Informational	Item to be discussed in Closed Session	Informational.
NEW BUSINESS **Item 4. Review and Approval of the Retirement Income Plan—Amendment, Restatement, and Freeze Plan.** • **RESOLUTION NO. 25-04—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT OF THE EL CENTRO REGIONAL**	General Counsel, Douglas Habig presented the item resolutions and explained the purpose of each resolution: • Resolution No. 25-04—Restatement of the plan updates and implements the technical corrections required to bring the Plan into full compliance, and authorizes the CEO to execute the Restatement. • Resolution No. 25-05—approves an amendment to the Plan that freezes the Plan and transfers sponsorship of the Plan to IVHD.	MOTION: by Ellett, second by Carter and carried to approve the RESOLUTION NO. 25-04—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT OF THE EL CENTRO REGIONAL MEDICAL CENTER RETIREMENT INCOME PLAN All present in favor; none opposed. Crankshaw abstained. MOTION: by Ellett, second by Marroquin and carried to approve the RESOLUTION NO.

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
MEDICAL CENTER RETIREMENT INCOME PLAN • **RESOLUTION NO. 25-05—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE AMENDMENT TO THE EL CENTRO REGIONAL MEDICAL CENTER RETIREMENT INCOME PLAN TO FREEZE BENEFIT ACCRURALS AND TRANSFER SPONSORSHIP TO THE IMPERIAL VALLEY HEALTHCARE DISTRICT**	• Both resolutions to be effective at the time of closing the transaction. The Board of Trustees considered each resolution listed under this agenda item individually, and a separate vote was taken on each.	25-05—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE AMENDMENT TO THE EL CENTRO REGIONAL MEDICAL CENTER RETIREMENT INCOME PLAN TO FREEZE BENEFIT ACCRURALS AND TRANSFER SPONSORSHIP TO THE IMPERIAL VALLEY HEALTHCARE DISTRICT All present in favor; none opposed. Crankshaw abstained.
Item 5. Review and Approval of the Benefits Plan (401 (a); 457 (b); Medical Plan; and Flexible Benefits Plan) Adoption Agreements, Plan Documents and Termination Amendments • **RESOLUTION NO. 25-06—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT, AMENDMENT, AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION PLAN** • **RESOLUTION NO. 25-07—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL**	General Counsel, Douglas Habig presented the item resolutions and explained the purpose of each resolution: • Resolution No. 25-06—approves the restated Adoption Agreement, Basic Plan Document and Termination Amendment for the 401(a) Plan, which update and implement the technical corrections required to bring the Plan into full compliance, terminates the 401(a) Plan effective immediately prior to closing, and authorizes the CEO to execute all necessary documents. • Resolution No. 25-07—approves the restated Adoption Agreement, Basic Plan Document and Termination Amendment for the 457(b) Plan, which update and implement the technical corrections required to bring the Plan into full compliance, terminates the 457(b) Plan effective immediately prior to closing, and authorizes the CEO to execute all necessary documents.	MOTION: by Ellett, second by Carter and carried to approve the RESOLUTION NO. 25-06—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT, AMENDMENT, AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER DEFINED CONTRIBUTION PLAN All present in favor; none opposed. Crankshaw abstained. MOTION: by Ellett, second by Marroquin and carried to approve the RESOLUTION NO. 25-07—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT, AMENDMENT, AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER DEFERRED COMPENSATION PLAN • **RESOLUTION NO. 25-08—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER EMPLOYEE BENEFIT PLAN** • **RESOLUTION NO. 25-09—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER FLEXIBLE BENEFITS PLAN**	• Resolution No. 25-08—approves the restated Plan Document and Summary Plan Description for the Medical Plan to evidence its formal adoption, terminates the Medical Plan effective immediately prior to closing and authorizes the CEO to execute all necessary documents • Resolution No. 25-09—approves the restated Plan Document for the Flexible Benefits Plan, which evidences its formal adoption and updates and implements any changes required to bring the Plan into full compliance, terminates the Flexible Benefits Plan effective immediately prior to closing and authorizes the CEO to execute all necessary documents The Board of Trustees considered each resolution listed under this agenda item individually, and a separate vote was taken on each.	APPROVING THE RESTATEMENT, AMENDMENT, AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER DEFERRED COMPENSATION PLAN All present in favor; none opposed. Crankshaw abstained. MOTION: by Ellett, second by Marroquin and carried to approve the RESOLUTION NO. 25-08—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER EMPLOYEE BENEFIT PLAN All present in favor; none opposed. Crankshaw abstained. MOTION: by Carter, second by Ellett and carried to approve the RESOLUTION NO. 25-09—A RESOLUTION OF THE EL CENTRO REGIONAL MEDICAL CENTER BOARD OF TRUSTEES APPROVING THE RESTATEMENT AND TERMINATION OF THE EL CENTRO REGIONAL MEDICAL CENTER FLEXIBLE BENEFITS PLAN

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
		All present in favor; none opposed. Crankshaw abstained.
FINANCE and OPERATIONAL UPDATE **Item 6. Review and Approval of the Financial Statements for Month and Year-to-Date as of November 2025.**	David Momberg presented the Financial Statements for Month and Year-to-Date as of November 2025 report and answered questions. Presentation included: • Comparative volumes vs. Prior Month/Year • Balance Sheet vs. Prior Month comparison • Operating Statement vs. Prior Month comparison • Monthly Cash Flow (Fiscal Year to Date)	MOTION: by Crankshaw, second by Marroquin and carried to approve the Financial Statements for Month and Year-to-Date as of November 2025. All present in favor; none opposed.
RECESS TO CLOSED SESSION		MOTION: by Ellett, second by Carter and carried to recess to Closed Session at 6:44pm for HEARING/ DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES and TRADE SECRETS. All present in favor to recess to Closed Session. None opposed
RECONVENE TO OPEN SESSION		The Board of Trustees reconvened to Open Session at 7:36pm.
ANNOUNCEMENT OF CLOSED SESSION ACTIONS, IF ANY—GENERAL COUNSEL		[**A. HEARING/DELIBERATIONS RE MEDICAL QUALITY COMMITTEE REPORTS/STAFF PRIVILEGES—GOVERNMENT CODE SECTION 37624.3**]

TOPIC	DISCUSSION/CONCLUSION	RECOMMENDATION/ACTION
		MOTION: by, Ellett second by Carter and carried to approve the Report of Medical Executive Committee's Credentials Recommendations Report for Appointments, Reappointments, Resignations and Other Credentialing/Privileging Actions of Medical Staff and/or AHP Staff. All present in favor; none opposed.
ADJOURNMENT		There being no further business, meeting was adjourned at approximately 7:37 pm.

BELEN GONZALEZ, BOARD EXECUTIVE SECRETARY

APPROVED BY

SYLVIA MARROQUIN, ACTING-BOARD PRESIDENT

OPEN SESSION

TO: HOSPITAL BOARD MEMBERS

FROM: Andrew LaFree, M.D., Chief of Staff

DATE: January 26, 2026

MEETING: Board of Trustees

SUBJECT: **IVHD MEDICAL STAFF BYLAWS**

BUDGET IMPACT: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _____

BACKGROUND: The proposed amended ECRMC Medical Staff Bylaws, now called **IVHD Medical Staff Bylaws**, were approved by the organized medical staff, voting members, on January 9, 2026, and are now presented for consideration and approval by the Board of Trustees.

DISCUSSION: These proposed medical staff bylaws are a consolidation of El Centro Regional Medical Center and Pioneers Hospital Medical Staff Bylaws. The Bylaws committees of both hospitals, with their approved medical staff attorney, jointly reviewed, deliberated, and agreed to achieve this final document.

RECOMMENDATION: (1) Approve (2) Do not approve

ATTACHMENT(S):

- Proposed IVHD Medical Staff Bylaws

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Valdez

ARTICLE I PURPOSES AND TERMS

1.1 Purpose

These bylaws are adopted in recognition of the interdependence and the responsibility of the Medical Staff, Administration, and the Board of Trustees to provide for the organization of the medical staff of the Imperial Valley Healthcare District and to provide a framework for self- government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the board of trustee, and relations with applicants to members of the medical staff. The organized medical staff both enforces and complies with these medical staff bylaws.

These bylaws recognize that the organized medical staff has the authority to establish and maintain patient care standards, including full participation in the development of hospital- wide policy, involving the oversight of care, treatment, and services provided by members and others in the hospital. The medical staff is involved with all aspects of delivery of health care within the hospital including, but not limited to, the treatment and services delivered by practitioners credentialed and privileged through the mechanisms described in these bylaws and the functions of credentialing and peer review.

These bylaws acknowledge that the provision of quality medical care in the hospital depends on the mutual accountability, interdependence, and responsibility of the medical staff and the hospital governing board for the proper performance of their respective obligations. To that end, the Medical Staff acknowledges that the Board of Trustees must act to protect the quality of medical care provided and the competency of the Medical Staff, and to ensure the responsible governance of the hospital. In adopting these Bylaws, the Medical Staff commits to exercise its responsibilities with diligence and good faith, and in approving these Bylaws, the Board of Trustees commits to supporting the Medical Staffs self- governance and independence in conducting the affairs of the Medical Staff. Accordingly, the Board of Trustees will not assume a duty or responsibility of the Medical Staff precipitously, unreasonably, or in bad faith; and will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill a substantive duty or responsibility in matters pertaining to the quality of patient care.

These bylaws are being adopted by the medical staff of Pioneers Memorial Hospital and El Centro Regional Medical Center to be effective concurrent with the merger of the Pioneers Memorial Hospital and El Centro Regional Medical Center.

1.2 Terms (Definitions)

1.2-1 **ADMINISTRATOR/CEO** means the person appointed by the Board of Trustees to serve in an administrative capacity.

1.2-2 **ALLIED HEALTH PROFESSIONAL / ADVANCED PRACTICE PROVIDER (AHP/APP/APP)** means an individual other than a licensed physician, dentist, clinical psychologist or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Board of Trustees, the Medical Staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical, dental, psychological, or podiatric care under the supervision or direction of a Medical Staff member possessing privileges to provide such care in the hospital and who may be eligible to exercise privileges and prerogatives in conformity with the policies adopted by the Medical Staff and Governing Body, these Bylaws and the Rules. AHP/APPs are not eligible for Medical Staff membership.

1.2-3 **AUTHORIZED REPRESENTATIVE or HOSPITAL'S AUTHORIZED REPRESENTATIVE** means the individual designated by the hospital and approved by the Medical Executive Committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these Bylaws.

1.2-4 **BOARD OF TRUSTEES** means the governing body of the hospital.

1.2-5 **CHIEF MEDICAL OFFICER** means a physician or surgeon employed by the Imperial Valley Healthcare District to provide necessary administrative support for the medical staff, communicate the views of the hospital administration to the medical staff, and serve as a liaison between the medical staff and the administration on particular issues. This position (standing alone) does not entitle its holder to vote on any matters of the medical staff or committee of the medical staff.

The CMO shall provide guidance to the Medical Staff as needed with respect to hospital-related clinical affairs, quality, credentialing and strategic planning, and provided support to the Medical Staff with respect to clinical performance evaluation, in particular, OPPE and FPPE. Further, the CMO will participate as a member of the Imperial Valley Healthcare District Board of Trustees in considering and making determinations based upon the Medical Staff's recommendations with regard to credentialing.

The CMO shall support the Medical Staff in performing its peer review functions by identifying possible candidates for investigation and providing other assistance as requested by the Medical Staff, consistent with the Medical Staff Bylaws and California peer review statutes and regulations. As a member of the Imperial Valley Healthcare District Board, the CMO is not eligible to participate in peer review hearings as a member of the hearing panel.

1.2-6 **CHIEF OF STAFF** means the chief officer of the medical staff elected by members of the medical staff.

1.2-7 **CLINICAL PRIVILEGES or PRIVILEGES** means the permission granted to medical staff members and allied health practitioners to provide patient care at the Hospital or any of its facilities, and including reasonable access to those hospital resources (including equipment, facilities and hospital personnel) which are necessary to effectively exercise those privileges.

1.2-8 **HOSPITA**L means each of the hospitals, medical centers, clinics, and other facilities that provide patient care services by providers credentialed by this medical staff as part of the Imperial Valley Healthcare District. The foregoing includes but is not limited to the facilities previously licensed to Pioneers Memorial Hospital and El Centro Regional Medical Center.

1.2-9 **IN GOOD STANDING** means a member who is not currently on suspension for a reason other than delinquent medical records, has no pending Medical Staff recommendation or action which is cause for requesting a Medical Staff hearing, and no disciplinary action in effect for which the member was entitled to request a Medical Staff hearing.

1.2-10 **INVESTIGATION** means a process formally commenced by the Medical Executive Committee to determine the validity, if any, to a concern or complaint raised against a member of the medical staff. An investigation is ongoing until either formal action is taken or the investigation is closed. An investigation does not include activity of the Physician Well Being Committee.

1.2-11 **LIMITED LICENSE PRACTITIONERS** means dentists, clinical psychologists, and podiatrists.

1.2 12 **MEDICAL EXECUTIVE COMMITTEE** means the executive committee of the medical staff which shall constitute the governing body of the medical staff as described in these bylaws.

1.2-13 **MEDICAL STAFF or STAFF** means those physicians (MD or DO or their equivalent as defined in Section 2.2-2(a)), dentists, podiatrists, and clinical psychologists who have been granted recognition as members of the medical staff pursuant to the terms of these bylaws.

1.2-14 **MEDICAL STAFF YEAR** means the period from 1 January to 31 December.

1.2-15 **MEMBER** means, unless otherwise expressly limited, any physician (MD or DO or their equivalent as defined In Section *2.2-2(a)),* dentist, podiatrist, and clinical psychologist holding a current license to practice within the scope of that license who is a member of the medical staff.

1.2-16 **PHYSICIAN** means an individual with an MD or DO degree or the equivalent degree (i.e., foreign) as recognized by the Medical Board of California (MBC) or the Board of Osteopathic Examiners (BOE), who is licensed by either the MBC or the BOE.

1.2- 17 **PRACTITIONER** means an individual licensed to practice one of the professions eligible for membership in the medical staff.

1.2. 18 **NAME** of this organization is: -the Medical Staff of Imperial Valley Healthcare District.

1.2.19 TELEMEDICINE means the use of electronic communication or other communication technologies to provide or support clinical care by a practitioner at a distant site to patients located at an originating distant site. Telemedicine Staff consists of practitioners who only provide diagnostic or treatment services to hospital patients via Telemedicine devices. Telemedicine devices include interactive (involving a real time or near real time two-way transfer of medical data and information) audio, video, or data communications (but do not include telephone or electronic mail communications) between physician and patients.

ARTICLE II MEMBERSHIP

2.1 NATURE OF MEMBERSHIP

No physician, dentist, podiatrist, or clinical psychologist, including those in a medical administrative position by virtue of a contract with the hospital, shall admit or provide medical or health-related services to patients in the hospital unless the physician is a member of the medical staff or has been granted temporary privileges in accordance with the procedures set forth in these bylaws. Medical staff membership shall confer only such clinical privileges and prerogatives as have been granted in accordance with these bylaws.

2.2 QUALIFICATIONS FOR MEMBERSHIP

Membership and privileges shall be granted, revoked or otherwise restricted or modified based only on-criteria as set forth in these bylaws.

2.2-1 General Qualifications

Only physicians, dentists, podiatrists, and clinical psychologists shall be deemed to possess basic qualifications for membership in the medical staff, except for the honorary and retired staff categories in which case these criteria shall only apply as deemed individually applicable by the medical staff, and who

(a) document their (1) current licensure, (2) adequate experience, education, and training, (3) current professional competence, (4) good judgment, and (5) current verified physical and mental health status, so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(b) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information or records received in the physician- patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

(c) maintain in force professional liability insurance in not less than the minimum amounts, as stated in the Medical Staff General Rules and Regulations, and as from time to time may be jointly determined by the Board of Trustees and Medical Executive Committee.

(d) are certified, are progressing towards certification in the specialty and each of the subspecialties for which privileges are requested by (1) boards which are duly organized and recognized by an American Board of Medical Specialties member board or (2) a board or association with equivalent requirements approved by the Medical Board of California or (3) a board or association with an Accreditation Council for Graduate Medical Education-approved postgraduate training program that provides complete training in that specialty or subspecialty. Applicants/Re-applicants who are progressing toward board certification must become board certified within five years of the initial granting of medical staff membership, unless extended for good cause by the Medical Executive Committee, and is within eligibility time-frame, or unless eligibility period is extended by the certifying board.

Notwithstanding the foregoing and recognizing that certain members may have been "grandfathered" from the Board Certification requirements as of the date the former El Centro Regional Medical Center and Pioneers Memorial Hospital adopted requirements for Board Certification, if a current members of the medical staff was "grandfathered" from the Board Certification requirements when that requirement was adopted and cannot reasonably be expected to pursue board certification at this time, that member may be considered for renewal of medical staff membership and privileges but only clinical privileges at that campus where they have held privileges and not for any additional privileges, if they can document sufficient training, experience, and competence, and otherwise meet the requirements of medical staff membership.

2.2-2 Particular Qualifications

(a) Physicians.

An applicant for physician membership in the medical staff, except for the honorary staff, must hold an MD or DO degree or their equivalent and a valid and unsuspended certificate to practice medicine issued by the Medical Board of California or Osteopathic Medical Board of California. For the purpose of this section, their

equivalent shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the American Board of Osteopathic Examiners.

(b) Limited License Practitioners.

(a) Dentists - An applicant for dental membership in the medical staff, except for the honorary staff, must hold a DDS or equivalent degree and a valid and unsuspended certificate to practice dentistry issued by the Dental
Board of California.

(b) Podiatrists - An applicant for podiatric membership on the medical staff, except for the honorary staff, must hold a DPM degree and a valid and unsuspended certificate to practice podiatry issued by the Board of Podiatric Medicine.

(c) Clinical Psychologists - An applicant for clinical psychologist membership on the medical staff, except for the honorary staff, must hold a clinical psychologist degree, have not less than two years clinical experience in a multi- disciplinary facility licensed or operated by this or another state or by the United States to provide health care or be listed in the latest edition of the National Register of Health Service Providers in Psychology, and hold a valid and unsuspended certificate to practice clinical psychology issued by the Board of Psychology.

2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization, is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital. Subject to and except as provided with respect to exclusive contracts for particular services, medical staff membership or clinical privileges shall not be revoked, denied, or otherwise infringed based on the member's professional or business interests. Neither the existence of an actual or potential conflict of interest, nor the disclosure thereof, shall affect a member's medical staff membership or clinical privileges.

2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of gender, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, or sexual orientation that does not pose a threat to the quality of patient care.

2.5 RULES OF MEDICAL STAFF MEMBERSHIP

Except for the honorary staff, the ongoing obligations and responsibilities of each member of the medical staff include:

(a) providing patients with the quality of care meeting the professional standards of the medical staff, and the member's applicable specialty board;

(b) abiding by the medical staff bylaws, medical staff rules and regulations, and policies;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership, including committee assignments;

(d) preparing and completing in timely fashion medical records for all the patients to whom the member provides care in the hospital; performing, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As detailed in the medical staff rules and regulations, a medical history and physical examination shall be completed no more than 30 days before, or 24 hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed within 30 days before admission or registration, the physician must complete and document an updated examination of the patient within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including changes in the patient's condition, must be

completed and documented by a physician, an oral maxillofacial surgeon, or other professional licensed individual in accordance with state law and Hospital policy.

(e) Abiding by the lawful ethical principles of the California Medical Association; the members professional association and/or specialty board.

(f) aiding in any medical staff approved educational programs for medical students, interns, resident physicians, resident dentists, staff physicians and dentists, nurses and other personnel;

(g) working cooperatively with members, nurses, hospital administration and others so as not to adversely affect patient care;

(h) Making appropriate arrangements for coverage of that member's patients as approved by the medical staff and consistent with the General Rules and Regulations;

(i) refusing to engage in improper inducements for patient referral;

(j) participating in continuing education programs as determined by the medical staff;

(k) participating voluntarily in such emergency service coverage or consultation panels as recommended by the medical staff and the member's department(s);

(l) serving as a proctor or other peer reviewer, and otherwise participating in medical staff peer review as reasonably requested by the member's department or the Medical Executive Committee;

(m) discharging such other staff obligations as may be lawfully established from time to time by the medical staff or Medical Executive Committee;

(n) Notify the Chief of Staff in writing no later than seven (7) calendar days from the occurrence of any of the following and provide such additional information as may be requested, regarding each of the following:

(i) Revocation, limitation, or suspension of their professional license or DEA registration, any court order to cease or restrict their professional practice, any reprimand or other disciplinary action taken by any state or federal governmental agency relating to their professional license, or the imposition of terms of probation by any state.

(ii) Recommendation to terminate or restrict staff membership or clinical privileges or action that summarily suspends or summary restricts or denies staff membership or privileges at any hospital or other health care institution, whether temporary or permanent.

(iii) Receipt of an initial sanction, or notice of the commencement of an investigation, the filing of charges relating to health care matters or exclusion from participation or payment by any federally funded health care organization including Medicare or Medicaid (Medi-Cal), or other action by the Department of Health Human Services, or any law enforcement agency or health regulatory agency of the United States or the State of California.

(iv) Lapse, cancellation or change of professional liability coverage including any change in amount or scope of coverage.

(v) The development of any mental or physical condition or other situation that could compromise the provider’s ability to perform the functions associated with their clinical privileges in a safe and effective manner.

(vi) The filing of any criminal misdemeanor or felony charges, or the entry of a judgement, settlement or nolo contendre plea with respect to any criminal misdemeanor or felony charges, including but not limited to DUI charges .

In addition, members shall timely notify the Medical Staff Office of any significant changes in the information required on appointment and reappointment.

(o) providing information to and/or testifying on behalf of the medical staff or an accused practitioner regarding any matter under an investigation pursuant to paragraph 6.3.3, and those which are the subject of a hearing pursuant to Article VII.

(p) Upon request of the Medical Executive Committee after it determines there is a reasonable concern regarding a member's or applicant's current health status that may affect the provider's ability to provide safe, quality care and/or fulfill the member's responsibilities as a member, to have an evaluation(s) and/or testing, which may include but not be limited to mental and/or physical examination, including but not limited to body fluid testing, by a professional or organization designated by the Medical Executive Committee, at the member's expense.

2.6 VOLUNTARY PARTICIPATION ON EMERGENCY DEPARTMENT BACKUP CALL PANELS

Participation on the emergency department backup call panel shall be voluntary. Membership on the medical staff shall not in any way be contingent on an applicant's willingness to participate on the emergency department's backup call panel. Physicians contracted for Emergency Department back up call panels must adhere to the terms defined in the contract.

2.7 STANDARDS OF PROFESSIONAL CONDUCT

The Medical Staff of the Imperial Valley Healthcare District is committed to a work environment in which all individuals are treated with respect and dignity. Each individual has the right to work in a professional atmosphere that promotes equal employment opportunities and prohibits discriminatory practices, including harassment. Therefore, it is expected that all relationships among persons in the working environment will be business-like and free of bias, prejudice and harassment. As a condition of membership and privileges, medical staff and allied health/advanced practice members shall continuously meet the requirements for professional conduct established in these bylaws. Non-members (i.e. Allied Health/Advanced Practice Staff) with privileges will be held to the same conduct requirements as members. Disruptive and inappropriate conduct can affect the quality of patient care. Refusal or failure to comply with these conduct requirements may result in corrective action in accordance with the Medical Staff Bylaws.

2.7-1 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of gender, race, age, color, religion, ancestry, national origin, disability, physical or mental impairment, marital status, or sexual orientation that does not pose a threat to the quality of patient care.

2.7-2 RETALIATION IS PROHIBITED

Reporting of all perceived incidents of discrimination, harassment , or disruptive conduct is encouraged and it is the policy of the Imperial Valley Healthcare District Medical Staff to investigate such reports. There is a ZERO TOLERANCE standard for retaliation against any individual who reports discrimination, ~~or~~ harassment, disruptive conduct or participates in an investigation of such reports. Anyone involved in any retaliatory acts may be subject to discipline and corrective action, pursuant to the Medical Staff Bylaws.

2.7-3 DISRUPTIVE BEHAVIOR

Disruptive and inappropriate medical staff member conduct affects or could affect the quality of patient care at the hospital and includes:

(a) "Harassment". By a medical staff member against any individual involved with the hospital (e.g., against another medical staff member, house staff, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation.

(b) "Intimidation". Deliberate physical, visual or verbal intimidation or challenge, including disseminating threats or pushing, grabbing or striking another person involved in the hospital; carrying a gun or other weapon in the hospital;

"Sexual harassment". Defined as unwelcome verbal or physical conduct of a sexual or gender- based nature, which may include, not limited to, and includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when:

- Submission to, or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment;
- This conduct substantially interferes with the individual's employment or creates and/or perpetuates an intimidating, hostile, or offensive work environment.
- Sexual harassment also includes conduct, which implies that employment, and/or employment benefits are conditioned upon acquiescence in sexual activities.
- Verbal harassment. Such as epithets, derogatory comments or slurs
- Physical harassment. Such as unwelcome touching, assault, or interference with movement or work
- Visual harassment. Such as the display of derogatory cartoons, drawings, or posters

(c) "Disruptive Conduct" May include, but is not limited to, behavior such as:

- Attacks Verbal or Physical. Leveled at other hospital personnel, physicians, vendors or patients, that are personal, irrelevant, or beyond the bounds of fair professional conduct.
- Impertinent and inappropriate comments (or illustrations) made in patient medical records, other official documents, employee and/or public display areas, impugning the quality of care in the hospital, or attacking particular employees, physicians, or hospital policies.
- Non-constructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

The medical staff considers these types of conduct as unprofessional and members involved may be subject to corrective action, up to and including termination of medical staff membership and privileges.

2.7-4 INDIVIDUALS AND CONDUCT COVERED

These Standards of Conduct apply to all applicants/members of the Medical and Allied Health Professional (AHP)/Advanced Practice Practitioner (APP) Staff. The described prohibited conduct is unacceptable in the workplace and in any work-related setting outside the workplace, such as during business trips, business meetings and business-related social events. Members who believe they are being subjected to such conduct, are urged to promptly advise the offender that his or her behavior is unwelcome and request that it be discontinued. Often this action alone will resolve the problem. It is recognized, however, that an individual may prefer to pursue the matter through informal or formal complaint procedures. The Medical Staff encourages reporting of all perceived incidents of discrimination, harassment, retaliation, or disruptive behavior regardless of the offender's identity or position. Members who believe that they have been the victims of such conduct should discuss their concerns with the department Chair, co-chair or Chief of Staff.

2.7-5 REPORTING

Any reported allegations of harassment, discrimination, retaliation or disruptive behavior will be investigated promptly. The investigation may include individual interviews with the parties involved and, where necessary, with individuals who may have observed the alleged conduct or may have other relevant knowledge. If the incident involves possible harassment, discrimination, retaliation or disruptive behavior by a member of the Medical or AHP Staff, the written complaint will be forwarded for investigation to the Chief of Staff. The Chief of Staff, Department Chair or co-chairs and/or designee(s) shall conduct an investigation pursuant to Medical Staff Bylaws. Confidentiality will be maintained throughout the investigation process to the extent consistent with adequate investigation and appropriate corrective action.

Misconduct constituting harassment, discrimination or retaliation will be dealt with appropriately. Responsive action may include, for example, training, referral to Physician Well Being for assistance or counseling, may include disciplinary action such as warning, reprimand, and other corrective action pursuant to the Medical Staff Bylaws.

Complaints of harassment, discrimination, retaliation or disruptive behavior which the maker knew or should have known to be false (as opposed to complaints which, even if unproven, are made in good faith), may be the subject of appropriate discipline.

2.7-6 REPORTING PROCESS

If a member of the medical staff is observed exhibiting any of the above described unacceptable behaviors, a notification form will be entered into the QRM system. The information will be forwarded to the Medical Staff Services office, for notification of the Chief

of Staff, and/or the respective department chair or co-chairs regarding receipt of notification. The Chief of Staff and/or the respective department chair or co-chairs will review and investigate the incident.

(1) The issue(s) will be reviewed and a determination for resolution will be made which may include the following, but not limited to:

- Discussion with involved physician, which shall be documented as a memo to the file
- Complaint determined to be a quality of care issue, refer to respective clinical department for Peer Review
- Letter to the physician requesting information allowing the physician to respond in writing
- Letter of reprimand to physician
- Physician will be sent information pertinent to the complaint, e.g. code of conduct, section of Rules and Regulations, Bylaws that relate to conduct expected of the medical staff
- Physician may be requested to attend the MEC to further discuss the issue/resolution
- Physician may be referred to the Physician Well Being Committee Chair
- Other resolutions as determined by the Chief of Staff/Department Chair or co-chairs

(2) If it appears there may be an imminent danger to the health of any individual, the Chief of Staff or designee will also be notified verbally immediately, with the notification form submitted within five (5) business days.

(3) Upon receipt of notification by the Chief of Staff, the observations will be investigated by the chief of staff and the respective department chair or co-chairs**,** or designees with documentation of such investigation.

(4) The documented review of the alleged events should include a precise description of the event(s) from all possible observers.

(5) If the evaluation confirms the reported behavior occurred and compromised or potentially compromised quality care, the involved member will be made aware of the findings by the Chief of Staff or the department chair or co-chairs. The initial approach should be collegial and helpful and the discussion should emphasize that such conduct is inappropriate and must cease.

(6) The member will be made aware of the assistance offered by the Physician Well Being Committee (herein after referred to as "PWBC"). If the affected practitioner is interested in meeting with the PWBC, a confidential discussion of the matter between the member, the Chief of Staff or designee and the chair of the PWBC will be scheduled.

(7) Should a member voluntarily, in confidence, seek the assistance of the Physician Well Being Committee because of disruptive, discriminatory or harassing behavior, it is appropriate for the committee to provide assistance. The Chief of Staff will be informed.

(8) The matter may be presented to the appropriate department chair or co-chairs at the request of the member.

2.7-7 SUBSEQUENT EPISODES

If the member continues a pattern of disruptive behavior, discriminatory or harassing behavior, the Chief of Staff or designee, will inform the member that he or she must meet with the PWBC and abide by an agreement, which may include but not be limited to progressive discipline, the member attending a PWBC – selected program, and/or other measures deemed appropriate by the PWBC. This referral shall be in writing and a copy shall be maintained in the "Chief of Staff" confidential file under in the Medical Staff Services Office. Refusal to meet with the PWBC or to enter into and comply with a PWBC proposed agreement ~~sponsored program~~ will result in a written referral to the Medical Executive Committee for action. The Physician Well Being committee shall make a report and recommendation to the Medical Executive Committee of the incidents and the refusal.

2.7-8 PEER REVIEW RECORDS OR BEHAVIOR REVIEWS

Notwithstanding any other provision of these bylaws of the rules and regulation, documentation relating to investigations of behavior, their conclusions, and any resulting corrective action shall be maintained by the medical staff office as peer review documents. As the Medical Staff needs to assess whether there may be a pattern of conduct that may not have been identified with isolated incidents, the records of all reviews of behavior shall be retained for possible reassessment, such as upon further reported incidents and upon reappointment.

ARTICLE III CATEGORIES OF MEMBERSHIP

3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, provisional, honorary, temporary, community based and administrative. Each time membership is granted or renewed, the member's staff category shall be determined.

3.2 ACTIVE STAFF

3.2-1 Qualifications

The active staff shall consist of members who:

(a) meet the general qualifications for membership set forth in Section 2.2;

(b) have offices or residences, which, in the opinion of the department and Medical Executive Committee, are located closely enough to the hospital to provide appropriate continuity of quality care;

(c) care for, or admit 12 or more patients per year in this hospital or who seek care at the Imperial Valley Healthcare District and involved in medical staff functions, medical staff meeting attendance as determined by the medical staff, please refer to Section 12.6 for detailed Active Staff meeting attendance requirements;

(d) have satisfactorily completed the provisional staff status requirements, including proctoring.

3.2-2 Prerogatives

Except as otherwise provided, the prerogatives of an active medical staff member who is in good standing shall be to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V;

(b) attend all general and special meetings of the Medical Staff and vote on medical staff bylaws and amendments, vote in Medical Staff elections and vote on all other matters presented at general and special meetings of the medical staff or via ballot when provided as an alternative for voting and vote on the department and committees to which the member is duly appointed; and

(c) hold staff, division, or department office and serve as a voting member of committees to which the member is duly appointed or elected by the medical staff or duly authorized representative thereof, so long as the activities required by the position fall within the member's scope of practice as authorized by law.

3.2-3 Transfer of Active Staff Member

After two (2) consecutive years in which a member of the active staff fails to regularly care for patients in this hospital or be regularly involved in medical staff functions as determined by the medical staff, that member shall be automatically transferred to the appropriate category, if any, for which the member is qualified.

3.3 COURTESY STAFF

3.3-1 Qualifications

The courtesy medical staff shall consist of members who:

(a) meet the general qualifications set forth in subsections (a)-(b) of Section 3.2-1; in Section 2.2;

(b) do not care for 12 or more patients per year in the hospital, or are not regularly involved in medical staff functions as determined by the Medical Executive Committee;

(c) are members in good standing of the active medical staff of another California licensed hospital, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(d) have satisfactorily completed the requirements of the provisional category.

3.3-2 Prerogatives

Except as otherwise provided, the courtesy staff member shall be entitled to:

(a) admit or render care for the Imperial Valley Healthcare District patients within the limitations of Section 3.3-1(b) and exercise such clinical privileges as granted pursuant to Article V; and

(b) are encouraged to attend general and special meetings of the medical staff but are not eligible to vote. on medical staff matters, for officers or on bylaws amendments;

(c) Are not eligible to vote on Medical Staff matters or hold office but may serve on committees, with the right to vote to be specified at the time of appointment. .

