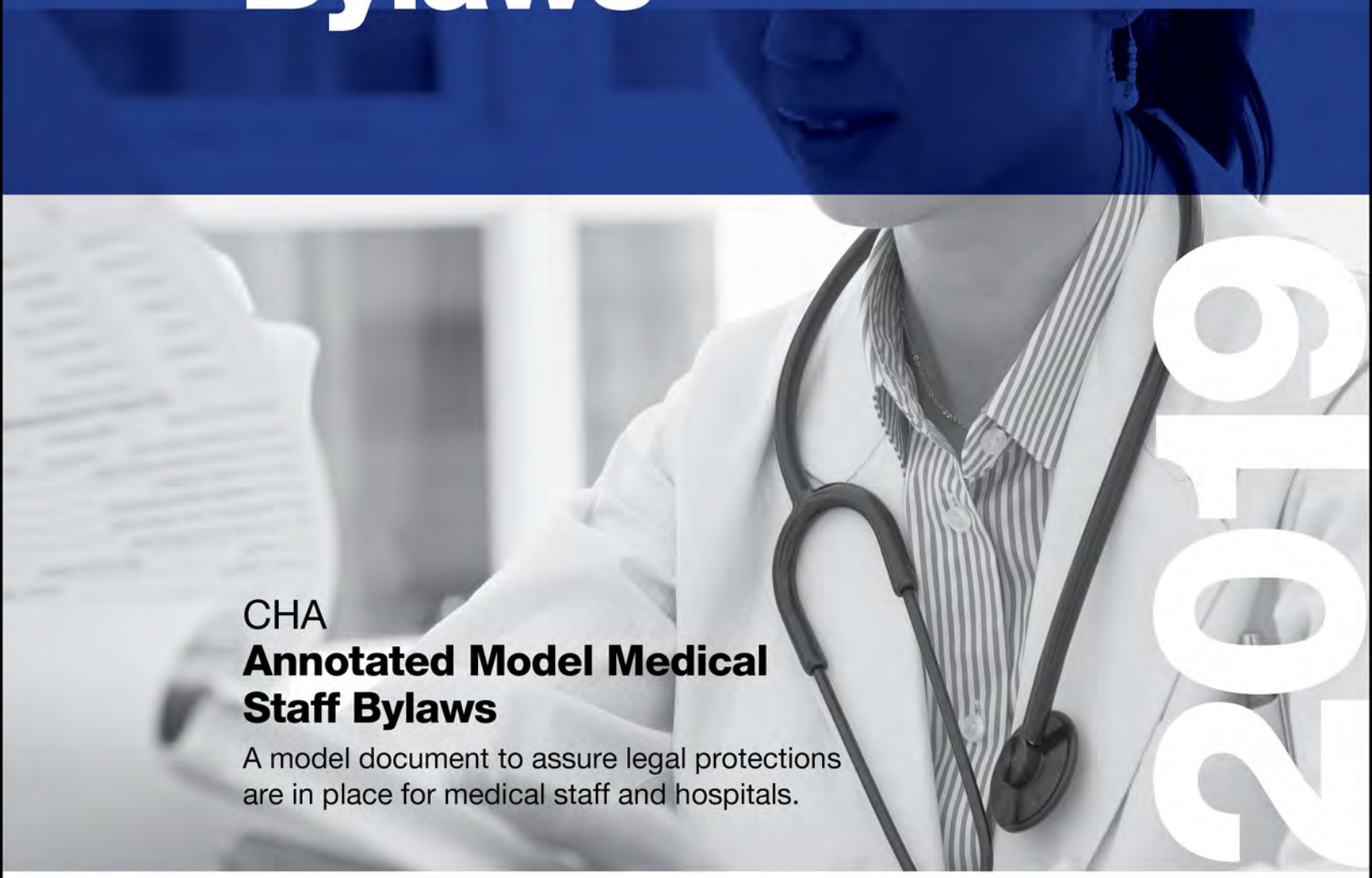
Medical Staff Bylaws



2019

CHA

Annotated Model Medical Staff Bylaws

A model document to assure legal protections are in place for medical staff and hospitals.

Arent Fox, LLP

Includes commentary

CALIFORNIA HOSPITAL ASSOCIATION

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This publication is provided as a service to the hospital members of the California Hospital Association. Hospitals are encouraged to use the model document as a template to create hospital-specific bylaws and rules.

These CHA *Model Medical Staff Bylaws and Rules* are intended as a resource to our members to assist them in developing their own Medical Staff Bylaws and Rules. While we have made every effort to achieve compliance with California law, Medicare Conditions of Participation, and The Joint Commission accreditation standards, they are not intended as legal advice, nor is there any representation that the documents are in fact compliant with all of these requirements. Because The Joint Commission remains the predominant accrediting organization for California hospitals, the CHA *Model Medical Staff Bylaws and Rules* have not been specifically tailored to other accrediting bodies standards. Users of these resource documents are advised to consult their own legal counsel to guide and advise them as to the legal implications and requirements for compliance in development of their own Medical Staff Bylaws, Rules, and associated policies and procedures.

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PREFACE

California law, Medicare Conditions of Participation, and accreditation standards all have specific requirements for what must be included in the Bylaws. Outside of those requirements, there is significant discretion as to what processes may be described in other documents. However, in some instances, certain information should be located in the Bylaws in order to promote a coherent approach to the process, to avoid redundancy, and to enhance ease-of-use. Therefore, these Model Bylaws are more comprehensive than previous versions.

Whenever a Medical Staff is adopting or amending Medical Staff Bylaws, it should keep in mind that the Medical Staff Bylaws may not conflict with the Hospital Bylaws. The documents must be compatible with each other, so Medical Staffs should review the existing Hospital Bylaws prior to drafting proposed Medical Staff Bylaws amendments.

Throughout the comments in this document, we refer to the Centers for Medicare & Medicaid Services as "CMS," and The Joint Commission as "TJC." We also refer to another accrediting body, DNV-GL, when discussing its National Integrated Accreditation for Healthcare Organizations (NIAHO).

Throughout this document, text appearing in black are the Model Bylaws; text appearing in red is commentary on those Bylaws.

CHA MODEL MEDICAL STAFF BYLAWS

DIVISION 1: MEDICAL STAFF STRUCTURE

ARTICLE 1

INTRODUCTION

1.1 Name

The name of this organization is the [insert name of hospital] Medical Staff and is referred to here as "the Medical Staff."

1.2 Organization and Purpose

1.2.1 The Medical Staff is organized for the purpose of maintaining a high quality of medical care provided in the Hospital and assuring the competency of the Hospital's Medical Staff. These Bylaws provide a framework for self-governance, assuring an organization of the Medical Staff that permits it to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of Medical Staff functions supportive of those purposes, and to account to the Governing Body for the effective performance of Medical Staff responsibilities. These Bylaws also provide the professional and legal structure for Medical Staff operations and a framework for the relationship between the Medical Staff and the Governing Body, and between the Medical Staff and its members and applicants.

1.2.2 The Medical Staff acknowledges that the Governing Body is ultimately responsible for everything at the Hospital, including the quality and safety of care, the competency of the Medical Staff, and the responsible governance of the Hospital. The Medical Staff commits to exercising its responsibilities with diligence and good faith, and acknowledges that if it does not fulfill its responsibilities, the Governing Body may act to do so; however, the Governing Body will not assume a Medical Staff duty or responsibility precipitously, unreasonably, or in bad faith. If the Governing Body acts to fulfill a Medical Staff responsibility, it will do so only in the reasonable and good faith belief that the Medical Staff has failed to fulfill that substantive duty or responsibility.

1.3 Definitions

1.3.1 ADVERSE ACTION and ADVERSE RECOMMENDATION mean actions and recommendations, respectively, that constitute grounds for a hearing pursuant to the Hearing and Appeals Article of the Medical Staff Bylaws.

1.3.2 ADMINISTRATOR or CHIEF EXECUTIVE OFFICER or PRESIDENT means the person appointed by the Governing Body to serve in an administrative capacity for the Hospital or his or her designee.

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

The area of allied health professional law is evolving. Whereas previously, allied health professionals tended to be discussed as a large, homogenous group, for the purposes of Medical Staff matters, they more recently have been distinguished into two groups: those who practice at a medical level of care (meaning, they do things that are otherwise the practice of medicine, and are also known as "Advanced Practice Professionals" or APPs) and, therefore, come under the Medical Staff's authority, and those who do not practice at that level. Examples of APPs can include, but are not limited to, chiropractors, clinical psychologists, physician assistants, nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, registered nurse first assistants, clinical nurse specialists, and advanced practice pharmacists. There is, however, no legal definition or legal limit to who may or may not be considered an APP.

Guidance from CMS and TJC suggests that advanced practice professionals should be credentialed and granted privileges through a Medical Staff process. However, TJC also has an FAQ that suggests this is only the case if the APP is also a "licensed independent practitioner" (which they are not in California). TJC also provides in recently revised Standard HR.01.02.01 that physician assistants and advanced practice registered nurses "can be credentialed, privileged, and reprivileged through the medical staff process or an equivalent process." EP 2 explains what constitutes an "equivalent process," which includes, among other things, input from the Medical Staff to make an informed decision regarding requests for privileges.

Regardless of the TJC's "equivalent process" provision, viewed from a purely logic-based perspective, if an APP is doing the same things as a physician (doing tasks that constitute the practice of medicine, though under some level of supervision or direction), it would be appropriate for the Medical Staff to credential APPs through a similarly-thorough process that includes review at the departmental and committee levels. These Bylaws and the Rules provide for such a process.

1.3.4 ALLIED HEALTH PRACTITIONER ("AHP") means a health care professional, other than a physician, dentist, [clinical psychologist] or podiatrist, who holds a license or other legal credential, as required by California law, that (a) permits the professional to provide health care services, and (b) has been designated by the Governing Body as a profession that is eligible for Allied Health Status. Allied Health Practitioners are ineligible for Medical Staff membership. However, they are eligible for privileges if they are Advanced

Practice Professionals, and for practice prerogatives if they are not Advanced Practice Professionals.

California law [Title 22, California Code of Regulations, Section 70701] limits Medical Staff membership to physicians, dentists, podiatrists, and clinical psychologists. Allied health practitioners are not permitted to be Medical Staff members. Although both CMS and TJC have broadened their lists of who may serve on the Medical Staff, state law remains a limiting factor.

Not all hospitals allow clinical psychologists to become Medical Staff members. If clinical psychologists are not on the Medical Staff, they are included in the definition of allied health practitioner. Include clinical psychologists in this definition only if the Medical Staff grants them membership.

1.3.5 ALLIED HEALTH STAFF means (a) those Allied Health Practitioners who are not employees of the Hospital but have been granted privileges or practice prerogatives to provide certain clinical services; and (b) all Advanced Practice Professionals, whether employed by the Hospital or not, who have been granted privileges to provide certain clinical services.

Because Advanced Practice Professionals practice at a medical level of care, they should be subject to Medical Staff oversight, regardless of whether or not they are employed by the Hospital.

1.3.6 CHIEF MEDICAL OFFICER or VICE PRESIDENT OF MEDICAL AFFAIRS means a physician appointed by the Governing Body as an administrator who, among other duties, is a liaison between the Medical Staff and Hospital administration.

Some hospitals have Chief Medical Officers who help the Medical Staff fulfill its functions and who often take very active roles in quality improvement and peer review. If a different title is used for the CMO, such as Vice President for Medical Affairs, the definition can be revised to refer to the title. Hospitals that do not have CMOs (or their equivalents) should delete the references and provisions throughout the Bylaws pertaining to the CMO.

1.3.7 CHIEF OF STAFF means the chief officer of the Medical Staff elected by the Medical Staff.

1.3.8 CLINICAL PRIVILEGES or PRIVILEGES means the permission granted by the Governing Body to individual Medical Staff members and Advanced Practitioner Practitioners to render specific patient services.