3.3-3 Limitation

Courtesy staff members who admit patients or care for more than 12 patients per year in the hospital as stated in Section 3.3-1 (b) shall, upon review of the Medical Executive Committee, be obligated to seek membership in the appropriate staff category.

3.4 CONSULTING STAFF

3.4-1 Qualifications

Any member of the medical staff in good standing may consult in that member's area of expertise; however, the consulting medical staff shall consist of practitioners who:

(a) meet the general qualifications set forth in Article 2.2;

(b) possess adequate clinical and professional expertise;

(c) are willing and able to come to the hospital on schedule or promptly respond when called to render clinical services within their area of competence;

(d) are members in good standing of the active medical staff of another hospital licensed by California or another state, although exceptions to this requirement may be made by the Medical Executive Committee for good cause; and

(e) have satisfactorily completed the requirements of the provisional category.

3.4-2 Prerogatives

The consulting medical staff member shall be entitled to:

(a) exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and educational programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment;

(c) Consulting staff members shall not be eligible to admit patients to the hospital, vote on medical staff bylaws, vote for officers, hold office in the medical staff organization, but may serve on committees with the right to vote to be specified at the time of appointment.

3.5 PROVISIONAL STAFF

3.5-1 Qualifications

The provisional staff shall consist of members who meet the general medical staff membership qualifications set forth in Sections 3.2-1 (a) and (b) or 3.4-l(a)-(d), and immediately prior to their application and appointment were not members (or were no longer members) of this medical staff.

3.5-2 Prerogatives

The provisional staff member shall be entitled to:

(a) admit patients and exercise such clinical privileges as are granted pursuant to Article V; and

(b) attend meetings of the medical staff and the department of which that person is a member, including open committee meetings and programs, but shall have no right to vote at such meetings, except within committees when the right to vote is specified at the time of appointment.

(c) Provisional staff members shall not be eligible to vote on bylaws amendments, vote for officers or vote on any other Medical Staff matter and may not hold office in the medical staff organization, but may serve on committees with the right to vote to be specified at the time of appointment.

3.5-3 Observation of Provisional Staff Member

Each provisional staff member shall undergo a period of observation by designated monitors as described in these Bylaws. The purpose of observation shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and advancement within staff categories. Observation of provisional staff members shall follow whatever frequency and format each department deems appropriate in order to adequately evaluate the provisional staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained. The results of the observation shall be communicated by the department chair or co-chairs to the Medical Executive Committee.

3.5-4 Term of Provisional Staff Status

A member shall remain in the provisional staff for a minimum period of 6 months, up to a maximum of 24 months if deemed necessary at the recommendation of the Medical Executive Committee upon a determination of good cause, which determination shall not be subject to review pursuant to Articles VI or VII.

3.5-5 Action at Conclusion of Provisional Staff Status

(a) If the provisional staff member has satisfactorily demonstrated the ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued medical staff membership, the member shall be eligible for placement in the active, courtesy or consulting staff as appropriate, upon recommendation of the Medical Executive Committee; and

(b) In all other cases, the appropriate department shall advise the Medical Executive Committee which, in turn, shall make its recommendation to the Board of Trustees regarding a modification or termination of clinical privileges or termination of medical staff membership. If the Provisional staff member does not have adequate patient activity to evaluate clinical competency, it will be deemed a voluntary automatic resignation without the rights to the Medical Staff hearing and appeal procedures in Article VII of these Bylaws.

3.6 COMMUNITY BASE/AFFILIATE STAFF

3.6-1 Qualifications

The Community Base/Affiliate Staff is a membership-only category, with no clinical privileges being granted, they do not intend to establish a practice at the Hospital. The primary purpose of the Affiliate Staff is to promote professional and educational opportunities, and to permit these individuals to access Hospital services for their patients by referral of patients to Active Staff members for admission and care. Community Base/Affiliate staff providers must apply for Medical Staff Membership by completion of a Medical Staff Application, submit applications for reappointment, and provide evidence/attest to, the following:

(a) Document their current licensure,
(b) Submission of CME documentation. "CME Attestation" will be accepted,
(c) Document education and training,
(d) Attest to current, adequate physical and mental health status,
(e) Willing to demonstrate, if asked, they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;
(f) are determined (1) to adhere to the ethics of their respective professions, (2) to be able to work cooperatively with others so as not to adversely affect patient care, (3) to keep as confidential, as required by law, all information

or records received in the physician- patient relationship, and (4) to be willing to participate in and properly discharge those responsibilities determined by the medical staff;

(g) maintain in force professional liability insurance in not less than the minimum amounts, as stated in the Medical Staff Bylaws, General Rules and Regulations, and as from time to time may be jointly determined by the Board of Trustees and Medical Executive Committee.

3.6-2 Prerogatives

The Community Based/Affiliate Staff Members must:

(a) maintain the confidentiality of patient information,

(b) Pay staff dues and assessments if/as established by the Medical Executive Committee

The Community Based/Affiliate Staff Members may:

(a) Order outpatient diagnostic services for patients;

(b) Make courtesy visits to patients;

(c) Review the medical records and test results (via electronic access) for any of their patients who are referred.

(d) Attend educational opportunities,

(e) Be invited to department or committee meetings, (without a vote), unless otherwise provided by these Bylaws;

Community Based Affiliate Staff Members may not/will not:

(a) Admit, treat, or consult on patients admitted to the Hospital;

(b) Write orders or progress notes, make notations in the medical record, or otherwise participate in the provision or management of clinical care to patients while in the hospital;

(c) Exercise clinical privileges in the hospital;

(d) Undergo Ongoing Professional Practice Evaluation or Focus Professional Practice Evaluation

(e) Hold elected office;

(f) Vote on medical staff bylaws amendment, vote for officers or vote on any other medical staff matters presented by ballot or at general or special meetings of the medical staff and / or department or committee meetings;

(g) Attend general staff meetings.

3.6-3 Request for Clinical Privileges

Members who wish to exercise clinical privileges must request a change in staff category, apply for clinical privileges and submit all requested documentation, and shall have the burden of proof to establish qualifications for the membership category requested and clinical privileges, as outlined in Articles II and IV of these Bylaws.

3.7 TELEMEDICINE STAFF

3.7-1 Qualifications

The telemedicine staff category shall consist of practitioners who provide diagnostic or treatment services to hospital patients via Telemedicine devices. Telemedicine devices include interactive (involving a real time or near real time two-way transfer of medical data and information), audio, video, or data communications, but do not include telephone or electronic mail communications, between physician and patients. Telemedicine members shall: (1) meet general qualifications set forth in Section 2.2; (2) possess adequate clinical competency and professional Judgement in the requested specialty.

3.7-2 Distant Site Credentialing

The Medical Staff will accept Telemedicine credentialing information and documents from another accredited facility under a Distant Site Credentialing Agreement. The Medical Staff will evaluate according to medical staff qualifications, with further acquisition of information per processes for completion of credentialing.

3.7-3 Prerogatives

Members of the telemedicine staff may consult and refer patients but may not admit. A telemedicine staff member is required to pay medical staff Dues. Except as may be designated by the Medical Executive Committee for the particular member of the telemedicine staff based upon a determination their services are required to meet an identified need, they are not eligible to vote on Medical Staff matters, including but not limited to amendments to bylaws or vote for officers and may not hold office within the Medical Staff organization, or serve on any committees. There is no right to a

hearing or further review to challenge the Medical Executive Committee's determination that an exception is not necessary to allow the member to vote, hold office or serve on a committee.

3.7-4 Obligations

Each member of the telemedicine staff shall abide with the Medical Staff Bylaws and Rules and Regulations and all other policies and procedures of the Medical Staff and the Hospital, as applicable to his/her activities in association with the hospital. Practitioners who wish to provide telemedicine services in rendering a diagnosis, providing interpretation of diagnostic exams, or
otherwise providing clinical treatment to a patient via telemedicine, shall be required to apply for and be granted clinical privileges for these services. Consideration of appropriate utilization of telemedicine equipment by the telemedicine practitioner shall be encompassed in granting of clinical privileging decisions.

3.8 HONORARY/RETIRED STAFF

3.8 -1 Qualifications

The honorary staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who do not ~~actively~~ practice at the hospital but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the hospital, and who continue to exemplify high standards of professional and ethical conduct, or are members who have retired from Active practice and, at the time of their retirement, were members in good standing of the Active medical staff and who continue to adhere to appropriate professional and ethical standards, as determined by the Medical Executive Committee.

3.8-2 Prerogatives

(a) Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital, or to vote on any medical staff matter or hold office in this medical staff organization;

(b) Notwithstanding Section (a) above, may serve on committees with or without vote at the discretion of the Medical Executive Committee;

(c) They may attend staff and department meetings, including open committee meetings and educational programs;

(d) Honorary Staff members are not eligible to vote but may serve on committees.

3.9 TEMPORARY STAFF

3.9-1 Qualifications

The temporary staff shall consist of physicians, dentists, podiatrists, and clinical psychologists who do not practice at the hospital but are important resource individuals for medical staff quality assessment and improvement activities. Such persons shall be qualified to perform the functions for which they are made temporary members of the staff.

3.9-2 Prerogatives

(a) Temporary medical staff members shall be entitled to attend all meetings of committees to which they have been appointed for the limited purpose of carrying out quality assessment and improvement functions;

(b) May not hold office in the medical staff organization or vote on medical staff matters;

(c) May, however, serve on designated committees with or without vote at the discretion of the Medical Executive Committee. Finally, they may attend medical staff meetings outside of their committees, upon invitation.

3.10 GRADUATE MEDICAL EDUCATION, (GME) RESIDENT STAFF

3.10-1 Qualifications

(a) Imperial Valley Healthcare District participates in a graduate medical education (GME) program. The organized medical staff has a defined process for the supervision of all trainees in this program carrying out patient care responsibilities by a licensed independent practitioner with appropriate clinical privileges.

(b) GME Resident staff membership shall be held by post-doctoral trainees (residents and fellows) in training programs of teaching institutions who are not eligible for another staff category and who are either licensed or registered with the appropriate State of California licensing board. All GME Resident staff members must obtain a license to practice medicine within the State of California when eligible.

3.10-2 Prerogatives / Limitations

(a) Appointment term shall be for one year, from date of initial appointment.

(b) Members of this category are not eligible to hold office within the medical staff, vote on bylaws amendments, vote for officers or vote on any other medical staff matters but they may participate in committees of the medical staff in a non-voting capacity.

(c) All medical care provided by a GME Resident Staff member is under the supervision of members of the active, courtesy, or consulting staff.

(d) GME Residents must be supervised by teaching staff in such a way that the trainee assumes progressively increasing responsibility for patient care according to their level of training, ability, and experience.

(e) Patient care shall be in accordance with the provision of a program approved by and in conformity with the Accreditation Council on Graduate Medical Education of the American Medical Association, the American Osteopathic Association, or the American Dental Association's Commission Dental Accreditation.

3.10-3 Responsibility of the Supervising Physician

(a) The supervising licensed independent physician represents resident staff in the development, review, and evaluation of resident staff patient care responsibilities at the training hospital including quality assessment and improvement, utilization review, risk management, and patient satisfaction.

(b) There is a mechanism for effective communication between the committee(s) responsible for professional graduate education and the organized medical staff and the governing body. The supervising licensed independent physician shall be advisory to the respective medical staff department and provide summarizing evaluations for each trainee. The chair or co-chairs of the respective medical staff department shall submit a report to the medical staff executive committee. The medical executive committee will submit report to the hospital board.

(c) The summary will include identification of mechanisms by which the supervisor(s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities. Also to be included: safety and quality of patient care, treatment, and services provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs at El Centro Regional Medical Center.

(d) Communication to the organized medical staff and hospital board about the patient care, treatment, and services provided by, and the related educational and supervisory needs of, its participants in the professional graduate education programs is completed on a quarterly basis.

(e) The organized medical staff delineates which participants in professional education programs may write patient care orders, the circumstances under which they may do so (without prohibiting licensed independent practitioners from writing orders), and what entries, if any, must be countersigned by a supervising licensed independent practitioner.

(f) All procedures completed by program trainees must be completed under the direct or indirect oversight of a supervising licensed independent practitioner.

3.11 LIMITATION OF PREROGATIVES

The prerogatives set forth under each membership category are general in nature and may be subject to limitation by special conditions attached to a particular membership, by other sections of these bylaws and by the medical staff rules and regulations.

3.12 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair or co-chairs of the meeting, subject to final decision by the Medical Executive Committee; and shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 5.4.

3.13 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the department, or pursuant t o a request by a member under Section 4.6, the Medical Executive Committee may recommend a change in the medical staff category of a member consistent with the requirements of the bylaws.

ARTICLE IV MEMBERSHIP AND MEMBERSHIP RENEWAL

4.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by the hospital in administratively responsible positions) shall exercise clinical privileges in the hospital or via telemedicine link unless and until that person applies for and obtains membership on the medical staff and is granted privileges as set forth in these bylaws, or, with respect to allied health practitioners, has been granted a service authorization or privileges under applicable medical staff policies. By applying to the medical staff for initial membership or renewal of membership (or, in the case of members of the honorary/retired staff, by accepting membership in that category), the applicant acknowledges responsibility to first review these bylaws and medical staff rules, regulations and policies, and agrees that throughout any period of membership that person will comply with the responsibilities of medical staff membership and with the bylaws, rules and regulations and policies of the medical staff as they exist and as they may be modified from time to time. Membership on the medical staff shall confer on the member only such clinical privileges as have been granted in accordance with these bylaws.

4.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for initial membership, membership renewal, advancement, or transfer, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. To the extent consistent with law, this burden may include submission to a medical or psychological examination, at the applicant's expense, if deemed appropriate, by the Medical Executive Committee, which shall select three practitioners from which the candidate may select the examining practitioner.

The applicant will be notified about any information that has not been received or that remains unverified. If the applicant fails to provide the information requested within 30 days of the request, the application shall be filed as incomplete and automatically withdrawn from consideration.

4.3 AUTHORITY TO GRANT, DENY AND REVOKE MEMBERSHIP

Approvals, denials and revocations of medical staff membership and/or privileges shall be made as set forth in these bylaws, but only after there has been a recommendation from the medical staff, or as set forth in Section 6.3-6.

4.4 DURATION OF MEMBERSHIP AND MEMBERSHIP RENEWAL

Except as otherwise provided in these bylaws, initial membership on the medical staff shall be for a maximum period of two years.
Approved membership renewals shall be for a period of up to two years.

4.5 APPLICATION FOR INITIAL MEMBERSHIP AND RENEWAL OF MEMBERSHIP

4.5-1 Application Form

An application form and credentialing process shall be approved by the Medical Executive Committee. In addition, the Medical Executive Committee may approve a pre-application form and policy that includes objective non-discretionary criteria to qualify to receive an application; any such failure to meet criteria in the pre-application policy to receive an application not to be grounds for a hearing as not based upon an individualized assessment of the provider's care or conduct. The application form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualifications, including, but not limited to, professional training and experience, current licensure, current DEA registration, certification of CPR training, and continuing medical education information related to the clinical privileges to be exercised by the applicant, this information will be verified by primary source verification;

(b) peer references from the same or similar specialty familiar with the applicant and who can attest to (includes but not limited to), the applicant's current medical, clinical knowledge, technical and clinical skills, clinical judgement, interpersonal skills communication skill, professionalism, these peer references will be verified by primary source verification;

(c) requests for membership categories, departments, and clinical privileges;

(d) past or pending challenges to any licensure or registration, i.e., professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction, loss, relinquishment of medical staff membership or privileges or any licensure or registration, and related matters, this information will be verified by primary source verification;

(e) current physical and mental health status as it may relate to the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law.;

(f) evidence of any unusual pattern or an excessive number of professional liability actions resulting in a final judgment against the applicant, any final judgments or settlements made against the applicant in professional liability cases, and any filed and served cases pending, this information will be verified by primary source verification;

(g) professional liability coverage, this information will be verified by primary source verification;

(h) any past, pending or current exclusion or suspension from a state or a federal health care program, and/or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice; this information will be verified by primary source verification.

(i) relevant practitioner-specific data as compared to aggregate data, when available;

(j) Morbidity and mortality data, when available

(k) Each application for initial membership on the medical staff shall be in writing, submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. The explanation shall require approval of the department and the Medical Executive Committee. When an applicant requests an application form, that person shall be given a copy of (which may be via electronic access) these bylaws, the medical staff and department rules and regulations, and, copies or summaries of any other applicable medical staff policies relating to clinical practice in the hospital.

(l) Each initial applicant or applicant for reappointment must provide the name of a covering physician, dentist podiatrist, psychiatrist or group with the same licensure as the applicant and with training in the same specialty or subspecialty with the same or similar training who must be a member of the medical staff at the campus for which they are applying for privileges. Written confirmation from the covering physician confirming that he/she agrees to be the covering physician will be obtained in the credentialing process. Any member who is unable to obtain coverage may request an audience with the Medical Executive Committee to discuss and explain need for waiver.

The Medical Executive Committee may at its sole discretion waive this requirement in special circumstances for the good of the community. e.g. the applicant is the sole practitioner in his/her specialty or subspecialty or to allow for the expansion of services at IVHD to include a new service for the hospital or community. The following exceptional conditions shall be considered:

1) New sub-specialist joining the medical staff:
   a. Same specialty not currently on staff
   b. None (0) or one (1) of same specialty available
   c. requirement temporarily waived
2) Surgeon may perform Outpatient Surgical procedures only,
3) To schedule inpatient procedures, there must be an alternate, or Surgeon agrees to stay in town until patient is discharged
4) New surgeon without backup will be proctored on outpatient cases performed

(m) Each applicant shall have a valid email address at which to receive electronic communications or alternate reliable way of communication.

(n) Each applicant is responsible for the accuracy and completeness of their applications for appointment and reappointment. Failure to disclose information requested on the application or requested by the Medical Staff on an application as part of the initial appointment or reappointment process application or providing false or misleading information may result in a decision that the application does not qualify for credentialing consideration or discipline, including but not limited to denial, suspension or termination of membership and/or privileges.

4.5-2 Effect of Application

In addition to the matters set forth in Section 4.1, by applying for membership on the medical staff each applicant:

(a) signifies willingness to appear for interviews in regard to the application;

(b) authorizes consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and authorizes such individuals and organizations to candidly provide all such information;

(c) consents to inspection of all records and documents that may be material to an evaluation of the applicant's qualifications and ability to carry out clinical privileges requested, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying;

(d) releases from any liability, to the fullest extent provided by law, all persons for their acts performed in connection with investigating and evaluating the applicant;

(e) releases from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;

(f) consents to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital or medical staff may have, and releases the medical staff and hospital from liability for so doing to the fullest extent permitted by law;

(g) if a requirement then exists for medical staff dues, acknowledges responsibility for timely payment of dues and assessments;

(h) agrees to provide for continuous quality care for patients;

(i) pledges to maintain an ethical practice, including refraining from illegal and unethical inducements for patient referral, providing for the continuous care of the applicant's patients, seeking consultation whenever necessary, refraining from failing to disclose to patients when another surgeon will be performing the procedures or services, and refraining from delegating patient responsibility to nonqualified or inadequately supervised practitioners or allied health practitioners; and

(j) pledges to be bound by the medical staff bylaws, rules and regulations, and policies approved in accordance with the processes in these bylaws.

(k) agrees that if membership and privileges are granted, and for the duration of medical staff membership, the member has an ongoing and continuous duty to report in writing to the Medical Staff Office within 14 days any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication when such correction, change, modification or addition may reflect adversely on current qualifications for membership or privileges.

(l) Agrees to participate in the mandatory Medical Staff Onboarding Orientation process. Upon approval, the practitioner will be notified and scheduled for Onboarding Orientation. At this time the practitioner will participate in the following: (1) Tour of the hospital and, or Outpatient clinic, focusing on the area of practice, with introductions to key persons in those areas, as possible; (2) 30-minute department specific education with the following departments: Medical Staff Services, Health Information, Clinical Documentation & Inquiry, Case Management, Clinical Educators for EMR training. During this process, the practitioners ID Badge will be obtained from HR, as well as the physician parking pass, and completion of the Positive Identification process will be confirmed. This process must be completed prior to the start of seeing patients at IVHD.

(m) Agrees and authorizes by consent, to a background investigation which includes records related to any criminal convictions felony, misdemeanor, department of motor vehicles, , military, education, licensing authorities, state and federal sanctioning authorities. This background investigation will be obtained on initial appointment, and at triggers (unusual adverse information), thereafter.

4.5-3 Verification of Information

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the medical staff office and an advance payment of medical staff dues and/or application processing fees paid to the medical staff, as required.

The medical staff office personnel, following the approved credentialing process, shall expeditiously seek to collect and/or verify the references, licensure status, and all other evidence submitted in support of the application. Upon approval of the Medical Executive Committee, portions of the verification process may be delegated to a credentials verification office.

The Medical Staff Office serving as the authorized representative shall query the National Practitioner Data Bank regarding the applicant or member. This information shall be included in the applicant's or member's credentials file.

The applicant shall be notified of any problems in obtaining the information required and any additional requested information, and it shall be the applicant's obligation to obtain all reasonably requested information. Failure to provide any requested information within thirty (30) days of a request shall be deemed a voluntary withdrawal of the application.

An application is considered complete when all the information requested has been received and verified. An incomplete application will not be processed. When an application is deemed complete it will be forwarded to the department chair or department co-chairs, as applicable, and credentials committee for review.

4.5-4 Department Action

After receipt of the application, the Department Chair or co-chairs, as applicable, to which the applicant has applied for privileges, shall review the application and supporting documentation, and may conduct a personal interview with the applicant at their discretion. The Department Chair or co-chairs, as applicable, shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges granted, and shall transmit to the Credentials Committee a written report and recommendation as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached. The Department Chair or co-chairs, as applicable, may determine that further information and/or documents are required for the application to be deemed complete and return the incomplete application to the Medical Staff Office for collection of information and documents or may recommend that the Medical Executive Committee defer action on the application.

4.5-5 Credentials Committee

The Credentials Committee shall review the application, evaluate and verify the supporting documentation, the Department Chair's or co-chairs' report and recommendations, and other relevant information. The Credentials Committee may elect to interview the applicant and seek additional information. As soon as practicable, the Credentials Committee shall transmit to the Medical Executive Committee, a written report and its recommendations as to appointment and, if appointment is recommended, as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The Credentials Committee may determine additional information or documents are required and return the application as incomplete to the Medical Staff Service Department. At any time, the Credentials Committee may request that the Medical Executive Committee defer action on the application.

4.5-6 Medical Executive Committee Action

At its next regular meeting after receipt of the chair's or co-chairs, as applicable, report and recommendation, or as soon thereafter as is practicable, the Medical Executive Committee shall consider the report and any other relevant information. The Medical Executive Committee may request additional information, return the matter to the department for further investigation, and/or elect to interview the applicant.

4.5-7 Effect of Medical Executive Committee Action

(a) Favorable Recommendation: When the recommendation of the Medical Executive Committee is favorable to the applicant, it shall be immediately forwarded, together with supporting documentation, to the Board of Trustees or, in cases eligible for expedited processing, applicable committee duly appointed by the Board to handle expedited review and recommendation.

(b) Adverse Recommendation: When a final recommendation of the Medical Executive Committee is adverse to the applicant, the Board of Trustees and the applicant shall be promptly informed by written notice within 7 days. The applicant shall then be entitled to procedural rights as provided in Article VII.

4.5-8 Action on the Application

At the next regularly scheduled meeting, the Board of Trustees may accept the recommendation of the Medical Executive Committee or may refer the matter back to the Medical Executive Committee for further consideration, stating the purpose for such referral and setting a reasonable time limit for making a subsequent recommendation. The following procedures shall apply with respect to action on the application:

If the Medical Executive Committee issues a favorable recommendation, the Board of Trustees shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence.

(a) If the Board of Trustees concurs in that recommendation, the decision of the Board of Trustees shall be deemed final action.

(b) The Board of Trustees may request additional information and return the application to the Medical Executive Committee.

(c) If the tentative final action of the Board of Trustees is unfavorable, the administrator shall give the applicant written notice of the tentative adverse recommendation and the applicant shall be entitled to the procedural rights set forth in Article VII. If procedural rights are waived by the applicant, the decision of the Board of Trustees shall be deemed final action.

(d) In cases eligible for expedited processing, favorable recommendation from the Medical Executive Committee will be forwarded to Board of Trustees for ratification by the Board at its next regularly scheduled meeting. The ratification by the board shall be deemed final. If the decision is adverse to the applicant, or the Board of Trustees fails to ratify the committee's decision, the matter shall be referred back to the Medical Executive Committee for evaluation.

(e) In the event the recommendation of the Medical Executive Committee, or any significant part of it, is unfavorable to the applicant the procedural rights set forth in Article VII shall apply.

(f) If procedural rights are waived by the applicant, the recommendations of the Medical Executive Committee shall be forwarded to the Board of Trustees for final action, which shall affirm the recommendation of the Medical Executive Committee if the Medical Executive Committee's decision is supported by substantial evidence. The board may request additional supporting documentation from the Medical Executive Committee and thereby delay a decision.

(g) If the applicant requests a hearing following the adverse Medical Executive Committee recommendation pursuant to Section 4.5-7(b) or an adverse Board of Trustees tentative final action pursuant to 4.5-7 (a) (3), the Board of Trustees shall take final action only after the applicant has exhausted all procedural rights as established by Article VII. After exhaustion of the procedures set forth in Article VII, the board shall make a final decision and may affirm, modify or reverse the decision, giving great weight to the decision of the judicial review committee but exercising its independent judgment in determining whether a practitioner was afforded a fair hearing as required by these Bylaws.

(h) Applicants are ineligible for expedited processing if, at the time membership may be granted, any of the following has occurred:

- The applicant submits an incomplete application,
- The medical staff executive committee makes a final recommendation that is adverse or has limitations,
- The applicant is under sanction by a third-party payer, i.e., Medicare, Medi-Cal, etc.,

The following situations shall result in ineligibility for the expedited process:

- Current challenge or a previously successful challenge to licensure or registration,
- Applicant has received an involuntary termination of medical staff membership at another organization,
- The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges,
- Determined there has been either a pattern, of, or an excessive number of professional liability actions resulting in final judgements against the applicant,
- The application contains unexplained gaps in time,
- The applicant has been named as a defendant in a criminal action and/or has been convicted of a crime.

(1) The applicant has received involuntary limitation, reduction, denial, or loss of clinical privileges.

4.5-9 Notice of Final Decision

The decision to grant, deny, revise, or revoke privilege(s) is disseminated and made available to appropriate internal and external persons or entities, as defined and approved by the medical staff, hospital and applicable law. Notice of the final decision shall be given to the Chief of Staff, the Medical Executive Committee, the chair and the co-chairs each department concerned, the applicant, and the Chief Executive Officer. The decision and notice to grant or renew membership shall include, if applicable: (1) the staff category to which the applicant becomes a member; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the membership. Notice of Privileges granted is also be distributed to all hospital departments involved via hospital intranet addressing current medical staff roster and privilege delineations.

4.5-10 Reapplication After Adverse Membership Decision

An applicant who has received a final adverse decision regarding membership shall not be eligible to reapply to the medical staff for a period of two (2) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists. A "final adverse" decision refers to a final decision under these bylaws and the conclusion of judicial appeals.

4.5-11 Timely Processing of Applications

Applications for staff membership shall be considered in a timely manner by all persons and committees required by these bylaws to act thereon. The following will provide a guideline for routine processing of applications:

(a) Evaluation and review of all supporting documents will be conducted by the medical staff office personnel no later than 45 days from receipt of application. Applicant will be notified of any/all missing items and requested to submit. Application is considered incomplete pending receipt of all missing items;

(b) Verification process of application will commence upon determination that all necessary documentation has been received and application is complete. Verification on a complete application will commence no later than 7-days after receipt;

(c) Review and recommendation by the appropriate department chair(s) and co-chairs', as applicable, and the credentials committee within 45 days of receipt of all required primary source verifications. The department chair(s) or co-chairs,, at their discretion, may request the input of another member of the department or may request an interview of the applicant at the next available department meeting;

(d) Review and recommendation by the Medical Executive Committee and Board of Trustees at their next regularly scheduled meetings; and;

(e) Final action: 180 days after receipt of all necessary documentation by the Medical Staff Office, or 7 days after conclusion of hearings.

Applications that remain incomplete 90 days after initial receipt by the medical staff office and written notice to the applicant, shall be considered withdrawn and no further processing will be performed.

4.6 MEMBERSHIP REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

4.6-1 Reappointment Application

At least one hundred twenty (120) days prior to the expiration date of the current staff appointment (except for temporary membership), a reapplication form approved by the Medical Executive Committee shall be provided to the medical staff member or allied health member. If an application for renewal of membership is not received within (30) days after the application has been mailed, written notice shall be promptly sent to the applicant advising that the application has not been received by the Medical Staff Office. At least ninety (90) days prior to the expiration date, each medical staff or allied health member shall submit to the Medical Staff Office the completed application form for renewal of membership and/or renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant including, but not limited to, the matters set forth in Section 4.5-1, as well as other relevant matters. Upon receipt of the application, the information shall be processed as set forth commencing at Section 4.5-3.

A medical staff or allied health member who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time upon a form approved by the Medical Executive Committee, except that such application may not be filed within *one year* of the time a similar request has been denied, unless evidence is presented of additional education, training, credentials, etc.

4.6-2 Effect of Application

The effect of an application for renewal of membership or modification of staff status or privileges is the same as that set forth in Section 4.5-2.

4.6-3 Standards and Procedure for Review

When a staff member submits the first application for renewal of membership, and no more than every two years thereafter, or when the member submits an application for modification of staff status or clinical privileges, the member shall be subject to an in-depth review generally following the procedures set forth in Sections 4.5-3 through 4.5-11.

4.6-4 Failure to File Application for Renewal of Membership

Failure without good cause to file a completed application for reappointment shall result in automatic resignation of Medical Staff membership and clinical privileges at the end of the current appointment period. In the event membership terminates for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

A reappointment application received past the due date or following such automatic resignation shall be processed in the manner specified for applications for initial appointment, except that the member shall not be required to undergo initial proctoring requirements for clinical privileges that were previously granted by the medical staff.

4.7 LEAVE OF ABSENCE

4.7-1 Leave Status

At the discretion of the Medical Executive Committee, a medical staff member may obtain a voluntary leave of absence from the staff upon submitting a written request to the Medical Executive Committee stating the approximate period of leave desired, which may not exceed one (1) year. During the period of the leave, the member shall not exercise clinical privileges at the hospital, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical staff. The reason for the leave of absence shall be included in the request.

4.7-2 Termination of Leave

At least 30 days prior to the termination of the leave of absence, or at any earlier time, the medical staff member may request reinstatement of privileges by submitting a written notice to that effect to the Medical Executive Committee. The staff member shall submit a summary of relevant activities during the leave, if the Medical Executive Committee so requests. The member's department chair or co-chairs, as applicable, shall make a recommendation to the Medical Executive Committee concerning the reinstatement of the member's privileges and prerogatives, and the procedure provided in Sections 4.1 through 4.5-1 0 shall be followed.

4.7-3 Failure to Request Reinstatement

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff and shall result in automatic resignation of membership, privileges, and prerogatives. A request for medical staff membership subsequently received from a member so terminated shall be submitted and processed in the manner specified for applications for initial membership.

4.7-4 Medical Leave of Absence

The Medical Executive Committee shall determine the circumstances under which a particular medical staff member shall be granted a leave of absence for the purpose of obtaining treatment for a medical condition or disability. In the discretion of the Medical Executive Committee, unless accompanied by a reportable restriction of privileges, the leave shall be deemed a medical leave which is not granted for a medical disciplinary cause or reason. Reactivation may be granted subject to monitoring and/or proctoring as recommended by the department and determined by the Medical Executive Committee, which shall not be deemed disciplinary action.

4.7-5 Military Leave of Absence

Requests for leave of absence to fulfill military service obligations shall be granted upon notice and review by the Medical Executive Committee. Reactivation of membership and clinical privileges previously held shall be granted, notwithstanding the provisions of Sections 4.7-2 and 4.7-3, but may be granted subject to monitoring and/or proctoring as recommended by the department and determined by the Medical Executive Committee which shall not be deemed ,disciplinary action.

ARTICLE V CLINICAL PRIVILEGES

5.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a member providing clinical services at this hospital shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be hospital specific, within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to the rules and regulations of the clinical department and the authority of the department chair or co-chairs, as applicable, and the medical staff. Medical staff privileges may be granted, continued, modified or terminated by the governing body of this hospital only upon recommendation of the medical staff, and approval of the board of trustees in accordance with the provisions of the medical staff bylaws.

5.2 DELINEATION OF PRIVILEGES IN GENERAL

5.2-1 Requests

Each application for initial membership or renewal of membership to the medical staff must contain a request for the specific clinical privileges desired or no longer desired by the applicant. A request by a member for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

5.2-2 Basis for Privileges Determination

(a) Requests for clinical privileges shall be evaluated on the basis of the member's education, training, experience, current demonstrated professional competence and judgment, clinical performance, current health status, and the documented results of patient care and other professional practice review and monitoring which the department and Medical Executive Committee deems appropriate. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges.

(b) No specific privilege may be granted to a member if the task, procedure or activity constituting the privilege is not available within the hospital despite the member's qualifications or ability to perform the requested privilege.

(c) The burden of providing sufficient information to evaluate a request and to demonstrate qualifications rests with the applicant. The provisions of Article IV apply to requests for privileges.