TJC and CMS both consider permissions granted to APPs to perform at a medical level of care to be "privileges." (See CMS State Operations Manual*, Appendix A, Interpretive Guideline, Section 482.12(a)(1) (Re. 172, 11-17-17) and TJC Standard HR.01.02.01.)*

1.3.9 COMPLETED APPLICATION means an application that includes all the information requested by the Medical Staff at any time during the application process by any person or committee charged with evaluating the application.

This definition of "completed application" limits the conclusion that an application is "complete" until the applicant has cooperated with all requests for information. This allows the Medical Staff to limit its evaluation of applications to those where clarifying information, when requested, has been produced. Some hospitals, however, may want to consider an application complete once the original application has been filled out. If so, this definition should be revised to reflect that.

1.3.10 CONFLICT OF INTEREST means a personal or financial interest or conflicting fiduciary obligation on the part of an individual or an immediate family member of that individual (including a spouse, domestic partner, child or parent) that may negatively impact, as a practical matter, the individual's ability to act in the best interests of the Medical Staff without regard to the individual's private or personal interest, or creates the impression of such a conflict.

Medical Staffs, together with the Governing Body and Administration, should develop conflicts of interest policies. If they have done so, the definition here should be revised to reflect the policy definition.

1.3.11 DAYS means calendar days, unless otherwise indicated.

1.3.12 DISTANT SITE HOSPITAL means a Medicare-certified hospital where a Telehealth Provider is located.

For hospitals that are TJC-accredited originating sites, the distant site hospital and entity also must be TJC-accredited.

1.3.13 DISTANT SITE ENTITY means an entity that provides telemedicine services and is not a Medicare-certified hospital.

For hospitals that are TJC-accredited originating sites, the distant site hospital and entity also must be TJC-accredited.

1.3.14 EX OFFICIO means service by virtue of office or position held. An ex officio appointment is with vote unless specified otherwise.

Alternatively, some Hospitals and Medical Staffs may choose to adopt this as "without vote, unless specified otherwise."

1.3.15 GOVERNING BODY means the [board of directors], [board of trustees], [district board] for the Hospital. As appropriate to the context and consistent with the Hospital's Bylaws, it may also mean any Governing Body committee or individual authorized to act on behalf of the Governing Body.

1.3.16 GOVERNING DOCUMENTS means the documents that create a system of rights, responsibilities, and accountability between the Medical Staff and the Governing Body, and between the Medical Staff and its members; they include the Hospital and Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, Department or Section Rules and Policies and Procedures, and any other document adopted by the Hospital or Medical Staff directly applicable to Medical Staff operations, the granting of membership or privileges on the Medical Staff, or the exercise of privileges at the Hospital.

This definition is a new concept. It is generally common throughout Bylaws to include several references to the "Medical Staff Bylaws, Rules and Regulations, and Policies and Procedures." Rather than listing each separately, this Model groups the documents together and refers to them collectively (where appropriate) as the "Governing Documents."

1.3.17 HOSPITAL means [insert name of hospital], and includes all inpatient and outpatient locations and services operating under the Hospital's license

1.3.18 IN GOOD STANDING means a member currently meets all membership requirements (including, but not limited to, meeting attendance requirements and payment of dues or assessments) and is not currently under any limitation of any Medical Staff rights or privileges. "Limitation" may include, but is not limited to, suspension, concurrent proctoring unrelated to initial privileges, or consultation requirement.

1.3.19 INVESTIGATION means the formal process initiated by the Medical Executive Committee, as set forth in the Investigations Article of these Bylaws. To constitute an investigation, this formally commenced process generally must be the precursor to a decision regarding whether or not to take corrective action, and is ongoing until either formal action is taken, or the investigation is closed. Except as otherwise provided in these Bylaws, only the Medical Executive Committee or Governing Body may take or recommend corrective action as the result of an investigation. An investigation does not include activity of the Medical Staff Wellbeing Committee, which lacks the authority to take or recommend corrective action.

This new language reflects, with some slight modification, guidance provided by the National Practitioner Data Bank as to what it considers to be an "investigation."

Notwithstanding the above, for the purposes of complying with applicable reporting requirements under Business and Professions Code Sections 805 and 805.01 or the National Practitioner Data Bank (collectively, "the Reporting Requirements"), the Medical Executive Committee will, as needed and on a case-by-case basis, evaluate whether a focused professional practice evaluation falls within the definition or description of "investigation" under the statutes, regulations, or guidance that govern the Reporting Requirements.

In 2015, the Health Resources and Services Administration issued an updated National Practitioner Data Bank (NPDB) Guidebook. Among other changes, the Guidebook clarified the definition of "investigation" as it applies to NPDB reporting. This is important because hospitals and other entities must, in certain instances, report when a practitioner resigns during an investigation. The 2015 Guidebook changes suggest that, in certain instances, a "for-cause" focused professional practice evaluation (FPPE) will be considered an "investigation" for reporting purposes. Therefore, while we historically have asserted that only Medical Executive Committee-initiated investigations trigger the resignation reporting requirement, hospitals and Medical Staffs should consult with legal counsel regarding whether, in any specific instance, they must report a resignation during an FPPE.

1.3.20 MEDICAL EXECUTIVE COMMITTEE means the executive committee of the Medical Staff.

1.3.21 MEDICAL STAFF means the organizational component of the Hospital that includes all Practitioners who have been granted recognition as Members pursuant to these Bylaws.

1.3.22 MEDICAL STAFF LEADER means any Medical Staff officer, department chair or vice chair, or committee chair.

1.3.23 MEDICAL STAFF YEAR means the period from [fill in].

1.3.24 MEMBER means, unless otherwise indicated in the Bylaws, Rules, or Policies, any Practitioner appointed to the Medical Staff.

1.3.25 MONTHLY or ONCE A MONTH means, for the purpose of Medical Staff committee meeting requirements, meeting at least once during at least eight months a year.

Medical Staff committees that meet "monthly" may take some months off.

1.3.26 NOTICE means a written communication (1) sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the Medical Staff or the Hospital, (2) sent by an electronic means approved by the Medical Executive Committee as an appropriate manner of communication, but only if directed to the Medical Staff as a whole, a Department as a whole, or a committee as a whole, and not directed toward an individual member, or (3) by any manner identified in the Special Notice definition.

1.3.27 PATIENT CONTACT means any provision of medical care by a Practitioner to a patient at the Hospital, including but not limited to, admission, consultation, surgical or other procedure, and care management, performed in any facility included on the Hospital's license or provided through a telemedicine link. The provision of medical care to a patient during a discrete admission at the Hospital

is one patient contact, regardless of the extent of medical care provided during that admission.

Not all hospitals and Medical Staffs may define patient contacts the same way. This definition can be altered to reflect current practice (for example, some may want to include only hospital-based contact in this definition).

1.3.28 POLICIES AND PROCEDURES means those documents adopted as Medical Staff policies in accordance with these Bylaws, unless specified otherwise. "Department Policies" or "Section Policies" means the department or section policies adopted in accordance with applicable Bylaws, Rules, or policy.

1.3.29 PRACTITIONER means a physician, podiatrist, dentist, or [clinical psychologist].

TJC defines practitioner broadly, as "any individual who is licensed and qualified to practice a health care profession … and is engaged in the provision of care, treatment, or services." For the purposes of these Bylaws, the definition is limited to only to those professions eligible for Medical Staff membership.

This list should include only those professionals who are authorized to be appointed to the Medical Staff. Title 22, California Code of Regulations, Section 70701(a)(1)(E) restricts membership to "physicians, dentists, podiatrists, and clinical psychologists;" however, dentists and podiatrists only need to be included if dental or podiatric services are provided at the Hospital [Title 22, California Code of Regulations, Section 70703(a)(1)].

Some hospitals allow clinical psychologists to join the Medical Staff, others do not. If psychologists are not Medical Staff members, they should not be included in this list. Throughout these Bylaws, hospitals and Medical Staffs should evalute references to clinical psychologists to ensure they accurately reflect their role at that institution. That said, a health care facility owned or operated by the state that offers care or services within a clinical psychologist's scope of practice must establish rules, regulations and procedures for consideration of an application for Medical Staff membership and clinical privileges submitted by a clinical psychologist.

1.3.30 RULES AND REGULATIONS or RULES means the Medical Staff Rules and Regulations adopted in accordance with these Bylaws unless specified otherwise. "Department Rules" or "Section Rules" means the department or section rules adopted in accordance with applicable Bylaws, Rules, or policy.

1.3.31 SPECIAL NOTICE means a notice sent by (1) certified or registered mail, return receipt requested, (2) via a courier delivery service that documents delivery (such as, but not limited to, FedEx or UPS), or (3) hand-delivery, with a signed receipt (or, if there is a refusal to sign, documentation that it was delivered).

1.3.32 SYSTEM means [insert name of health system].

"System" should be defined for hospitals that are part of a health system and choose to implement cooperative credentialing and peer review among the health system entities. Throughout these Bylaws, enabling language authorizes such cooperative arrangements. Hospitals that are not part of a health system, or that do not wish to participate in such cooperative arrangements, should not adopt the system-oriented provisions that are identified by the term "System" or "System Member."

1.3.33 SYSTEM MEMBER means a facility or entity (such as an affiliated hospital, urgent care center, surgery center, foundation or other entity) that is part of the system.

"System" should be defined for hospitals that are part of a health system and choose to implement cooperative credentialing and peer review among the health system entities. Throughout these Bylaws, enabling language authorizes such cooperative arrangements. Hospitals that are not part of a health system, or that do not wish to participate in such cooperative arrangements, should not adopt the system-oriented provisions that are identified by the term "System" or "System Member."

1.3.34 TELEHEALTH means the mode, as defined by law, of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth includes synchronous (real time) interactions and asynchronous store and forward transfers of patient information without the presence of the patient.

Definition adapted from California Business and Professions Code Section 2290.5.

1.3.35 TELEMEDICINE means that subset of Telehealth services delivered to Hospital patients by Practitioners or Allied Health Staff.

1.3.36 TELEHEALTH PROVIDER or TELEMEDICINE PROVIDER means Practitioners or Allied Health Staff who have been granted privileges by this Hospital to provide services only via Telehealth modalities.

1.4 Delegation of Tasks

1.4.1 The Governing Body, the Hospital administration, or a Medical Staff Leader may delegate the tasks assigned to them by the Governing Documents to appropriate designees, unless the Governing Documents express otherwise, or such delegation is contrary to law or accreditation requirement.

This is a new provision that Medical Staffs may want to consider, but that also carries some risk. Delegation can help promote efficiency in Medical Staff operations and limit the need to repeatedly include the phrase, "or designee," in Governing Documents. However, delegation also can be misused if not carefully exercised and monitored. When considering this paragraph, Medical Staffs and hospitals should

evaluate how delegation is currently used in their hospital and whether they can provide the appropriate oversight.

1.4.2 When a Medical Staff Member is unable to perform an assigned task, a Medical Staff Leader may perform the task or delegate it to another appropriate designee. If there are any questions as to who should perform the task, the Chief of Staff shall make the assignment.

1.4.3 Any member who acts in the name of this Medical Staff without proper authority shall be subject to disciplinary action.

1.5 Medical Staff Responsibilities

The Medical Staff is responsible to the Governing Body for the following:

1.5.1 The adequacy and quality of care rendered to patients;

Title 22, California Code of Regulations, Section 70703(a).

1.5.2 Initiating, developing, and adopting Medical Staff Bylaws, rules, and regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld;

California Business and Professions Code Section 2282.5 (a)(6), and Title 22, California Code of Regulations, Section 70703(b).

1.5.3 Assuring that the Bylaws provide formal procedures for the evaluation of staff applications and credentials, appointments, reappointments, assignment of clinical privileges, appeals mechanisms and such other subjects or conditions which the Medical Staff and Governing Body deem appropriate;

California Business and Professions Code Section 2282.5 (a)(6), and Title 22, California Code of Regulations, Section 70703(b).

1.5.4 Abiding by and establishing a means of enforcement of its Bylaws;

California Business and Professions Code Section 2282.5 (a)(6), and Title 22, California Code of Regulations, Section 70703(b).

1.5.5 Establishing clinical criteria and standards for Medical Staff membership and privileges, and enforcing those criteria and standards;

California Business and Professions Code Section 2282.5(a)(1).

1.5.6 Making recommendations regarding granting membership and delineating privileges;

1.5.7 Establishing clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not

limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records;

California Business and Professions Code Section 2282.5(a)(2).

1.5.8 Organizing committees to fulfill the functions required by state and federal law or accreditation standards, or as otherwise requested by the Governing Body;

1.5.9 Providing leadership to departments/services;

1.5.10 Providing ongoing evaluation of care;

1.5.11 Organizing and supporting professional education and community health education and support services;

1.5.12 Investigating, when authorized by these Bylaws, members or Allied Health Staff and taking corrective action where warranted;

1.5.13 Providing processes for fair hearings;

1.5.14 Operating in a manner that permits the Hospital to meet its obligations to the community, as well as to comply with state and federal law and accreditation standards;

1.5.15 Exercising its rights and responsibilities in a manner that does not jeopardize the Hospital's license, Medicare and Medi-Cal provider status, accreditation, or [tax exempt status].

1.6 Self Governance and Independent Rights

California Business and Professions Code Section 2282.5 provides that the Medical Staff has certain self-governance rights. We detail them here.

1.6.1 The Medical Staff's right to self-governance includes:

(a) Establishing, in Medical Staff Bylaws, rules, or regulations, criteria and standards for Medical Staff membership and privileges, and enforcing those criteria and standards.

(b) Establishing, in Medical Staff Bylaws, rules, or regulations, clinical criteria and standards to oversee and manage quality assurance, utilization review, and other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

(c) Selecting and removing Medical Staff officers.

(d) Assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff.

(e) The ability to retain and be represented by independent legal counsel at the expense of the Medical Staff.

This right applies to University of California Medical Staffs only "upon approval by the Regents of the University of California or their designee in accordance with the Bylaws of the Regents, which approval shall not be unreasonably denied."

(f) Initiating, developing, and adopting Medical Staff Bylaws, rules, and regulations, and amendments thereto, subject to the approval of the Governing Body, which approval shall not be unreasonably withheld.

1.6.2 The Medical Staff has certain independent rights with which the Governing Body may not interfere. Those rights are:

(a) Right to counsel. Upon the authorization of the Medical Executive Committee, the Medical Staff may retain and be represented by independent legal counsel, who shall be compensated through Medical Staff funds.

(b) Right to dues. The Medical Staff has the ability to assess dues and use them for its own purposes.

(c) Right to select officers. The Medical Staff may select and remove Medical Staff officers without interference.

1.7 Meet and Confer

The Medical Staff and the Governing Body shall meet and confer in good faith to resolve any disputes regarding the Medical Staff's rights and responsibilities and any disputes regarding the operation or outcome of the processes detailed in the Governing Documents; if necessary, the Medical Staff and Governing Body shall follow the conflict resolution process referenced in the Rules.

California Business and Professions Code, Section 2282.5(c), requires the Medical Staff and Governing Body to "meet and confer" for disputes over independent rights. In this section, the Model broadens the "meet and confer" application beyond disputes over the Medical Staff's independent rights to include almost any matter in which the Medical Staff and Governing Body are jointly involved. The goal of broadening the meet and confer provision is to encourage the Medical Staff and Governing Body to work together to collegially address disputes over a broad range of issues.

1.8 Health System Affiliation

This Hospital is part of, or affiliated with, the System. To maintain high professional standards and provide efficient patient care and support services, the Hospital and Medical Staff are authorized to work cooperatively with other System Members and affiliates to develop processes and policies for cooperation in fulfilling the Medical Staff's responsibilities, including those involving committees, credentialing, peer review, investigations, corrective action, and hearings. In developing these processes and policies, the Hospital and Medical Staff shall ensure that this cooperation does not limit the

Hospital's or Medical Staff's ability to meet its own legal and accreditation responsibilities.

These are optional provisions for facilities that want cooperative appointment, reappointment, and peer review procedures with other System Members. Such cooperative processes are generally advisable only where the System Members are located in the same geographic area and the involved practitioner seeks membership at more than one facility or entity in that area (this could include geographically proximate hospitals, surgery centers, medical foundations, etc.).

ARTICLE 2

OFFICERS, MEMBERS AT LARGE, AND CHIEF MEDICAL OFFICER

TJC requires that all members of the Medical Staff, including podiatrists, dentists, and clinical psychlogists (if staff members), be eligible to be members of the MEC. One or more at-large positions helps accommodate this.

2.1 Identification of Officers

TJC Standard MS.01.01.01, EP 19, requires the Bylaws to include a list of all Medical Staff officer positions. Medical Staffs have discretion as to which officer positions they have and what they are called. This list is only an example of possible officers.

The officers of the Medical Staff are:

2.1.1 Chief of Staff

2.1.2 Vice Chief

Some hospitals refer to this officer as the "Chief of Staff Elect," especially if the officer automatically succeeds the Chief of Staff at the end of the term.

2.1.3 Secretary/Treasurer

2.1.4 Immediate Past Chief of Staff

2.2 Qualifications

Several of these qualifications are optional; they are suggestions to establish commitment to service.

Officers of the Medical Staff must:

2.2.1 Be a physician, dentist, or podiatrist;

Changes to the Medicare Conditions of Participation in 2014 allows dentists and podiatrists, along with physicians, to serve as chief of staff if permitted under state law. California law does not prohibit such service, though Medical Staffs can consider limiting these offices to physicians, given the broad responsibilities of the office holders suggest. Before doing so, Medical Staffs should consult with legal counsel to determine whether such limitations would implicate anti-discrimination laws.

2.2.2 Have served on the Active Staff for at least _____ years prior to nomination;

2.2.3 Have served on a Medical Staff committee or been involved in performance improvement functions for at least two years prior to nomination, or have served as a Department Chair;

2.2.4 Be members of the Active Staff in good standing at the time of nomination and election, and remain members of the Active Staff in good standing throughout their term;

This can include other staff categories (defined in the Membership Status Article); generally, officers should be members who are actively practicing at the Hospital.

2.2.5 At the time of nomination and election, not be subject to any adverse recommendations that, if become final, would limit the Practitioner's appointment or privileges;

2.2.6 Disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in the Governing Documents; and

TJC Standard LD.02.02.01 requires the hospital leadership groups to work together to define in writing what constitutes conflicts of interests that could affect safety and quality of care, treatment, and services. They also must develop a written policy defining how conflicts of interests will be addressed, and that such conflicts are disclosed.

2.2.7 Demonstrate an understanding of the Medical Staff's purposes and functions, including the Medical Staff's responsibilities to the Governing Body.

2.2.8 Be willing to faithfully discharge the duties and responsibilities of the position.

2.3 Terms of Office

2.3.1 Elections are held in the fall of odd-numbered years and Officers shall take office the following January.

2.3.2 The term of office shall be two years. No officer shall serve consecutive terms in the same position.

Two-year terms are recommended to build skills and continuity of leadership. Medical Staffs also can choose to allow officers to serve consecutive terms.

2.4 General Responsibilities

All officers of the Medical Staff are representatives of the Medical Staff and must:

2.4.1 Understand and work toward the fulfillment of the Medical Staff purpose and responsibilities, as described in Article 1;

2.4.2 Promote compliance with the Governing Documents by all Medical Staff members;

2.4.3 Represent the needs of Medical Staff members; and

2.4.4 Comport themselves in a responsible, professional, and collegial manner.

2.5 Specific Duties

2.5.1 Chief of Staff. The Chief of Staff serves as the chief officer of the Medical Staff. The Chief of Staff's duties include, but are not limited to:

(a) Being responsible for the organization and conduct of the Medical Staff;

(b) Enforcing the Governing Documents;

(c) Promoting quality of care, implementing sanctions when indicated, and promoting compliance with procedural safeguards when corrective action has been requested or initiated;

(d) Calling, presiding at, and being responsible for the agenda of all meetings of the Medical Staff;

(e) Serving as Chair of the Medical Executive Committee with vote;

(f) Serving as an ex officio member of all other Medical Staff committees without vote, unless otherwise provided in the Governing Documents;

(g) Appointing, in consultation with the Medical Executive Committee, committee members for all standing, ad hoc, and special Medical Staff, liaison, or multi-disciplinary committees, except where otherwise provided by the Governing Documents, and designating the Chairs of these committees, except where otherwise provided by the Governing Documents;

(h) Serving as, or appointing members of the Medical Staff to serve as, a Medical Staff liaison to participate in the development of Hospital policies;

Title 22, California Code of Regulations, Section 70701(a)(9), provides that the Bylaws shall include an effective formal means for the Medical Staff, as a liaison, to participate in the development of all hospital policies.

(i) In the interim between Medical Executive Committee meetings, performing those responsibilities of the committee that, in his or her reasonable opinion, must be accomplished prior to the next regular or special meeting of the committee;

(j) Being a spokesperson for the Medical Staff in external professional and public relations;

(k) Consulting directly with the Governing Body periodically (and at least twice) throughout the year about, at a minimum, the quality of medical care provided to Hospital patients;

Medicare Conditions of Participation, 42 C.F.R. Section 482.12(a)(10)

(l) Serving on liaison committees with the Governing Body and Hospital administration, as well as outside licensing or accreditation agencies;

(m) Interacting with the Chief Executive Officer and Governing Body in all matters of mutual concern within the Hospital and communicating to the Medical Staff any concerns expressed by the Governing Body;

(n) Representing the views and policies of the Medical Staff to the Governing Body and to the Chief Executive Officer and serving as an ex-officio member of the Governing Body [without vote];

Some hospitals have the Chief of Staff serve on the Governing Body with vote; other hospitals do not. District hospitals must review the law regarding their governance when determining whether the Chief of Staff may vote.

(o) Regularly reporting to the Governing Body on the performance of Medical Staff functions;

(p) Being accountable to the Governing Body, in conjunction with the Medical Executive Committee, for the Medical Staff's effective performance of its responsibilities; and

(q) Performing such other functions as may be assigned to him or her by these Bylaws, the Medical Staff, or the Medical Executive Committee.

2.5.2 Vice Chief. The Vice Chief's duties include, but are not limited to:

(a) Assuming the duties of the Chief of Staff and acting with full authority as Chief of Staff in his or her absence;

(b) Serving on the Medical Executive Committee;

(c) Performing other duties as assigned by the Chief of Staff or the Medical Executive Committee, or as delineated in the Governing Documents; and

(d) [Automatically succeeding the Chief of Staff at the beginning of the next Medical Staff term or sooner should the office become vacant for any reason during the Chief of Staff's term of office.]

Not all Medical Staffs have the Vice Chief automatically succeed the Chief of Staff. Accession of the Vice Chief helps to assure better continuity and preparation for the responsibilities of the position, but it requires a longer commitment by the member.

2.5.3 Secretary-Treasurer. The Secretary-Treasurer's duties include, but are not limited to:

(a) Serving on the Medical Executive Committee;

(b) Overseeing compliance with the notice requirements detailed in these Bylaws as they relate to Medical Staff meetings, elections, and document amendment;

(c) Overseeing the keeping of accurate and complete minutes of meetings of the Medical Executive Committee and Medical Staff;

(d) Preparing an annual proposed Medical Staff budget of anticipated income and expenditures, to be approved by the Medical Executive Committee and distributed to the Medical Staff for its consideration at the Annual Meeting;

(e) Overseeing the collection of, safeguarding of, and accounting for any Medical Staff funds and making disbursements authorized by the Medical Executive Committee;

(f) Reporting on the Medical Staff finances to the Medical Executive Committee at least quarterly and at the General Medical Staff meeting, or as otherwise detailed in any Medical Staff policy regarding accounting and reporting;

(g) Performing other duties as assigned by the Chief of Staff or the Medical Executive Committee, or as delineated in the Governing Documents.