5.2-3 Criteria for "Cross-Specialty" Privileges within the Hospital

Any request for clinical privileges that are either new to the Hospital or that overlap more than one department shall initially be reviewed by the appropriate departments, in order to establish the need for, and appropriateness of, the new procedure or

services. The Medical Executive Committee shall facilitate the establishment of hospital-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad-hoc committee with representation from all appropriate Departments.

5.3 PROCTORING / FOCUSED PROFESSIONAL PERFORMANCE EVALUATION PROCTORING

5.3-1 General Provisions

Except as otherwise determined by the Medical Executive Committee, all initial members to the medical staff and all members granted new clinical privileges shall be subject to a period of initial FPPE proctoring. During this period, determination as to suitability to continue to exercise the clinical privileges granted in that department shall be determined. Each new member or recipient of new clinical privileges shall be assigned to a department where performance on an appropriate number of cases, as established by the respective department, approved by the Medical Executive Committee, shall be conducted by the department chair or co-chairs, as applicable, or designee. During the period of proctoring the respective department may accept reciprocal proctoring performed at another facility where the member has medical staff privileges, as follows: (1) one proctored case must include care performed at one of the facilities that is part of the Hospital and the remainder of the required number of observed cases may be submitted by reciprocal proctoring from another accredited hospital, (must be CMS approved accrediting body, i.e., TJC, DNV, HFAP, URAC), (2) except for the one case that must be performed at one of the facilities that is part of the Hospital for which a proctoring report is required, a proctoring summary will be accepted indicating the types, number, and outcomes of cases proctored, and, (3) the cases proctored should reflect the privileges granted at IVHD. Additional proctoring may be required, in accordance with respective department rules and regulations.

The member shall remain subject to initial FPPE proctoring until the Medical Executive Committee has been furnished with:

(a) a report signed by the chair of the co-chairs, as applicable, department(s) to which the member is assigned describing the types and numbers of cases observed and the evaluation of the applicant's performance, a statement that the applicant appears to meet all of the qualifications for unsupervised practice in that department, has discharged all of the responsibilities of staff membership, and has not exceeded or abused the prerogatives of the category to which membership was granted;

(b) Proctoring may be required at the discretion of the department or Medical Executive Committee at any time during the provisional period, and under those other circumstances outlined in Section 6.2-2, FPPE of Initial Privileges, in these Medical Staff Bylaws, and includes but not limited to:

1) as a condition of privilege renewal for privileges performed so infrequently that assessment of current competence is not feasible; and
2) whenever the department or the Medical Executive Committee determines that additional information is needed to assess a practitioner's current competency. Proctoring in these circumstances in which there is inadequate information to evaluate competence shall not be deemed discipline and not grounds for the procedures in Article VII.

5.3-2 Failure to Complete Proctoring

If a new member fails within the time of provisional membership to furnish the certification required, or if a member exercising new clinical privileges fails to furnish such certification within the time allowed by the department, those specific clinical privileges shall automatically be resigned and the member shall not be afforded the procedural rights provided in Article VII.

(a) Failure to Complete Necessary Volume: Any initial appointee or member exercising new clinical privileges who fails to satisfactorily complete the required number of proctored cases within the time frame established in the bylaws and the rules and regulations shall be deemed to have voluntarily withdrawn his or her request for membership or the relevant privileges, and he or she shall not be afforded the procedural rights provided in Article VII. However, the department has discretion to extend the time for completion of proctoring in appropriate cases. The inability to obtain such an extension shall not give rise to procedural rights described in Article VII.

(b) Failure to Satisfactorily Complete Proctoring. If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during the proctoring period, the Medical Executive Committee, based on the recommendation of the department Chair or co-chairs, as applicable, may extend or recommend that the relevant privileges be revoked and the member shall be afforded the procedural rights as provided in Article VII.

(c) The failure to complete proctoring for any specific privilege shall not, by itself, preclude advancement from provisional staff. If advancement is approved by the Medical Executive Committee before completion of proctoring, the proctoring will continue for the specified privileges. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed within a reasonable time after any such advancement. Such voluntary relinquishment or termination of the privilege(s) does not entitle the member to procedural rights as described in Article VII.

5.3-3 Medical Staff Advancement

The failure to successfully complete proctoring for any specific clinical privileges shall not, of itself, preclude advancement in medical staff category of any member. If such advancement is granted absent such certification, continued proctorship on the uncertified procedure shall continue for the specified time period at the determination of the department, and as approved by the Medical Executive Committee.

5.4 CONDITIONS FOR PRIVILEGES OF LIMITED LICENSE PRACTITIONERS

5.4-1 Admissions

When dentists and any oral surgeons, podiatrists, clinical psychologists, who do not hold history and physical privileges who are members of the medical staff admit patients, a physician member of the medical staff with history and physical privileges must document and conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry, podiatry or clinical psychology, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

5.4-2 Surgery

Surgical procedures performed by dentists and podiatrists shall be under the overall supervision of the co-chairs of the department of surgery or the their designee.

5.4-3 Medical Appraisal

All patients admitted for care in a hospital by a dentist, oral maxillofacial surgeon, podiatrist, or clinical psychologist shall receive the same basic medical appraisal as patients admitted to other services, and the dentists or oral maxillofacial surgeons, podiatrists, clinical psychologists shall seek consultation with a physician member to determine the patient's medical status and need for medical evaluation whenever the patient's clinical status indicates the presence of a medical problem. Where a dispute exists regarding proposed treatment between a physician member and a limited license practitioner based upon medical or surgical factors outside of the scope of licensure of the limited license practitioner, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate department(s).

5.5 SECTION OMITTED

5.6 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges may be considered under two circumstances: (1) To fulfil an important patient care treatment, and service need; (2) When an applicant for new privileges with a complete application that raises no concerns is awaiting review and approval by the medical staff executive committee and the board of trustees (this includes the initial applicant, as well as the current member or AHP who is requesting one or more additional privileges). There is no right to temporary privileges and a granting of temporary privileges is not binding or conclusive with respect to an applicant's pending request for appointment or privileges. Temporary privileges for applicants may be granted for no more than 120 days.

5.6-1 Patient Care Needs

(a) **Important Patient Care Need**

Temporary clinical privileges may be granted where good cause exists to allow a physician, dentist, podiatrist, clinical psychologist or AHP to provide patient care treatment, service, and continuity of care, provided that the procedure described in this section, Section 5.6-4, has been completed.

(b) **Locum Tenens**

Temporary clinical privileges may be granted to a person serving as a locum tenens in order to fulfill an important patient care need to provide continuity of care, provided that the procedure described in Article IV has been completed. Such privileges may attend only patients of the member for whom that person is providing locum tenens coverage, for a period not to exceed 90 days in a twelve-month period. The Medical Executive Committee may recommend a longer period for good cause, not to exceed 120 days.

5.6-2 Pending Application for Medical Staff Membership and Privileges

Temporary clinical privileges may be granted to an applicant for new privileges while awaiting review and approval by the Medical Executive Committee provided that the procedure described in Section 5.6-4(a)(2) has been completed, and that the applicant has no current or previously successful challenge to professional licensure or registration, no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges . Such privileges shall not exceed a period of 120 days.

5.6-3 Temporary Membership and Temporary Privileges Not Co-Extensive

Temporary members of the medical staff pursuant to Section 5.6 are not, by virtue of such membership, granted temporary clinical privileges.

5.6-4 Application and Review

(a) Pendency of Application. Upon receipt of a completed Initial Application or request for additional privileges from a physician, dentist, podiatrist, clinical psychologist or AHP authorized to practice in California and a recommendation from the Credentials Committee and Department Chair or co-chairs, as applicable, for approving the application, the chief executive officer on the recommendation of either the applicable clinical department chairpersons, or the Chief of Staff *or designee* may grant temporary privileges to a member upon verification of the following consistent with these Medical Staff Bylaw, 2.2:

(1) current licensure
(2) relevant training or experience
(3) ability to perform the privileges requested
(4) other criteria required by the medical staff bylaws.
Query and evaluation of the National Practitioner Data Bank Report
(5) a complete application
(6) no current or previously successful challenge to licensure or registration
(7) not subject to involuntary termination of medical staff membership at another organization
(8) not subject to involuntary limitation, reduction, denial or loss of clinical privileges

(b)Locum Tenens and to Fulfill an Important Patient Care Need. With respect to temporary privilege applications to fulfill an important patient care need or a locum tenens, only after receipt of an application for clinical privileges and supporting documentation and verification of:

(1) current licensure, report has no sanction activity or any restriction against the medical license*;*
(2) training and current competence for privileges requested;
(3) OIG,
(4) National Practitioner Data Bank report obtained and does not contain adverse information that the department chair or co-chairs, as applicable, or Chief of Staff determines may impact safe patient care or have a direct bearing on the ability to perform the requested privileges,
(5) Verification of professional liability insurance in the required amounts as established in these bylaws;
(6) Verification that applicant has no sanction activity or any restriction against their medical license*;*
(7) The respective department chair, a co-chair, or designee, has contacted at least one person who: -Has recently worked with the applicant *in the same or similar specialty;* -Has recently *directly* observed the applicant's professional performance over a reasonable time; -Provides reliable information regarding the applicant's current professional competence to perform the privileges requested, ethical character, and ability to work well with others so as not to adversely affect patient care, or other criteria required by medical staff bylaws.

(c) Temporary clinical privileges sought for the care of specific patients are limited to a maximum of four (4) patients in any twelve month period and are limited to the duration of the patient's stay in the hospital. Temporary privileges to act as a locum tenens may not exceed sixty (60) day increments with a maximum to not exceed 180 days in a twelve month period. Temporary clinical privileges will not be granted to practitioners to act as primary surgeon, perform deliveries, or to act as the primary practitioner or licensed clinical psychologist for patients in the intensive care units.

(d) After reviewing the applicant's file and supporting documents, Chief of Staff (or designee) shall make a recommendation regarding granting of temporary privileges, the Chief Executive Officer (or designee) shall give final approval. Notice shall be distributed as needed within the hospital.

(e) The omission of any information, response or recommendation specified in this section shall preclude the granting of temporary privileges.

5.6-5 General Conditions

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chair or co-chairs, as applicable, to which the applicant has been assigned, and shall ensure that the chair, co-chair or their designee, is kept closely informed as to the applicant's activities within the hospital.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed following the procedure as set forth in Section 5.6-4. A medical staff applicant's temporary privileges shall automatically terminate if the applicant ' s application for membership or the privileges is withdrawn. As necessary, the appropriate department chair or, or applicable co-chairs, or in their absence, the chair of the Medical Executive Committee, shall assign a member of the medical staff to assume responsibility for the care of such member's patient(s). The wishes of the patient shall be considered in the choice of a replacement medical staff member.

(c) Requirements for proctoring and monitoring, including but not limited to those in Section 5.3, shall be imposed on such terms as may be appropriate under the circumstances upon any member granted temporary privileges by the Chief of Staff after consultation with the departmental chair, co-chairs or the their designee.

(d) All persons requesting or receiving temporary privileges shall be bound by the bylaws and rules and regulations of the medical staff.

5.7 EMERGENCY PRIVILEGES

In the case of an emergency involving a particular patient, any member of the medical staff with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license. The member shall make every reasonable effort to communicate promptly with the department chair or co-chairs, as applicable, or their designee concerning the need for emergency care and assistance by members of the medical staff with appropriate clinical privileges, and once the emergency has passed or assistance has been made available, shall defer to the department chair or co-chairs with respect to further care of the patient at the hospital.

In the event of an emergency under subsection (a) any person shall be permitted to do whatever is reasonably possible to save the life of a patient or to save a patient from serious harm. Such persons shall promptly yield such care to qualified members the medical staff with approved clinical privileges when it becomes reasonably available.

Emergency privileges under subsection (a) shall not be used to force members to serve on emergency department call panels.

5.8 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and/or the hospital is unable to handle the immediate patient needs, the Hospital CEO, Chief of Staff *or* his/her designee may grant disaster privileges.

(1) Authorization to grant. In the absence of the Chief of Staff or Chief Executive Officer, the Chief Medical Officer, or his/her designee may grant the disaster privileges. The granting of privileges under this section shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges.

(2) Determination. An initial granting of disaster privileges is reviewed by a person authorized to grant disaster privileges within 72 hours to determine whether the disaster privileges should be continued. The decision to continue or terminate privileges will be determined by the Chief of Staff or his/her designee, the Department Chair or co-chairs, or their designee, or in their absence, the CEO or his/her designee. Continuation or termination of temporary disaster privileges will be communicated by the Medical Staff Office, Disaster Command Center, and to all hospital departments and supervisory personnel (including Disaster Team Leaders), and to the practitioner(s) to whom disaster privileges have been granted.

(3) Verification process. The credentials verification process of individuals who receive disaster privileges under this subsection has been developed in advance of a disaster situation, and shall be in accordance with these Bylaws.

(4) Management/oversight of disaster privileged individuals. There shall be oversight of the care, treatment, and services provided. This shall be accomplished by oversight by an IVHD medical staff member. This may consist of direct observation and/or clinical record review.

(5) Identification. Each individual granted disaster privileges will be issued an IVHD name badge, to allow staff to readily identify them.

(6) Verifications. The medical staff has a mechanism to ensure that the verification process of the credentials and privileges of individuals who receive disaster privileges begins as soon as the immediate situation is under control. Those authorized under subsection (a) may grant disaster privileges upon presentation of a valid picture ID issued by a state, federal or regulatory agency and at least one of the following:

(a) current picture hospital ID card clearly identifying professional designation.

(b) A current California medical license to practice to practice in the state of California, or waiver by a federal, state, or municipal entity granting authority to practice out of state during a state or federal emergency.

(c) When applicable, identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT) or MRC, ESAR- VHP, or other recognized state or federal organizations or groups.

(d) Identification indicating that the individual has been granted authority by a federal, state, or municipal entity to render patient care in disaster circumstances.

(e) Verification by current hospital affiliation, or current peer, of knowledge regarding the volunteer's ability to act as a licensed independent practitioner during a disaster,

(f) Current professional licensure of those providing care under disaster privileges is verified from the primary source as soon as the immediate emergency situation is under control or within 72 hours from the time the volunteer licensed independent practitioner presents to the hospital, whichever comes first.

(g) National Practitioner Data Bank, OIG

(7) If primary source verification cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the hospital documents all of the following:

(a) The reason(s) verification could not be performed within 72 hours of the practitioner's arrival,
(b) Evidence of the licensed independent practitioner's demonstrated ability to continue to provide adequate care, treatment and services.
(c) Evidence of an attempt to perform primary source verification as soon as possible.

(8) Upon approval, Notification of Disaster Privileges granted, will be distributed to all departments involved.

5.9 HISTORY AND PHYSICAL PRIVILEGES

Histories and physicals can be conducted or updated and documented only pursuant to specific privileges granted upon request to qualified physicians and allied health staff who are members of the medical or allied health staff, or seeking temporary privileges, acting within their scope of practice.

Oral maxillofacial surgeons who have successfully completed a postgraduate program in oral maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education and have been determined by the medical staff to be competent to do so, may be granted the privileges to perform a history and physical · examination related to oral maxillofacial surgery. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member of the medical staff with history and physical privileges must conduct or directly supervise the admitting history and physical examination, except the portion related to oral maxillofacial surgery, and assume responsibility for the care of the patient's medical problems present at the time of admission or which may arise during hospitalization which are outside of the oral maxillofacial surgeon's lawful scope of practice.

Every patient receives a history and physical within twenty-four hours of admission, unless a previous history and physical performed within thirty days of admission (or registration if an outpatient procedure) is on record, in which case that history and physical will be updated within twenty-four hours of admission. Every patient admitted for surgery must have a history and physical within 24 hours prior to surgery, unless a previous history and physical performed within thirty days prior to the surgery is on record, in which case that history and physical will be updated within twenty-four hours of the surgery.

5.10 MODIFICATION OF CLINICAL PRIVILEGES OR DEPARTMENT ASSIGNMENT

On its own, upon recommendation of the, department, or pursuant to a request under Section 4.6-l, the Medical Executive Committee may recommend a change in the clinical privileges or department assignment(s) of a member. The Medical Executive Committee may also recommend that the granting of additional privileges to a current medical staff member be made subject to monitoring in accordance with procedures similar to those outlined in Section 5.3-1.

5.11 LAPSE OF APPLICATION

If a medical staff member requesting a modification of clinical privileges or department assignments fails to timely furnish the information reasonably necessary to evaluate the request, the application shall be considered withdrawn, and the applicant shall not be entitled to a hearing as set forth in Article VII.

ARTICLE VI EVALUATION AND CORRECTIVE ACTION

Peer review, fairly conducted, is essential to preserving the highest standards of medical practice.

6.1 PEER REVIEW

The medical staff committees, departments, department chairs and cochairs are responsible for carrying out delegated review and quality improvement functions in accordance with the medical staff's peer review policy. They may counsel, educate, refer for education or evaluation, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action proceedings. Comments, suggestions and warnings may be issued orally or in writing. The practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the committee. Any informal actions, monitoring or counseling shall be documented in the member's file. Medical Executive Committee approval is not required for such actions, although the actions shall be reported to the Medical Executive Committee. This shall not be construed to confer any rights upon a practitioner to any routine monitoring and education prior to corrective action. These actions shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights under Article VII.

6.2 ONGOING PEER REVIEW

All Medical Staff and Allied Health Members are subject to evaluation based on medical staff peer review criteria, adopted consistent with these bylaws. Evaluation results are used in privileging, system improvement, and when warranted, corrective action.

6.2-1 Peer Review Criteria

Departments shall develop and routinely update peer review criteria based on current practices and standards of care, which shall be used in evaluating those applying for membership and privileges and the performance of members and privileges holders. Included in the departmental peer review criteria are the types of data to be collected for evaluation. At a minimum, departments shall, where relevant, collect and evaluate department members' data pertaining to:

a) Operative and other clinical procedure(s) performed and their outcomes
b) Pattern of blood and pharmaceutical usage
c) Requests for tests or procedures
d) Appropriateness of clinical practice patterns
e) Patterns of length of stay
f) Significant departures from established patterns of clinical practice
g) Morbidity and mortality
h) Practitioner's use of consultants

In addition, each department shall add and update department-specific criteria at least annually for ongoing peer review of department members. Department criteria are subject to the approval of the Medical Executive Committee. Approved criteria as updated are made known and accessible to all members.

6.2-2 Focused Professional Performance Evaluation (FPPE) of Initial Privileges

All initial grants of privileges shall be subject to FPPE proctoring, under these bylaws and otherwise reviewed for compliance with the relevant departmental peer review criteria. The purpose of a focused review is to determine if the practitioner's performance and behavior meets the minimum standard of behavior or clinical care as is established by the Medical Staff. FPPE is not considered a formal investigation as defined in the Medical Staff Bylaws and is not subject to rights afforded in a formal investigation.

If the FPPE results in an action plan to recommend additional proctoring, monitoring, as stated above the FPPE is not considered a formal investigation as defined in the Medical Staff Bylaws and is not subject to rights afforded in a formal investigation.

If the FPPE results in a recommendation for formal investigation, the process outlined in the Medical Staff Bylaws will be followed. In this circumstance, FPPE is an intensified assessment of data or events which relate to the performance or behavior of a specific practitioner holding clinical privileges.

The FPPE for cause process may be triggered:

a) When a practitioner has the credentials to suggest competence, but additional information or a period of evaluation is needed to confirm competence in the organization's setting.
b) If questions arise regarding a currently privileged practitioner's ability to provide safe, high quality patient care.
c) Sentinel Event/Adverse Event
d) Behavior Issues
e) Trends in practice determined to be outside internal and/or external standards of care. A trend is defined as:
   - A practitioner with three category III evaluations within a two year period.
   - Significant deviations in practice identified through the ongoing professional practice evaluation (OPPE) process.

6.2-3 Initiation of FPPE for cause

a) When an FPPE for cause is triggered by an unsatisfactory performance on OPPE, initial FPPE, or other PEER review concerns, a plan for the FPPE will be developed.

b) This FPPE plan will include the cause of the FPPE Plan, planned period of observation, and nature of expected practice change, the specific actions and specific mechanism by which the monitoring will occur (e.g. peer observation, retrospective chart review, proctoring of procedures performed, etc.) required by the FPPE, data to be collected during the FPPE, and any limitations on practice during the course of the FPPE, will be clearly defined by the Department Chair or co-chairs to the physician-of-record. The individual undergoing the FPPE will receive a copy of the FPPE plan.

c) Following completion of the FPPE time period, the respective Chair or co-chairs (or designee) will meet with the individual undergoing the FPPE and determine whether the FPPE was completed adequately and if further action needs to be taken.

d) The respective Department Chair or co-chairs will notify the Medical Executive Committee regarding plan for initiation of FPPE. Once the FPPE is completed, results will be reported within 90-days of initiation.

e) The Medical Executive Committee will be informed of successful closure of FPPE, or, if FPPE is not successfully completed, recommendation regarding privileges will be forwarded by the Department, to the committee for discussion and action.

f) If necessary, an extension of the FPPE may be approved by the respective Department Chair or co-chairs and Chief of Staff. The practitioner will be notified as to the length of the extension which should not exceed an additional 60-days. This shall be reported at the next regularly scheduled Medical Executive Committee meeting.

all members.

6.2-4 Ongoing Professional Performance Evaluation (OPPE) of Members

OPPE is the continuous evaluation of the practitioner's professional performance in order to identify and resolve any potential problems with a practitioner's performance. It allows the Medical Staff to identify professional practice trends that impact quality of care and patient safety on an ongoing basis, provides an evaluation of an individual practitioner's performance and includes opportunities to improve patient care based on recognized standards. OPPE uses multiple sources of information for individual evaluation which is factored into the decision to maintain existing privilege(s), revise an existing privilege, or to revoke an existing privilege prior to or at the time of reappointment. OPPE includes, but is not limited to review of the following:

a) Direct observation
b) Monitoring of diagnostic and prescribing patterns
c) Compliance with hospital policies that have been approved by the Medical Executive Committee, Medical Staff Bylaws and Medical Staff Rules and Regulations
d) Clinical Standards and the use of rates compared against established benchmarks
e) Results of any required monitoring/proctoring
f) Utilization data
g) Core Measures Compliance
h) National Patient Safety Goals
i) The six areas of general competency (patient care, medical/clinical knowledge, practice-based learning, interpersonal and communication skills, professionalism, and system-based practice)
j) Easily retrievable from existing databases whenever feasible.

After initial granting of privileges, the professional practice and professional conduct of each department's medical staff members will be evaluated at nine month intervals, or sooner if indicated, and on reappointment. A performance summary that includes the performance data identified by the department for collection and review will be submitted to the department for review. The Department Chair or co- chairs, applicable, shall report to the MEC the results of the review with any recommendations at the time of credentialing and when issues are identified. If there are any concerns with a practitioner's performance as a result of the OPPE, the concerns will be communicated to the practitioner and documented in his/her credentials file, and may result in a focused review and /or corrective action in accordance with these Medical Staff Bylaws.

Each clinical department shall determine what performance data it will collect and review which then must be approved by the MEC on behalf of the Medical Staff. Each department will determine the processes to the extent it will use to accumulate and review the data. To the extent a Medical Staff committee has been designated to fulfill the above department functions, the committee will fulfill those functions. The committee will report the outcome of these reviews to the applicable department and the MEC.

6.2-5 Results of Review

Information resulting from OPPE of members according to the relevant department criteria and analyzed by the process established in these bylaws must be acted upon by the department and forwarded to the Medical Executive Committee. Resulting action can be, but is not limited to:

a) documenting in the member's credentials file the member's performance;
b) identifying issues that require a focused evaluation;
c) determining that the privilege should be continued
d) recommending to the Medical Executive Committee needed changes in hospital systems to improve patient safety or the quality of patient care;
e) recommending limiting a privilege or privileges or other corrective action described in these bylaws.

The fact of the peer review and any recommendations and determinations pertaining to the member shall be included in the member's credentials file and dealt with according to these bylaws.

6.2-6 External Peer Review

External peer review may be used as needed in the medical staff peer review process as delineated under these bylaws. The Medical Executive Committee, upon request from a Department or upon its own motion, in evaluating or investigating an applicant, privileges holder, or member. The Medical Executive Committee shall consider obtaining external peer review in the following circumstances:

a) Committee or department review(s) that could affect an individual's membership or privileges do not provide a sufficiently clear basis for action;
b) No current Medical Staff member can provide the necessary expertise in the clinical procedure or area under review;
c) to promote impartial peer review;
d) Upon the request of the practitioner. If requested by the practitioner, the cost will be underwritten by the practitioner; however, the selection will be approved by the department and ratified by the Medical Executive Committee.

6.3 CORRECTIVE ACTION

6.3-1 Criteria for Initiation

Any person may provide information to the medical staff about the conduct, performance, or competence of its members. When reliable information indicates a member may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the hospital; (2) unethical; (3) contrary to the medical staff bylaws and rules or regulations;
or (4) below applicable professional standards, a request for an investigation or action against such member may be initiated by the Chief of Staff, a department chair or co-chairs, or the Medical Executive Committee.

6.3-2 Initiation

A request for an investigation must be in writing, submitted to the Medical Executive Committee, and supported by reference to specific activities or conduct alleged. If the Medical Executive Committee initiates the request, it shall make an appropriate recording of the reasons.

6.3-3 Investigation

If the Medical Executive Committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The Medical Executive Committee may conduct the investigation itself, or may assign the task to an appropriate Medical Staff Officer, medical staff department, or standing or ad hoc committee of the medical staff. The Medical Executive Committee in its discretion may appoint practitioners who are not members of the medical staff as temporary members of the medical staff for the sole purpose of serving on a standing or ad hoc committee, and not for the purpose of granting these practitioners temporary clinical privileges under Section 5.6, should circumstances warrant.

If the investigation is delegated to an officer of a committee other than the Medical Executive Committee, such officer or committee shall proceed with the investigation in a prompt manner and shall forward a written report of the investigation to the Medical Executive Committee as soon as practicable. The report may include recommendations for appropriate corrective action. The member shall be notified that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate.

The individual or body investigating the matter may, but is not obligated to, conduct interviews with persons involved; however, such investigation shall not constitute a hearing as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply. Despite the status of any investigation, at all times the Medical Executive Committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

6.3-4 Executive Committee Action

As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall take action, which may include one or more of the following, without limitation:

a) determining no corrective action be taken;

b) referring the member to the Wellness Committee for evaluation and follow up as appropriate;

c) deferring action for a reasonable time where circumstances warrant;

d) issuing letters of admonition, letters of education**,** censure, reprimand, or warning, although nothing herein shall be deemed to preclude department heads, the Chief of Staff or Medical Executive Committee from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected member may make a written response, which shall be placed in the member's file;

e) recommending the imposition of terms of probation or special limitation upon continued medical staff membership or exercise of clinical privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring;

f) recommending reduction, modification, suspension or revocation of clinical privileges;

g) recommending reductions of membership status or limitation of any prerogatives directly related to the member's delivery of patient care;

h) recommending suspension, revocation or probation of medical staff membership;

i) determining whether the action is taken for any of the reasons required to be reported pursuant to Business & Professions Code §805.01.

j) taking other actions deemed appropriate under the circumstances.

The date of the conclusion of the investigation shall be documented.

6.3-5 Subsequent Action

If corrective action as set forth in Section 7.2(a)- (l) is recommended by the Medical Executive Committee, that recommendation shall be supported by substantial evidence and transmitted to the Board of Trustees.

So long as the recommendation is supported by substantial evidence the recommendation of the Medical Executive Committee shall be adopted by the board as final action unless the member requests a hearing, in which case the final decision shall be determined as set forth in Article VII.

6.3-6 Initiation by Board of Trustees

If the Medical Executive Committee fails to investigate or take disciplinary action, contrary to the weight of the evidence,- the Board of Trustees may direct the Medical Executive Committee to initiate investigation or disciplinary action, but only after consultation with the Medical Executive Committee. The board's request for medical staff action shall be in writing and shall set forth the basis for the request. If the Medical Executive Committee fails to take action in response to that Board of Trustees direction, the ad hoc dispute mediation process set forth in these bylaws (unless immediate action is required to protect the health or safety or any individual, in which event the procedures for summary suspension shall apply).

If the dispute mediation process does not result in action by the Medical Executive Committee, and the Board of Directors still believes action is necessary, then the Board of Directors may initiate an investigation or corrective action. However, the Board of Directors shall not initiate an investigation or corrective action under this section unless it has documented a reasonable and good faith belief that the medical staff has failed or declined to fulfill a substantive duty or responsibility pertaining to the quality or delivery of patient care. In addition, any investigation or corrective action by the Board of Directors must comply with Articles VI and VII of these medical staff bylaws, and the Board of Directors shall not act precipitously, unreasonably, or in bad faith.

6.4 SUMMARY RESTRICTION OR SUSPENSION

6.4-1 Criteria for Initiation

Whenever a member's conduct is such that failure to take action may result in an imminent danger to the health of any individual, then the Chief of Staff, the Medical Executive Committee, or Chair or co-chair of the department in which the member holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such member. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the Board of Trustees, the Medical Executive Committee and the administrator. In addition, the affected medical staff member shall be provided with a written notice of the action which notice fully complies with the requirements of Section 6.4-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of summary restriction or suspension, the member's patients shall be promptly assigned to another member by the department chair, a co-chair or by the Chief of Staff, considering where feasible, the wishes of the patient in the choice of substitute member.

6.4-2 Written Notice of Summary Suspension

The affected medical staff member may be verbally notified of the summary action and shall promptly be provided with written notice of such summary action. This initial written notice shall generally describe the reasons for the action. This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the Medical Executive Committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

6.4-3 Medical Executive Committee Action

Within ten (10) days after such summary restriction or suspension has been imposed, a meeting of the Medical Executive Committee (or a subcommittee with at least one member from his/her department appointed by the chief of staff) shall be convened to review and consider the action. Upon request, the member may attend and make a statement concerning the issues under investigation, on such terms and conditions as the Medical Executive Committee may impose, although in no event shall any meeting of the Medical Executive Committee, with or without the member, constitute a hearing within the meaning of Article VII, nor shall any procedural rules apply. Upon at least three (3) days' written notice, the member may be required to attend this meeting. The Medical Executive Committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the member with notice of its decision within two *working* days of the meeting.

6.4-4 Procedural Rights

Unless the Medical Executive Committee terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process and the member shall be entitled to the procedural rights afforded by Article VII.

6.4-5 Initiation by Board of Trustees

If the chief of staff, or designee, and the department chair or co-chairs or designee in which the member holds privileges are not available to summarily restrict or suspend the member's membership or clinical privileges, the Board of Trustees or designee may immediately suspend a member's privileges if a failure to suspend those privileges is likely to result in an imminent danger to the health of any person, provided that the Board of Trustees (or designee) made reasonable attempts to contact the Chief of Staff, or designee, and the head of the department or designee before the suspension.

Such a suspension is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify such a summary suspension within two working days, excluding weekends and holidays, the summary suspension shall terminate automatically. If the Medical Executive Committee does ratify the summary suspension, all other provisions under Section 6.4 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the Medical Executive Committee for purposes of compliance with notice and hearing requirements.

6.5 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the member's privileges or membership shall be suspended or limited as described, which action shall be final without a right to hearing or further review, except where a bona fide dispute exists as to whether the circumstances have occurred that triggered the automatic action. If a hearing is requested, it shall be limited to whether the grounds for automatic suspension or restriction occurred: Evidence shall not include that the determination that lead to the action that triggered the automatic action was reasonable are warranted.

6.5-1 Licensure

(a) Revocation, Suspension or Court Order to not Practice: Whenever a member's license or other legal credential authorizing practice in this state is revoked or suspended, or if there is a Court order not to practice, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

(b) Restriction: Whenever a member's license or other legal credential authorizing practice in this state is limited or restricted by the applicable licensing or certifying authority or restricted by a Court order, any clinical privileges which the member has been granted at the hospital which are within the scope of said limitation or restriction shall be automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

(c) Probation: Whenever a member is placed on probation by the applicable licensing or certifying authority, membership status and clinical privileges shall automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.

(d) Expiration: Whenever a member's license or other legal credential authorizing practice in this state expires, his or her membership and/or clinical privileges shall become immediately suspended as of the date such action becomes effective. Failure to renew the expired licensure within 90-days of Suspension, will result in the member's automatic termination of membership and privileges.

6.5-2 Controlled Substances

Whenever a member's DEA certificate is revoked, limited or suspended, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate, as of the date such action becomes effective and throughout its term.

Probation: Whenever a member's DEA certificate is subject to probation, the member's right to prescribe such medications shall automatically become subject to the same terms of the probation, as of the date such action becomes effective and throughout its term.

Whenever a member's DEA certificate on file expires, the member shall automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its expired term, UNLESS the Medical Staff Office has received verification from the Drug Enforcement Administration that the DEA certificate is still "active." This can be the case in delays of renewal of valid certificates for up to six (6) months past the expiration date.

In each of the above situations, the member shall submit a promptly submit a written plan to the Medical Executive Committee to assure the member’s patients promptly are prescribed medications. Failure to timely provide a plan acceptable to the Medical Executive Committee or the applicable department chair or co-chair shall result in automatic suspension of privileges pending receipt and approval of such plan.

6.5-3 Medical Records

Members of the medical staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Staff Bylaws, General Rules and Regulations, and hospital policy and procedure that has been approved by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff, or the Chief of Staff's designee, after notice of delinquency for failure to complete medical records within such period. Review of the suspension list will occur at the next regularly scheduled Medical Executive Committee meeting.

For the purpose of this Section, related privileges means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within the hospital for future patients. Members whose privileges have been suspended for delinquent records may admit patients only in life- threatening situations. The suspension shall continue until all delinquent records are complete. Failure to complete delinquent medical records within 90 days, will result in automatic resignation of medical staff membership and clinical privileges.