2.5.4 Immediate Past Chief of Staff. The Immediate Past Chief of Staff's duties include, but are not limited to:

(a) Serving on the Medical Executive Committee;

(b) Serving as an advisor to other Medical Staff Leaders; and

(c) Performing other duties as are assigned by the Chief of Staff or the Medical Executive Committee, or as are delineated in the Medical Staff Bylaws, Rules, or policies.

2.6 At-Large Members

If the Medical Staff limits officer positions to physicians, then TJC–accredited organizations should adopt one or more at-large member positions to assure that non-physician Medical Staff members have the opportunity to serve on the Medical Executive Committee, as required by TJC Standard MS.02.01.01, EP 3.

2.6.1 The Medical Staff shall select _____ members-at-large. Members-at-large are not officers.

2.6.2 At the time of nomination, election, and throughout their term, members-at-large must be in good standing and not be subject to any adverse recommendation that, if it were to become final, would limit the Practitioner's appointment or privileges.

2.6.3 Candidates for member-at-large positions must disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in these Medical Staff Bylaws, Rules, or policy.

2.6.4 Members-at-large shall serve on the Medical Executive Committee.

2.7 Nominations

All the time frames for nominations and elections may be revised to meet the Medical Staff's needs, as long as a fair election process is maintained.

Nominations for office or member-at-large positions are made by the nominating committee or by petition, as described below. Due to the requirement to determine the qualifications of candidates and to disclose conflicts of interests prior to elections, nominations from the floor shall not be accepted during any election.

Medical Staffs that allow nominations from the floor should delete the sentence above.

2.7.1 By Committee

(a) At least 150 days prior to an election being held, the Medical Executive Committee shall appoint a nominating committee. The nominating committee will include the Chief of Staff, the Immediate Past Chief of Staff, and at least three other members selected by the Medical Executive Committee. The nominating committee shall meet at least 120 days prior to the scheduled election.

There is flexibility in the composition of this committee; what is described here is only one option.

(b) At least 90 days prior to the election, the nominating committee shall request names of potential candidates from members of the Medical Staff. Such request can be made either by mail, email, or by posting the request in Medical Staff common areas, or any combination of those

means. The nominating committee is not obligated to include any names it receives as a result of this request on the slate of candidates submitted to the Medical Staff.

(c) The nominating committee shall confirm that any potential candidate meets the qualifications set forth in this Article, is willing to serve if elected, and fulfills the conflicts of interest obligations as defined in the Governing Documents.

(d) At least 60 days before the election, the nominating committee shall develop a slate of candidates meeting the qualifications for the position for which they are being nominated. At least one candidate shall be nominated for each of the following positions:

(i) [Chief of Staff]

This is only if the Vice Chief does not automatically become Chief of Staff at the end of the term.

(ii) Vice Chief

(iii) Secretary-Treasurer

(iv) Member-at-large, if any positions are open for election

2.7.2 By Petition

The Medical Staff can nominate candidates for any open office or member-at-large position by petition signed by at least 25% of members eligible to vote. The candidate must meet the qualifications detailed in this Article, and the candidate's name and proposed office must appear on each page of the petition where signatures appear. The candidate must submit a statement signifying a willingness to run. Such nominations must be received by the Chief of Staff at least 30 days prior to ballots being distributed.

2.8 Election

2.8.1 The election may be held either by mail ballot or by an electronic means approved by the Medical Executive Committee and the Governing Body at least six months prior to the election. Any approved electronic means shall provide for voter security and confidentiality and shall be detailed in a written policy that is distributed to the Medical Staff.

2.8.2 At least 15 days prior to the deadline to return the ballots or vote electronically, the ballot with the slate of candidates and the conflicts of interest form filled out by each candidate pursuant to the Governing Documents shall be sent to the voting members of the Medical Staff. The ballot may be sent by mail or by an

electronic means and shall identify the deadline for the return of ballots or for voting electronically. Ballots received after the deadline shall not be counted.

2.8.3 The Chief of Staff shall appoint a Medical Staff member who is not a candidate for office to monitor and validate the election process.

2.8.4 The candidate receiving a simple majority of votes shall be elected. If there are three or more candidates and none receive a simple majority, there shall be a run-off election between the two candidates receiving the highest number votes. The Medical Executive Committee shall approve a process for a timely run-off election.

This Model does not include a minimum number of votes that must be received for an election to be valid. Medical Staffs can include such a minimum – for example, requiring ballots from at least 25% of those members eligible to vote in order for the results to be calculated.

2.8.5 In an election or run-off where each of two candidates receive 50% of the vote, 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.

2.9 Recall of Officer or Member-at-Large

2.9.1 A Medical Staff officer or member-at-large may be recalled from office for any of the following:

(a) Failing to comply with the Governing Documents;

(b) Failing to perform the duties of the position held;

(c) Failing to demonstrate a willingness to promote patient safety over all other concerns;

(d) Demonstrating an unwillingness to work with the Hospital toward attaining its lawful and reasonable goals;

(e) Conduct detrimental to the interests of the Medical Staff or the Hospital;

(f) Demonstrating an inability to work with and motivate others to achieve the objectives of the Medical Staff organization in the context of the Hospital's lawful and reasonable objectives.

(g) Any condition that renders the individual incapable of fulfilling the duties of that office; or

(h) Failure to continuously meet the qualifications for the office or position.

2.9.2 Recall of a Medical Staff officer or member-at-large may be initiated by a majority of the Medical Executive Committee or by a petition signed by at least one-third of the Medical Staff members eligible to vote for officers. On each page where signatures appear, the petition must include the name and office of the person proposed to be subject to the recall and state that the purpose of the petition is to call for a recall vote.

2.9.3 Upon the initiation of the recall process, the Medical Executive Committee shall set a date for the vote on recall by those Medical Staff members eligible to vote for officers. The date of the vote shall be no later than 45 days after the initiation of the recall process. The individual subject to the recall vote shall be given at least 15 days' Special Notice prior to the recall vote and may submit a written statement to the Medical Executive Committee and to the Medical Staff prior to the vote.

2.9.4 Recall shall require a two-thirds vote in favor of recall by those Medical Staff members eligible to vote for officers and who timely cast a ballot.

This means that recall is effective if the vote is in favor by two-thirds of votes received. Another option would be to instead require that at least two-thirds of all Medical Staff members eligible to vote do so in favor of the recall.

2.10 Vacancies

Vacancies in office occur upon resignation, removal, death, or failure to continuously meet the qualifications of office. Vacancies shall be filled as follows:

2.10.1 If there is a vacancy in the office of Chief of Staff, the Vice Chief will serve until the end of the unexpired term of the Chief of Staff. If the unexpired term is less than one year, then the Vice Chief who served out that term shall continue to serve as Chief of Staff for the following two-year term.

Do not include this sentence if the Medical Staff elects a new Chief of Staff every two years. This provision only applies if the Vice Chief automatically succeeds the Chief of Staff at the end of the terms. In those cases, the provision addresses instances where a Vice Chief assumes a vacancy for a very brief period; with this sentence, the Vice Chief will stay in that role to the expiration of the original term, plus the two-year term to which he or she was expected to succeed.

2.10.2 If there is a vacancy in the office of Vice Chief, the Medical Executive Committee will appoint an individual who satisfies the officer qualifications set forth in in this Article to the office if the vacancy is for a period of less than one year. If the vacancy occurs one year or more prior to the next term, the MEC shall hold a special election for Vice Chief. The Vice Chief elected in the special election shall automatically succeed the Chief of Staff at the beginning of the next Medical Staff term.

Do not include this sentence if the Medical Staff elects a new Chief of Staff every two years. This provision only applies if the Vice Chief automatically succeeds the Chief of Staff at the end of the terms.

2.10.3 If there is a vacancy in the office of Secretary-Treasurer, or of a member-at-large of the Medical Executive Committee, the Medical Executive Committee will appoint an individual who satisfies the qualifications for the position in issue set forth in this Article until a special election can be held at the discretion of the Medical Executive Committee.

2.10.4 Vacancies in the office of Immediate Past Chief of Staff will not be filled.

2.11 Chief Medical Officer

This section should be included only if the Hospital has a Chief Medical Officer.

2.11.1 Appointment

The Chief Medical Officer shall be appointed by the Governing Body after soliciting input from the Medical Executive Committee. The Medical Executive Committee shall participate in the interview process for the selection of a Chief Medical Officer.

2.11.2 Responsibilities

(a) The Chief Medical Officer's duties are delineated by the Governing Body in keeping with the general provisions set forth in subparagraph (b) below. The Medical Executive Committee approval is required for any Chief Medical Officer duties that relate to authority to perform functions on behalf of the Medical Staff or directly affect the performance or activities of the Medical Staff.

(b) The Chief Medical Officer shall:

(i) Serve as administrative liaison among Hospital administration, the Governing Body, outside agencies and the Medical Staff;

(ii) Assist the Medical Staff in performing its assigned functions and coordinating such functions with the responsibilities and programs of the Hospital; and

(iii) In cooperation and close consultation with the Chief of Staff and the Medical Executive Committee, supervise the day-to-day performance of the Medical Staff office and the Hospital's quality improvement personnel.

2.11.3 Participation in Medical Staff Committees

The Chief Medical Officer:

(a) Shall be an ex officio member without vote, unless otherwise provided in the Governing Documents, of all Medical Staff Committees, except the Joint Conference Committee (which the Chief Medical Officer shall attend as a resource person) and any hearing committee.

(b) May attend any department or section meeting.

ARTICLE 3

DEPARTMENTS/SERVICES

Medicare Conditions of Participation, 42 C.F.R. Section 482.22(c)(3), requires the Bylaws to describe the Medical Staff's organizational structure. This is also required in TJC Standard MS.01.01.01, EP 12. This Article is designed to meet that requirement.

Some hospitals have begun opting for "service lines" over departments. Because delegation of departments appears to remain the dominant Medical Staff structure at this time, we are keeping the term "Departments" in this model. Hospitals should revise the term if necessary to best fit their needs, and make appropriate revisions throughout the document.

The following provisions apply for departmentalized Medical Staffs. Some hospitals have many departments, while smaller hospitals may not have any. If the Medical Staff is not organized into departments, this Article should be deleted, and the Medical Staff should evaluate whether the functions described here should be assigned to a Medical Staff Committee.

3.1 Organization of Clinical Departments

3.1.1 The Medical Staff shall be organized into clinical departments.

3.1.2 The departments shall fulfill the clinical, administrative, quality improvement, risk management, utilization management, and collegial and education functions as described in the Governing Documents.

3.1.3 Subject to the Governing Body's approval, the Medical Executive Committee may create, eliminate, or combine departments for better organizational efficiency, or may divide them into sections or divisions.

3.1.4 Each member shall be assigned membership in at least one department and shall comply with the responsibilities of membership in any department or any section or division to which he or she is assigned.

3.2 Identification of Departments

Although this Model includes almost all the details regarding department structure in the Bylaws, identifying *the departments in the Rules, rather than in the Bylaws, makes reorganization an easier process.*

The departments of the Medical Staff are identified in the Medical Staff Rules.

3.3 Functions of Departments

The Departments shall be responsible for the following, in accordance with the Governing Documents:

3.3.1 Conducting performance evaluations and monitoring of all department members and APPs exercising privileges in the department and continuous assessment and improvement of the quality of care, treatment and services (including periodic demonstrations of ability).

3.3.2 Credentials review.

3.3.3 Recommending to the Medical Executive Committee criteria for granting clinical privileges and performing specified services within the department.

3.3.4 Initiating and assisting in the conduct of performance improvement and corrective action, when indicated.

3.3.5 Conducting orientations and continuing education consistent with any relevant Governing Documents.

3.3.6 Planning and budget review, including making recommendations regarding space and other resources needed by the department.

3.3.7 Meeting regularly to perform its functions and reporting to the Medical Executive Committee regarding its activities and recommendations for improvement.

There is no specific requirement for how often a department must meet. However, regular meetings are recommended to ensure that its functions are fulfilled.