Bona fide vacation or illness may constitute an excuse subject to approval by the Chief of Staff or designee.

6.5-4 Failure to Pay Dues/Assessments

Dues and Fees assessed, as required under these Bylaws or applicable Medical Staff Rules or policies, will be collected at the time of pre-application, initial application and reappointment. Assessment for the pre-application is 50% of the application fee. A pre-application, initial application, or reappointment will be considered incomplete if the required dues and assessments have not been received by the Medical Staff Office. This action will result in, (1) Credentialing of Pre-application or initial application will not proceed until fees are submitted; (2) Reappointment will result in automatic resignation of membership and clinical privileges at the end of the current appointment period.

6.5-5 Professional Liability Insurance

Failure to maintain professional liability insurance shall result in the automatic suspension of a member's clinical privileges. If within 90-days after written warning of the delinquency, the member does not provide evidence of required professional liability insurance, the member's membership shall be automatically terminated.

6.5-6 Failure to Satisfy Special Attendance Requirement

Failure of a member without good cause to provide information or appear when requested by a medical staff committee as described in these bylaws shall result in the referral to the Medical Executive Committee. Absent documented good cause as determined by the Medical Executive Committee, such failure shall result in the automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided requested information and/or satisfied the special attendance requirement. Privileges may be restored effective immediately by the Chief of Staff upon evidence of compliance, which shall be confirmed by the Medical Executive Committee at the next regular scheduled meeting. This section does not apply to attendance requirements for regular meetings such as department, committee, quarterly, annual meetings and continuing medical education programs.

6.5-7 Felony Conviction or Plea

A practitioner who has been convicted of, or who has pled guilty or no contest to, a felony related directly to his/her professional practice or patient relationships, within the past seven (7) years, shall not be entitled to apply for initial appointment to the medical staff. If a member of the medical staff is convicted of, or pleads guilty or no contest to a felony directly related to his/her professional practice or patient relationships, the member's medical staff membership and privileges shall be automatically suspended pending review by the Medical Executive Committee. If the Medical Executive Committee confirms that the felony was directly related to the member's professional practice or patient relationships, the member's staff membership and privileges shall automatically terminate without right to a hearing. If the Medical Executive Committee determines the felony was not directly related to the member's professional practice or patient relationships, the member shall be permitted to request reinstatement. Such automatic actions shall be implemented following the criminal conviction or plea regardless of whether an appeal is filed.

6.5-8 Medical Executive Committee Deliberation

Within 7 business days after action is taken or warranted as described in Sections 6.5-1 through 6.5-6, the Medical Executive Committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these bylaws.

6.5-9 Exclusion From Governmental Program(s)

A practitioner who is excluded as a provider from any governmental health care program (including but not limited to Medicare and Medi-Cal) may not apply for initial appointment to the medical staff. If a member of the medical staff is excluded as a provider from such governmental program, the member's membership and privileges shall be automatically terminated without right to a hearing.

6.5-10 Criminal Charges

All of the clinical privileges of an individual who is charged with a felony that constitutes a "crime against a person" or attempted "crime against a person", as defined by California law, (e.g. murder, mayhem, robbery, assault, or battery, sex-related crimes) or is charged with a sex related misdemeanor (e.g. sexual assault, sexual battery, or indecent exposure), shall be automatically suspended pending the individual's presentation for the Chief of Staff's review and approval of a plan that would protect Hospital patients from risk of such charged conduct pending resolution of the criminal charges. The cost of complying with such plan shall be at the individual's sole cost and expense.

ARTICLE VII HEARINGS AND APPELLATE REVIEWS

7.1 GENERAL PROVISIONS

7.1-1 Process to Challenge Quasi-Legislative Measures

Any practitioner whose clinical privileges, staff membership or practice opportunities are adversely affected by a quasi-legislative bylaw, rule, regulation, policy or procedure adopted by the Medical Staff in accordance with these bylaws may challenge the measure by providing written notice to the Medical Executive Committee setting forth all information, reasons and arguments supporting the challenge. Upon receipt of such a notice, the Medical Executive Committee shall conduct such review of the matter as it deems proper. Such review shall include an opportunity for the affected practitioner to address the Medical Executive Committee or at the discretion of the Medical Executive Committee, ad hoc sub-committee. The Medical Executive Committee shall give the affected practitioner notice of its resolution of the issue with a copy to the Board of Trustees. The Board of Trustees may conduct its own review of the matter following notice from the Medical Executive Committee. Any disagreement between the Board of Trustees and the Medical Executive Committee shall be submitted to an Ad Hoc Dispute Mediation Committee. This shall be the sole process for challenging a quaisi-legislative measure and there is no right to the hearing or appellate review procedures described in this Article VII for a quasi legislative measure.

7.1-2 Exhaustion of Remedies

If adverse action described in Section 7.2 is taken or recommended, the applicant or member must exhaust the remedies afforded by these bylaws before resorting to legal action.

7.1-3 Application of Article

For purposes of this Article, the term "member" may include "applicant" and those with temporary privileges, as it may be applicable under the circumstances, unless otherwise stated. In addition to medical staff members and applicants, clinical psychologists who are providing or applying to provide professional services in the hospital, but are not members of the medical staff, are entitled to the hearing rights specified in this article.

7.1-4 Timely Completion of Process

The hearing and appeal process shall be completed within a reasonable time.

7.1-5 Final Action

Recommended adverse actions described in Section 7.2 shall become final only after the hearing and appellate rights set forth in these bylaws have either been exhausted or waived, and only upon being adopted as final actions by the Board of Trustees.

7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following actions or recommended actions taken for a medical disciplinary case or reason shall be deemed actual or potential adverse action and constitute grounds for a hearing:

(a) denial of medical staff membership;
(b) denial of requested advancement in staff membership status, or category;
(c) denial of renewal of medical staff membership;
(d) demotion to lower medical staff category or membership status;
(e) suspension of staff membership, which lasts longer than 14 consecutive days;
(f) revocation of medical staff membership;
(g) denial of requested clinical privileges;
(h) involuntary reduction or restriction of current clinical privileges for a cumulative total of 30 days or more in any 12 month period;
(i) suspension of clinical privileges which last longer than 14 consecutive days;
(j) termination of all clinical privileges;
(k) involuntary imposition of significant consultation or monitoring requirements (excluding monitoring incidental to provisional status and Section 5.3); or
(l) any other disciplinary action or recommendation imposed by the Medical Staff that must be reported to the Medical Board pursuant to California Business and Professions Code Section 805 and/or the National Practitioner Data Bank.

7.3 REQUESTS FOR HEARING

7.3-1 Notice of Action or Proposed Action

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the Chief of Staff or designee on behalf of the Medical Executive Committee shall give the member prompt written notice of:

(a) the recommendation or final proposed action and that, except with respect to actions reported to Business & Professions Code §805.01, such action , if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank if required;

(b) the reasons for the proposed action including the acts or omissions with which the member is charged ;(3) the right to request a hearing pursuant to Section 7.3-2, and that such hearing must be requested within [30] days; and (4) a summary of the rights granted in the hearing pursuant to the medical staff bylaws.

7.3-2 Request For Hearing

The member shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the Medical Executive Committee with a copy to the Board of Trustees. In the event the member does not request a hearing within the time and in the manner described, the member shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

7.3-3 Time and Place for Hearing

Upon receipt for a request for hearing, the Medical Executive Committee shall schedule a hearing and, within 30 days give notice to the member of the time, place and date of the hearing. Unless extended by the judicial review committee or hearing officer, the date of the commencement of the hearing shall be not less than 30- days from the date of notice, nor more than 60-days from the date of receipt of the request by the Medical Executive Committee for a hearing; provided, however, that when the request is received from a member who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made, so long as the member has at least 30-days from the date of notice to prepare for the hearing or waives this right.

7.3-4 Notice of Hearing

Together with the notice stating the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice unless waived by a member under summary suspension, the Chief of Staff or designee on behalf of the Medical Executive Committee shall provide the reasons for the recommended action, including the acts or omissions with which the member is charged, a list of the charts in question, where applicable, and a list of the witnesses (if any) expected to testify at the hearing on behalf of the Medical Executive Committee. The content of this list is subject to update pursuant to Section 7.4-1.

7.3-5 Judicial Review Committee

When a hearing is requested, the Chief of Staff as designee of the Medical Executive Committee shall appoint a judicial review committee composed of not less than three (3) members and two (2) alternates of the medical staff. The judicial review committee members shall be impartial, shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active medical staff, the Medical Executive Committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. Membership on a judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, the committee shall also include an individual practicing the same specialty as the member. It shall not be deemed feasible if there is not an individual in the same specialty as the member who is willing and able to serve. All other members shall have MD or DO degrees or their equivalent as defined in Section 2.22(a).

7.3-6 Failure to Appear or Proceed

Failure without good cause of the member to personally attend and proceed at such a hearing in an efficient and orderly manner shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

7.3-7 Postponements and Extensions

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the hearing officer on a showing of good cause, or upon agreement of the parties. The Medical Executive Committee shall exercise ongoing oversight over the hearing to ensure the timely resolution of issues.

7.3-8 Hearings Prompted By Board of Trustees Action

If the hearing is based upon an adverse decision or recommendation of the Board of Trustees, the Board of Trustees or its designee shall fulfill the duties assigned to the Medical Executive Committee or the Chief of Staff when the Medical Executive Committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended

action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

7.4 HEARING PROCEDURE

7.4-1 Prehearing Procedure

(a) If either side to the hearing requests in writing a list of witnesses, within 15-days of such request, and in no event less than 10-days before commencement of the hearing, each party shall furnish to the other a written list of the names of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. The member shall have the right to inspect and copy documents or other evidence upon which the charges are based, as well as all other evidence relevant to the charges. The member shall also have the right to receive at least thirty (30) days prior to the hearing a copy of the evidence forming the basis of the charges which is reasonably necessary to enable the member to prepare a defense, including all evidence which was considered by the Medical Executive Committee in determining whether to proceed with the adverse action, and any exculpatory evidence in the possession of the hospital or medical staff. The member and the Medical Executive Committee shall have the right to receive all evidence that will be made available to the Judicial Review Committee. Failure to disclose the identity of a witness or produce copies of all documents expected to be produced at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

The Medical Executive Committee shall have the right to inspect and copy any documents or other evidence relevant to the charges which the member possesses or controls at least thirty (30) days prior to the hearing.

(b) The failure by either party to provide access to this information at least 30-days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable members, other than the member under review.

(c) The hearing officer shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. in so doing, the hearing officer shall consider:

(1) whether the information sought may be introduced to support or defend the charges;

(2) the exculpatory or inculpatory nature of the information sought, if any;

(3) the burden imposed on the party in possession of the information sought, if access is granted; and

(4) any previous requests for access to information submitted or resisted by the parties to the same proceeding.

(d) The Medical Staff and member shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the impartiality of any judicial review committee member and the hearing officer shall be ruled on by the hearing officer.

(e) It shall be the duty of the member and the Medical Executive Committee or its designee to exercise reasonable diligence in notifying the chair of the judicial review committee of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible, in order that decisions concerning such matters may be made in advance of the hearing. Objections to any prehearing decisions may be succinctly made at the hearing.

7.4-2 Representation

The hearings provided for in these bylaws are for the purpose of intra-professional resolution of matters bearing on professional conduct, professional competency, or character.

The member shall be entitled to representation by legal counsel in any phase of the hearing, if the member so chooses, and shall receive notice of the right to obtain representation by an attorney at law. In the absence of legal counsel, the member shall be entitled to be accompanied by and represented at the hearing by an individual of the member's choosing who is not also an attorney at law, and the Medical Executive Committee shall appoint a representative who is not an attorney to present its action or recommendation, the materials in support thereof, examine witnesses, and respond to appropriate questions. The Medical Executive Committee shall not be represented by an attorney at law if the member is not so represented.

7.4-3 The Hearing Officer

The Medical Executive Committee shall recommend to the Board or its designee a hearing officer to preside at the hearing. The hearing officer shall be an attorney at law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the hospital, the medical staff or the involved medical staff member or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall preside over the voir dire process and may question panel members directly, and shall make all rulings regarding service by the proposed hearing panel members or the hearing officer. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting evidence and argument during the hearing and

shall have the authority and discretion to make all rulings on questions, which pertain to matters of law, procedure or the admissibility of evidence.

The Hearing Officer's authority shall include, but not be limited to, making rulings with respect to requests and objections pertaining to the production of documents, requests for continuances, designation and exchange of proposed evidence, evidentiary disputes, witness issues including disputes regarding expert witnesses, and setting reasonable schedules for timing and/or completion of all matters related to the hearing.

At the commencement of the hearing, the hearing officer may also apprise the judicial review committee of its right to terminate the hearing due to the member's failure to cooperate with the hearing process, but shall not independently make that determination or otherwise recommend such a termination at any other time. Except as provided above, if the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting fair and reasonable time limits on either side's presentation of its case.

If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote. The hearing officer may assist the committee with drafting the hearing committee's decision.

In all matters, the hearing officer shall act reasonably under the circumstances and in compliance with applicable legal principles. In making rulings, the hearing officer shall endeavor to promote a less formal, rather than more formal, hearing process and also to promote the swiftest possible resolution of the matter, consistent with the standards of fairness set forth in these Bylaws. When no attorney is accompanying any party to the proceedings, the hearing officer shall have authority to interpose any objections and to initiate rulings necessary to ensure a fair and efficient process.

7.4-4 Record of the Hearing

A court reporter shall be present to make a record of the hearing proceedings, and the pre- hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the shorthand reporter shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. The judicial review committee may, but shall not be required to, order that oral evidence shall be taken only on oath administered by any person lawfully authorized to administer such oath.

7.4-5 Rights of the Parties

Within reasonable limitations, both sides at the hearing may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross- examine or impeach witnesses who shall have testified orally on any matter relevant to the issues, and otherwise rebut evidence, as long as these rights are exercised in an efficient and expeditious manner. The member may be called by the Medical Executive Committee and examined as if under cross-examination.

7.4-6 Miscellaneous Rules

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Any relevant evidence, including hearsay, shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. The judicial review committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate. At its discretion, the judicial review committee may request or permit both sides to file written arguments. The hearing process shall be completed within a reasonable time after the notice of the action is received, unless the hearing officer issues a written decision that the member or the Medical Executive Committee failed to provide information in a reasonable time or consented to the delay.

Upon stipulation of the parties or upon the ruling of the Hearing Officer and concurrence by the judicial review committee, if the judicial review committee has been appointed, the proceedings may be held remotely via electronic access with audio and visual means and recording. The foregoing may include but not be limited to the evidentiary hearing session, deliberation, the taking of oaths, conducting any prehearing meetings such as voir dire and any other matter related to the hearing. The stipulation or ruling of the Hearing Officer/Arbitrator shall address procedural safeguards to assure the confidentiality of the proceedings and a fair process, including but not limited to how evidence will be managed.

7.4-7 Burdens of Presenting Evidence and Proof

(a) At the hearing the Medical Executive Committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The member shall be obligated to present evidence in response.

(b) An applicant for membership or additional privileges shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate

evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be permitted to introduce information or documents requested by the medical staff but not produced during the application process unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for applicants, throughout the hearing, the Medical Executive Committee shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, that its action or recommendation is reasonable and warranted.

7.4-8 Adjournment and Conclusion

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the Medical Executive Committee and the member may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed. The hearing shall not be deemed finally adjourned until the judicial review committee completes its deliberations.

7.4-9 Basis for Decision

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The judicial review committee shall affirm the action or recommended action of the medical executive committee if its action or recommended action is one of the reasonable and warranted options based upon the evidence.

7.4-10 Decision of the Judicial Review Committee

Within 30- days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the Medical Executive Committee. If the member is currently under suspension, however, the time for the decision and report shall be 15- days after final adjournment. A copy of said decision also shall be forwarded to the administrator, the Board of Trustees, and to the member. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the member and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision

The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws, but shall otherwise be affirmed by the Board of Trustees as the final action if it is supported by greater weight of the evidence, following a fair procedure.

7.5 APPEAL

7.5-1 Time for Appeal

Within thirty (30) days after receipt of the decision of the judicial review committee, either the member or the Medical Executive Committee may request an appellate review. A written request for such review shall be delivered to the Chief of Staff, the administrator, and the other party in the hearing. If a request for appellate review is not requested within such period, that action or recommendation shall be affirmed by the Board of Trustees as the final action if it is supported by the greater weight of the evidence, following a fair procedure.

7.5-2 Grounds for Appeal

A written request for an appeal shall include an identification of the grounds for appeal and a clear and concise statement of the facts in support of the appeal. The grounds for appeal from the hearing shall be: (a) substantial noncompliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice; (b) the decision was not supported by the greater weight of the evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5.

7.5-3 Time, Place and Notice

If an appellate review is to be conducted, the appeal board shall, within thirty (30) days after receipt of notice of appeal, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The date of appellate review shall not be less than thirty (30) nor more than sixty (60) days from the date of such notice, provided however, that when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review shall be held as soon as the arrangements may reasonably be made, not to exceed forty-five (45) days from the date of the notice. The time for appellate review may be extended by the appeal board for good cause.

7.5-4 Appeal Board

The Board of Trustees may sit as the appeal board, or it may appoint an appeal board which shall be composed of not less than [3] members of the Board of Trustees. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to

assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the Board of Trustees shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

7.5-5 Appeal Procedure

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision., if feasible. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives.

The appeal board shall present to the Board of Trustees its written recommendations as to whether the Board of Trustees should affirm or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

7.5-6 Decision

(a) Except as provided in Section 7.5-6(b), within [30] days after the conclusion of the appellate review proceedings, the Board of Trustees shall render a final decision and shall affirm the decision of the judicial review committee if the judicial review committee's decision is the greater weight of the evidence, following a fair procedure.

Should the Board of Trustees determine that the judicial review committee decision is not supported by the greater weight of evidence or that a fair procedure was not afforded, the board may modify or reverse the decision of the judicial review committee and may instead, or shall, where a fair procedure has not been afforded, remand the matter to the judicial review committee, if feasible, for reconsideration, stating the purpose for the referral. The Board of Trustees shall carefully consider the recommendation of the Judicial Review Committee and shall not act arbitrarily or capriciously. The Board of Trustees may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing in compliance with the bylaws, rules or regulations and in determining whether the Judicial Review Committee's findings with regard to any issues of conduct, behavior or compliance with bylaws, rules or policies were reasonable and warranted.

(b) If the matter is remanded to the judicial review committee for further review and recommendation, the committee shall promptly conduct its review and make its recommendations to the Board of Trustees. This further review and the time required to report back shall not exceed thirty (30) days in duration except as the parties may otherwise agree or for good cause as jointly determined by the chair of the Board of Trustees and the judicial review committee.

(c) The decision shall be in writing, shall specify the reasons for the action taken, shall include the text of the report which shall be made to the National Practitioner Data Bank and the Medical Board of California, if any, and shall be forwarded to the Chief of Staff, the medical executive and credential committee, the subject of the hearing, and the administrator.

7.5-7 Right to One Hearing

Except in circumstances where a new hearing is ordered by the Board of Trustees or a court because of procedural irregularities or otherwise for reasons not the fault of the member, no member shall be entitled to more than one evidentiary hearing and one appellate review on any matter which shall have been the subject of adverse action or recommendation.

7.6 Exceptions to Hearing Rights

7.6.1 Hospital Contract Practitioners.

Removal of practitioners who provide care pursuant to an exclusive contract with the hospital shall be governed by the terms of their contracts with the hospital. The hearing and review rights set forth in this Article VII do not apply to a practitioner whose application for Medical Staff membership and/or clinical privileges was not accepted, or whose membership and/or privileges were limited or terminated on the basis that the privileges sought or held are the subject of an exclusive contract. The hearing rights of this Article VII only shall apply if an action is taken which must be reported under Business and Professions Code Section 805 or National Practitioner Data Bank and/or privileges which are independent of the practitioner's exclusive contract are removed or suspended.

7.6-2 Automatic Suspension or Limitation of Practice Privileges

No hearing is required when a member's license or legal credential to practice has been revoked or suspended as set forth in Section 6.5-1(a). In other cases described in Sections 6.5-1 and 6.5-2, the issues which may be considered at a hearing, if requested, shall not include evidence designed to show that the determination by the licensing or credentialing authority or certifying authority was unwarranted, but only whether the member may continue practice in the hospital with those limitations imposed.

7.7 NATIONAL PRACTITIONER DATA BANK REPORTING

The authorized representative shall report an adverse action to the National Practitioner Data Bank only when required by law and regulation and only using the description set forth in the final action as adopted by the Board of Trustees. The authorized representative shall report any and all revisions of an adverse action, including, but not limited to, any expiration of the final action consistent with the terms of that final action.

7.8 **DISPUTING REPORT LANGUAGE**

If no hearing was requested, a member who is the subject of a proposed adverse action report to the Medical Board of California or the National Practitioner Data Bank may request an informal meeting to dispute the text of the report filed. The report dispute meeting shall not constitute a hearing and shall be limited to the issue of whether the report filed is consistent with the final action issued. The meeting shall be attended by the subject of the report, the Chief of Staff, and the hospital's authorized representative, or their respective designees.

If a hearing was held, the dispute process shall be deemed to have been completed.

ARTICLE VIII ALLIED HEALTH PROFESSIONAL/ ADVANCED PRACTICE PROFESSIONAL STAFF

8.1 DEFINITIONS

Allied Health Practitioner or Advanced Practice Practitioner (AHP/APP or APP), means a health care professional, other than a physician, dentist or podiatrist who holds a license or other legal credential, as required by California law, to provide certain professional services.

AHP/APP or APP means those who may or may not be employees of the hospital, and are not eligible for medical staff membership, but are eligible for AHP/APP/APP Staff and have been granted a service authorization to provide certain clinical services.

Service Authorization means the permission granted to an Allied Health Staff member to provide specified patient care services within the member's qualifications and scope of practice.

8.2 RESPONSIBILITIES

Each AHP/APP shall:

a) Meet those responsibilities required by the medical staff bylaws, rules and regulations and policies, if not so specified, meet those responsibilities specified in the bylaws, rules and regulations and policies for medical staff members as are generally applicable.

b) Retain appropriate responsibility within the AHP/APP area of professional competence for the care of each patient in the hospital for whom the AHP/APP is providing services.

c) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required, in evaluating AHP/APP applicants, in supervising initial AHP/APP appointees of the same specialty.

8.3 QUALIFICATIONS

An AHP/APP is eligible for a service authorization in this hospital if the practitioner:

(a) Holds a license, certificate, or other legal credential in a category of AHP/APPs which the Board of Trustees has identified as eligible to apply for service authorizations;

b) Documents the practitioner's experience, background, training, current competence, judgment, and ability with sufficient adequacy to demonstrate that any patient treated by the practitioner will receive care of the generally recognized professional level of quality established by the medical staff;

c) Any AHP/APP will automatically require, at a minimum, concurrent FPPE Proctoring on a minimum of the first ten (10) cases, to include a sampling of the privileges granted. Other conditions may be implemented by the department Chair or co-chairs, as deemed appropriate;

d) Is determined, on the basis of documented references: to adhere strictly to the lawful ethics of the practitioner's profession, to work cooperatively with others in the hospital setting so as not to affect adversely patient care, and to be willing to commit to and regularly assist the medical staff in fulfilling its obligations related to patient care, within the areas of the practitioner's professional competence and credentials; and

e) Agrees to comply with all medical staff bylaws, general rules and regulations, and department rules, and protocols to the extent applicable to the AHP/APP; and

f) Maintains professional liability insurance with a suitable insurer, with minimum limits as determined by the Medical Executive Committee, in accordance with these bylaws.

8.3 CATEGORIES OF AHP/APP/APP'S ELIGIBLE TO APPLY FOR SERVICE AUTHORIZATIONS

The categories of AHP/APP, based on occupation or profession, which shall be eligible to apply for Allied Health Staff membership and for service authorization in the hospital and the corresponding service authorization prerogatives, terms, and conditions for each such AHP/APP category shall be designated by the Board of Trustees, upon the recommendation of the Medical Executive Committee, and when approved by the Board of Trustees, shall be set forth in the medical staff rules and regulations or policy. . Such actions by the Medical Executive Committee and the Board of Trustees shall be based upon the recommendations of the relevant departments for the designation of categories of AHP/APPs eligible to apply for service authorization and the delineation of corresponding service authorization prerogatives, terms, and conditions for each such AHP/APP category. The Medical Executive Committee, and Board of Trustees shall review the designation of categories of AHP/APPs eligible to apply for service authorizations at least annually and at other time when requested by the Medical Executive Committee.

8.4 PROCEDURE FOR GRANTING SERVICE AUTHORIZATION

All initial applications and renewal applications shall be processed in a parallel manner to that provided in Article IV, Membership and Membership Renewal, of these Medical Staff Bylaws. Documentation to substantiate all requirements and qualifications must be submitted with the application.

Applications for initial granting and renewal shall be submitted for review by the Interdisciplinary Practice Committee and the respective assigned department for recommendations, which will then be forwarded to the Medical Executive Committee and Board of Trustees for final approval. Each AHP/APP must apply for renewal of service authorization and practice privileges every two (2) years, in the same manner as described in Article IV.

8.4-1 Granting Service Authorization

(a) An AHP/APP whose scope of practice allows independent practice must provide services under the supervision of a medical staff member, or a specific group of medical staff members.

(b) An AHP/APP must apply and qualify for a service authorization and must designate a physician member or specific group of medical staff members of the medical staff who, concurrently with the AHP/APP's application, agrees to be responsible for, supervise, collaborate with, to the extent necessary, for the general medical condition of patients for whom the AHP/APP proposes to render services in the hospital.

8.4-2 Effect of Adverse Decision

An AHP/APP who has received an final adverse decision regarding their application for a service authorization, or withdrew their application for a service authorization following an adverse recommendation by the Medical Executive Committee, or after having been granted a service authorization has received a final adverse decision resulting in termination of the authorization or, has relinquished their service authorization following the issuance of a Medical Staff or Board of Trustees recommendation adverse to their service authorization, shall not be eligible to reapply for the service authorization affected by such decision or recommendation for a period of at least twenty-four (24) months from the date that the adverse decision became final, the application was withdrawn, or the AHP/APP relinquished their service authorization.

8.4-3 Request for New Category of Service Authorization

AHP/APP who does not have licensure or certification in an AHP/APP category identified as eligible for service authorizations may not apply for a service Authorization but may submit a written request to the Administrator, asking the Board of Trustees to consider designating the appropriate category of AHP/APPs as eligible to apply for service authorizations. Upon receipt of such a request, the Board of Trustees shall forward a copy of the request to the Medical Executive Committee for its recommendation, and shall also request the recommendation of any affected department or division. The Board of Trustees shall consider such request and the Medical Executive Committee's recommendation, as well as the recommendation of any affected department or division, either before or at the time of its annual review of the categories of AHP/APPs., in accordance with these Bylaws.

8.4-4 Assignment to Clinical Department

Each AHP/APP who is granted a service authorization shall be assigned to the clinical department appropriate to his/her occupational or professional training and, unless otherwise specified in the medical staff rules and regulations, shall be subject to terms and conditions that parallel those specified in Article II-Membership, as they may logically apply to AHP/APPs and may be appropriately tailored to the particular category of AHP/APPs. Each AHP/APP who practices at IVHD must maintain communication with the relevant physician in order to enable the physician to assume responsibility, to the extent it is indicated, for the general medical condition of the patient. Each AHP who does not practice independently shall be subject to the supervision of one or more members of the medical staff who have been approved to provide such supervision or direction by the Board of Directors upon recommendation of the Medical Executive Committee.

8.5 PREROGATIVES AND RESPONSIBILITIES

8.5-1 **Prerogatives**

The prerogatives which may be extended to a member of a particular category of AHP/APP shall be defined in the medical staff rules and regulations and/or policies. Such prerogatives may include:

(a) Provision of specified patient care services subject to a medical staff member's responsibility, to the extent indicated, for the patient's general medical condition and under the general Article V of the medical staff, and, where the AHP/APP does not practice independently, also under the supervision and direction of a member of the Active medical staff who will supervise that category of AHP/APP. AHP/APP services must be consistent with the service authorization granted to the AHP/APP and within the scope of the AHP/APP's licensure or certification.

(b) Service on medical staff and hospital committees except as otherwise expressly provided in the medical staff bylaws, rules and regulations. An AHP/APP may not serve as chair of medical staff committees.

(c) Attendance at meetings of the department to which the AHP/APP is assigned, as permitted by the department rules and regulations, and attendance at medical staff educational programs in the AHP/APP's field of practice. An AHP/APP may not vote at department, division, committee meetings.

8.5-1 **Responsibilities**

Each AHP shall:

(a) Meet those responsibilities required by the medical staff rules and regulations and if not so specified, meet those responsibilities specified in [Section 2.5 of Article II] as are generally applicable to the more limited practice of the AHP.

(b) Retain appropriate responsibility within his or her area of professional competence for the care of each patient in the hospital for whom he or she is providing services.

(c) Participate, when requested, in patient care audit and other quality review, evaluation, and monitoring activities required of AHPs, in evaluating AHP applicants, in supervising initial AHP appointees of his or her same occupation or profession or of an occupation or profession which is governed by a more limited scope of practice statute, and in discharging such other functions as may be required by the medical staff from time to time.

8.6 CONTINUING COMPETENCY EVALUATION

To provide continuous, measurable, and objective monitoring of AHP/APP practice, all Allied Health Providers (AHP/APP's) functioning in the hospital setting shall be subject to evaluation and monitoring by OPPE and FPPE, as described in Section 6 of these Bylaws. Periodic chart review shall also be conducted by the supervising physician to ensure that appropriate and competent medical care is provided to patients in a variety of settings.

Each AHP/APP granted privileges to practice at this facility will be reviewed by the supervising physician. The charts selected for review, should be a representative sample of the patient contacts that the AHP/APP is encountering. The reviewing physician will review the medical record and document findings utilizing the approved forms for this purpose. Feedback will be provided to the AHP/APP by the reviewing physician. These reports will be reviewed by the Department Chair or co-chairs, as applicable, during the reappointment process of the AHP/APP. It is the responsibility of the AHP/APP to assure the required documentation is completed and forms are forwarded to the Medical Staff Office.

8.7 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS

8.7-1 General Procedures

(a) At any time, the Chief of Staff or Chief of the Department or Division to which the AHP/APP has been assigned may recommend to the Medical Executive Committee (MEC) that an AHP/APP's service authorization be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the Medical Executive Committee agrees that corrective action is appropriate, the Medical Executive Committee shall recommend specific corrective action to the hospital's Board of Trustees. A Notification Letter regarding the recommendation shall be sent by certified mail to the subject AHP/APP. The notification Letter shall inform the AHP/APP of the recommendation and the circumstances giving rise to the recommendation.

(b) Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied Health Staff member, except for a clinical psychologist, to the hearing rights set forth in Articles VI and VII However, an AHP/APP shall have the right to challenge any recommendation which would constitute grounds for a. hearing under Section 7.2 of the Bylaws (to the extent that such grounds are applicable by analogy to the Allied Health Staff) by filing a written request for an AHP/APP Health Staff hearing with the Medical Executive Committee within fifteen (15) days of receipt of the Notification Letter. Upon receipt of a request, the Medical Executive Committee or its designee, shall afford the AHP/APP an opportunity for an AHP/APP Health Staff hearing concerning the grievance. The hearing need not be conducted according to the procedural rules applicable to member hearings; however the purpose of the AHP/APP Health Staff hearing is to allow both the AHP/APP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. A record of the AHP/APP Health Staff hearing shall be made.

(c) Within 30-days following the AHP/APP Health Staff hearing, the Medical Executive Committee, based on the AHP/APP Health Staff hearing and all other aspects of the investigation, shall make a final recommendation to the Board of Trustees, which shall be communicated in writing, sent by certified mail, to the subject AHP/APP. The final recommendation shall discuss the circumstances giving rise to the recommendation any pertinent information from the interview. Prior to acting on the matter, the Board of Trustees may, in its discretion, offer the affected practitioner the right to appeal to the Board or a subcommittee thereof. The Board of Trustees shall adopt the Medical Executive Committee's recommendation, so long as it is reasonable, appropriate under the circumstances and supported by greater weight of the evidence. The final decision by the Board of Trustees shall become effective upon the date of its adoption. The AHP/APP shall be provided promptly with notice of the final action, sent by certified mail.

8.7-2 Summary Suspension

(a) Notwithstanding Section 8.7-1, an Allied Health Practitioner's service authorization may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such or restriction may be imposed by the Chief of Staff, the Medical Executive Committee, or the respective department chair or co-chair, or designee, to which the Allied Health Practitioner has been assigned. Unless otherwise stated, the summary action

shall become effective immediately upon imposition, and the person responsible for taking such action shall promptly give written notice of the action to the Board of Trustees, the Medical Executive Committee, and the CEO. The notice shall also inform the practitioner of the right to file a grievance. The practitioner's right to file a grievance and subsequent

interview procedures shall be in accordance with Section 8.7-1, except that all reasonable efforts shall be made to ensure that the practitioner is given an interview and that final action is taken within 14-days or as promptly thereafter as practicable.

(b) The affected practitioner may be verbally notified of the action and shall be promptly notified in writing of the summary action. The notice shall include the reasons for the action and that such action was necessary because of a reasonable probability that failure to take the action could result in imminent danger to the health of an individual.

(c) Within ten (10)) working days following the action, the Interdisciplinary Practice Committee shall meet to consider the matter and make a recommendation to the M e d i c a l Executive Committee as to whether the summary suspension should be vacated or continued pending the outcome of any interview with the affected practitioner. Within ten (10) working days following the imposition of the action, the Medical Executive Committee shall meet and consider the matter in light of any recommendation forwarded from the Interdisciplinary Practice Committee or the Committee on Allied Health Practitioners. Within two (2) working days following the Medical Executive Committee's meeting, the Medical Executive Committee shall provide written notice to the affected practitioner regarding its determination on whether the summary action should be vacated or continued pending the outcome of any interview proceeding.

8.7-3 Automatic Suspension, Termination or Restriction

Notwithstanding subsection 8.7-1, above, an AHP/APP 's service authorization shall automatically terminate in the event that:

(a) The AHP/APP's certification, license, or other legal credential expires or is revoked or subject to a Court order that prohibits the AHP/APP from providing care.

(b) With respect to an AHP/APP practice under physician supervision:

(1) the medical staff membership or privileges to supervise the AHP/APP of the supervising physician is terminated, whether such termination is voluntary or involuntary; or

(2) the AHP/APP’s only supervising physician no longer agrees to act in such capacity for any reason, or the relationship between the AHP/APP and the AHP/APP’s only supervising physician is otherwise terminated, regardless of the reason therefore;

(c) Where the AHP/APP's service authorization is automatically terminated for reasons specified in above, the AHP/APP may apply for reinstatement as soon as the AHP/APP has found another physician medical staff member who agrees to supervise the AHP/APP and receives privileges to do so. In this case, the Medical Executive Committee may, in its discretion, expedite the reapplication process.

(d) Notwithstanding subsection 8.7-1, above, in the event that the AHP/APP's certification or license is restricted, suspended, or made the subject of an order of probation, the AHP/APP's service authorization shall automatically be subject to the same restrictions, suspension, or conditions of probation.

(e) Where the AHP/APP's privileges are automatically terminated, suspended, or restricted pursuant to this subsection, the notice and interview procedures under subsection 8.7-1 shall not apply and the AHP/APP shall have no right to an interview except, within the discretion of the Medical Executive Committee, regarding any factual dispute over whether or not the circumstances giving rise to the automatic termination, suspension, or restriction actually exist.

(f) When the AHP/APP's employment with the hospital is terminated, their privileges automatically will terminate and the notice and interview procedures under subsection 8.7-1 shall not apply and the AHP/APP shall have no right to an interview.

8.7-4 Applicability of Section

The rights afforded by this section shall not apply to any decision regarding whether a category of AHP/APP shall be eligible for a service authorization and the terms or conditions of such decision pursuant to Section 8.3 of this Article.

8.8 REAPPLICATION

Not more than every 2 years, each AHP/APP on the Allied Health Staff must reapply for a renewed service authorization in accordance with Section 8.4, and in the same manner described in section 4.5 of these bylaws.

ARTICLE IX OFFICERS

9.1 OFFICERS OF THE MEDICAL STAFF

9.1-1 Identification

The officers of the medical staff shall be the Chief of Staff, Vice Chief of Staff, Immediate Past Chief of Staff, and Secretary/Treasurer.

9.1-2 Qualifications

Officers must be members in good standing of the active medical staff at the time of their nominations and election, and must remain members of the active staff in good standing, in accordance with these Medical Staff Bylaws during their term of office. Failure to maintain such status shall create a vacancy in the office involved. All officers must be licensed as physicians and surgeons, Board certified, given the nature of their duties in office. In addition to exercising their responsibilities pursuant to Section 14.6, officers shall verbally disclose all actual or potential conflicts of interest in the course of each medical staff meeting or other event where such a disclosure may be relevant. Any potential conflicts so disclosed shall be resolved as set forth in Section 14.6 and must be announced in writing to those with voting rights prior to election.

9.1-3 Nominations

(a) The medical staff election year shall be each even numbered medical staff year. i.e., nominations and elections to be conducted in even years, with term to commence on January 1 of the immediately following January 1. A nominating committee shall be appointed by the Medical Executive Committee not later than 120 days prior to the annual staff meeting to be held during the election year or at least 45 days prior to any special election.

(b) A nominating committee composed of an equal number of members who primarily practice at the hospital that previously was known as Pioneers Memorial Hospital and primarily practice as the hospital that previously was known as El Center Regional Medical Center. It shall include the immediate past Chief of Staff, the current Chief of Staff and two Active staff members elected by the Medical Executive Committee. Although additional Active Staff many be nominated, unless the Vice Chief of Staff declines to run or does not meet criteria to serve as Chief of Staff, the Vice Chief of Staff automatically shall be nominated for Chief of Staff.

(c) The members nominated by the nominating committee shall be sent to the voting members of the Medical Staff at least sixty (60) days prior to the date of the annual staff meeting or thirty (30) days prior to any special election. Further nominations may be made for any office by any voting member of the medical staff, provided that the name of the candidate is submitted in writing to the chair of the nominating committee, is endorsed by the signature of at least 10% of other members who are eligible to vote, and bears the candidate's written consent. These nominations shall be delivered to the chair of the nominating committee, c/o the Medical Staff Office, as soon as reasonably practicable, but at least thirty (30) days prior to the date of election. If any nominations are made in this manner, the voting members of the medical staff shall be advised by notice delivered or mailed at least 10 days prior to the meeting. Conflict of interest Disclosure rules will apply. Nominees must disclose any conflicts of interest.

(d) If there are disputes regarding the nomination or election process, including but not limited to if a nominee meets criteria to serve in the particular office pursuant to the rotation required by Section 9.2., or outcome, the matter shall be referred to the Medical Executive Committee, which shall have authority to resolve such disputes.

9.1-4 Elections

The Vice Chief of Staff elect shall automatically become a nominee for the Chief of Staff (unless he/she declines the position). The Vice Chief of Staff, and Secretary-Treasurer shall be voted upon and results announced at the annual meeting of the medical staff which falls during the election year.

In accordance with Section 14.6, all nominees for election shall disclose in writing to the nominating committee medical staff those current or impending personal, professional, or financial" affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Such disclosure statement shall accompany the ballot.

Voting shall be by secret written ballot, and authenticated sealed mail ballots may be counted. Written ballots shall include handwritten signatures on the envelope for comparison with signatures on file, when necessary.

A nominee shall be elected upon receiving a majority of the valid votes cast.

If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the Medical Executive Committee shall decide the election by secret written ballot at its next meeting or a special meeting called for that purpose.

9.1-5 Term of Elected Office

Except for the initial officers who may have a term shorter than two years as a result of the merger date, each officer shall serve a two (2) year term, commencing on the first day of the medical staff year (January 1) following the election. Each officer shall serve in each office until the end of that officer's term, or until a successor is elected, unless that officer shall sooner resign or be removed from office. At the end of that officer's term, the Chief of Staff shall automatically assume the office of immediate past Chief of Staff.

9.1-6 Recall of Officers

Any Medical Staff Officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or acts of moral turpitude. Recall of a Medical Staff Officer may be initiated by the Medical Executive Committee or shall be initiated by a petition signed by at least one-third of the members of the medical staff eligible to vote for officers. Recall shall be considered at a special meeting called for that purpose. Recall shall require a two-thirds vote of the medical staff members eligible to vote for Medical Staff Officers who actually cast-vote at the special meeting in person or by mail ballot.

9.1-7 Vacancies in Elected Office

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies, other than that of the Chief of Staff, shall be filled by appointment by the Medical Executive Committee until the next regular election. If there is a vacancy in the office of Chief of Staff, a nominating committee shall be immediately appointed to elect a replacement Chief of Staff. The Vice Chief of Staff shall serve as an interim Chief of Staff until a member is elected from the Active Staff who primarily practices at the same general acute care location where the Chief of Staff who vacated that position primarily practiced. Upon election, the new Chief of Staff shall serve out the remaining term of the prior Chief of Staff and the Interim Chief of Staff shall resume holding the position of Vice Chief of Staff. While the vice Chief of staff is acting as the Interim Chief of Staff, the Medical Executive Committee may appoint an interim officer to fill this office.

9.2 ROTATION OF OFFICERS HOSPITAL

9.2-1 The initial Chief of Staff and Secretary/Treasurer shall be a members of the Active Staff who actively practiced at either the former Pioneers Memorial Hospital Medical Staff or the El Centro Regional Medical Center Medical Staff. If both Chief of Staff from those two former medical staffs wish to continue as the initial Chief of Staff, the two Chiefs of Staffs shall draw straws to determine who shall continue as Chief of Staff. The initial Immediate Past Chief of Staff shall be the member who was the Chief of Staff from what was the other medical staff prior to the merger and the Vice Chief of Staff shall be the Vice Chief of Staff from the same former medical staff as the Immediate Past Chief of Staff. The initial Vice Chief of Staff shall be the member who was Vice Chief of Staff at the same hospital as the initial Immediate Past Chief of Staff and the initial Secretary/Treasurer shall be the member who was Vice Chief at the same Hospital as the initial Chief of staff prior to the merger of the two medical staffs. Thereafter, Chiefs of Staff and other officers shall be nominated and elected as described in these bylaws, subject to a requirement that the subsequent officers must alternate as between members the two campuses. E.g. if the current Chief of Staff and Secretary/Treasurer primarily practice at the campus that previously was Pioneers Memorial Hospital, then the next Chief of Staff and Secretary/Treasurer must primarily practice at the campus that previously was El Centro Regional Medical Center.

9.2-2 An individual cannot serve as Chief of Staff more than one (1) term during a six (6) year period.

9.3 DUTIES OF OFFICERS

9.3-1 Chief of Staff

The Chief of Staff shall serve as the chief officer of the medical staff. The duties required of the Chief of Staff shall include, but not be limited to:

(a) enforcing the medical staff bylaws and rules and regulations, implementing sanctions where indicated, and enforcing compliance with procedural safeguards where corrective action has been requested or initiated;

(b) calling, presiding at, and being responsible for the agenda of all meetings of the general medical staff and or special meetings of the medical staff;

(c) serving as a voting member and chair of the Medical Executive Committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) serving as an ex officio member of all other staff department/committees without vote, unless Chief of Staff membership in a particular department/committee is required by these bylaws, or is otherwise a member of the department/committee;

(e) interacting with the administrator in all matters of mutual concern within the hospital and Board of Trustees;

(f) appointing, in consultation with or subject to ratification by the Medical Executive Committee, committee members for all standing committees other than the Medical Executive Committee and all ad hoc medical staff, special medical staff, liaison, or multidisciplinary committees, except where otherwise provided by these bylaws and, except where otherwise indicated, designating the chairs of committees;

(g) representing the views and policies of the medical staff to the administration and Board of Trustees at every Board of Trustees meeting;

(h) being a spokesperson for the medical staff in external professional and public relations;

(i) performing such other functions as may be assigned to the Chief of Staff by these bylaws, the medical staff, or by the Medical Executive Committee;

(j) serving on liaison committees with the Board of Trustees and administration, as well as outside licensing or accreditation agencies;

9.3-2 Vice Chief of Staff

The Vice Chief of Staff shall assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff. The Vice Chief of Staff shall be a voting member of the Medical Executive Committee, shall attend and represent, at the direction of and in the absence of the Chief of Staff, the views and policies of the medical staff to the Board of Trustees at every Board of Trustees meeting. The Vice Chief of Staff shall serve as Chair of the Bylaws Committee and shall perform such other duties as the Chief of Staff may assign or as may be delegated by these bylaws, or by the Medical Executive Committee.

932-3 Immediate Past Chief of Staff

The immediate past Chief of Staff shall be a voting member of the Medical Executive Committee and a and shall perform such other duties as may be assigned by the Chief of Staff or delegated by these bylaws, or by the Medical Executive Committee.

9.3-4 Secretary-Treasurer

The secretary-treasurer shall be a voting member of the Medical Executive Committee. The duties shall include, but not be limited to:

(a) maintaining a roster of members;

(b) assuring that accurate and complete minutes of all Medical Executive Committee and general medical staff meetings are kept;

(c) calling meetings on the order of the Chief of Staff or Medical Executive Committee;

(d) attending to all appropriate correspondence and notices on behalf of the medical staff

(e) assuring that all funds of the medical staff are received and preparing an annual proposed budget of anticipated income and expenditures, for approval by the medical staff, and preparing on a quarterly basis a financial statement in accordance with generally accepted accounting principles (GAAP), and recommending, where needed, the creation of a finance subcommittee to assist in these duties;

(f) excusing absences from meetings on behalf of the Medical Executive Committee; and

(g) performing such other duties as ordinarily pertains to the office or as may be assigned from time to time by the Chief of Staff or Medical Executive Committee.

9.4 COMPENSATION OF MEDICAL STAFF OFFICERS

Medical Staff Officers should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the medical staff bank account, for which the medical staff has sole responsibility. The payment to individual officers should be in the amount determined by the Medical Executive Committee. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the medical staff budget for hospital approval. Payment to each officer under this provision shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole determination of the Medical Executive Committee.

ARTICLE X CLINICAL DEPARTMENTS AND DIVISIONS

10.1 ORGANIZATION OF CLINICAL DEPARTMENTS AND DIVISIONS

The medical staff shall be organized into clinical departments. Each department shall be organized by the Chief of Staff as a separate component of the medical staff and shall have a chair or co-chairs selected and entrusted with the authority, duties, and responsibilities specified in Section 10.6. A department may be further divided, as appropriate, into divisions which shall be directly responsible to the department within which it functions, and which shall have a division chief selected and entrusted with the authority, duties and

responsibilities specified in Section 10.7. When appropriate, the Medical Executive Committee may recommend to the medical staff the creation, elimination, modification, or combination of departments or divisions.

10.2 DEPARTMENTS

The initial departments are:

1) Anesthesia
2) Emergency Medicine
3) Medicine
4) Pediatrics
5) Obstetrics / Gynecology
6) Radiology
7) Surgery / Pathology
8) Ambulatory Care

Recognizing that with experience after the merger the foregoing departments may need revision, upon unanimous approval by the Medical Executive Committee and approval by the Board of Trustees, the departments listed above and the designation of which departments have co-chairs in Section 10.6-1 may be revised, and that such revisions shall not be deemed amendments to the Bylaws, subject to the following:

(a) All members of the Active Medical Staff shall be notified after the Medical Executive Committee's approval of the foregoing proposed revisions and the right to object to them before the approved revisions are submitted to the Board of Trustees for approval. If the Active Staff submits a petition objecting to the proposed revision pursuant to Section 11.5-3 (a), the proposed revision shall be deemed an amendment to the Bylaws that must be approved by the Medical Staff.

(b) Any revision of the proposed revisions pursuant to this Section must result in an equal number of Medical Executive Committee members who primarily practice at the facilities formerly known as Pioneers Memorial Hospital and El Centro Regional Medical Center.

10.3 ASSIGNMENT TO DEPARTMENTS AND DIVISIONS

Each member shall be assigned membership in at least one department, or division within a department, if any, within such department, but may also be granted membership and/or clinical privileges in other departments or divisions consistent with practice privileges granted.

10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department. The number of such reviews to be conducted during the year shall be as determined by the Medical Executive Committee in consultation with other appropriate committees. The department shall routinely collect information about important aspects of patient care provided in the department, periodically assess this information, and develop objective criteria for use in evaluating patient care. Patient care reviews shall include all clinical work performed under the jurisdiction of the department, regardless of whether the member whose work 1s subject to such review 1s a member of that department.

(b) Recommending to the Medical Executive Committee criteria for the granting of clinical privileges and the performance of specified services within the department.

(f) submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications;

(g) Conducting, participating and making recommendations regarding continuing education programs pertinent to departmental clinical practice;

(h) Reviewing and evaluating departmental adherence to: (1) medical staff policies and procedures and (2) sound principles of clinical practice;

(i) Coordinate and manage patient care treatment and services, provided by the department's members, with other practitioners, with nursing and other ancillary patient care services.

(j) Meeting at least quarterly for the purpose of considering patient care review findings and the results of the department's other review and evaluation activities, as well as reports on other department and staff functions.

(k) Establishing such committees or other mechanisms as are necessary and desirable to perform properly the functions assigned to it, including proctoring protocols.

(l) Taking appropriate action when important problems in patient care and clinical performance or opportunities to improve care are identified.

(m) Accounting to the Medical Executive Committee for all professional and medical staff administrative activities within the department.

(n) Appointing such committees as may be necessary or appropriate to conduct department functions.

(o) Formulating recommendations for departmental rules and regulations reasonably necessary for the proper discharge of its responsibilities subject to the approval by the Medical Executive Committee and the medical staff;

(p) Establishing priorities, communicate findings, conclusions, recommendations and actions for performance improvement and patient health outcomes;

(q) Performing peer review in accordance with approved Peer Review Policy and as established/identified by the medical staff and hospital leadership.

10.5 FUNCTIONS OF DIVISIONS

Subject to approval of the Medical Executive Committee, each division shall perform the functions assigned to it by its department chair. Such functions may include, without limitation, retrospective patient care reviews, evaluation of patient care practices (performance improvement and peer review), credentials review and privileges delineation, and continuing education programs. The division shall transmit regular reports to the department chair on the conduct of its assigned functions.

10.6 DEPARTMENT CO-CHAIRS AND CHAIRS

10.6-1 Qualifications

With the exception of Pediatrics and Ambulatory care that each shall have one Department Chair, there shall be co-chairs of each department with a co-chair who primarily practices at the facility that formerly was El Centro Regional Medical Center and a co-chair who primarily practices at the facility formerly was Pioneers Memorial Hospital. Department Co-Chairs shall be members of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. Department chairs and co-chairs must be Board certified by an appropriate specialty board, and if there is no Active Staff who meets the foregoing requirements who is able to serve as chair or co-chair, must demonstrate comparable competence as established through the credentialing process. Additional qualifications shall include such attributes as the ability to understand the purposes and functions of the medical staff; a demonstrated willingness to ensure that patient welfare takes precedence over other concerns; a demonstrated willingness to abide by lawful and reasonable policies and procedures of the medical staff and hospital; administrative ability as applicable to their respective assignment; the ability to work with and motivate others toward achieving the objective of the medical staff and hospital; and demonstrated clinical competence in his/her field of practice. Must have proven experience in medical staff leadership.

Chairs and co-chairs may designate, subject to the Medical Executive Committee's approval, vice-chairs to assist with specific functions and report back to the co-chair. The Vice Chairs of Pediatrics and Ambulatory Care may act as the designee of their chair in the Chair's absence. A Vice Chair in a department with Co-chairs, may lead Department meetings that only are address matters applicable co-chair's campus during the co-chair's temporary absence. Vice Chairs must be a member of the Active Staff who primarily practices at the campus where they have been appointed as a co-chair's vice chair. The vice chair term of office shall coincide with the co-chair who designated the vice chair. In addition to exercising their responsibilities pursuant to Section 14.6, all department co-chairs, and vice chairs shall disclose all actual or potential conflicts of interest in writing prior to their election or appointment and verbally in the course of each department meeting or other event where such a disclosure may be relevant. Any potential conflicts so disclosed shall be resolved as set forth in Section 14.6.

10.6-2 Selection

The process for electing Department chairs and co chairs shall be through such mechanism as the Department establishes in its Rules or policies that are approved by the Medical Executive Committee.. Vacancies due to any reason shall be as specified in the Department's Rules or policies. If such Rules or policies are unclear or not specific to a situation or the outcome of an election or a Department fails to timely select a Chair or co-chair, the Medical Executive Committee shall resolve the matter. To promote continuity, the Medical Executive Committee shall designate approximately half of the Departments to elect their co-chairs in even number election years and the other half in odd number election years.

10.6-3 Term of Office

Each department chair, co-chair and vice-chair shall serve a 2 year term which coincides with the medical staff year or until their successors are chosen, unless they shall sooner resign, be removed from office, or lose their medical staff membership or clinical privileges in that department. Department officers shall be eligible to succeed themselves.

10.6-4 Removal

After appointment and ratification, removal of a department chair, co-chair, or vice-chair from office may occur for cause by a two-thirds vote of the department members eligible to vote on departmental matters who cast votes. Such removal must be approved by the Medical Executive Committee.

10.6-5 Duties

As appropriate to the department, each co-chair shall have the following authority, duties and responsibilities. , and the vice-chair, in the absence of the chair, shall assume all of them and shall otherwise perform such duties as may be assigned by the Medical Executive Committee:

(a) act as presiding officer at departmental meetings;

(b) report to the Medical Executive Committee and to the Chief of Staff regarding all clinically related, professional and administrative activities within the department;

(c) generally and continuously monitor the quality of patient care and professional performance rendered by members with clinical privileges in the department through a planned and systematic process; oversee and maintain the effective conduct of the patient care, evaluation, and monitoring functions delegated to the department by the Medical Executive Committee in coordination and integration with organization wide quality assessment and improvement activities;

(d) actively involved in the improvement of medical assessment, measurement, and treatment of patients;

(e) develop and implement departmental programs for retrospective patient care review, ongoing monitoring of practice, credentials review and privilege delineation, medical education, utilization review, and quality assessment and improvement and all other clinically related activities of the department;

(f) be a member of the Medical Executive Committee, be responsible for all clinically related activities of the department, give guidance on the overall medical policies of the medical staff and hospital and make specific recommendations and suggestions regarding the department;

(g) Evaluating and making appropriate recommendations to the Medical Executive Committee regarding the qualifications of applicants seeking membership or renewal of membership and clinical privileges within that department;

(h) review and evaluate the qualifications of each practitioner applying for initial membership, renewal of membership, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the respective departments;

(i) submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to membership, membership category, department affiliation, clinical privileges, and special conditions; investigate, review and report on matters referred by the chief of staff or the Medical Executive Committee regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member;

(g) transmit to the Medical Executive Committee recommendations concerning practitioner appointment and classification, reappointment, membership and criteria for clinical privileges and, renewal of membership in the department, criteria for clinical privileges, monitoring of specified services, and corrective action with respect to persons with clinical privileges in the department;

(h) endeavor to enforce the medical staff bylaws, rules, policies and regulations within the department;

(i) implement within the department appropriate actions taken by the Medical Executive Committee;

(j) participate in every phase of administration of the department, including maintaining a quality control program, as appropriate, recommending sufficient number of qualified and competent persons to provide care, treatment, and services, and space and other resources needed by the department; cooperation with the nursing service and the hospital administration in matters such as personnel (including assisting in determining the qualifications and competence of department/service personnel who are not licensed independent practitioners and who provide patient care services), supplies, special regulations, standing orders and techniques;

(k) assist in the preparation of such annual reports, including budgetary planning, pertaining to the department as may be required by the Medical Executive Committee;

(l) assess and recommend to the Board of Trustees, through the Medical Executive Committee, off-site sources for needed patient care, treatment, and services not provided by the department or the hospital;

(l) integrate the department or service into the primary functions of the hospital, and coordinate and integrate interdepartmental and intradepartmental services;

(m) develop and implement departmental policies and procedures that guide and support the provision of care, treatment, and services in the department;

(n) provide orientation and continuing education of all persons in the department or service;

(o) recommend delineated clinical privileges for each member of the department;

(p) determine the qualifications and competence of department or service personnel who are not licensed independent practitioner (i.e. allied health) and who provide patient care, treatment, and services;

(q) recommend space and other resources needed by department;

(r) appoint a special or ad hoc committee to perform specific functions within the scope of the department's or department chair's or co-chairs' duties to report back the department or to the department chair or co-chairs as specified in the appointment of the committee;

(s) perform such other duties commensurate with the office as may from time to time be reasonably requested by the Chief of Staff or the Medical Executive Committee.

Each co-chair shall address the issues in this Section 10.6-5 that pertain solely to its campus. For issues that affect both campuses, the co-chairs shall agree upon which co-chair shall assume primary responsibility for that function, with all recommendations to be subject to the other co-chair's agreement with the proposed recommendation or action. The co-chairs' failure to agree on a recommendation or action shall be referred to the Chief of Staff to assist in resolving. If not resolved with the Chief of Staff's assistance, the recommendation or action shall be referred to the Medical Executive Committee that shall have the ultimate responsibility on behalf of the Medical Staff to resolve the matter. Each co-chair shall chair such department meetings that are called to address issues at that co-chairs campus. Unless otherwise agreed by the co-chairs, the co-chairs shall rotate chairing department meetings that are joint meetings of the members of the two campuses.

10.6-6 Compensation of Department Co-Chairs

Department Co-Chairs should be compensated for their work spent representing and leading the medical staff. Such compensation shall come from the medical staff bank account, for which the medical staff has sole responsibility. The payment to individual physicians should be in the amount determined by the Medical Executive Committee. If the hospital provides any funds specifically earmarked for such compensation, those funds should be requested and accounted for in the medical staff budget for hospital approval. Payment to each physician shall be contingent upon each physician's proper performance of those duties, and the evaluation and determination of the quality of that performance is in the sole determination of the Medical Executive Committee.

10.7 DIVISION CHIEFS

Divisions may be established at the recommendation of the Department co-chairs and approved by the Medical Executive Committee, provided there are at least three (3) physicians in the proposed division.

10.7-1 Qualifications

Each division shall have a chief who shall be a member of the active medical staff and a member of the division, and shall be qualified by training, experience, and demonstrated current ability in the clinical area covered by the division. In addition to exercising their responsibilities pursuant to Section 14.6, division chiefs shall verbally disclose all actual or potential conflicts of interest in the course of each division meeting or other event where such a disclosure may be relevant. Any potential conflicts so disclosed shall be resolved as set forth in Section 14.6.

10.7-2 Selection

Each division chief shall be elected by the division members pursuant to such mechanism as the medical staff may adopt. Regardless of the mechanism utilized, In accordance with Section 14.6, all nominees for selection, appointment or election shall disclose in writing to the Medical Executive Committee and department co-chairs those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Vacancies due to any reason shall be filled for the unexpired term by the department chair.

10.7-3 Term of Office

Each division chief shall serve a *two-year* term which coincides with the medical staff year or until a successor is chosen, unless the division chief shall sooner resign or be removed from office or lose medical staff membership or clinical privileges in that division. Division chiefs shall be eligible to succeed themselves.

10.7-4 Removal

After appointment and ratification, a division chief may be removed by the division members eligible to vote and the Medical Executive Committee.

10.7-5 Duties

Each division chief shall:

(a) act as presiding officer at division meetings;

(b) assist in the development and implementation, in cooperation with the department chair, of programs to carry out the quality review, and evaluation and monitoring functions assigned to the division;

(c) evaluate the clinical work performed in the division;

(d) conduct investigations and submit reports and recommendations to the department chair regarding the clinical privileges to be exercised within the division by members of or applicants to the medical staff; and

(e) perform such other duties commensurate with the office as may from time to time be reasonably requested by the department chair, department co-chair, the Chief of Staff, or the Medical Executive Committee.

ARTICLE XI COMMITTEES

11.1 DESIGNATION

Medical staff committees shall include but not be limited to, meetings of departments and divisions, meetings of committees established under this Article, Medical Staff Rules or Medical Staff policies and meetings of special or ad hoc committees created by the Chief of Staff, Medical Executive Committee or by departments (pursuant to Sections 10.4(h) and (k) or department c co-chairs. The committees described in this Article shall be the standing committees of the medical staff. Additional standing committees may be included in the Medical Staff Rules or Medical Staff policies. Special or ad hoc committees may be created by the Chief of Staff, Department co-chairs or the Medical Executive Committee to perform specified tasks. Unless otherwise specified, the chair and members of all committees shall be appointed by and may be removed by the chief of staff, subject to consultation with or ratification by the Medical Executive Committee. In accordance with Section 14.6, all nominees for appointment to medical staff committees shall, at least 20 days prior to the date of appointment, disclose in writing to the Medical Executive Committee and the Chief of Staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the hospital, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the committee. Medical staff committees shall be responsible to the Medical Executive Committee.

11.1-2 Qualifications

In addition to exercising the responsibilities pursuant to Section 14.6, committee members shall verbally disclose all actual or potential conflicts of interest in the course of each medical staff meeting or other event where such a disclosure may be relevant. Any potential conflicts so disclosed shall be resolved as set forth in Section 14.6.

11.2 GENERAL PROVISIONS

11.2-1 Terms of Committee Members

Unless otherwise specified, committee members shall be appointed for a term of *2 years,* and shall serve until the end of this period or until the member's successor is appointed, unless the member shall sooner resign or be removed from the committee.

11.2-2 Removal

If a member of a committee ceases to be a member in good standing of the medical staff, or loses employment or a contract relationship with the hospital pursuant to which the member provides services at the hospital and is no longer has an active practice in the community, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Medical Executive Committee.

11.2-3 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made; provided however, that if an individual who obtains membership by virtue of these bylaws is removed for cause, a successor may be selected by the Medical Executive Committee.

11.3 MEDICAL EXECUTIVE COMMITTEE

11.3-1 Composition

The majority of voting Medical Executive Committee members are fully licensed doctors of medicine or osteopathy and may include other practitioners and any other individuals as determined by the organized medical staff. All members of the organized medical staff, of any discipline or specialty, are eligible for membership on the medical executive committee.

The committee consists of the following voting members:

(a) The officers of the medical staff (Chief of Staff, Vice Chief of Staff, Secretary/Treasurer, Immediate Past Chief of Staff);

(b) The department chairs and co-chairs;

(c) Not more than two at-large members who are members of the Active Staff and only are appointed to assure an equal number of voting members who actively practice at the facilities that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center, their appointment to be by the Chief of Staff if such appointee(s) must be from that officer's practice location and to be by the Vice Chief of staff if such appointee(s) must be from that officer's practice location.

The committee's ex-officio non-voting members shall include the Chief Executive Officer, Chief Medical Officer (if there are two Chief Medical Officers, then both).

At the committee's discretion, invited Guests to the MEC may include the Chief Nursing Officer, Director Quality/Risk Management. From time-to time, the Chief of Staff may invite other guests to join all or part of a particular meeting.

A Medical Executive Committee member can be removed from the committee only if the medical staff acts to remove that member from the position held as an officer, chair or co-chair , or at-large member, which is as described in Sections 9.1-6 for the recall of officers, or, in the case of department co-chairs is described in Section 10.6-4.

11.3-2 Duties

The organized medical staff delegates authority in accordance with law and regulation to the Medical Executive Committee to carry out medical staff responsibilities. The Medical Executive Committee carries out its work within the context of the organization functions of governance, leadership, and performance improvement. The Medical Executive Committee has the primary authority for activities related to self-governance of the medical staff and for performance improvement of the professional services provided by licensed independent practitioners and other practitioners privileged through the medical staff process. The Medical Executive Committee makes recommendations, as defined in these bylaws, to the Board of Trustees on, at least, all of the following:

1) making recommendations directly to the Board of Trustees on the organized medical staff organization's structure,

2) The process used to review credentials and delineate privileges;

3) The delineation of privileges for each practitioner privileged through the medical staff process;

4) The executive committee's review of and actions on reports of medical staff committees, departments, and other assigned activity groups.

5) provide leadership for measuring, assessing, and improving processes that primarily depend on the activities of the one or more medical staff and other practitioners credentialed and privileged through the medical staff process.

6) provide leadership in activities related to oversight and establishment of protocols related to pain assessment, pain management and safe opioid prescribing; and the process of analyzing and improving patient satisfaction and safety

The Medical Executive Committee shall be accountable to the organized medical staff. In addition to the foregoing, the duties of the Medical Executive Committee, are:

(1) seeking out the views of the medical staff on all appropriate issues;

(2) conveying accurately to the chief executive officer and to the Board of Trustees the views of the medical staff on all issues, including those relating to safety and quality;

(3) representing and acting on behalf of the medical staff in the intervals between medical staff meetings within the scope of its responsibilities as defined by the medical staff and subject to such limitations as may be imposed by these bylaws;

(4) coordinating and implementing the professional and organizational activities and policies of the medical staff;

(5) receiving and acting upon reports and recommendations from medical staff departments, divisions, committees, and assigned activity groups;

(6) recommending actions to the Board of Trustees on matters of a medical-administrative nature;

(7) developing and adopting appropriate policies to enable privileges holders to maintain the level of practice required under, and to more specifically implement, these Bylaws;

(8) establishing appropriate criteria for cross-specialty privileges in accordance with Section 5.2-3;

(9) making recommendations to the Board of Trustees, on medical staff membership, the process used to review credentials and delineate privileges, the delineation of privileges for each practitioner privileges through the medical staff process, and the Medical Executive Committee's review of and actions on reports from medical staff committees, departments, regarding findings, conclusions, recommendations, and actions to improve performance

(10) actively involved in the measurement, assessment of sentinel event data;

(11) evaluating the medical care rendered to patients in the hospital;

(12) participating in the development of all hospital policy, practice, and planning;

(13) reviewing the qualifications, credentials, performance and professional competence, and character of applicants and staff members, and making recommendations to the Board of Trustees meeting regarding staff membership and renewals of membership, assignments to departments, clinical privileges, and corrective action;

(14) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all members including the initiation of and participation in medical staff corrective or review measures when wan-anted;

(15) taking reasonable steps to develop educational activities and programs that are related to the type or services and treatment offered by the hospital, and findings of performance improvement activities. Programs will be developed for the medical staff, other members of the healthcare team, as well as patients and families.