3.3.8 Any additional responsibility assigned by the Medical Executive Committee.

3.4 Department Meetings and Committees

The department may develop committees to fulfill the department's functions. These committees constitute Medical Staff committees. Each department or its committees, if any, must meet regularly to carry out its duties.

3.5 Sections

Some hospitals and Medical Staffs refer to these units as "Divisions."

Within each department, the Practitioners of the various specialty groups may organize themselves as a clinical section, subject to the approval of the Medical Executive Committee and Governing Body. Each section may develop rules specifying the section's purpose and responsibilities, the qualifications for section leaders, its method of selecting section leaders, and section leaders' responsibilities. These rules shall be effective when approved by the Department, Medical Executive Committee, and Governing Body. Section leaders report directly to the Department Chair. While sections may assist departments in performance of departmental functions, responsibility and accountability for performance of departmental functions shall remain at the departmental level.

Medical Staffs approach sections (or divisions) in different ways. The language here gives sections discretion in the selection of leaders; however, Medical Staffs may want to develop universal rules for how section leaders are selected, and what responsibilities those leaders have.

3.6 Department/Service Officers

3.6.1 Qualifications

Each department shall have a chair and vice-chair. The chair and vice chair shall:

(a) Be members of the Active Staff in good standing at the time of nomination and election and remain members of the Active Staff in good standing throughout their term;

The qualifications identified here are, except as otherwise indicated, optional.

(b) At the time of nomination and election, not be subject to any adverse recommendation that, if it becomes final, would limit the Practitioner's appointment or privileges;

The qualifications identified here are, except as otherwise indicated, optional.

(c) Disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in the Governing Documents;

(d) Be qualified by licensure and have demonstrated ability in at least one of the clinical areas covered by the department.

(e) Be certified by an appropriate specialty board, unless no one so certified is available;

TJC Standard MS.01.01.01 requires department chairs to be board certified or "hold comparable competence." Title 22, California Code of Regulations, has multiple provisions requiring, where feasible, board certification for certain departments. The Model Bylaws default to requiring board certification to ensure the standard is met.

(f) Be willing to faithfully discharge the duties and responsibilities of the position.

3.6.2 Responsibility of Chair

TJC MS.01.01.01, EP 3, provides that the requirements of EP 36 must be stated in the Bylaws. The below paragraphs (a) through (o) accomplish this. The paragraphs that follow (o) include additional common department chair responsibilities.

The department chair's roles and responsibilities include at least the following:

(a) Clinically-related activities of the department.

(b) Administratively-related activities of the department, unless otherwise provided by the Hospital.

(c) Continuing surveillance of the professional performance of all individuals in the department who have delineated clinical privileges.

(d) Recommending to the Medical Staff the criteria for clinical privileges that are relevant to the care provided in the department.

(e) Recommending clinical privileges for each member of the department.

(f) Assessing and recommending to the relevant Hospital authority off-site sources for needed patient care, treatment, and services not provided by the department or the organization.

(g) Integration of the department or service into the primary functions of the organization.

(h) Coordination and integration of interdepartmental and intradepartmental services.

(i) Development and implementation of policies and procedures that guide and support the provision of care, treatment, and services.

(j) Recommendations for a sufficient number of qualified and competent persons to provide care, treatment, and services.

(k) Determination of the qualifications and competence of department or service personnel who are not licensed independent practitioners and who provide patient care, treatment, and services.

(l) Continuous assessment and improvement of the quality of care, treatment, and services.

(m) Maintenance of quality control programs, as appropriate.

(n) Orientation and continuing education of all persons in the department.

(o) Recommending space and other resources needed by the department or service.

(p) Chairing all department meetings.

(q) Serving as an ex officio member of all committees of his or her department and attending such committee meetings as deemed necessary for adequate information flow.

(r) Assuring that records of performance are maintained and updated for all members of his or her department.

(s) Reporting on activities of the Medical Staff to the Governing Body when called upon to do so by the Chief of Staff or the Chief Executive Officer.

(t) Serving as a member of the Medical Executive Committee, if identified as a Medical Executive Committee member.

(u) Performing such additional responsibilities as may be delegated to him or her by the Medical Executive Committee or the Chief of Staff.

3.6.3 Responsibility of Vice Chair

Each Vice Chair shall assist the Department Chair to perform his or her duties and, in the absence or disability of the Department Chair, be responsible for performing the duties of the Department Chair. This includes, but is not limited to, assuming the Chair's voting rights on all Medical Staff or Department Committees. The Vice Chair also shall perform any other duties assigned by the Department Chair or the Medical Executive Committee.

3.6.4 Nominations

(a) In a voting year for the Department, each department through its Department Committee, or through a Nominating Committee that includes at least three active staff members from the department appointed by the Department Chair, shall nominate at least one person meeting the qualifications in this Article for each of the offices of Chair and Vice Chair.

(b) In addition, the department members may select candidates for office by a petition signed by at least 25% percent of active staff members from the department. The candidate must meet the qualifications detailed in this Article, and the candidate's name and proposed office must appear on each page where signatures appear. The candidate must submit a statement signifying a willingness to run. Such nominations must be received by the department Chair or Nominating Committee at least 45 days prior to the scheduled elections.

(c) All nominees for election to department offices shall, at least 30 days prior to the date of election, disclose all conflicts of interests, as defined in the Governing Documents, in writing to the department Chair or Nominating Committee. The department Chair or Nominating Committee shall evaluate the significance of such disclosures and discuss any significant conflicts with the nominee.

3.6.5 Election

(a) The election shall be held at least 30 days prior to the end of the current department officers' terms.

(b) The election may be held via any manner approved for the election of Medical Staff Officers, or by an in-person vote at any special or regularly-scheduled Department meeting where the election was on the agenda and the agenda was sent to all voting members at least 15 days prior to the meeting.

(c) For elections that occur at a Department meeting, notice of the slate of candidates and the conflicts of interest form filled out by each candidate pursuant to the Governing Documents shall be sent to all voting members at least 15 days prior to the meeting. The election shall take place at the meeting, via secret ballot.

(d) For elections that occur via mail or electronic vote, at least 15 days prior to the deadline to return the ballots or to vote electronically, the ballot with the slate of candidates and the conflicts of interest form filled out by each candidate pursuant to the Governing Documents shall be sent to the voting members of the Department. The ballot shall identify the deadline, if any, for the return of ballots or for voting electronically. Ballots received after the deadline shall not be counted.

(e) The candidate receiving a simple majority of votes shall be elected. If there are three or more candidates and none receive a simple majority, there shall be a run-off election between the two candidates receiving the highest number votes. The Medical Executive Committee shall approve a process for a timely run-off election.

The Model does not include a minimum number of votes that must be received. Medical Staffs can include a minimum for the election to be valid (for example, ballots from at least 25% of voting members).

(f) In an election or run-off where each of two candidates receive 50% of the vote, 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.

3.6.6 Term of Office

(a) The Medical Executive Committee shall determine which years each department holds elections. The Chairs and Vice Chairs shall take office the January following the election.

Some Medical Staffs choose to stagger department elections to preserve some continuity of leadership, especially if department chairs also serve on the Medical Executive Committee.

(b) The term of office shall be two years.

3.6.7 Recall

Department Chairs and Vice Chairs may be recalled for the reasons identified for the recall of Medical Staff Officers, and in a manner consistent with the process for the recall of Medical Staff Officers, except that (a) for recall not initiated by the Medical Executive Committee, only members of the department eligible to vote may sign the petition to initiate the recall and vote in the recall election; (b) the department leader's written statement, if any, shall be sent only to department members, and (c) no removal shall be effective until it is ratified by the Medical Executive Committee.

3.6.8 Vacancies

Vacancies in the office of Department Chair shall be filled by the Vice Chair. Vacancies in the office of Vice Chair shall be filled via special election if a year or more is left in the term, and by appointment by the Chair after consultation with the Department members if less than a year is left in the term.

ARTICLE 4

COMMITTEES

There are a variety of ways to organize Medical Staff committees. Smaller hospitals have traditionally minimized the number of committees — sometimes assigning many or all responsibilities to the Medical Executive Committee (MEC). Larger hospitals, on the other hand, traditionally have multiple committees, each with assigned responsibility to perform distinct functions. Non-departmentalized hospitals necessarily need a different structure.

The most important consideration when designing committee structure is assuring that all required Medical Staff functions are assigned to one or more committees. The Bylaws or Rules must specify each committee's composition, minimum meeting frequency, and member voting rights, keeping in mind that in this Model, ex officio members are presumed to have voting rights unless otherwise specified. These Bylaws describe general provisions applicable to all committees are described in the Bylaws.

TJC Standard MS.01.01.01, EP 20, requires the details of the Medical Executive Committee to be included in the Bylaws, but does not require the same of other committees. These Bylaws and Rules are consistent with the growing trend toward encouraging greater flexibility in the committee structure by having only the Medical Executive Committee described in the Bylaws and all other committees described in the Rules.

4.1 Designation

4.1.1 Medical Staff committees include, but are not limited to, any committee described in the Governing Documents; meetings of a Department; meetings of a Section; any ad hoc, special, or sub-committee created by a (a) committee described in the Governing Documents, (b) Department, or (c) Section; any meeting that takes place pursuant to the meeting provisions of these Bylaws; or any meeting of the Medical Staff as a whole.

4.1.2 Any meeting or activities related to the business of Medical Staff committees shall be considered Medical Staff committee proceedings and shall be entitled to the protections and immunities afforded to peer review committees under state and federal law.

4.1.3 All Medical Staff committees shall be responsible to the Medical Executive Committee.

4.2 Creation

4.2.1 The Medical Staff's standing committees shall be those identified in these Bylaws or in the Rules, and those designated as standing committees by the Departments or Sections.

4.2.2 Subject to the available resources of the Medical Staff Administration, any committee can create a subcommittee, such as a special committee or ad hoc committee, to perform specified tasks. The committee chair shall inform the

Medical Executive Committee when a subcommittee is created. The committee chair may appoint individuals in addition to, or other than, members of the standing committee to the subcommittee after consulting with the Chief of Staff regarding Medical Staff member appointees, and the Chief Executive Officer regarding Hospital Staff appointees.

4.2.3 No committee shall create a special committee or ad hoc committee to perform a task already assigned to another committee. Committees shall, as appropriate, attempt to coordinate their efforts to maximize efficiency and minimize redundancy.

4.3 Appointment and Nonmembers

4.3.1 Unless otherwise specified in the Governing Documents, the chair and members of all committees shall be appointed by, and may be removed by, the Chief of Staff, subject to consultation with and approval by the Medical Executive Committee; however, the Chief of Staff may not remove persons who are ex officio members of the committee or whose membership is required by the Governing Documents.

4.3.2 A Medical Staff committee is composed as stated in the description of the committee in the Governing Documents. Unless provided otherwise in the Bylaws or Rules, Medical Staff committees may include persons who are not Medical Staff members or otherwise affiliated with the Hospital, depending on the committee's functions.

4.3.3 Each Medical Staff member who serves on a committee participates with vote unless the Governing Documents designate the position as nonvoting.

4.3.4 The Chief of Staff, subject to the approval of the Chief Executive Officer or his or her designee, shall appoint any non-Medical Staff members who serve in non-ex officio capacities.

4.3.5 Unless otherwise provided in the Bylaws or Rules, terms of appointment shall be for [_____] years, subject to earlier resignation or removal. Committee members may be appointed for consecutive terms, without limit. Insofar as possible, terms in any individual committee shall be staggered to achieve continuity.

4.3.6 A committee chair may, in his or her discretion, allow a Medical Staff member or Allied Health Staff member who is not a committee member to attend a portion of a committee meeting that is of importance to the member. The committee chair will exercise his or her judgment regarding whether any guest is permitted to attend a portion of the committee meeting in which confidential information regarding another Practitioner or Allied Health Staff member is discussed. Committee guests must abide by the confidentiality and other rules that apply to committee members.

4.4 Ex Officio Members

Unless otherwise provided in the Governing Documents, the Chief of Staff and the Chief Executive Officer [and the Chief Medical Officer], or their respective designees are ex officio members of all standing and special committees of the Medical Staff, except the Well-Being Committee, and shall serve without vote.

4.5 Committee Chairs

4.5.1 In appointing committee chairs, the Chief of Staff's goal shall be to appoint individuals who:

It may not always be possible to appoint chairs who meet each of the following qualifications, but it is a goal worth pursuing.

(a) Have demonstrated a commitment to the Medical Staff's responsibilities,

(b) Support the mission of the Hospital,

(c) Understand how the committee's duties and actions impact the Medical Staff's and Hospital's legal and credentialing obligations, and are committed to lead in a manner that promotes compliance with those obligations; and

(d) Are knowledgeable about the committee's area of focus.

4.5.2 Committee chairs are expected to conduct committee meetings in an efficient and expeditious manner and to ensure that proper decorum is maintained. Committee chairs also are responsible for ensuring that the committee functions in a manner designed to achieve and fulfill the committee's duties.

4.5.3 Committee chairs may call on outside consultants or special advisors, but only after obtaining approval from the Chief of Staff and, if the Hospital is to pay for any portion of the consultant or special advisor's fee, approval from the Chief Executive Officer.

4.5.4 Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair.

4.5.5 Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

4.6 Conflicts of Interest

As noted earlier, Medical Staffs should develop conflict of interest policies.

Every committee member, regardless of whether the person serves as an ex officio member, must disclose all conflicts of interests, as defined in the Governing Documents, and not have any disqualifying conflict of interest as defined in the Governing Documents. In addition, committee members must orally

identify any conflicts of interest relating to a particular subject matter when that subject is discussed in committee. The member, either upon his or her own initiative or upon direction from the Chair, shall recuse himself or herself from any discussion or action that may be impacted by the conflict of interest.

4.7 Representation on Hospital Committees and Participation in Hospital Functions

TJC Leadership Standards require that the Medical Staff have the opportunity to participate in governance.

Upon the Governing Body's approval, the Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

4.8 Charters

The composition, duties, and meeting frequency of each standing committee shall be described in the Bylaws or the Rules. All committees are accountable to the Medical Executive Committee.

4.9 Medical Executive Committee

The Medical Executive Committee is the executive committee of the Medical Staff.

4.9.1 Composition

Departmentalized hospitals often include the Department Chairs as members of the Medical Executive Committee; often, key committee chairs are also members (although both of these approaches can result in a very large committee). The MEC usually includes one or more at-large representatives as well. Medicare Conditions of Participation, 42 C.F.R. Section 482.22(b), requires that the majority of the executive committee be doctors of medicine or osteopathy, so the Bylaws' description of the Medical Executive Committee's composition should take that into account.

TJC Standard MS.02.01.01, EPs 3 requires that all members of the Medical Staff, including non-physician practitioners, be eligible to be members of the MEC (an at-large position helps accommodate this), and EP 4 requires that a majority of the members must be physicians (doctors of medicine or osteopathy) who are actively practicing at the Hospital. Limiting officer and other positions to Active Staff members achieves this.

(a) A majority of the members of the Medical Executive Committee shall be doctors of medicine or doctors of osteopathy. The Medical Executive Committee shall be composed of:

(i) The Medical Staff Officers;

(ii) The member(s)-at-large;

(iii) [The Department Chairs];

(iv) The chairs of the [INSERT COMMITTEE NAMES HERE];

(v) The Chief Executive Officer or designee as ex officio;

Both TJC and DNV-GL require that the Chief Executive Officer be a Medical Executive Committee member. Neither require that the Chief Executive Officer have a right to vote.

(vi) The Chief Medical Officer or designee as ex officio;

This is common, but not required.

(vii) The Chief Nursing Executive or designee as ex officio.

For DNV-accredited hospitals, the chief nursing officer also must be an MEC member (see NIAHO Standard MS.5, SR.2).

(b) If at any time the composition requirements in (a) above result in less than a majority the members of the Medical Executive Committee not being doctors of medicine or doctors of osteopathy, then notwithstanding any other provision in these Bylaws, the Medical Staff will hold a special election for sufficient additional members-at-large to serve on the Medical Executive Committee. In such special elections, only doctors of medicine or doctors of osteopathy shall be eligible for election as at-large members. The Medical Executive Committee shall set a date for the election that is later more than 90 days from the date that the need for a special election is identified. The special election shall, to the extent feasible, comply with the election procedures identified in these Bylaws for at-large members, except that (i) the Medical Executive Committee may stand in the place of the Nominating Committee, (ii) the Medical Executive Committee may modify the deadlines and dates as needed to facilitate an efficient process, as long as that process remains fair, and (iii) such number of at-large members shall be elected as to result in a majority of the members of the Medical Executive Committee being doctors of medicine or doctors of osteopathy.

As noted above, CMS and TJC require that a majority of voting members on the MEC be doctors of medicine or doctors of osteopathy. In the exceedingly rare occurrence that the described composition results in this standard not being met, the Medical Staff can invoke this provision to add more members to the Medical Executive Committee.

4.9.2 Duties

The Medical Staff delegates to the Medical Executive Committee broad authority to oversee the operations of the Medical Staff. This includes, but is not limited to, the authority and responsibility over the matters identified below, as well as

anything else identified throughout these Bylaws as being within the Medical Executive Committee's authority. The Medical Staff may delegate additional authority to, or remove authority from, the Medical Executive Committee through amendment of these Bylaws.

TJC Standard MS.01.01.01, EP 20, requires that the Medical Staff Bylaws describe the authority delegated to the MEC, and how that authority is delegated or removed. We recommend a broad and general grant of authority, because it is simply not possible to foresee and describe every occasion or circumstance that may necessitate MEC decision making; and because a narrow grant of authority will likely lead to constant challenges and unnecessary undermining of respect for the MEC's important role.

The Medical Executive Committee shall:

(a) Assure that the Medical Staff fulfills each of its purposes and responsibilities, as described in Article 1 and elsewhere in these Bylaws.

(b) Supervise the performance of all Medical Staff functions, which shall include:

(i) Requiring regular reports and recommendations from the departments, committees and officers of the Medical Staff concerning their discharge of assigned functions;

(ii) Issuing directives as appropriate to assure effective performance of all Medical Staff functions; and

(iii) Following up to assure implementation of all directives.

(c) Review and make recommendations to the Governing Body on reports of Medical Staff committees, departments, and other assigned activity groups.

(d) Oversee the coordination of the activities of the committees and departments.

(e) Make recommendations to the Governing Body on Medical Staff membership, the Medical Staff structure, the process used to review credentials and delineate privileges, and the delineation of privileges for each Practitioner and APP privileged through the Medical Staff process.

(f) Oversee and ensure that the Medical Staff establishes criteria and standards for Medical Staff membership and privileges, and enforce those criteria and standards in reviewing the qualifications, credentials, performance, and professional competence and character of applicants and staff members.

(g) Oversee and ensure that the Medical Staff establishes clinical criteria and standards to oversee and manage quality assurance, utilization review, and

other Medical Staff activities including, but not limited to, periodic meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records.

(h) Evaluate the performance of Practitioners exercising clinical privileges whenever there is doubt about the ability of an applicant, member, or Allied Health Practitioner to perform requested privileges.

(i) Based upon input from the departments and Credentials Committee, make recommendations regarding all applications for Medical Staff appointment, reappointment, and privileges.

(j) When indicated, initiate Focused Professional Practice Evaluations and/or pursue disciplinary or corrective actions affecting Medical Staff members or APPs.

(k) With the assistance of the Chief of Staff, supervise the Medical Staff's compliance with:

(i) The Governing Documents;

(ii) The Hospital's Bylaws, Rules, and policies;

(iii) State and federal laws and regulations; and

(iv) Applicable accreditation requirements.

(l) Adopt and amend rules and regulations, and do so in a manner consistent with these Bylaws.

(m) Oversee the development and amendment of Medical Staff policies, approve (or disapprove) all such policies, and oversee the implementation of those policies.

(n) Implement, as they relate to the Medical Staff, the Hospital's approved policies.

(o) Confer and meet in good faith with the Governing Body or its designee to resolve disputes with the Governing Body, or delegate that meeting to another committee;

(p) With the Department Chairs, set departmental objectives for establishing, maintaining, and enforcing professional standards within the Hospital and for continually improving the quality of care rendered in the Hospital; assist in developing programs to achieve these objectives, including, but not limited to, Ongoing Professional Practice Evaluations.

(q) Regularly report to the Governing Body through the Chief of Staff and the Chief Executive Officer on at least the following:

(i) The outcomes of Medical Staff quality improvement programs, providing sufficient background and detail to assure the Governing Body that quality of care is consistent with professional standards; and

(ii) The general status of any Medical Staff disciplinary or corrective actions in progress.

(r) Promote the ethical and collegial practice of all Practitioners and APPs.

(s) Assist the Hospital in reviewing and advising on sources of clinical services provided by consultation, contractual arrangements, or other agreements; in evaluating the safety and quality of services provided via consultation, contractual arrangements, or other agreements; and in providing relevant input to notice-and-comment proceedings or other mechanisms that may be implemented by Hospital administration in making exclusive contracting decisions.

(t) Prioritize and assure that Hospital-sponsored educational programs incorporate the recommendations and results of Medical Staff quality assessment and improvement activities.

(u) Establish, as necessary, ad hoc committees to fulfill particular functions for a limited time; such committees will report directly to the Medical Executive Committee.

(v) Establish the date, place, time, and program of the regular meetings of the Medical Staff.

(w) Represent and act on behalf of the Medical Staff between meetings of the Medical Staff.

(x) Take such other actions as may reasonably be deemed necessary in the best interests of the Medical Staff and the Hospital.

4.9.3 Meetings

The Medical Executive Committee shall meet regularly, and at least quarterly, during the calendar year. A record of its proceedings and actions shall be maintained.

ARTICLE 5

MEETINGS AND VOTING

5.1 Medical Staff Meetings

5.1.1 Regular Meetings

There shall be at least one regular meeting of the Medical Staff during each Medical Staff year. The date, place, and time of the meeting(s) shall be determined by the Chief of Staff. The Chief of Staff shall present a report on significant actions the Medical Executive Committee took during the time since the last Medical Staff meeting and on other matters believed to be of interest and value to the membership. No business shall be transacted at any Medical Staff meeting except that stated in the notice calling the meeting.

5.1.2 Special Meetings

Special meetings of the Medical Staff may be called at any time by the Chief of Staff, Medical Executive Committee, or Governing Body, or upon the written petition of 10 percent of the voting members. A petition requesting a special meeting shall state the reasons for the meeting on each page where signatures appear. The meeting must be called within 30 days after receipt of such request, and notice shall be provided to the Medical Staff at least 15 days before the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

5.1.3 Combined or Joint Medical Staff Meetings

The Medical Staff may participate in combined or joint Medical Staff meetings with staff members from other hospitals, health care entities, or the County Medical Society. However, precautions shall be taken to assure that confidential Medical Staff information and patient information is not inappropriately disclosed and that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

5.2 Department and Committee Meetings

5.2.1 Regular Meetings

Departments and committees, by resolution, may provide the time, date, and location for holding regular meetings; no notice other than the resolution is required. Each department shall meet regularly, and at least quarterly, to review and discuss patient care activities and to fulfill other departmental responsibilities.

5.2.2 Special Meetings

A special meeting of any department or committee may be called by, or at the request of, its Chair, the Medical Executive Committee, Chief of Staff, or by one third of the group's current members, but not fewer than three members. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

5.2.3 Combined or Joint Department or Committee Meetings

The departments or committees may participate in combined or joint department or committee meetings with staff members from other hospitals, health care entities, or the County Medical Society. Precautions shall be taken to assure that confidential Medical Staff information and patient information are not inappropriately disclosed and that this Medical Staff (through its authorized representative(s)) maintains access to, and approval authority of, all minutes prepared in conjunction with any such meetings.