(16) designating such committees as may be appropriate or necessary to assist in carrying out the duties and responsibilities of the medical staff and/or the medical executive committee, including by not limited to making recommendations to the medical executive committee for approval or rejections of appointments and clinical privileges and rules or policies applicable to particular campuses of the hospital;

(17) reporting to the medical staff at each regular staff meeting;

(18) assisting in the obtaining and maintenance of accreditation;

(19) developing and maintaining methods for the protection and care of patients and others in the event of internal or external disaster;

(20) appointing such special or ad hoc committees as may seem necessary or appropriate to assist the Medical Executive Committee in carrying out its functions and those of the medical staff;

(21) reviewing the quality and appropriateness of services provided by contract physicians;

(22) reviewing and approving the designation of the hospital's authorized representative for National Practitioner Data Bank purposes;

(23) establishing a mechanism for dispute resolution between medical staff members (including limited license practitioners) involving the care of a patient;

(24) affirmatively implementing, enforcing and safeguarding the self-governance rights of the medical staff to the fullest extent permitted by law, such rights of the medical staff including but not limited to the following:

(a) initiating, developing and adopting medical staff bylaws, rules and regulations, and amendments thereto, subject to the approval of the hospital governing board, which approval shall not be unreasonably withheld;

(b) selecting and removing Medical Staff Officers;

(c) assessing medical staff dues and utilizing the medical staff dues as appropriate for the purposes of the medical staff;

(d) retaining and being represented by independent legal counsel at the expense of the medical staff;

(e) establishing, criteria and standards for medical staff membership and privileges, and for enforcing those criteria and standards;

(f) establishing clinical criteria and standards to oversee and manage quality improvement, utilization review and other medical staff functions including, but not limited to, periodic meetings of the medical staff and its committees and departments and review and analysis of patient medical records;

(g) taking such action as appropriate to enforce Section 14.9 of these bylaws regarding the prohibition against retaliation directed towards a member;

(25) taking such other steps as appropriate to meet and confer in good faith to resolve disputes with the governing body, or any other person or entity, regarding any self- governance rights of the medical staff;

(26) after having met and conferred in good faith to remedy any dispute under subsection(s) of this section, exercising its discretion as appropriate to resolve the dispute, up to and including resort to resolution of the matter in the courts as permitted by law;

(27) reviewing the job description (e.g. qualifications, responsibilities, and reporting relationships) of medical directorships in the hospital both to assure their adequacy for medical staff purposes, and to avoid a conflict of duties between the medical director and any medical staff leader;

(28) provide upon request of a medical staff member, a listing of all medical directorship position in the hospital;

(29) participating in the interview and review of candidates for position of Chief Medical Officer, Chief Executive Officer, Chief Operating Officer, Chief Nursing Officer and the Chief Financial Officer or medical director in the hospital, and recommend the approval or veto of the selection of any such candidate in the hospital; and in approving or vetoing the selection of any such candidate.

(30) reviewing the performance of the hospital's Chief Medical Offer and medical directors periodically and transmitting the results of that review to the hospital board for its consideration;

(31) fulfilling such other duties as the medical staff has delegated to the Medical Executive Committee in these bylaws.

(32) participating in the review of prospective clinical contracts that are clinical in nature;

(33) participate in the review of the annual budget process;

(34) participate in the strategic planning process

(35) via a majority vote of the Medical Executive Committee, request the termination of an individual in a Chief Medical Officer or medical director position. The Board of Trustees shall give great weight to the recommendation of the Medical Executive Committee. Prior to removing an individual from a member of the administrative staff, the CEO shall meet and discuss the action with the Medical Executive Committee.

(36) upon identifying unresolved concerns with a member's or AHP's health that may adversely affect their ability to competently exercise their clinical privileges and fulfill their duties, requiring a that the provider have a physical or mental health evaluation(s) at the provider's expense by a practitioner(s) acceptable to the Medical Executive Committee and to release the results of such evaluation(s) (only as may adversely affect the provider's ability to competently exercise their clinical privileges, and fulfill their duties) to the Medical Executive Committee or its designee, and to set deadlines for the foregoing with automatic suspension for failure to timely comply pending compliance.

(37) interpret the Medical Staff's Bylaws, Rules and Regulations and policies if the application or implementation of a particular situation is disputed or there is a request for clarification.

11.3-3 Meetings

The Medical Executive Committee shall meet as often as necessary, but at least ten (10) times per year, and shall maintain a record of its proceedings and actions. The Medical Executive Committee may create a schedule that is a combination of locations, and remote and in person meetings and an alternative manner of approving actions between meetings as provided in Section 12.4-2 of these Bylaws. . The record shall also contain for each action taken, the number of persons who voted to approve, disapprove and who abstained..

11.5 AD HOC DISPUTE MEDIATION COMMITTEE

All disputes between hospital administration or the Board of Trustees and the medical staff ("Party" or "Parties" as applicable) relating to the medical staffs rights of self-governance as set forth in California Business and Professions Code Section 2282.5 ("Dispute") that have not been resolved by prior informal meetings and discussions shall be addressed and mediated in accordance with the process described in this Section. In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party, stating the nature of the Dispute. Within three (3) business days following receipt of such notice, both Parties shall appoint representatives to the committee as provided below. Neither Party shall initiate any legal action related to the Dispute until the committee has completed its efforts to mediate the Dispute.

11.5-1 Composition

An ad hoc committee shall be comprised of three (3) members appointed by the Board of Trustees, and three (3) members appointed by the Medical Executive Committee. The six (6) members shall appoint an outside professional mediator as the seventh member, and the mediator shall serve as chair of the committee, but shall have no vote. The Parties shall cooperate to select the mediator from a list of candidates provided by a service such as JAMS (Judicial Arbitration and Mediation Service) or the American Arbitration Association. The cost of the mediator shall be divided equally between the Parties.

11.5-2 Duties

The committee shall receive and promptly review the written request(s) for initiation of the Dispute mediation process. The committee may request such assistance as it deems necessary to gather relevant information and consider the opposing viewpoints. The committee then shall meet and confer in good faith to formulate a recommendation for mediation of the Dispute. The committee's efforts shall continue for up to sixty (60) days. After that period, the mediator shall prepare a written report of the committee's findings and recommendations and transmit it to the Parties if the committee has reached consensus, or the committee may ask the Parties for additional time to consider the Dispute. Both Parties must agree to any such extension of time. If the committee has not reached consensus, but chooses not to request additional time, the mediator shall submit a written report outlining any areas of agreement and the remaining issues, but shall not make any recommendations. Following receipt of the mediator's report, the Parties may adopt the committee's recommendations, agree to some alternative resolution of the Dispute, or refer the Dispute back to the committee with instructions for further mediation efforts. Unless requested by the Parties to continue its deliberations, the committee shall dissolve thirty (30) days after the mediator has made his or her report to the Parties.

11.5-3 Medical Executive Committee - Medical Staff Dispute Resolution Process

Disputes between the Medical Executive Committee and voting members of the Active Staff, shall be resolved as follows:

(a) If a majority of the members of the Active Staff sign a petition objecting to an action of the Medical Executive Committee relating to these Bylaws, General Medical Staff Rules and Regulations, policies or other official Medical Executive Committee actions, such petition shall be transmitted to the Medical Executive Committee via the Chief of Staff or the Medical Staff Office. The foregoing may include but not be limited to, removing and reassigning a duty or duties delegated to

the Medical Executive Committee for an indefinite or stated period of time, for a reason identified. This section shall not pertain to issues involving an individual provider's credentialing, peer review, corrective action or discipline.

(b) The Medical Executive Committee shall, within sixty (60) days after it receives such petition via the Chief of Staff or Medical Staff Office, meet with representative of those who have signed the petition to discuss and attempt to resolve the matter by mutual agreement.

(c) If the Medical Executive Committee and such representatives cannot agree on the subject matter of such petition, a consultant or a mediator may be engaged, by mutual agreement of the Medical Executive Committee and such representatives, to assist in resolving the dispute. If such consultant or a mediator is engaged, the parties shall share equally in the costs of such consultant or mediator is engaged, the parties shall share equally in the costs of such consultant or mediator, provided however, that in no event shall the consultant or mediator be the Board of Trustees or a representative thereof.

(d) If a matter relating to these Bylaws or the General Medical Staff Rules and Regulations or policies is not resolved within ninety (90) days after such matter was transmitted to the Medical Executive Committee via the Chief of Staff or Medical Staff Office, the Medical Executive Committee and such representatives shall prepare separate written statements of their respective positions and submit them to the Board of Trustees within no more than thirty (30) days thereafter, to be considered by the Board of Trustees for final decision.

11.6 HEALTH INFORMATION MANAGEMENT COMMITTEE

11.6-1 Composition

The Health Information Management Committee shall consist of, insofar as possible, the Chair, at least one representative from each clinical department, but no less than two physician members, the nursing service, the medical records department, and information systems, and hospital administration. The committee shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

11.6-2 Duties

The duties of the Health Information Management committee shall include:

(a) Review and evaluation of medical records, or a representative sample, to determine whether they:

- properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and
- are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital; and

(b) Quality of medical history and physical examinations is monitored for

- Accuracy
- Timeliness - completed within 24 hours
- Content to include, at a minimum: chief complaint, details of present illness, relevant past, social and family history, physical examination, statement on conclusions.

(c) review and make recommendations for medical staff and hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, indexing, storage, destruction; and

(d) provide liaison with hospital administration and medical records personnel in the employ of the hospital on matters relating to medical records practices.

(e) provide input and guidance on development, maintenance and ongoing support of an electronic medical records systems

11.6-3 MEETINGS

The Health Information Management Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Executive Committee as necessary but at least quarterly.

11.7 UTILIZATION REVIEW COMMITTEE

11.7-1 Composition

The utilization review committee shall consist of the chair and sufficient members to afford fair representation, at least one representative from each clinical department, but no less than two physician members, selected by the Chief of Staff. The committee

shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.
The director of case management shall be a member of the utilization review committee.

11.7-2 Duties

The duties of the utilization review committee shall include:

(a) conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety;

(b) establishing a utilization review plan which shall be approved by the Medical Executive Committee and reviewed no less than annually;

(c) obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system;

(d) oversee activities performed by physician advisors, including review of the medical necessity for admissions, extended stays, services rendered, and maintaining proper continuity of care upon discharge;

(e) evaluating the medical necessity of continued hospital services for particular patients where appropriate, and ensuring that (i) the attending physician is consulted, and the availability of hospital facilities and services is considered prior to any decision that further inpatient stay is not medically necessary, and (ii) written notice of any decision that further inpatient care is not medically necessary is given within two (2) days following that determination; and

(f) recommend education and training and evaluation of documentation by clinical to support coding and case management

11.7-3 MEETINGS

The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a report of its activities and recommendations to the Medical Executive Committee.

11.8 PHARMACY / THERAPEUTICS / MEDICATION ERROR REDUCTION PLAN (MERP)

11.8-1 COMPOSITION

The pharmacy and therapeutics committee shall consist of at least 2 representatives from the medical staff, a representative from the pharmaceutical service, as well as from the nursing service, dietary director, and hospital administration. The committee shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

11.8-2 DUTIES

The duties of the pharmacy and therapeutics committee shall include:

(a) assisting in the formulation of professional practices and policies regarding the continuing evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the hospital, including antibiotic usage;

(b) advising the medical staff and the pharmaceutical service on matters pertaining to the choice of available drugs;

(c) making recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

(d) periodically developing and reviewing a formulary or drug list for use in the hospital;

(e) evaluating clinical data concerning new drugs or preparations requested for use in the hospital;

(f) establishing standards concerning the use and control of investigational drugs and of research in the use of recognized drugs;

(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities;

(h) reviewing use of medications, all adverse drug reactions and medication errors; and

(i) developing proposed policies and procedures for, and continuously evaluating the appropriateness of blood and blood products usage, including the screening, distribution, handling and administration, and monitoring of blood and blood components' effects on patients;

DUTIES - Nutritional Support

(a) advising the medical staff on matters pertaining to the choice of available enteral formulas;

(b) periodically reviewing the formulas for standard use in the hospital;

(c) annual review of the diet manual and making recommendations for change when necessary;

(d) provide continuing liaison with medical and nursing staff regarding nutritional care of patients and education of staff; and

(e) review quality assurance clinical indicators.

11.8-3 Meetings

The committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee as needed but at least quarterly.

11.9 INFECTION CONTROL COMMITTEE

11.9-1 Composition

The infection control committee membership shall consist of at least two (2) representatives of the medical staff to include infectious disease specialist (if available)/infection control officer, and physician representatives from pathology, medicine and surgery, as well as the individual employed in a surveillance or epidemiological capacity, and a representative from pharmacy services. It may include non-voting representatives from administration, nursing, lab/microbiology and other relevant hospital services. The committee shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

11.9-2 Duties

The duties of the infection control committee shall include:

(a) developing a hospital-wide infection control program and maintaining surveillance over the program;

(b) developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow up activities;

(c) developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques in accordance with the approved hospital-wide surveillance program and hospital and medical staff policies and procedures;

(d) developing written policies defining special indications for isolation requirements;

(e) coordinating action on findings from the medical staff's review of the clinical use of antibiotics;

(f) acting upon recommendations related to infection control received from the Chief of Staff, the Medical Executive Committee, departments and other committees; and

(g) reviewing sensitivities of organisms specific to the facility and proper utilization of appropriate drugs.

11.9-3 Meetings

The infection control committee shall meet as often as necessary at the call of its chair but at least quarterly. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Committee.

11.10 CREDENTIALS COMMITTEE

11.10-1 Composition

The committee shall consist of at least three (3) members of the active medical staff appointed by Chief of Staff, in addition to the Vice Chief of Staff, who shall serve as Committee Chair. The committee shall include an equal number of Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

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11.10-2 Duties

(a) Review and evaluate the qualifications of each practitioner applying for initial membership, renewal of membership, or modification of clinical privileges, and, in connection therewith, obtain and consider the recommendations of the appropriate departments;

(b) Submit required reports and information on the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to membership, membership category, department affiliation, clinical privileges, and special conditions;

(c) Review and report on matters referred by the chief of staff or the medical executive committee regarding the qualifications, conduct, professional character or competence of any applicant or medical staff member; and

(d) Submit periodic reports to the medical executive committee on its activities and the status of pending applications.

(e) The review and evaluation of qualifications of AHP/APP practitioners applying for initial membership, renewal of membership, or modification of scope of service privileges, shall follow the same process as medical staff members, with addition of IDP chair review (see 11.13 of these bylaws).

11.10-3 Meetings

The committee shall meet monthly (except August), following a similar schedule as the Medical Executive Committee. The Bylaws/Credentials Committee shall maintain a record of its proceedings and shall report its activities and recommendations to the Medical Executive Committee.

11.11 PHYSICIAN WELL BEING COMMITTEE

11.11-1 Composition

The Physician Well Being Committee shall be comprised of no less than *3* members of the medical staff, a majority of which, including the chair, shall be physicians. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee. When there is a conflict of interest, the committee chair will recuse the member and the Chief of Staff will appoint a substitute. In so far as possible, the committee shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

11.11-2 Duties

(a) Purpose

The purpose of the Physician Well Being committee process is:

(1) to identify and address matters of individual health for members and other licensed provider who is credentialed by the medical staff. Any referred matters will first be evaluated for credibility of the complaint, allegation, or concern.

(2) Facilitate the rehabilitation, rather than discipline, by assisting a practitioner to retain and to regain optimal professional functioning that is consistent with protection of patients.

(3) Provides education for licensed independent practitioners and other organization staff about illness and impairment recognition issues specific to their professional practices, including at-risk criteria: mental and behavior health problems, burnout, communication and interpersonal issues, physical and cognitive problems and alcohol and/or substance use disorders.

If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner may be unable to safely perform the privileges he or she has been granted, the matter is forwarded for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

The Physician Well Being process will facilitate confidential diagnosis, treatment, and rehabilitation of members and other licensed providers who are credentialed by the medical staff and who suffer from a potentially impairing condition, as well as, provide education related to prevention of physical, psychiatric, or emotional illness.

(b) Process Addresses

(1) Self referral by a licensed independent practitioner.

(2) Referral by others and maintaining informant confidentiality.

(3) Referral of the licensed independent practitioner to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

(4) Maintenance of confidentiality of the physician or other licensed provider seeking referral or referred for assistance, except as limited by applicable law, ethical obligation, 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 physician or other licensed provider who is credentialed by the medical staff and the safety of patients until the rehabilitation is complete and periodically thereafter, if required.

(7) Reporting to the organized medical staff leadership instances in which a the physician or other licensed provider is providing unsafe treatment.

(8) Initiation of appropriate actions when a the physician or other licensed provider fails to complete the required rehabilitation program.

(c) Referrals.

(1) Practitioners who are referred to a rehabilitation, treatment, evaluation program approved by the medical staff, must enroll in the program within 30-days of receipt of the notice to register for said program and complete the program timely, within the program established timeframe.

(2) Other referral of the physician or other licensed provider to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

(3) The practitioner must authorize the program to release information on the progress of the practitioner while in the program, monitoring the individual's progress through rehabilitation or treatment programs.

(d) Involvement.

Medical Staff / AHP/APP member involvement with the Physician Well Being Committee is voluntary. If a member refuses to participate with the Committee in the evaluation, monitoring, or health-related issues, then the issue will be referred to the appropriate Medical Staff Department/Committee/officer for action.

(e) Confidentiality of Information.

All information received by the Physician Well Being Committee will be maintained in a separate confidential file stored in a locked area in the Medical Staff Office. All health-related information will be maintained in a separate, confidential, and secure file.

(f) Authority of the Physician Well Being Committee, Limitations.

(1) The Committee shall not be involved in any quality of care review.
(2) Any identified quality of care issues will be immediately referred to appropriate Medical Staff peer review committee.
(3) The committee may not provide supervision of the clinical practice of a member.
(4) The Committee has no authority to take disciplinary action.

11.11-3 Meetings

The committee shall meet at least annually and as often as necessary. It shall maintain only such record of its proceedings as it deems advisable, but shall report on its activities, to the Medical Executive Committee and Board of Trustees.

11.12 BIOETHICS COMMITTEE

11.12-1 Composition

The bioethics committee shall consist of a minimum of three (3) physicians including Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center., and includes the Committee Chair, appointed by the Chief of Staff and approved by the Medical Executive Committee. Consultation committee shall include such other staff members as Physician-of –record, all consultants on case being referred for discussion. It shall also include CEO, CMO, representatives from nursing, quality improvement, case management, social services. Attendance may include, as needed, lay representatives from clergy, ethicists, attorney.

11.12-2 Duties

The bioethics committee shall serve primarily as an advisory committee, providing ethics consultations. Committee shall participate in development of guidelines for consideration of cases having bioethical implications; development and implementation of procedures for the review of such cases; development and/or review of institutional policies, procedures regarding care and treatment of such cases. Conduct periodic review of policies, protocols, procedures, pertaining to clinical ethics such as Advanced Directives, Withholding and Withdrawing Life-Sustaining Treatments, Informed Consent, and Organ Procurement.

The Bioethics committee will consider any bioethical issue that directly relates to the care and/or treatment of patients. Its role does not extend to issues which, while may be ethical in nature, are not directly related to patient care. The Committee shall have the authority to resolve conflicts as to whether an issue is bioethical in nature and requires consultation.

The committee shall perform concurrent and/or retrospective review of cases for the evaluation of bioethical policies; consultation with concerned parties to facilitate communication and aid conflict resolution; and education of the hospital staff on issues in clinical ethics.

11.12-3 Recommendations

Any recommendation resulting from a consultation is advisory and intended to enhance decision making, and in no way replace the patient, family, physician relationship. Recommendations from the consultation will be discussed with the attending physician by the Chair, or designee. The basic concepts of the medical ethics that are considered by committee members in making a recommendation include:

- Autonomy. Respect for an individual's right to self-determination as well as creating conditions necessary for autonomous choice, including disclosure of medical condition, privacy, confidentiality and respect for individual values
- Beneficence. Consideration to the best way to promote the patient's welfare with the care team's obligation to benefit the patient and to prevent and remove harm.
- Non-maleficence. Consideration of "doing-no-harm", that needless harm or injury is not created for the patient either through commission or omission.
- Justice. The fair allocation of scarce resources.
- Dignity. The patient and the treatment team have the right to dignity.
- Truthfulness and honesty. The concept of informed consent.

11.12-4 Consultations

When needed, the bioethics committee can act as a resource and give assistance to those charged with decision-making in situations where there is disagreement among the patient, family, guardian, staff, physician, concerning appropriate patient care issues. The goals of a consultation are:

(a) To promote the patient's right's rights, autonomy, and self-determination in the context of medical decisions;
(b) To promote shared decision making between patient, family, guardian, and their clinicians;
(c) To promote the awareness of ethical issues among health professionals and provide an avenue for care providers, patients, and significant others;
(d) To promote fair policies and procedures that maximize the likelihood of achieving good patient-centered outcomes;
(e) To protect the integrity of the institution in its respect for the quality and value of human life.
(f) When a Consultation is needed includes, but not limited to, the following situations:
    - Concerns about the competency of a patient;
    - Lack of Advance Directives, Living Will, or Health Care Power of Attorney, when a patient is unable to make important or life-sustaining medical decisions, due to incompetence or medical condition;
    - When there is family disagreement over life-sustaining treatments of a patient;
    - When there is patient/family/guardian disagreement over the medical care/treatment of a patient;
    - In cases where the patient/family/guardian are demanding extreme or inappropriate medical interventions;
    - When more help is needed in assisting family and clinical team with decisions;
    - When concerns about maintaining patient dignity and comfort are not being resolved;
    - When there is conflict regarding end-of-life decisions;
    - Questions concerning brain death, severe coma, persistent vegetative state;
    - In cases where issues of futility arise in conflict with patient, family, guardian wishes;
    - In difficult cases involving withholding or withdrawing treatment;
    - When family religious or cultural practices and beliefs are in opposition or conflict;
    - Major issue related to obtaining or failure to obtain appropriate consent;
    - In cases involving organ donation after cardiac death.

11.12-5 Documentation of Consultation

The Chair or designee shall document in the patient's medical record a minimum of following:

- Source of the referral
- Ethical issues addressed, assessments, analysis
- Justification supporting recommendations
- Closing, resolution achieved or additional meeting needed.

11.12-6 Meetings

Bioethics Consultation. The committee recognizes that often a consultation request is prompted by an emergency or immediate need by caregivers to resolve a bioethical question or dilemma. Committee consultation access will be available within 24 hours or as soon as possible.

- During normal business hours consultation access may be requested through the medical staff services office. Staff will facilitate scheduling of meeting, within 24 hours.
- During weekends and holidays, access will be by direct conversation between requesting physician and Bioethics Committee Chair. Requesting physician will contact the Chair directly to discuss specifics of case. Following discussion, the Chair has the authority to make a recommendation, or may refer case for Consultation, the next normal business day.

Bioethics Committee. Shall meet as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the Medical Executive Committee.

11.13 INTERDISCIPLINARY PRACTICE/ALLIED HEALTH PROFESSIONAL STAFF COMMITTEE

11.13-1 Composition

The interdisciplinary practice/allied health professional committee (IDPC/AHP/APP) shall consist of, at a minimum, the chief nursing officer, the administrator or designee, and an equal number of physicians, appointed by the Medical Executive Committee, and registered nurses, appointed by the chief nursing officer. In addition, when the hospital has a psychiatric unit and one or more clinical psychologists on its medical staff, one or more clinical psychologists shall be appointed by the Medical Executive Committee. Licensed or certified health professionals other than registered nurses who perform functions requiring standardized procedures or a practice agreement shall be included in the committee. The chair of the committee shall be a physician member of the active medical staff appointed by the Chief of Staff and approved by the Medical Executive Committee. The committee shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

11.13-2 Duties

The IDPC/AHP/APP committee shall perform functions consistent with the requirements of law and regulation. At a minimum, the committee shall establish written policies and procedures for interdisciplinary medical practice and exercise jurisdiction over issues related to granting of non-physician and advanced practice nurses service authorizations and implementation of standardized procedures as needed. Activities shall include but not be limited to:

(a) provision for securing recommendations from members of the medical staff in the medical specialty or clinical field of practice under review, and from persons in the appropriate nonmedical category who practice in the clinical field of specialty under review;

(b) method for the approval of standardized procedures in which affirmative approval of the administrator or designee 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 facility staff in the medical and nursing specialties under review;

(c) providing for maintaining clear lines of responsibility for the nursing service for nursing care of patients and of the medical staff for medical services in the facility;

(d) establishment of an intended line of approval for each recommendation of the committee.

(e) evaluating and making recommendations regarding the need for and appropriateness of the performance of in-hospital services by allied health practitioners (AHP/APPs).

(f) evaluating and making recommendations regarding the mechanism for evaluating the qualifications and credentials of AHP/APPs who are eligible to apply for and provide in-hospital services;

(g) evaluating and making recommendations regarding the minimum standards of training, education, character, competence, and overall fitness of AHP/APPs eligible to apply for the opportunity to perform in- hospital services;

(h) evaluating and making recommendations regarding identification of in-hospital services which may be performed by an AHP/APP, or category of AHP/APPs, as well as any applicable terms and conditions thereon; and

(i) evaluating and making recommendations regarding the professional responsibilities of AHP/APPs who have been determined eligible to perform in-hospital services.

(j) making recommendations regarding appropriate monitoring, supervision, and evaluation of AHP/APPs who may be eligible to perform in-hospital services.

(k) evaluating and reporting whether in-hospital services proposed to be performed or actually performed by AHP/APPs are inconsistent with the rendering of quality medical care and with the responsibilities of members of the medical staff.

(l) evaluating and reporting on the effectiveness of supervision requirements imposed upon AHP/APPs who are rendering in-hospital services.

(m) periodically evaluating and reporting on the efficiency and effectiveness of in-hospital services performed by AHP/APPs.

(n) Review and make recommendations regarding applications for initial granting and of renewal of clinical privileges for AHP/APP's and make recommendations regarding the rescinding of such prerogatives.

The IDPC/AHP/APP shall routinely report to the Board of Trustees through the Medical Executive Committee and, in addition, shall submit including an annual report of its activities directly to the Board of Trustees and the Medical Executive Committee.

11.13-3 Meetings

The IDPC/AHP/APP shall meet at the call of the chair at such intervals as the chair or the Medical Executive Committee may deem appropriate or at least quarterly, and shall report its activities and recommendations to the Medical Executive Committee.

11.14 BYLAWS COMMITTEE

11.14-1 Composition

The committee shall consist of at least three (3) members of the active medical staff appointed by Chief of Staff, in addition to the Vice Chief of Staff, who shall serve as Committee Chair. The committee shall include Medical Staff members who practice at each of the two campuses that formerly were Pioneers Memorial Hospital and El Centro Regional Medical Center.

11.14-2 Duties

(a) developing and submitting recommendations to the Medical Executive Committee and medical staff for changes in medical staff bylaws and General Rules as necessary to reflect or improve current medical staff practices; and

(b) reviewing the hospital bylaws and related policies, which shall be provided by the hospital and made available by the Medical Staff Office to any medical staff member upon request, for inconsistencies and conflicts with medical staff documents and reporting issues and recommendations to the Medical Executive Committee for its review.

11.14-3 Meeting Frequency

The committee shall meet to review the Bylaws at least once every year and shall meet as often as necessary at the call of its chair. It shall maintain a record of its activities and report to the Medical Executive Committee.

11.15 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Board of Trustees may determine, as a matter of policy and in accordance with state and federal law, that certain hospital clinical facilities may be used only on an exclusive basis in accordance with written contracts between the hospital and qualified professionals, or in a limited fashion pursuant to a closed/limited staff policy. The medical executive committee will review and make recommendations to the Board of Trustees regarding quality of care issues related to such exclusive arrangements in the following situations:

(a) the decision to execute an exclusive contract in a previously open department or service;

(b) the decision to renew or modify an exclusive contract in a particular department or service;

(c) the decision to terminate an exclusive contract in a particular department or service.

(d) The medical executive committee shall also review and make recommendations to the Board of Trustees regarding quality of care issues related to the selection, performance evaluation, and any change in retention or replacement of physicians with whom the hospital has a contract. Prior to any decision being made, the Board of Trustees shall be required to review and approve the recommendations of the medical executive committee regarding these contracts, which approval shall not be unreasonably withheld.

11.16 TISSUE REVIEW FUNCTION

The tissue review function shall be performed by the Pathology Department. The function shall include review of surgical cases in which a specimen (tissue or non-tissue) is removed and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. The Medical Executive Committee may describe a system by which the *tissue review function* shall be coordinated with departmental medical/surgical case review. The results of the tissue review shall be reported as often as necessary to the medical executive committee, but at least quarterly.

ARTICLE XII MEETINGS

12.1 STAFF MEETINGS

12.1-1 Annual Meeting

There shall be an annual meeting of the medical staff. The chief of staff, or such other officers, department or division heads, or committee chairs as the chief of staff or Medical Executive Committee may designate, shall present reports on actions taken during the preceding year and on other matters of interest and importance to the members. Notice of this meeting and its agenda items shall be given to the members at least 10 days prior to the meeting held in December.

12.1-2 Regular Meetings

In addition to the Annual meeting, there shall be at least one regular meetings of the general medical staff such that there are biannual meetings of the general medical staff semi-annually. The date, place and time of the regular meetings shall be determined by the Medical Executive Committee, and adequate notice shall be given to the members. Such notices may also be posted in medical staff common areas such as Medical Staff Offices, dining rooms, and lounges.

12.1-3 Agenda

The order of business at a meeting of the medical staff shall be determined by the O and Medical Executive Committee. The agenda may include, insofar as feasible:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the Chief of Staff, departments, and committees, and the administrator;

(c) election of officers and others when required by these bylaws, provided that members may vote in person by attending the meeting or may submit their own secret verified ballot through a process specified by the Medical Executive Committee;

(d) reports by responsible officers, committees and departments on the overall results of patient care audits and other quality review, evaluation, and monitoring activities of the staff and on the fulfillment of other required staff functions;

(e) old business; and

(f) new business. Any item of new business that is not urgent or emergent, as determined by the medical staff, may be placed on the agenda for the next meeting.

12.1-4 Special Meetings

Special meetings of the medical staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called upon the written request of 10% of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled by the Medical

Medical Executive Committee within 30 days after receipt of such request. No later than 10 days prior to the meeting, notice shall be mailed or delivered to the members of the staff which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

12.2 COMMITTEE AND DEPARTMENT MEETINGS

12.2-1 Regular Meetings

Except as otherwise specified in these bylaws, the chairs of committees, departments and divisions may establish the times for the holding of regular meetings. Notice of all meetings and their agenda items shall be given to the members. Reasonable notice of any meeting and its agenda items shall be provided electronically to each medical staff member.

12.2-2 Special Meetings

A special meeting of any medical staff committee, department or division may be called by the chair or co-chairs, thereof, the Medical Executive Committee, or the Chief of Staff, or shall be called by written request of one-third of the current members, eligible to vote, but not less than *2* members and not less than forty-eight (48) hours notice unless the Chief of Staff determines an urgent situation requires more immediately meeting by the Medical Executive Committee.

12.3 QUORUM

12.3-1 Staff Meetings

(a) The presence of 20% of the total members of the active medical staff will constitute a quorum at any regular or special meeting for the purpose of amending these bylaws, the general rules and regulations of the medical staff, or for the election of medical staff officers.

12.3-2 Department and Committee Meetings

A quorum of fifty percent (50%) of the voting members shall be required for Medical Executive Committee meetings. For other committees and departments, a quorum shall consist of two (*2)* of the voting members.

12.4 VOTING AND MANNER OF ACTION

12.4-1 Voting

Unless otherwise specified in these bylaws, only members of the Active Staff may vote in medical staff department committee meetings, or staff elections. Voting may be accomplished by email or other electronic and/or telephone means where permitted by the chair of the meeting on either an individual or group basis, so long as adequate precautions are in place to ensure authentication and security. At the request of a member, voting shall be by secret ballot.

12.4-2 Manner of Action

Except as otherwise specified, the action of a majority of the v o t i n g members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. Valid action may be taken without a meeting by a committee if it is acknowledged in writing, setting forth the action so taken, which is signed by at least two-thirds of the voting members entitled to vote.

12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters. Members who were entitled to attend the meeting shall be entitled to review the meeting minutes by scheduling a meeting to do so in the Medical Staff Office. Further, the minutes shall include the names of those who disclosed potential conflicts of interest and those who abstained and/or recused themselves. Minutes of all medical staff meetings (except the minutes relating to peer review and matters discussed in executive session), shall be available to any voting member upon request, by visiting the Medical Staff Office and reviewing the minutes in the applicable meeting file. The chair or co-chairs, as applicable, of each medical staff department and committee will submit a report to the Medical Executive Committee.

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12.6 ATTENDANCE REQUIREMENTS

12.6-1 Regular Attendance

Except as stated below, each member of the Active staff shall meet the following meeting requirements. Failure to satisfy the meeting attendance requirements may result in a change in staff status upon reappointment.

(a) Attend at least twenty-five percent of the annual and annual general staff meeting in the two year appointment cycle, e.g., if there are two annual meetings and two general staff meetings, required to attend at least one, and

(b) At least fifty 50 percent of all meetings of each department, division, and committee to which the member is assigned.

(c) In the event a practitioner is unable to attend his/her assigned department or committee meeting, the agenda, minutes, and handouts of the meeting will be available for review by the practitioner for 15-days following the meeting. Practitioner must sign and date acknowledging review. Practitioner will be given credit for “attendance” for doing so in this matter for one (1) meeting per year. This does not include Section 12.6-3 Special Attendance.

Additionally:

(a) Each member of the consulting or courtesy staff and members of the provisional staff who qualify under criteria applicable to courtesy or consulting members shall be required to attend such meetings as may be determined by the Medical Executive Committee;

(b) Temporary members of the medical staff under Section 5.6 are excluded from meetings requirements.

12.6-2 Absence from Meetings

Any member who is compelled to be absent from any medical staff, department, division, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department, division, or committee, or the secretary-treasurer for medical staff meetings, failure to meet the attendance requirements may be grounds for removal from such committee or for corrective action.

12.6-3 Special Attendance

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a department, division, or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice or conduct is involved, the notice shall be given at least 7 days prior to the meeting, shall include the time and place of the meeting, a general indication of the issue involved and state that attendance is required. Failure of a member to appear and respond at any meeting to which notice was given that attendance was required, , unless excused by the Medical Executive Committee upon a showing of good cause, shall result in an automatic suspension of all of the practitioner’s clinical privileges until such time that the attendance and response requirement is satisfied. On a case-by-case basis, the Department Chair and Chief of staff may agree to terminate the suspension upon receipt of the practitioner’s written response that addresses the issues that were to be discussed at the meeting and which provides an acceptable explanation for failure to attend the required meeting

12.7 VIRTUAL MEETINGS

A committee or department meeting action may be conducted by email, telephone conference or conferencing software such as Zoom or similar, which shall be deemed to constitute a meeting for the matters communicated. Record of the action shall be prepared as minutes of the meeting.

12.8 CONDUCT OF MEETINGS

Medical Staff and committee meetings shall be run in a manner determined by the individual who is the chair of the meeting. When parliamentary procedure is needed, as determined by the chair or evidenced by a majority vote of those attending the meeting, the latest edition of Robert's Rules of Order shall determine procedure, however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

12.9 CLOSED/EXECUTIVE SESSION

Closed/ Executive session is a meeting of a medical staff committee, department, or division, or of the medical staff as a whole at which only voting medical staff members may be present unless others are expressly requested by the member presiding at the meeting to attend. Executive session may be called by the presiding member at the request of any medical staff committee member, and shall be called by the presiding member pursuant to a duly adopted motion. Executive session may be called, at the discretion of the chair, to discuss peer review issues, personnel issues, matters directly impacting self-governance or any other sensitive issues requiring confidentiality. Any person (member, administrative staff, etc.) may be excluded from an executive session at the direction of the chair or by vote of the members of the department, division or committee. Minutes of executive session only may be reviewed by those who were permitted to attend the executive session.

ARTICLE XIII CONFIDENTIALITY, IMMUNITY AND RELEASES

13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within this hospital, an applicant:

(a) authorizes representatives of the hospital and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the hospital who would be immune from liability under Section 13.3 of this Article;

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this hospital.

13.2 CONFIDENTIALITY OF INFORMATION

13.2-1 General

Records and proceedings of all medical staff committees having the responsibility of evaluation and improvement of quality of care rendered in this hospital, including, but not limited to, meetings of the medical staff meeting as a committee of the whole, meetings of departments and divisions, meetings of committees established under Article XI, and meetings of special or ad hoc committees created by the Medical Executive Committee or by departments and including information regarding any member or applicant to this medical staff shall, to the fullest extent permitted by law, be confidential. Any person attending the meeting will not disclose any discussions or outcomes that occurred during the meeting. Dissemination of such information and records shall only be made where expressly required by law, pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee or its designee.

13.2-2 Breach of Confidentiality

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments, divisions, or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate.

13.3 IMMUNITY FROM LIABILITY

13.3-1 For Action Taken

The medical staff, hospital and each representative of the medical staff and hospital shall be immune, to the fullest extent allowed by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the medical staff or hospital.

13.3-2 For Providing Information

The medical staff, hospital and each representative of the medical staff and hospital and all third parties shall be immune, to the fullest extent allowed by law, from liability to an applicant or member for damages or other relief by reason of providing information to a

representative of the medical staff or hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

13.4 ACTIVITIES AND INFORMATION COVERED

The confidentiality and immunity provided by this Article shall apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

(a) application for appointment, reappointment or clinical privileges;
(b) corrective action;
(c) hearings and appellate reviews;
(d) utilization reviews;
(e) other department, or division, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct;
(f) queries and reports concerning the National Practitioner Data Bank, peer review organization, the Medical Board of California, and similar queries and reports.

13.5 RELEASES

Each applicant or member shall, upon request of the medical staff or hospital, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

13.6 INDEMNIFICATION

The hospital shall indemnify, defend and hold harmless the medical staff and its individual members and its and those who provide services at the request of the medical staff or its representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review or quality assessment or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, including, but not limited to, (1) activities as a members of any medical staff committee. (2) as a member of or witness in the peer review or hearing process, (3) as a member of or witness for the hospital board or any hospital task force, group, or committee, and (4) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member, AHP or applicant. The medical staff, member or other person covered by this Section may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses or expenses by the medical staff, member or other person covered by this Section is not a condition precedent to the hospital's indemnification obligations hereunder. A party may request that a dispute relating to the application of this provision be referred to the Ad Hoc Dispute Mediation Committee.

13.7 PATIENT PRIVACY

13.7-1 Commitment to Privacy Rule Compliance

The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time
(the "Privacy Rule"). Medical staff members shall protect the privacy of patients' health information as required by the Privacy Rule and applicable state law. Further, the medical staff is committed to complying with the Privacy Rule in a manner that reasonably minimizes disruption to quality patient care.

13.7-2 Organized Health Care Arrangement

The Privacy Rule permits multiple covered entities that provide care in a clinically integrated care setting, such as the hospital setting, to declare themselves an Organized Health Care Arrangement ("OHCA"). OHCA status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations of the arrangement. Such activities include peer review, credentialing, quality assurance and utilization review. As such, OHCA status protects patient privacy while minimizing disruption
to quality patient care. Accordingly, by applying for and exercising clinical privileges at the Hospital, each medical staff member and Allied Health Professional agrees to participate in the hospital's OHCA. As such, all members of the medical staff or Allied Health Professional shall abide by the hospital's privacy policies and procedures.

13.7-3 Joint Notice of Privacy Practices

The Privacy Rule requires a health care provider that is a Covered Entity (as defined in the Privacy Rule) to deliver a notice of privacy practices to a patient no later than the provider's first date of service to the patient. Health care providers that participate in an OHCA may comply with this requirement by joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule.
Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a medical staff member or Allied

Health Professional in connection with his or her provision of services in the hospital, by applying for and exercising clinical privileges at the hospital, each medical staff member and Allied Health Professional agrees to abide by the terms of the joint Notice of Privacy Practices of the hospital and the medical staff then in effect.

13.7-4 Discipline

Whenever a medical staff member or Allied Health Professional uses or discloses health information in a manner inconsistent with the hospital's privacy policies, the and procedures or Joint Notice of Privacy Practices, the member may be disciplined in accordance with the medical staff bylaws

ARTICLE XIV GENERAL PROVISIONS

14.1 MEDICAL STAFF RULES AND REGULATIONS AND POLICIES

The Medical Executive Committee is hereby authorized to establish Medical Staff rules and regulations and policies as provided in this Article.

14.2 GENERAL RULES AND REGULATIONS

The Medical Executive Committee, propose the adoption, amendment, or repeal of the General Medical Staff rules and regulations for approval by the Board, following notice to the members of the Active Staff. General Medical Staff rules and regulations shall become effective when approved by the Board – which approval shall not be unreasonably withheld. If the Board withholds its approval for a General rule and regulation recommended by the Medical Executive Committee, the Medical Executive Committee may submit the matter to an Ad Hoc Dispute Mediation Committee for mediation If there is a conflict between the bylaws and the rules and regulations, the bylaws shall prevail. The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff rules and regulations.

14.3 ADOPTION AND INCORPORATION OF POLICIES, PROCEDURES, CRITERIA AND STANDARDS

All policies, procedures, criteria, standards, or other documents for use in medical staff activities, including but not limited to, membership, privileges, quality assurance, utilization review, and review and analysis of patient medical records shall be approved by the Medical Executive Committee and the Board of Directors. Conflicts between the medical staff and Board of Directors with regard to policy and procedure changes that cannot be resolved through informal means shall be referred to the Ad Hoc Mediation Committee. Upon adoption, such documents shall be deemed part of the medical staff bylaws, rules and regulations.

14.4 DEPARTMENT CLINICAL SERVICE RULES

A clinical service may propose rules applicable to that service to the Medical Executive Committee. Clinical service rules shall become effective upon approval by the Medical Executive Committee and the Board. The Board shall not unreasonably withhold its approval. If the Board does not approve a proposed clinical service rule, the Medical Executive Committee may submit the matter to an Ad Hoc Dispute Mediation Committee for mediation as provided in Section 11.5. If there is a conflict between the bylaws and the clinical service rules, the bylaws shall prevail.

14.5 PETITION

The members of the Active Staff, by a written petition signed by at least one- third (1/3) of the members of the Active Staff members of the medical staff who are in good standing, , may petition the Medical Executive Committee to initiate a proposal to adopt, amend or repeal a Rule or policy. Such petition shall identify exact language to be added, changed or deleted. If the Medical Executive Committee agrees with the proposed change, it may recommend the change following the processes in these Bylaws. If the Medical Executive Committee does not agree with the proposed change, the Medical Executive Committee shall meet with the proponents of the proposed change to discuss and attempt to resolve the disagreement. If the disagreement has not been resolved in one hundred eighty (180) days from the date the proposal was delivered to the Medical Executive Committee, the Chief of Staff shall call a special meeting of the Active Staff to consider the proposal. Subsequent to following the process this Section 14.5, the organized medical staff shall have the propose revisions to the rules or policies directly to the governing body subject to the following: (i) The adoption or amendment must be in writing and signed by at least two-thirds (2/3) of the Active Staff who are in good standing, and (ii) the adoption or amendment cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.

14.5. Urgent Amendment of Rules

The Medical Executive Committee. with the approval of the Board of Trustees may adopt amendments to general medical staff rules or departments rules provisionally without notice to the general medical staff upon a documented need for an urgent amendment to comply with applicable law or regulatory agency. Following notice of such action, members of the active staff, by petition signed by at least one-third of such members, may ask the Medical Executive Committee to reconsider such changes.

14.2 DUES OR ASSESSMENTS

The Medical Executive Committee shall have the power to decide the amount of annual dues or assessments, if any, for each category of medical staff membership.

All Active, Courtesy, Consulting, Provisional, Community Based, Telemedicine and Allied Health, Advances Practice Professional Staff member shall be required to pay a pre-application, initial application fee and bi-annual dues. Amount shall be determined by the Medical Executive Committee and approved by the voting members of the organized medical staff. *(See details in Medical Staff Process: Collection of Medical Staff Fees, Dues, Assessments.)*

Failure to pay such dues shall result in those actions specified in of these Bylaws. Additional fees may be assessed on members for specific reasons as outlined in this section.

14.2-1 Medical Staff Funds

Medical Staff funds, regardless from what source (i.e., medical staff dues, hospital funds) shall be under the sole control of the Medical Staff. All medical staff members may at all reasonable times inspect all bank statements and the quarterly financial statements prepared pursuant to Section 9.2-4. Use of the medical staff funds will be determined by the Medical Executive Committee.

14.2-2 Application Fees

(a) Pre-Application Fee. A non-refundable fee will be due at the time of Pre-Application. The remainder of the non-fundable fee is due and payable at the time of submission of initial application.

(b) Initial Application Fee. All Medial Staff and AHP/APP Practitioner applicants for shall be required to pay a non-refundable application fee, due and payable upon submission of application.

14.2-3 Reapplication Fee (Dues)

(a) Medical Staff Members and AHP/APP Staff Members shall be required to pay a non-refundable reapplication fee every two-years, due and payable upon submission of reappointment application.

(b) Allied Health Professional Staff Members shall be required to pay a non-refundable reapplication fee equal to 50% of the amount required of Medical Staff Members, also due and payable upon submission of reappointment application.

14.2-4 Other Fees, Assessments (Medical Staff, AHP/APP members).

When submitting a new application, following automatic resignation/termination for any of the reasons noted below, an additional $100 fee assessment shall be charged. (This is in addition to Application fee described above.)

•Failure to complete delinquent medical records, •Failure to pay dues, and/or assessments, •Failure to maintain professional liability insurance

14.3 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the Medical Executive Committee may deem appropriate.

14.4 DIVISION OF FEES

Any division of fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

14.5 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service, first-class postage prepaid. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Chief of the Medical Staff,
c/o Medical Staff Services
1415 Ross Avenue
El Centro, California 92243

Or

Chief of Staff
c/o Medical Staff Services
207 West Legion Road
Brawley, CA 92221

Mailed notices to a member, applicant or other party, shall be to the addressee at the address as it last appears in the official records of the medical staff or the hospital.

14.6 DISCLOSURE OF INTEREST AND CONFLICT OF INTEREST RESOLUTION

For the purposes of these bylaws, Conflict of Interest means a personal or financial interest or conflicting fiduciary obligation that makes it difficult, as a practical matter, for the individual to act in the best interests of the medical staff without regard to the individual's private or personal interest. Such an interest may also be held by an immediate family member of that individual, including that individual's spouse, domestic partner, child or parent.

The disclosure of an interest, as set forth in these bylaws, does not automatically mean that an actual conflict of interest exists. Whether a disclosed interest constitutes a conflict is determined as set forth below.

14.6-1 Application

(a) In order to encourage unbiased, responsible management and decision-making, all medical staff leaders, including officers, department chairs, department co-chairs, , division chairs, medical staff representatives, and medical staff members serving on committees shall comply with the disclosure of interest and conflict of interest requirements as relevant to the position held and the circumstances, consistent with these bylaws.

(b) These bylaws shall be the unique and exclusive mechanism for discerning and acting upon conflicts of interest applicable to medical staff members. Only those medical staff members who also serve on the governing body may be required to adhere to a disclosure and conflict of interest policy, if any, of the governing body.

14.6-2 General Requirements

(a) No member may exercise any leadership or committee role unless or until the member completes the Disclosure of Interest Form approved by the Medical Executive Committee as consistent with these bylaws. This form shall be updated by such members within thirty (30) days of the occurrence of any changes relating to statements on that form. This form shall be available for viewing by any member of the medical staff access if upon submitting to the Medical Staff Office an attestation that the access is for bona fide medical staff purposes and not for individual personal use. Nor may the information be shared with non-medical staff members.

(b) Members holding any leadership or committee role must disclose their potential conflict of interest relevant to the subject under discussion when they address a medical staff body and prior to voting upon the subject where a potential conflict of interest exists.

14.6-3 Information to be Disclosed

Potential conflicts include, but are not limited to current or impending:

(a) Competitive or personal relationships, activities, or interests that may influence a member's decisions or actions;

(b) Grants or other financial, academic or professional relationships involving research relating to decisions under review;

(c) Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, in any hospital, hospital system, and/or ambulatory health facility;

(d) Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, in any company that furnishes goods or services to the hospital or is seeking to provide goods or services to the hospital;

(e) Employment, consulting or other personal compensation agreement with any hospital or ambulatory health facility;

(f) Ownership or investment interests in excess of $5,000 or 5% of the whole, whichever is less, or a director, trustee, officer or key employee in, a managed care company that contracts with or could contract with the hospital;

(g) Receipt of gifts including goods, services, or honoraria from the hospital or any company or person who contracts with or otherwise sells or may sell directly or indirectly to the hospital, in excess of $100.

(h) Employment, consulting or other personal compensation agreement with any quality assurance, credentialing, and/or utilization review entity, including but not limited to any third party payor, quality improvement organization, or the Medical Board of California.

(i) Any other personal or financial interest or conflicting fiduciary obligation that may raise a conflict of interest.

14.6-4 Conflict Resolution

(a) Not all disclosures of a potential conflict of interest requires the member's abstention or recusal, however, a member may abstain from voting on any issue. A member shall be recused if the member reasonably believes that the member's ability to render a fair and independent decision is or may be affected by a conflict of interest. A recused member shall not be counted in determining the quorum for that vote but may answer questions or otherwise provide information about the matter after disclosing the conflict. A recused member must not be present for the remainder of the deliberations or the vote.

(b) If a member has not voluntarily recused him/herself and a majority of voting members of the committee or in the staff meeting vote that the member should be excused from discussion or voting due to conflict of interest, the chair of the meeting hall excuse the member.

(c) If a member discloses a potential conflict of interest and requests a vote regarding excusing that member, the member shall leave the room while the issue is being discussed and voted upon.

(d) The minutes of the meeting shall include the names of those who disclosed potential conflicts and those who abstained shall be recused themselves.

14.6-5 Corrective Action

Medical staff members who fail to comply with all provisions of these bylaws concerning actual or potential conflicts of interest shall be subject to corrective action under these bylaws, including but not limited to removal from the medical staff position.

14.7 NOMINATION OF MEDICAL STAFF REPRESENTATIVES

Candidates for positions as medical staff representatives to local, state and national hospital medical staff sections should be approved by the Medical Executive Committee.

14.8 MEDICAL STAFF CREDENTIALS FILES

14.8-1 Insertion of Adverse Information

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credentials file.

Any person may provide information to the medical staff about the conduct, performance or competence of its members.

(a) When a request is made for insertion of adverse information into the medical staff member's credentials file, the respective department chair or co-chairs, as applicable, and Chief of Staff shall review such a request.

(b) After such a review a decision will be made by the respective department chair or co-chairs, as applicable, and Chief of Staff to:

(1) not insert the information;

(2) notify the member of the adverse information by a written summary and offer the opportunity to rebut this assertion before it is entered into the member's file;

(3) insert the information along with a notation that a request has been made to the Medical Executive Committee for an investigation as outlined in Section 6.3-2 of these bylaws.

(c) This decision shall be reported to the Medical Executive Committee. The Medical Executive Committee, when so informed, may either ratify or initiate contrary actions to this decision by a majority vote.

14.8-2 Review of Adverse Information at the Time of Reappraisal and Renewal of Membership

The following applies to the review of adverse information in the medical staff member's credentials file at the time of reappraisal and renewal of membership.

(a) Prior to recommendation on renewal of membership, the department, as part of its reappraisal function, may review any adverse information in the credentials file pertaining to a member.

(b) Following this review, the departments may determine whether documentation in the file warrants further action.

(c) With respect to such adverse information, if it does not appear that an investigation and/or adverse action at the time of membership renewal is warranted, the department shall so inform the Medical Executive Committee.

However, if an investigation and/or adverse action at the time of membership renewal is warranted, the department shall so inform the Medical Executive Committee, which shall take such action as it deems reasonable and warranted in accordance with these Bylaws.

14.8-3 Confidentiality

The following applies to records of the medical staff and its departments, divisions, and committees responsible for the evaluation and improvement of patient care:

(a) The records of the medical staff and its departments and committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

(b) Access to such records shall be limited to duly appointed officers and committees of the medical staff for the sole purpose of discharging medical staff responsibilities and subject to the requirement that confidentiality be maintained.

(c) Information which is disclosed to the governing body of the hospital or its appointed representatives-in order that the governing body may discharge its lawful obligations and responsibilities-shall be maintained by that body as confidential.

(d) Information contained in the credentials file of any member may be disclosed with the member's consent, or to any medical staff or professional licensing board, or as required by law. However, any disclosure outside of the medical staff that is not required by law or regulation shall require the authorization of the Chief of Staff and the concerned department chair or co-chairs and notice to the member.

(e) A medical staff member shall be granted access to the individual's credentials file, subject to the following provisions:

(1) timely notice of such shall be made by the member to the Chief of Staff or the Chief of Staff's designee;

(2) the member may review, and receive a copy of, only those documents provided by or addressed personally to the member.

(f) in the event a notice of action or proposed action is filed against a member, access to that member's credentials file shall be governed by the medical staff hearing and appeals sections of these bylaws.

14.9 PUNITIVE OR RETALIATION PROHIBITED

(a) Neither the medical staff, its members, committees or department heads, the governing body, its chief administrative officer, or any other employee or agent of the hospital or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

(b) The medical staff recognizes and embraces that it is the public policy of the State of California that a physician and surgeon be encouraged to advocate for medically appropriate health care for their patients. To advocate for medically appropriate health care includes, but is not limited to, the ability of a physician to protest a decision, policy, or practice that the physician, consistent with that degree of learning and skill ordinarily possessed by reputable physicians practicing according to the applicable legal standard of care, reasonably believes impairs the physician's ability to provide medically appropriate health care to their patients. No person, including but not limited to the medical staff, the hospital, its employees, agents, directors or owners, shall retaliate against or penalize any member for such advocacy or prohibit, restrict or in any way discourage such advocacy, nor shall any person prohibit, restrict, or in any way discourage a member from communicating to a patient information in furtherance of medically appropriate health care.

(c) Notwithstanding the foregoing sections (a) and (b), if the member exercises those rights in a manner that violates the Code of Conduct or medical staff's standards, such as exercised in bad faith or in an abusive or disruptive manner, this section does not preclude corrective and/or disciplinary action as authorized by these medical staff bylaws for such conduct.

14.10 MEDICAL STAFF REPRESENTATION BY LEGAL COUNSEL

Upon the authorization of the medical staff, or of the Medical Executive Committee acting on its behalf, the medical staff may retain and be represented by independent legal counsel who, to the extent practicable, shall not be employed by a law firm representing the hospital. The medical staff shall enter into a written engagement letter with the individual selected to be independent legal counsel affirming that the medical staff, not the hospital, is the counsel's client, that the counsel represents solely the interests of the medical staff, and that the attorney-client privilege of confidentiality applicable to all communications between the counsel and the medical staff is held solely by the medical staff, regardless of whether the medical staff or a third party pays the counsel's fees. In the event the counsel is paid for by a third party, the counsel shall also provide a written assurance to the medical staff that there will be no interference by the third party with the

counsel's independence of professional judgment or with the attorney-client relationship, as required by State Bar of California Rules of Professional Conduct, Rule 3-310.

ARTICLE XV ADOPTION AND AMENDMENT OF BYLAWS

15.1 ADOPTION, AMENDMENT OR REPEAL OF BYLAWS

Proposals to adopt, amend or repeal Bylaws may be initiated by either of the following methods:

(a) The Medical Executive Committee, with the recommendation of the Bylaws Committee, Chief of Staff or on its own motion, may recommend adoption, amendment or repeal of bylaws to the voting members of the Medical Staff as provided in this article.

(b) The members of the Active Staff, by a written petition signed by at least one- third (1/3) of the members of the Active Staff in good standing who are entitled to vote, may petition the Medical Executive Committee to initiate a proposal to amend, or repeal these bylaws. Such petition shall identify exact language to be added, changed or deleted. If the Medical Executive Committee agrees with the proposed change, it may recommend the change as provided in point (a) above. If the Medical Executive Committee does not agree with the proposed change, the Medical Executive Committee shall meet with the proponents of the proposed change to discuss and attempt to resolve the disagreement. If the disagreement has not been resolved in one hundred eighty (180) days from the date the proposal was delivered to the Medical Executive Committee, the Chief of Staff shall call a special meeting of the Active Staff to consider the proposal.

(c) Subsequent to following the process in Section (b), the organized medical staff shall have the ability to adopt medical staff bylaws, rules and regulations, and/or policies, and/or amendments thereto, and propose them directly to the governing body subject to the following: (i) The adoption or amendment must be in writing and signed by at least two-thirds (2/3) of the members of the Active Staff medical staff in good standing, and (ii) the adoption or amendment cannot contravene or be inconsistent with federal, state, or local law, regulation, or accreditation standards set forth by The Joint Commission.

15.2 ACTION ON BYLAW CHANGE

The b y l a w s change shall require an affirmative vote of at more than 50% majority of votes cast, by members, voting in person, or electronic vote, or by written ballot, provided that at least fourteen (14) days' advance written notice, accompanied by the proposed Bylaws and/or alterations, has been given. Voting cannot be delegated to another person.

15.3 APPROVAL

Bylaw changes adopted by the medical staff shall become effective following approval by the Board of Trustees, which approval shall not be withheld unreasonably or automatically within 60 days if no action is taken by the Board of Trustees.

After bylaws, rules and regulations and medical staff policies are approved, medical staff members are provided with copies of the revisions in the bylaws, rules and regulations and medical staff policies through such mechanism as the medical executive committee decides is reasonable and reliable. If Board approval is withheld, the reasons for doing so shall be specified by the Board of Trustees in writing, and shall be forwarded to the Chief of Staff, the Medical Executive Committee and the Bylaws Committee. At the request of the Medical Executive Committee, the Board's disapproval shall be submitted to the Ad Hoc Dispute Mediation Committee for mediation as provided in in these Bylaws.

15.4 TECHNICAL CORRECTIONS TO BYLAWS

The Medical Executive Committee shall have the authority to adopt such corrections to the Bylaws as are in it judgment strictly technical clarification or renumbering, or necessary to correct punctuation, spelling or other grammar errors. After adoption, such corrections shall be communicated to the Medical Staff and to the Board of Trustees. Technical corrections are effective immediately upon adoption by the Medical Executive Committee but are subject to reversal by vote of the Board of Trustees or by a majority vote of the Active Staff within sixty (60) days of adoptions.

15.5 EXCLUSIVITY

The mechanism described herein shall be the sole method for the initiation, adoption, amendment, or repeal of the medical staff bylaws.

15.6 EFFECT OF THE BYLAWS

(a) These bylaws may not be unilaterally amended or repealed by the medical staff or Board of Trustees.

(b) No medical staff governing document and no hospital corporate bylaws or other hospital governing document shall include any provision purporting to allow unilateral amendment of the medical staff bylaws or other medical staff governing document.

(c) Hospital shall assure that its corporate bylaws, policy, rules, or other hospital requirements shall not conflict with medical staff bylaw provisions, rules, regulations and/or policies and procedures. To the extent of any inconsistency, the Medical Staff Bylaws, rules and policies shall control.

15.7 SUCCESSOR IN INTEREST/AFFILIATIONS

15.7-1 Successor in Interest

These bylaws, and privileges of individual members of the medical staff accorded under these bylaws, will be binding upon the medical staff, and the Board of Trustees of any successor in interest in this hospital, except where hospital medical staffs are being combined. In the event that the staffs are being combined, the medical staffs shall work together to develop new bylaws which will govern the combined medical staffs, subject to the approval of the hospital's Board of Trustees or its successor in interest. Until such time as the new bylaws are approved, to the extent there may be differences, the existing bylaws of each institution will remain in effect.

15.7-2 Affiliations

Affiliations between the hospital and other hospitals, health care systems or other entities shall not, in and of themselves, affect these bylaws.

15.7 CONSTRUCTION OF TERMS AND HEADINGS

The captions or headings in these bylaws are for convenience only and are not intended to limit or define the scope of or affect any of the substantive provisions of these bylaws. These bylaws apply with equal force to both genders wherever either term is used.

ARTICLE XVI SIGNATURES

ADOPTED by the Medical Staff on

_____ ___, 2026

APPROVED by the Board of Trustees on

_____ __, 2026

_____

.,Chief of Staff

_____

On behalf Board of Trustees

OPEN SESSION

TO: HOSPITAL BOARD MEMBERS

FROM: Andrew LaFree, M.D., Chief of Staff

DATE: January 26, 2026

MEETING: Board of Trustees

SUBJECT: **MEDICAL STAFF GENERAL RULES AND REGULATIONS, AMENDMENTS, URGENT**

BUDGET IMPACT: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _____

BACKGROUND: The proposed amendments to the ECRMC General Rules and Regulations were initiated to comply with California State Regulatory, Title 22, related to History and Physical documentation requirement. The detailed amendments are attached and presented for approval.

DISCUSSION: The ECRMC General Rules and Regulations were amended for regulatory compliance, as per attached detailed description.

These urgent amendments are proposed in accordance with provision noted below:

Medical Staff Bylaws, 14.1-1 Urgent Amendment of Rules

The Medical Executive Committee. with the approval of the Board of Trustees may adopt amendments to general medical staff rules or departments rules provisionally without notice to the general medical staff upon a documented need for an urgent amendment to comply with applicable law or regulatory agency. Following notice of such action, members of the active staff, by petition signed by at least one-third of such members, may ask the Medical Executive Committee to reconsider such changes.

RECOMMENDATION: (1) Approve (2) Do not approve

ATTACHMENT(S):

- Proposed amendments, General Medical Staff Rules and Regulations

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Valdez

January 26, 2026

SUBJECT: MEDICAL STAFF GENERAL RULES AND REGULATIONS AMENDMENTS

Medical Staff Rules & Regulations, 8.7, B, (3) History and Physical Examination Report, Amendments

8.7, B. History and Physical Examination Report.

(1) A History and Physical content to include, at a minimum:

- **Basic patient identification data**
- Chief complaint
- Details of present illness
- Relevant past medical history
- **Medication history as clinically indicated**
- Physical examination
- **Assessment (or Provisional diagnosis)**
- **Treatment Plan**

January 26, 2026

SUBJECT: ANESTHESIOLOGY DEPARTMENT RULES AMENDMENTS/ADDITIONS

Required elements of documentation:

Pre-Anesthesia

- **Patient Interview: Medical history (including anesthesia, surgical, drug, and allergy history), current medication list, NPO status, and the patient's ability to give informed consent.**
- **Physical Examination: Including vital signs, height and weight, and documentation of airway assessment and cardiopulmonary assessment.**
- **Review of Objective Data: Relevant diagnostic data (e.g., lab results, ECG, X-rays).**
- **Risk Assessment: Assignment of ASA Physical Status (including emergent status, if applicable).**
- **Anesthetic Plan: Including the type of anesthesia, post-anesthesia care, pain management plan, and discussion of informed consent (risks, benefits, and alternatives).**

Post Anesthesia

The documented PAE must clearly include an assessment of the patient's condition, conforming to current standards of anesthesia care:

- **Respiratory function - Respiratory rate; Airway patency; Oxygen saturation**
- **Cardiovascular function - Pulse rate; Blood pressure**
- **Aldrete Scale evaluations 1 and 2. Depending on the procedure, additional types of monitoring and assessment may be necessary.**

- **Timeline: The PAE must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services.**
- **The 48-hour timeframe begins when the patient moves into the designated recovery area.**
- **Individual patient risk factors may require the evaluation to be completed sooner.**
- **Qualified Practitioner: It must be performed and documented by an individual qualified to administer anesthesia (e.g., an anesthesiologist, other physician, CRNA, or AA). This does not need to be the same person who administered the anesthesia.**
- **Patient Participation: The evaluation should not begin until the patient is sufficiently recovered to participate (e.g., answer questions, perform simple tasks).**

If a patient is unable to participate (due to sedation or ventilation), a PAE must still be documented within 48 hours with a notation of the patient's inability to participate and the reason.

PATHOLOGY DEPARTMENT RULES AMENDMENTS

MANDATORY EXAMINATION OF TISSUE SPECIMENS (Cal. Code Regs. Title. 22, § 70243(g), 70527(c)(5), 70223(g)):

Mandatory Examination of Tissue Specimens (Cal. Code Regs. Title. 22, § 70243(g)):

- Tissue specimens must be examined by a physician certified or eligible for certification in anatomical and/or clinical pathology by the American Board of Pathology, or possessing equivalent qualifications.
- Oral specimens may be examined by a dentist certified or eligible as an oral pathologist.
- A record of the findings must become part of the patient's medical record.
- A tissue file must be maintained at the hospital or the consulting pathologist's principal office.

Surgical Specimen Handling (§ 70223(g))

All anatomical parts, tissues, and foreign objects removed by operation must be delivered to a pathologist designated by the hospital. A report of the pathologist's findings must be filed in the patient's medical record.

Handling of Outpatient Surgery Specimens (Cal. Code Regs. Title 22, § 70527(c)(5)):

For outpatient surgery, the general requirements include the delivery of all anatomical parts, tissues, and foreign objects removed to a pathologist designated by the hospital. A report of findings must be filed in the patient's medical record.

Clinical Laboratory Service General Requirements (Cal. Code Regs. Title 22, § 70243):

- Hospitals must maintain or arrange for clinical laboratory services, including pathology.
- The laboratory system must identify the patient, test requested, date and time the specimen was obtained, and any special handling required.
- Procedures must be established to ensure the satisfactory collection of specimens.
- Reports of all laboratory examinations must be made a part of the patient's medical record as soon as practical.

  - Tissue specimens shall be examined by a physician who is certified or eligible for certification in anatomical and/or clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or possesses qualifications which are equivalent to those required for certification.
  - Oral specimens may be examined by a dentist who is certified or eligible for certification as an oral pathologist by the American Board of Oral and Maxillofacial Pathology.
  - A record of the findings shall become a part of the patient's medical record.
  - A tissue file shall be maintained at the hospital or the principal office of the consulting pathologist.

ECRMC
El Centro Regional Medical Center
An Agency Of The City Of El Centro

TO: HOSPITAL BOARD MEMBERS

FROM: David Momberg, Chief Financial Officer

DATE: Jan 26, 2025

MEETING: Board of Trustees

SUBJECT: Dec 2025 Month and Year-to-Date Financial Statements

BUDGET IMPACT: _X_ Does not Apply

A. Does the action impact/affect financial resources? ___Yes ___ No

B. If yes, what is the impact amount: _____

BACKGROUND: The month of Dec resulted in net operating loss of ($684K), a negative margin of 5.1% and positive EBIDA of $1.16M. FYTD EBIDA is positive at $2.4M and positive margin YTD of 3.3%.

DISCUSSION: For a more detailed description of financial performance, please see the attached Financial Report.

RECOMMENDATION: (1) Approve (2) Do not approve

ATTACHMENT(S):

- Financial Packet for Dec 2025

Approved for agenda, Chief Executive Officer

Date and Signature: Pablo Valdez

December 2025 Financial Report

January 26, 2025

To: Finance Committee

From: David Momberg, Chief Financial Officer

The following package contains:

- Comparative volumes vs. Prior Month/Year
- Balance Sheet vs. Prior Month comparison
- Operating Statement vs. Prior Month comparison
- Monthly Cash Flow (Fiscal Year to Date)

Balance Sheet:

a) Cash and Cash Equivalents increased ($1.2M) related to Rate Range payment received ($6.3M) partially offset by higher expenses and one additional payroll run processed through the month.
b) Due from Third-Party payors decreased ($3.6M) related to Rate Range payment received ($6.3M) partially offset by other programs pending to receive.
c) Deferred Outflows of Resources – Pension decreased ($720k) due to lower payments made during the month related to credit on pension account.
d) Accrued Compensation and Benefits decreased $(1.7M) mainly due to payroll taxes paid before month-end, coupled with employee vacation time used.
e) Days in A/R increased to 86.19 from 82.77. The goal is 50 days.
f) Accounts payable days decreased, 74.8 vs. 87.69 days from previous month.
g) Current Ratio is 1.49 (1.47 last month).