5.3 Notice of Meetings

Written notice stating the place, day, and time of any regular or special Medical Staff meeting or of any regular or special department or committee meeting not held pursuant to resolution shall be delivered electronically, personally, or by mail to each person entitled to attend. Such notice shall be given not fewer than [two] working days nor more than [45] days before the date of the meeting. Personal attendance at a meeting shall constitute a waiver of notice.

5.4 Quorum

It can be a challenge for Medical Staff committees to meet their quorum requirements on a regular basis. Therefore, the attendance requirement for establishing a quorum should not be unrealistic but should reflect the need to ensure fair and appropriate committee action. Additionally, Medical Staffs can consider adopting other ways to establish a quorum – for example, a quorum for regularly scheduled meetings could be the presence of the committee chair (or his or her designee) and two other voting committee members.

5.4.1 Medical Staff Meetings

The presence of the greater of [25] percent of the voting members, or three voting members, at any regular or special meeting of the Medical Staff shall constitute a quorum.

5.4.2 Committee Meetings

The presence of [50] percent of the voting members shall be required for Medical Executive Committee meetings. For other committees, a quorum shall consist of [30] percent of the committee's voting members, but in no event less than three voting committee members.

5.4.3 Department Meetings

The presence of the greater of [25] percent of the voting members, or three voting members, at any regular or special department meeting shall constitute a quorum.

5.5 Manner of Action

Some Medical Staffs may require that the chair refrain from voting except when necessary to break a tie. This is not the approach adopted in this Model (see earlier provisions regarding Committee Chairs), but it can be adopted.

5.5.1 Except as otherwise specified, the action of a majority of the 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 so long as any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be required by these Bylaws.

5.5.2 Committee and Department meetings may be held in person, telephonically, via internet conference, or other electronic systems, so long as the quorum requirements are met and the meeting is held in a manner that allows all committee members the opportunity to hear, participate, and (if a voting member) vote. The validity of actions does not depend on whether the meeting was held in person, telephonically, via internet conference, or other electronic systems.

5.5.3 Valid action may be taken without a meeting if at least [10] days' notice of the proposed action has been given to all members entitled to vote, and the proposed action is thereafter approved in writing or via email by at least two thirds of the members entitled to vote, with such writing or email specifying the proposed action the member is approving.

5.6 Minutes

Minutes of all meetings shall be prepared. Minutes shall include a record of the attendance of members, the vote taken on each matter, and the names of any individuals who recused themselves from discussion or vote on any matter. The minutes shall be signed by the presiding officer or his or her designee and forwarded to the Medical Executive Committee or other designated committee and Governing Body. Each committee shall maintain a permanent file of the minutes of each meeting. When meetings are held with outside entities, access to minutes shall be limited as necessary to preserve the protections from discovery, as provided by California law.

5.7 Attendance

There are no legal or accreditation standards setting specific attendance requirements for meetings, and this section is optional. However, reasonable attendance standards provide an excellent means for achieving broad participation of Medical Staff members in Medical Staff and department activities.

5.7.1 Attendance Requirements

(a) Each member of a Medical Staff category required to attend meetings shall be required to attend [two] general staff meetings and [50] percent of department or section meetings during the two-year reappointment period. Committee members must attend [50] percent of all meetings of the committee to which the member is appointed.

If the Medical Staff only has one general meeting a year, then this requirement should be changed.

(b) A member may be excused from attendance at a regularly scheduled meeting if the member provides prompt notice to the person chairing the meeting of the anticipated absence, and if the chair excuses the absence for good cause.

5.7.2 Failure to Meet Attendance Requirements

Imposing penalties for failing to meet attendance requirements is optional. Medical Staffs can reject or modify this provision.

Medical Staff members will be notified semi-annually if they have not yet met the attendance requirements. Practitioners who do not meet the meeting attendance requirements at the end of the appointment period will, if reappointed, be considered not to be in good standing and may be subject to corrective action or an assessment of a fine. Members who serve on committees and who fail to meet attendance requirements may be removed prior to the end of their term on the committee.

5.7.3 Special Appearance

(a) A committee or department may require a Practitioner or APP to appear at any meeting where the Practitioner's or APP's clinical performance or professional conduct is being discussed. When possible, the meeting chair should give the Practitioner at least [10] days advanced written notice of the time, place, and subject of the meeting. The notice shall inform the Practitioner or APP that his or her appearance is mandatory and that his or her failure to appear may result in an automatic suspension of privileges and referral to the Medical Executive Committee for possible corrective action.

(b) If a Practitioner or APP fails to attend the meeting after being notified that his or her appearance is mandatory, and the failure to appear is not excused by the Medical Executive Committee, then his or her privileges shall be automatically suspended pursuant to the Automatic Suspension, Termination, and Limitation provisions of the Corrective Action Article of these Bylaws, and he or she shall be referred to the Medical Executive Committee for possible corrective action.

5.8 Conduct of Meetings

Unless otherwise specified, the chair of meetings shall use [Robert's Rules of Order] as a reference for conducting the meeting; however, failure to follow these rules shall not invalidate action taken at the meeting.

Other sources of parliamentary procedure are Sturgis, Standard Code of Parliamentary Procedure, and Parliamentary Procedure at-a-Glance.

5.9 Electronic Voting

Unless otherwise provided in these Bylaws, any vote for an election, adoption, or amendment process may be accomplished through an electronic voting process approved by the Medical Executive Committee, so long as the Medical Executive Committee has determined that the electronic voting process has sufficient safeguards to protect the integrity of the vote and the process has been approved by the Governing Body. "Electronic voting process" includes, but is not limited to, email and web-based voting processes.

ARTICLE 6

GOVERNING DOCUMENTS

6.1 Identification of Governing Documents

6.1.1 The documents that govern the Medical Staff's operations and its responsibilities, as well as the responsibilities and practices of the members, other Practitioners, and Allied Health Staff at the Hospital, include the Hospital and Medical Staff Bylaws, Rules and Regulations, Policies and Procedures, Department or Section Rules and Policies and Procedures, and any other document adopted by the Hospital or Medical Staff directly applicable to Medical Staff operations, the granting of membership on the Medical Staff, or the exercise of privileges at the Hospital. Applicants, Medical Staff members, and any other person holding privileges shall be governed by any Governing Document that is properly adopted.

6.1.2 The Medical Staff Bylaws describe the fundamental principles of Medical Staff self-governance and accountability to the Governing Body. The key standards for Medical Staff membership, appointment, reappointment, privileging, corrective action, and hearings and appeals are set out in the Bylaws. Additional provisions may be set out in other Governing Documents.

6.1.3 Amendments to the Medical Staff Governing Documents shall be made in good faith and be consistent with the Medical Staff's legal, accreditation, and ethical obligations. Under no circumstance may the Medical Staff amend a Governing Document in a manner that conflicts with the Hospital's Bylaws or that would jeopardize the Hospital's licensure, Medicare certification, accreditation status, or not-for-profit status.

6.2 Bylaws

Title 22, California Code of Regulations, Section 70703(b), requires that the Bylaws be adopted by a vote of Medical Staff members. TJC Standard MS.01.01.01, EP2, provides that the adoption or amendment of the Bylaws cannot be delegated, meaning it requires a vote of the medical staff, not of the executive committee. DNV-GL does not have the same limitation, but California regulations still apply.

6.2.1 Adoption

The Medical Staff Bylaws may be adopted by (a) an affirmative vote of greater than 50% of the members voting, as long as at least 30% of the members eligible to vote cast ballots, followed by (b) the approval of the Governing Body, which approval shall not be unreasonably withheld. The Medical Staff Bylaws shall be effective immediately upon the Governing Body's approval, unless the Medical Staff Bylaws specify, at the time of vote and adoption, a later effective date.

These numbers can be changed.

The Medical Staff Bylaws shall be reviewed on an as-needed basis, but at least once every two years. Additionally, Hospital administration may develop and recommend proposed Bylaws, and should be consulted as to the impact of any proposed Bylaws on Hospital operations and feasibility.

This is not required by law or accreditation standard, but is good practice to assure the Bylaws are currently compliant with legal and accreditation standards.

6.2.2 Amendment

(a) Any proposal to amend or repeal these Bylaws shall be requested by the Medical Executive Committee, the Chief of Staff, or a committee charged with reviewing the Medical Staff Bylaws, or upon written petition submitted to the Medical Executive Committee signed by at least 25% of the members of the Medical Staff in good standing who are entitled to vote. Any petition from the Medical Staff must include the exact wording of the proposed amendment or repeal on every page on which signatures appear.

Each Medical Staff should evaluate and establish an appropriate threshold for processing amendments proposed by a petition of the Medical Staff. The number should be sufficiently high so that the interests of individuals or a disgruntled few are not controlling the processes. But it also needs to be set in recognition that in small Medical Staffs, the interests of a few may represent the prevailing view of the Medical Staff. Finally, the number should be reasonable – i.e., not so high that the provisions can never be invoked.

(b) Proposed amendments meeting the above parameters shall be submitted to the Governing Body for comment at least 30 days before they are distributed to the Medical Staff for a vote. If the Governing Body has any concerns regarding any proposed amendment, it will contact the Chief of Staff within 21 days after receiving the proposed amendments for discussion. If the Governing Body has comments on the proposed amendments after its discussion with the Chief of Staff, its comments will be circulated with the proposed amendments at the time they are distributed to the Medical Staff for a vote.

Business and Professions Code Section 2282.5 establishes the Medical Staff's right to adopt Bylaws and sets out a standard for Governing Body approval (the approval shall not be unreasonably withheld). This provision affords an opportunity for the Medical Staff to learn about any concerns the Governing Body may have before the provisions go for a vote and at a point where it may be possible to discuss issues of disagreement. Medical Staffs can choose to adopt a more formal "meet and confer" process here, but a discussion with the Chief of Staff would be a good place to start.

(c) Proposed amendments meeting the above parameters shall be submitted to the Medical Staff for vote only after the Medical Executive Committee

has determined that the proposed amendment does not conflict with existing Hospital Bylaws.

TJC MS.01.01.01, EP 4, provides that the "medical staff Bylaws, rules and regulations, and policies, the governing body bylaws, and the hospital policies are compatible with each other and are compliant with law and regulation." During the Bylaws revision process, the need to assure that the proposed changes to the Medical Staff Bylaws do not conflict with existing Hospital Bylaws often is overlooked. Including this requirement in the Bylaws may prevent incompatible amendments being sent for vote.

(d) Voting shall be conducted at a special meeting called for that purpose, via a mail ballot, or via an electronic voting process, as described elsewhere in these Bylaws. The ballot, in whatever form, must specify what language in the Bylaws is proposed to be added, amended, moved, or deleted.

(e) Amendments shall require (i) an affirmative vote of greater than 50% of the members voting, as long as at least 30% of the members eligible to vote cast ballots, followed by (ii) the approval of the Governing Body, which approval shall not be unreasonably withheld.

These numbers can be changed.

(f) Amendments shall be effective immediately upon approval of the Governing Body, unless the ballot specifies a later effective date.

6.2.3 Technical and Editorial Corrections

California law, CMS, and TJC all prohibit unilateral amendment of the Bylaws, and TJC requires a Medical Staff vote for amendment. However, generally accepted practice is to allow non-substantive corrections without the formal amendment process. Hospitals may wish to consult with their own legal counsel and/or TJC before adoption.

The Medical Executive Committee shall have the power to adopt such amendments to the Bylaws that are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Bylaws, or amendments made necessary because of punctuation, spelling or other errors of grammar or expression or inaccurate cross-references. No substantive amendments are permitted pursuant to this section. The action to amend may be taken by motion and acted upon in the same manner as any other motion before the Medical Executive Committee. After approval, such amendments shall be communicated in writing or electronically to the Medical Staff and to the Governing Body. Such amendments are effective upon adoption by the Medical Executive Committee; provided however, that they may be rescinded by vote of the Medical Staff or Governing Body within 120 days of the date of adoption by the Medical Executive Committee. Such vote of the Medical Staff will be held in the same manner as a vote on an amendment of the Bylaws.