Income Statement – Current Month Actual vs. Prior Month:

a) Our Inpatient Revenue is 4.3% higher due to higher patient days (1,510 vs. 1,371 prior month).
b) Our Outpatient Revenue is 4.7% higher mainly due to higher Emergency Room visits (3,052 vs. 2,765 prior month) coupled with higher Clinic visits (4,411 vs 4,018 prior).
c) Other Operating Revenue returns to normal activity after last month's correction.
d) Contractuals for the month are 82.3% of gross revenues (83.4% YTD).
e) Charity and Bad debt are 1.2% of gross revenues.
f) Registry is 51.3% lower related to lower Pharmacy contract labor.
g) Employee benefits is 99.6% higher due to insurance expense catch-up for previous month.
h) Professional Fees – Non-Medical is 223.1% higher due asset transfer legal invoices from Sheppard Mullin.
i) Depreciation and Amortization is back to normal after accrued depreciation was released due to Cerner not being capitalized yet.
j) December 2025 shows a Net loss of $684k (*$1.2M positive EBIDA*).

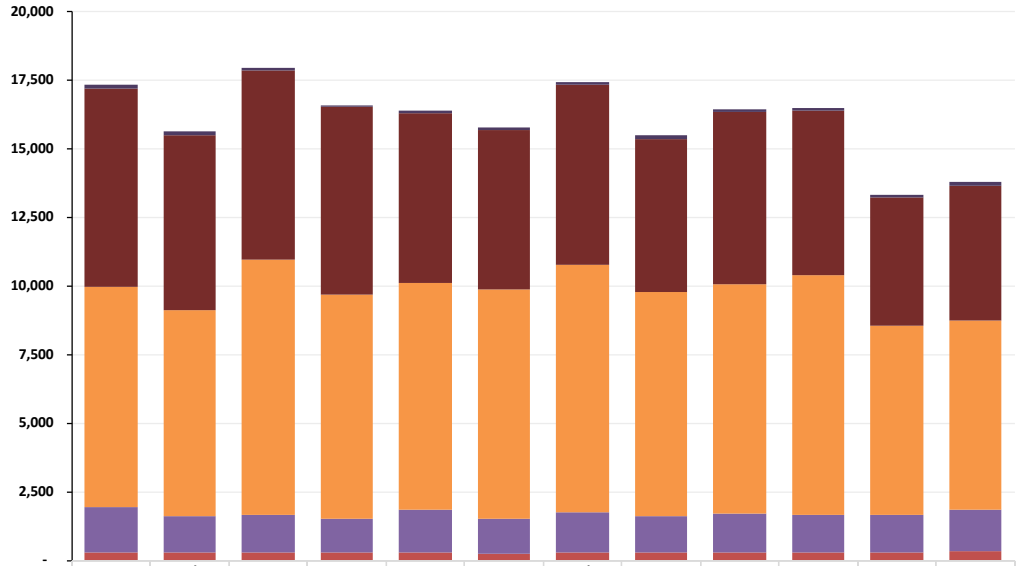
Definitions:

- **EBIDA** - Earnings Before Interest, Depreciation, and Amortization.
- **Contribution Margin** – Total Revenue minus Expenses (excluding functional areas of IT, Finance, HR, and management assessments/restructuring costs).
- **EBIDA Margin** – EBIDA/Total Revenue.
- **Operating Expenses Per Day** – Total Expenses less Depreciation divided by Days.
- **Operating Revenue Per Day** – Operating Income/Days.
- **Days Cash on Hand** – Cash/Operating Expenses per Day.
- **Days Revenue in A/R** – Accounts Receivable/Operating Revenue per Day.
- **Current Ratio** – Current Assets/Current Liabilities.
- **Equity Financing Ratio** – Total Capital/Total Debt.

El Centro Regional Medical Center
Comparative Volumes as of December 31, 2025

	Sep 2025	Oct 2025	Nov 2025	Dec 2025	YTD Actual	YTD Budget	YTD Variance
Adult Admissions (excl. Observation)	292	301	275	318	1,757	1,604	153
Patient Days (excl. Observation)	1,417	1,343	1,371	1,510	8,441	8,020	421
Average Length of Stay (excl. Observation)	4.9	4.5	5.0	4.7	4.8	5.0	(0.2)
Average Daily Census (excl. Observation)	47.2	43.3	45.7	48.7	46.1	15.3	30.8
Average Daily Census (ADC) Observation	3.0	2.7	3.7	4.5	3.5	4.5	(1.0)
Total ADC (including Observation)	50.2	46.1	49.4	53.2	49.7	19.8	29.8
Observation Days (excluding Obstetrics)	89	85	110	140	648	828	(180)
Outpatient Visits (excluding Clinics)	8,352	8,732	6,912	6,931	48,108	45,768	2,340
Emergency Room Visits	2,792	2,970	2,765	3,052	17,204	16,947	257
El Centro Rural Health Clinic Visits	3,281	3,152	2,310	2,585	17,521	20,548	(3,027)
Calexico Rural Health Clinic Visits	2,292	2,197	1,708	1,826	12,722	16,229	(3,507)
Rural Health Clinic Visits - Total	5,573	5,349	4,018	4,411	30,243	36,777	(6,534)
Wound Healing Center Visits	137	165	127	133	678	858	(180)
Oncology Center Visits	581	528	532	482	3,134	3,731	(597)
Oncology Center Infusion Procedures	1,213	1,342	1,202	1,411	7,856	8,326	(470)
Surgeries without C-Sections	461	527	421	371	2,663	2,578	85
DaVinci Cases	48	66	55	49	270	311	(41)

Rolling-12 Volume Trend



	Jan 2025	Feb 2025	Mar 2025	Apr 2025	May 2025	Jun 2025	Jul 2025	Aug 2025	Sep 2025	Oct 2025	Nov 2025	Dec 2025
Observation Days	123	108	84	69	111	110	100	124	89	85	110	140
Total Clinic Visits (RHCs, ONC, WHC)	7,224	6,386	6,899	6,836	6,203	5,820	6,556	5,596	6,291	6,042	4,677	4,893
Outpatient Visits (excl. Clinics)	8,038	7,531	9,341	8,165	8,238	8,357	9,017	8,164	8,352	8,732	6,912	6,931
Adult Patient Days (excl. Observation)	1,660	1,323	1,344	1,241	1,563	1,260	1,466	1,334	1,417	1,343	1,371	1,510
Adult Admissions	285	270	298	289	302	256	292	279	292	301	275	318

ECRMC BALANCE SHEET COMPARED TO PRIOR MONTH

	December 31, 2025	November 30, 2025	Variance ($)	Variance (%)
Assets				
Current Assets:				
Cash and Cash Equivalents	$ 5,789,900	$ 4,631,497	$ 1,158,403	25%
Net Patient Accounts Receivable	22,158,445	21,483,327	675,118	3%
Other Receivables	247,982	244,406	3,575	1%
Due from Third-Party Payors	37,467,724	41,057,506	(3,589,782)	-9%
Inventories	2,971,793	2,975,549	(3,756)	0%
Prepaid Expenses & Other	1,122,731	1,065,116	57,615	5%
Total Current Assets	69,758,573	71,457,400	(1,698,827)	-2%
Assets Limited as to Use				
Restricted Building Capital Fund	321,024	307,977	13,047	4%
Funds Held by Trustee for Debt Service	13,232,710	12,570,679	662,031	5%
Restricted Programs	11,497	11,497	-	0%
Total Assets Limited as to Use	13,565,231	12,890,153	675,078	5%
Property, Plant, and Equipment: Net	157,899,009	158,052,105	(153,096)	0%
Other Assets	1,076,862	1,055,067	21,795	2%
Total Assets	242,299,675	243,454,725	(1,155,050)	0%
Deferred Outflows of Resources				
Deferred Outflows of Resources - Pension	(2,085,452)	(1,365,852)	(719,600)	53%
Total Deferred Outflows of Resources	(2,085,452)	(1,365,852)	(719,600)	53%
Total Assets and Deferred Outflows of Resources	$ 240,214,224	$ 242,088,874	$ (1,874,650)	-1%
Liabilities				
Current Liabilities:				
Current Portion of Bonds	1,435,000	1,430,000	5,000	0%
Current Portion of Capital Lease Obligations	880,590	878,213	2,377	0%
Accounts Payable and Accrued Expenses	27,268,174	26,408,268	859,906	3%
Accrued Compensation and Benefits	8,881,588	10,617,737	(1,736,148)	-16%
Due to Third-Party Payors	9,754,692	9,236,173	518,519	6%
Total Current Liabilities	48,220,044	48,570,392	(350,347)	-1%
Long-Term Bond Payable, Less Current Portion	111,113,401	111,214,668	(101,267)	0%
Capital Lease Obligations, Less Current Portion	3,819,583	4,039,755	(220,172)	-5%
Notes Payable, Less Current Portion	23,851,852	24,370,370	(518,519)	-2%
Net Pension Liability	59,644,700	59,644,700	-	0%
Total Liabilities	246,649,580	247,839,885	(1,190,305)	0%
Deferred Inflows of Resources	-	-	-	0%
Deferred Inflows of Resources - Pension	-	-	-	0%
Total Deferred Inflows of Resources				
Net Position				
Restricted Fund Balance	27,126	27,126	-	0%
Fund Balance	(6,462,483)	(5,778,138)	(684,345)	12%
Total Net Position	(6,435,356)	(5,751,011)	(684,345)	12%
Total Liabilities, Deferred Inflows of Resources and Net Position	$ 240,214,224	$ 242,088,874	$ (1,874,650)	-1%
Days Cash on Hand	14.74	12.02		
Days Revenue in A/R	81.80	86.22		
Days in A/P	90.53	87.69		
Current Ratio	1.45	1.47		
Debt Service Coverage Ratio	2.15	1.75		

STATEMENTS OF OPERATIONS COMPARISON TO BUDGET

	MTD September 30, 2025	MTD October 31, 2025	MTD November 30, 2025	MTD December 31, 2025	YTD December 31, 2024	YTD December 31, 2025	YTD BUDGET December 31, 2025
Adult Admissions	292	301	275	318	1,532	1,757	1,604
Adult Patient Days (excl. Observation)	1,417	1,343	1,371	1,510	7,798	8,441	8,020
Outpatient Visits (excl. Clinics)	8,352	8,732	6,912	6,931	43,205	48,108	45,768
Total Clinic Visits (RHCs, ONC, WHC)	6,291	6,042	4,677	4,893	41,598	34,055	41,366
Observation Days	89	85	110	140	996	648	828
OPERATING REVENUE							
I/P Revenue	$ 15,297,795	$ 15,400,126	$ 15,738,608	$ 16,419,418	$ 92,163,459	$ 94,151,548	$ 94,514,253
O/P Revenue - Laboratory	5,994,847	6,122,795	5,581,064	5,879,473	36,751,793	36,399,473	35,043,719
O/P Revenue - CT Scanner	5,788,942	6,024,188	6,039,224	6,345,163	38,060,066	37,188,306	66,444,834
O/P Revenue - Emergency Room	6,605,232	6,923,155	7,053,181	7,458,801	38,951,903	42,163,419	38,460,755
O/P Revenue - Oncology	559,911	609,364	735,114	730,954	29,912,778	4,071,733	19,442,311
O/P Revenue - Others	21,711,198	22,458,466	21,501,656	22,436,299	112,979,783	135,782,291	145,296,181
Gross Patient Revenues	55,957,925	57,538,094	56,648,847	59,270,108	348,819,782	349,756,769	399,202,053
Other Operating Revenue	440,899	1,838,265	(1,227,436)	332,045	2,451,102	1,944,798	2,538,726
Total Operating Revenue	56,398,824	59,376,358	55,421,410	59,602,153	351,270,884	351,701,567	401,740,779
Contractuals							
IP Contractuals	12,084,394	11,371,369	9,124,296	11,312,704	70,796,190	67,689,776	71,866,404
OP Contractuals	37,393,866	37,322,791	36,338,944	36,708,622	201,091,259	219,468,385	252,125,072
Charity	18,428	88,624	53,588	47,125	800,556	428,473	871,809
Provision for Bad Debts	689,493	664,405	620,158	693,460	3,399,650	3,941,769	3,416,258
Other Third Party Programs	(2,474,250)	(2,474,250)	(2,474,250)	(2,474,250)	(9,075,278)	(15,011,065)	(8,954,267)
M/Cal Disproportionate Share	0	0	0	0	(330,000)	0	(264,000)
Total Deductions	47,711,931	46,972,940	43,662,737	46,287,661	266,682,376	276,517,338	319,061,277
Total Net Revenues	8,686,893	12,403,419	11,758,673	13,314,492	84,588,508	75,184,229	82,679,502
EXPENSES							
Salaries & Wages	5,370,856	5,513,623	5,095,830	5,126,388	31,252,822	31,213,184	31,774,661
Registry	100,149	43,713	104,212	50,746	108,394	540,861	164,386
Employee Benefits	864,178	830,373	469,764	937,717	5,843,794	4,921,528	5,561,398
Employee Benefits - Pension GASB 68	719,600	710,134	719,600	719,600	3,307,445	4,298,671	3,693,889
Professional Fees - Medical	766,560	1,483,487	1,365,126	1,293,415	7,314,846	8,020,254	9,018,554
Professional Fees - Non-Med	195,416	183,378	115,107	371,960	1,286,845	1,558,464	1,264,025
Supplies - Medical	2,628,526	2,572,922	2,413,458	2,610,913	14,942,948	15,421,789	14,657,807
Supplies - Non-Medical	158,138	141,705	153,765	162,957	858,597	873,098	962,421
Food	89,393	94,233	83,978	83,409	482,602	521,568	479,188
Repairs and Maintenance	532,268	756,576	634,608	538,141	4,224,094	3,716,393	4,112,423
Other Fees	573,605	584,684	630,726	496,173	3,589,918	3,246,379	3,807,867
Lease and Rental	36,762	9,824	28,756	33,782	156,104	168,613	174,147
Utilities	188,382	164,846	190,528	180,694	1,242,301	1,081,385	1,182,809
Depreciation and Amortization	548,724	555,687	227,580	543,389	3,661,048	3,022,301	3,643,650
Insurance	179,516	169,807	169,807	174,273	1,168,805	1,097,064	1,099,579
Other Expenses	148,861	72,882	104,884	116,241	696,232	690,434	674,521
Total Operating Expenses	13,100,934	13,887,872	12,507,728	13,439,797	80,136,794	80,391,986	82,271,325
Operating Income	(4,414,041)	(1,484,453)	(749,055)	(125,305)	4,451,713	(5,207,757)	408,178
Operating Margin %	-50.8%	-12.0%	-6.4%	-0.9%	5.3%	-6.9%	0.5%
Non-Operating Revenue and Expenses							
Investment Income	38,954	38,487	39,040	25,870	277,872	353,264	342,458
Grants and Contributions Revenue	0	0	0	0	63,120	0	637,872
Non Operating Revenue/(Expense)	0	0	0	0	661,875	0	397,125
Interest Expense	(589,160)	(586,217)	(585,092)	(584,909)	(3,559,494)	(3,518,021)	(3,568,849)
Total Non-Operating Rev. and Expenses	(550,206)	(547,730)	(546,052)	(559,040)	(2,556,627)	(3,164,756)	(2,191,394)
(Deficit)/Excess Rev. Over Exp.	$ (4,964,247)	$ (2,032,183)	$ (1,295,107)	$ (684,345)	$ 1,895,087	$ (8,372,513)	$ (1,783,216)
(Deficit)/Excess Rev. Over Exp. %	-57.1%	-16.4%	-11.0%	-5.1%	2.2%	-11.1%	-2.2%
EBIDA	(3,106,763)	(180,145)	237,165	1,163,553	12,423,074	2,466,480	9,123,172
EBIDA %	-35.8%	-1.5%	2.0%	8.7%	14.7%	3.3%	11.0%

El Centro Regional Medical Center

Monthly Cash Flow

Unaudited

	July 2025	August 2025	September 2025	October 2025	November 2025	December 2025	Year-to-Date 2026
Cash Flow From Operating Activities							
Net Income/(Loss)	$ 1,531,620	$ (928,870)	$ (4,964,247)	$ (2,060,067)	$ (1,295,258)	$ (684,345)	**$ (8,401,167)**
Adjustments to reconcile net income to net cash:							
Add: Depreciation	576,457	570,465	548,724	555,687	227,580	543,389	**$ 3,022,301**
Capital Lease Interest	4,729	4,807	4,518	4,063	3,656	3,067	**$ 24,840**
Bond Interest	578,211	578,211	578,211	578,211	578,211	578,211	**$ 3,469,264**
Accounts Receivable	181,484	117,559	5,349,354	2,077,513	893,317	(675,118)	**$ 7,944,109**
Other Receivables	161,635	(26,032)	(19,841)	(50,501)	23,728	(3,575)	**$ 85,414**
Inventory	(22,343)	(46,520)	1,424	1,141	12,225	3,756	**$ (50,315)**
Prepaid Expenses/Other Assets	(696,936)	477,026	(95,484)	66,263	58,132	(79,410)	**$ (270,408)**
Accounts Payable and Accrued Expenses	1,035,816	1,216,039	340,127	(1,502,650)	736,667	185,428	**$ 2,011,427**
Accrued Compensation and Benefits	(1,907,284)	211,863	427,550	561,175	444,359	(1,736,148)	**$ (1,998,485)**
Third-Party Liabilities	(2,473,448)	(3,782,432)	(1,812,277)	631,228	(5,689,044)	3,589,782	**$ (9,536,191)**
Net Pension Obligation	719,600	710,137	719,600	710,134	4,719,600	719,600	**$ 8,298,671**
Net Cash From Operating Activities	$ (310,459)	$ (897,746)	$ 1,077,659	$ 1,572,197	$ 713,173	$ 2,444,636	**$ 4,599,461**
Cash Flow From Investing Activities							
Fixed Assets - Gross	$ (804,470)	$ (518,646)	$ (691,873)	$ (599,649)	$ (52,014)	$ (390,293)	**$ (3,056,946)**
Intangible Assets - Gross	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
Restricted Assets	3,912,524	(666,888)	(669,248)	(670,923)	(673,488)	(675,078)	**$ 556,898**
Net Cash From Investing Activities	$ 3,108,054	$ (1,185,535)	$ (1,361,121)	$ (1,270,572)	$ (725,503)	$ (1,065,371)	**$ (2,500,047)**
Cash Flow From Financing Activities							
Bond Payable	$ (4,719,631)	$ -	$ -	$ -	$ -	$ -	**$ (4,719,631)**
Capital Leases	(234,766)	(240,557)	(286,507)	(238,790)	(183,988)	(220,862)	**$ (1,405,471)**
Notes Payable	-	-	-	-	-	-	**$ -**
Net Cash From Financing Activites	$ (4,954,397)	$ (240,557)	$ (286,507)	$ (238,790)	$ (183,988)	$ (220,862)	**$ (6,125,102)**
Total Change In FY 2026 Cash	$ (2,156,803)	$ (2,323,837)	$ (569,969)	$ 62,835	$ (196,318)	$ 1,158,403	**$ (4,025,689)**
Cash & Cash Equivalents, Beginning Balance	9,815,589	7,658,786	5,334,948	4,764,979	4,827,814	4,631,497	**9,815,589**
Cash & Cash Equivalents, Ending Balance	**$ 7,658,786**	**$ 5,334,948**	**$ 4,764,979**	**$ 4,827,814**	**$ 4,631,497**	**$ 5,789,900**	**5,789,900**

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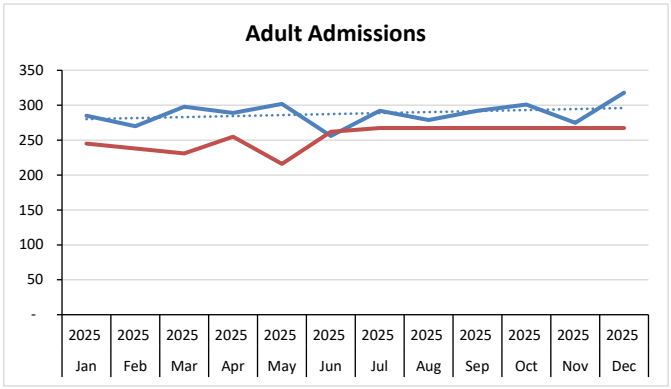
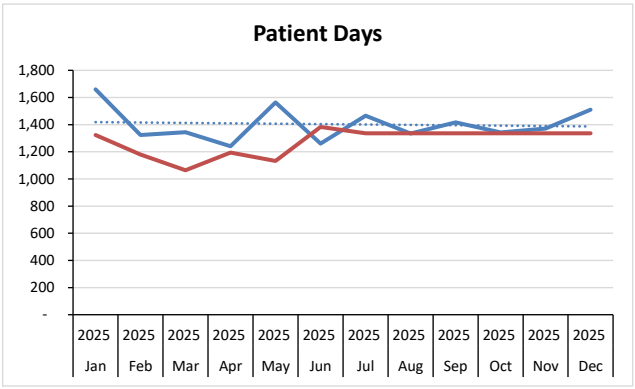
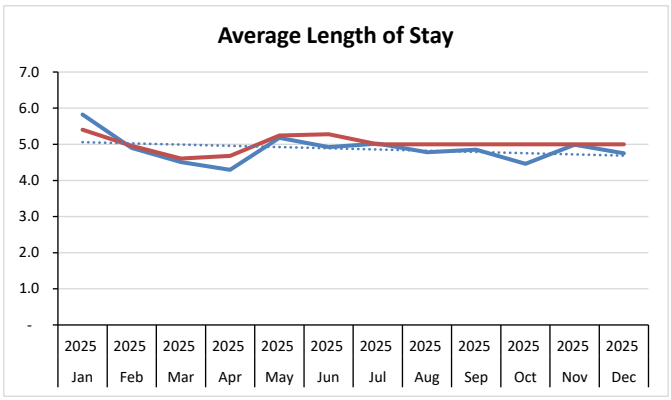
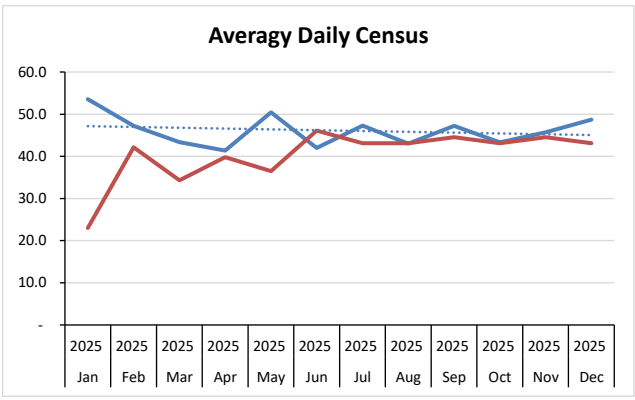
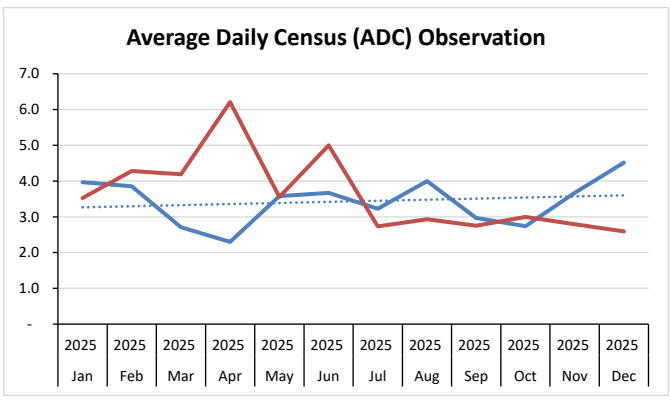
El Centro Regional Medical Center
Rolling-12 Volume trend

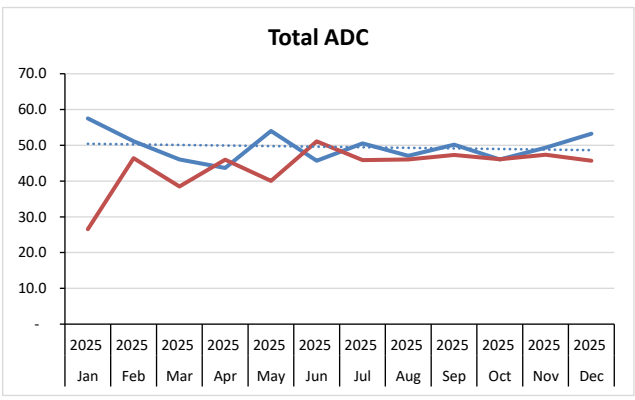


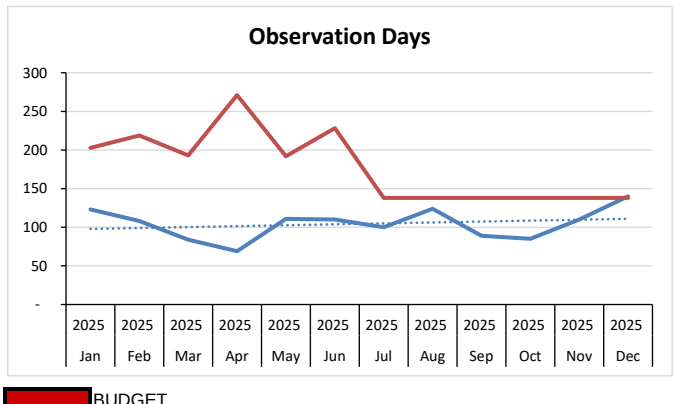


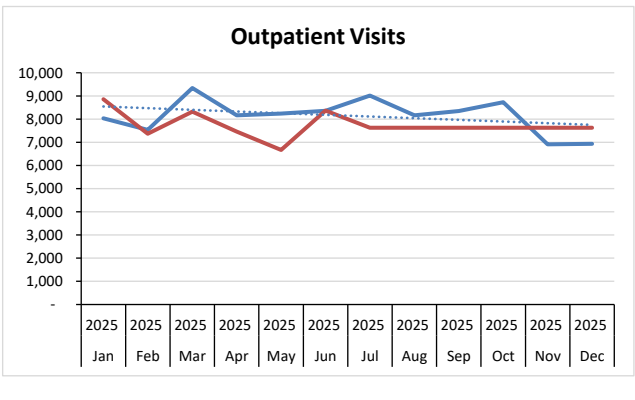






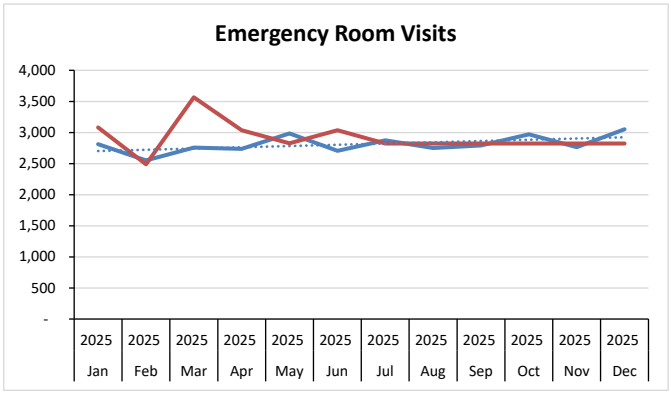


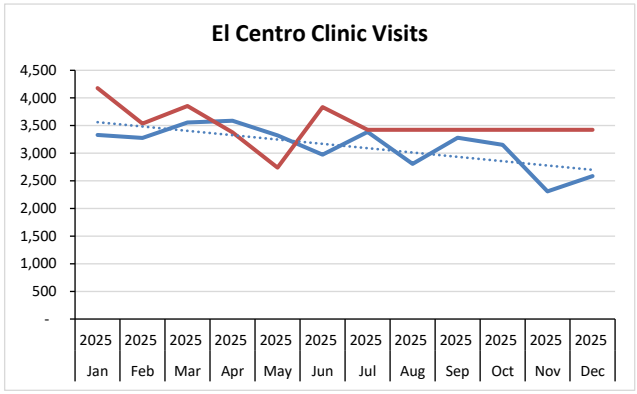


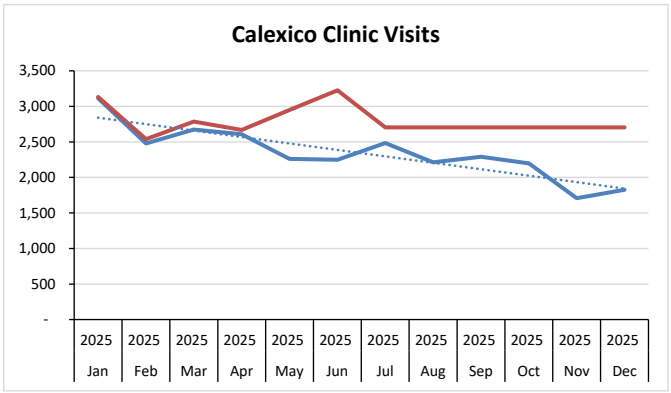


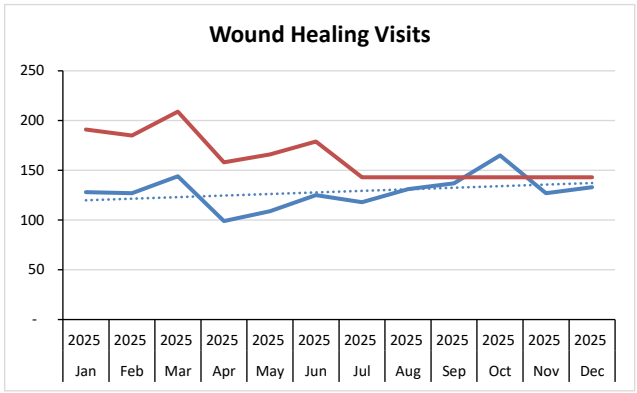
BUDGET
ACTUALS

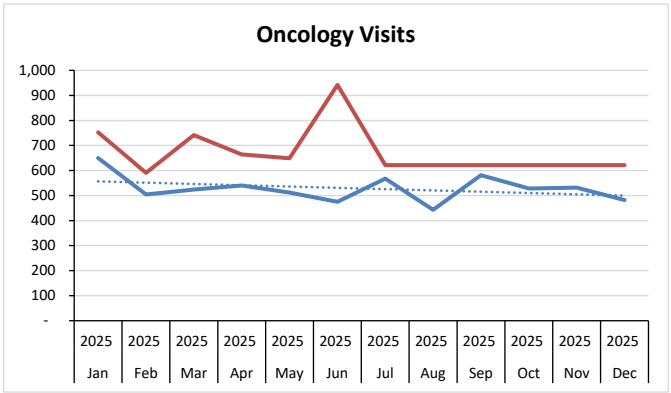
El Centro Regional Medical Center
Rolling-12 Volume trend

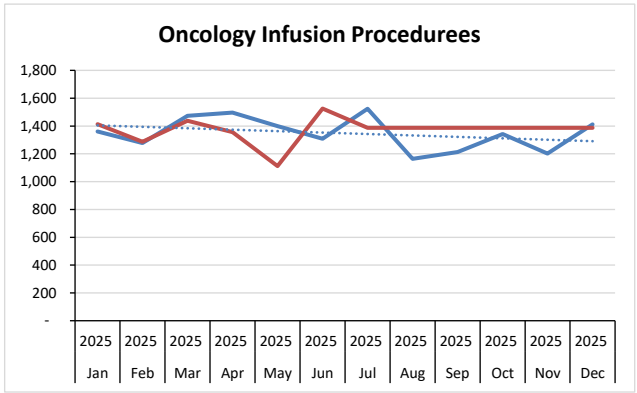


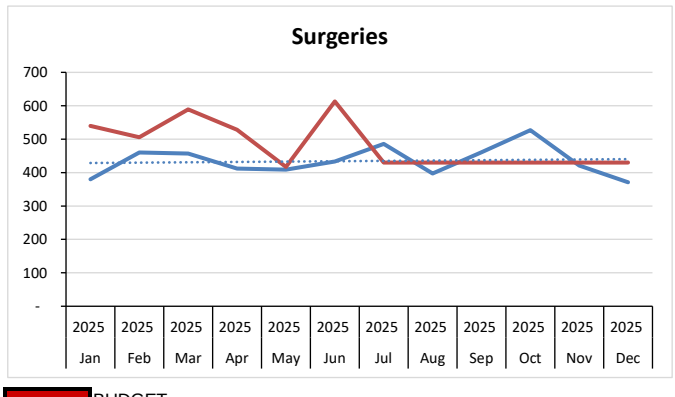


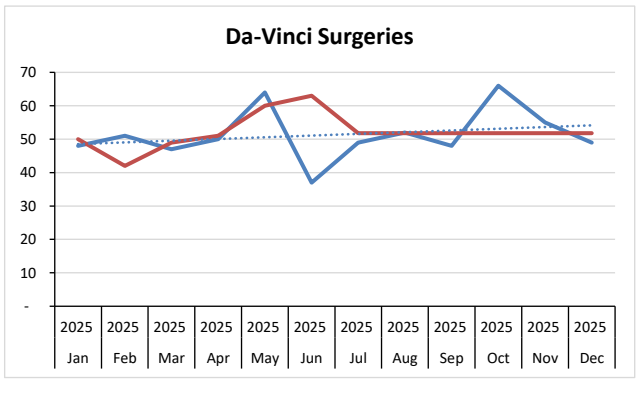












BUDGET
ACTUALS