6.2.4 Legal and Accreditation Compliance

The Medical Staff agrees to work cooperatively with the Governing Body to assure that the Bylaws comply with legal and accreditation standards on an on-going basis. As part of its legal and accreditation responsibilities, the Medical Staff acknowledges and agrees that it will, in a timely manner, amend the Medical Staff Bylaws in order to assure compliance with state or federal law, Medicare requirements, court order, or accreditation standards. If the Medical Staff unreasonably fails to exercise its responsibility to adopt or amend the Bylaws to make these types of non-discretionary amendments, the Governing Body may take such actions that are within its authority.

Hospital legal counsel should be consulted before any decision to exercise the residual authority described here. TJC standards preclude unilateral amendment of the Bylaws; however, the Governing Body remains ultimately responsible for the Hospital, including ensuring compliant Bylaws.

6.3 Rules and Regulations

TJC has several requirements found in MS.01.01.01, EPs 8-11, for the adoption of rules and policies. The provisions that follow comply with those standards.

6.3.1 Identification

The Medical Staff adopts rules and regulations necessary to implement more specifically the general principles found within these Bylaws, subject to the Governing Body's approval. If there is a conflict between these Bylaws and the Rules and Regulations, the Bylaws shall prevail. The Rules and Regulations shall be reviewed regularly, and at least every two years, and the mechanism described in these Bylaws shall be the sole method for the initiation, adoption, amendment, or repeal of the Medical Staff Rules and Regulations.

Another time period can be selected.

6.3.2 Adoption and Amendment

The Medical Staff delegates to the Medical Executive Committee the authority to initiate and adopt such general rules and regulations as it may deem necessary for the proper conduct of the Medical Staff's work and to periodically review and revise the rules and regulations. Additions or changes to the general Medical Staff rules and regulations (Proposed Rules) may be proposed by the Medical Executive Committee, the Chief of Staff, or by petition submitted to the Medical Executive Committee and signed by at least 25% of members of the Medical Staff in good standing who are entitled to vote. Any petition from the Medical Staff must include the names of the Medical Staff members who are contact persons for the petition and the exact wording of the Proposed Rule on every page on which signatures appear. Proposed Rules shall be reviewed and acted upon as follows:

Each Medical Staff should evaluate and establish an appropriate threshold for processing amendments proposed by petition of the Medical Staff. The number should be sufficiently high so that the interests of individuals or a disgruntled few are not controlling of the processes. But it also needs to be set in recognition that in small Medical Staffs, the interests of a few may represent the prevailing view of the Medical Staff. Finally, the number should be reasonable – i.e., not so high that the provisions can never be invoked.

(a) Except with respect to circumstances requiring urgent action, as described below, the Medical Executive Committee shall not act on any Proposed Rule until members of the Medical Staff and the Governing Body have had a reasonable opportunity to review and comment on the Proposed Rule. Notice regarding a Proposed Rule shall be communicated electronically or through mail to members of the Medical Staff and to the Governing Body at least 30 days prior to the scheduled Medical Executive Committee meeting where the vote is to take place, together with instructions on how to communicate comments to the Medical Executive Committee.

Similar to the Bylaws amendment process, it is appropriate for the Governing Body to have an opportunity to review and comment on proposed rules before their adoption.

(b) The Medical Executive Committee shall inform the Medical Staff regarding whether it has approved or rejected the Proposed Rule.

(c) If the Medical Executive Committee fails to approve a Proposed Rule that has been submitted by petition as described above, the members of the Medical Staff identified as contact persons on the petition may invoke the Conflict Management process described in the Rules.

(d) If, after the Conflict Management process, the Medical Executive Committee does not adopt the Proposed Rule, the Medical Staff may petition to have the Proposed Rule submitted to the Medical Staff for a vote. The petition to hold the vote must be supported by signatures from at least 25% of members of the Medical Staff who are entitled to vote and must include the purpose of the petition on every page on which signatures appear. The vote shall be held in a manner consistent with the process used for the amendment of the Medical Staff Bylaws, including the distribution of Governing Body comments, if any.

(e) Following approval by the Medical Executive Committee or by a vote of the Medical Staff, the Proposed Rule shall be forwarded to the Governing Body for approval, which approval shall not be withheld unreasonably. The Rule shall become effective immediately following the approval of the Governing Body.

6.3.3 Urgent Revisions

This provision is consistent with TJC Standard MS.01.01.01, EP 11.

(a) Notwithstanding the above, in cases of a documented need for an urgent amendment to rules and regulations necessary to comply with law or regulation, the Medical Executive Committee may provisionally adopt, and the Governing Body may provisionally approve, an urgent amendment without prior notification of the Medical Staff. In such cases, the Medical Executive Committee shall provide notice to the Medical Staff as soon as practicable about the amendment.

(b) The Medical Staff shall have the opportunity for retrospective review of and comment on the provisional amendment. If no petition is submitted as described in the next sentence, the provisional amendment stands and is no longer provisional. The provisional amendment shall be challenged by submitting a petition requesting repeal of the amendment to the Medical Staff Administration within 30 days after the Medical Executive Committee provides notice of the change; such petition shall be signed by more than 50% of the members of the Medical Staff who are entitled to vote and shall have the names of contact persons for the petition and the purpose of the petition included on every page on which signatures appear. In the event of such challenge, the Conflict Management process detailed in the Rules is implemented. The provisional amendment shall remain in effect during the Conflict Management process. At the conclusion of that process, a revised amendment may be, if necessary, submitted to the Medical Executive Committee and Governing Body for action consistent with the amendment process described above.

6.4 Policies and Procedures

6.4.1 Adoption

The Medical Executive Committee may adopt and amend policies and procedures as necessary for the accomplishment of Medical Staff processes, subject to the Governing Body's approval, which approval shall not be unreasonably withheld. If there is a conflict between these Bylaws and a policy, the Bylaws shall prevail. If there is a conflict between the Rules and Regulations and a policy, the Rules and Regulations shall prevail. Proposed new or revised policies (proposed policies) for the Medical Executive Committee's consideration may arise from any responsible committee, department, Medical Staff officer, or by petition signed by at least 25% of members of the Medical Staff who are entitled to vote. Any petition from the Medical Staff must include the names of the Medical Staff members who are contact persons for the petition and the exact wording of the proposed policy on every page on which signatures appear.

As discussed with Bylaws and Rules and Regulations amendments, this number can be adjusted as appropriate for the Medical Staff.

(a) If the Medical Executive Committee fails to approve a proposed policy that has been submitted by petition as described above, the members of the Medical Staff identified as contact persons on the petition may invoke the Conflict Management process described in the Rules. If, after the Conflict Management process, the Medical Executive Committee does not adopt the proposed policy, the Medical Staff may petition to have the proposed policy submitted to the Medical Staff for a vote. The petition to hold the vote must be supported by signatures from at least 25% of members of the Medical Staff who are entitled to vote and must include the purpose of the petition on every page on which signatures appear. The vote shall be held in a manner consistent with the process used for the amendment of the Medical Staff Bylaws, including the distribution of Governing Body comments, if any.

(b) Following approval of a proposed policy by the Medical Executive Committee or by a vote of the Medical Staff, the Medical Executive Committee shall inform the Medical Staff of the approval of the proposed policy and shall forward the proposed policy to the Governing Body for approval, which approval shall not be withheld unreasonably. The policy shall become effective immediately following the approval of the Governing Body.

TJC MS.01.01.01, EP 9, provides that when the Medical Executive Committee adopts a policy or an amendment thereto, it communicates this to the Medical Staff.

6.5 Department and Section Rules

6.5.1 Subject to the approval of the Medical Executive Committee and Governing Body, each department may formulate its own rules for conducting its affairs and discharging its responsibilities. Hospital administration also may develop and recommend proposed department rules, and in any case should be consulted as to the impact of any proposed department rules on Hospital operations and feasibility. Such rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or other policies.

6.5.2 Subject to the approval of the department that oversees the section, the Medical Executive Committee, and the Governing Body, each section may formulate rules for conducting its affairs and discharging its responsibilities. Hospital administration also may develop and recommend proposed section rules, and in any case should be consulted as to the impact of any proposed section rules on Hospital operations and feasibility. Such rules shall not be inconsistent with the Medical Staff or Hospital Bylaws, Rules, or policies.

6.6 Forms

Forms necessary for use in connection with Medical Staff appointments, reappointments, delineation of privileges, corrective action, notices, recommendations, reports and other matters shall be approved by, and may be amended by, the Medical Executive Committee, subject to approval by the Governing Body.

6.7 Non-Contractual Nature of Governing Documents

6.7.1 The Bylaws, Rules and Regulations, and Policies and Procedures and other Governing Documents are not, and shall not be deemed to be, contracts of any kind between the Governing Body, the Hospital, the Medical Staff and/or any individual (including any Medical Staff member, applicant, or AHP), unless the document provides that it is a contract, agreement, or release.

6.7.2 Application for, the conditions of, and the duration of appointment to the Medical Staff, or the granting of privileges to a Practitioner or to an AHP, shall not be deemed contractual in nature. The consideration of applications and the granting and continuance of any privileges at this Hospital are based solely upon a Practitioner's or AHP's continued ability to justify the exercise of privileges. The granting of privileges does not obligate the Practitioner or AHP to practice at the Hospital.

6.7.3 Notwithstanding the above, all rights, responsibilities, and obligations of Medical Staff membership are enforceable as a condition of membership.

6.8 Notice by Posting on Medical Staff Website

For the notice requirements relating to Proposed Rules and to policies, the Medical Executive Committee may meet those obligations by posting the Proposed Rule or the policy on the Medical Staff website, as long as the Medical Executive Committee sends a notice electronically or through mail within the time frames provided above informing those members of the Medical Staff who are entitled to vote that the Proposed Rule or the policy is available on the Medical Staff website. The electronic or mailed notice must include the web address for the Medical Staff website.

ARTICLE 7

Dues and Additional Provisions

7.1 Dues and Assessments

Business and Professions Code Section 2282.5 grants the Medical Staff the right to establish dues and to control expenditures. It is important, however, that a tax-exempt hospital's Medical Staff expenditures are compatible with the hospital's tax-exempt purposes.

7.1.1 The Medical Executive Committee may establish reasonable annual dues, if any, for each category of Medical Staff membership, and determine the manner of expenditure of the Medical Staff funds. However, such expenditures must be appropriate to the purposes of the Medical Staff [and shall not jeopardize the nonprofit tax-exempt status of the Hospital].

7.1.2 The Medical Executive Committee may develop policies, subject to the Governing Body's approval, for the assessment of fines for noncompliance with Medical Staff Governing Documents or Hospital policy, including, but not limited to, fines for noncompliance with medical record requirements.

7.2 Compensation of Medical Staff Leaders

Medical Staffs can compensate leaders who provide services to the Medical Staff. This may implicate anti-kickback laws and the Stark Law; therefore, Medical Staffs and hospitals should consult with legal counsel before entering into any arrangements to compensate any practitioner.

The Medical Staff may compensate Medical Staff Leaders for work performed pursuant to their duties as officers, department leaders, or committee chairs. The amounts of such compensation shall be determined by the Medical Executive Committee and shall be paid from the Medical Staff's own funds. The amounts and form of compensation must comply with any applicable federal or state laws regarding physician compensation[, and shall not jeopardize the nonprofit tax-exempt status of the Hospital]. If the Hospital contributes funds to the Medical Staff, the Hospital shall have the authority to review any compensation arrangement to determine its compliance with state and federal laws, [as well as any impact it may have on the nonprofit tax-exempt status of the Hospital,] and shall have the authority to approve or withhold approval of the compensation arrangement. Compensation is contingent on the Medical Staff Leader's fulfillment of his or her duties, which shall be determined by the Medical Executive Committee.

7.3 No Retaliation

This paragraph is not required, but it may help assure compliance with California's prohibition against retaliation.

7.3.1 Neither the Medical Staff, its members, committees, or department heads; nor the Governing Body, the Chief Executive Officer, or any other employee or agent of the Hospital or Medical Staff, shall discriminate or retaliate, in any manner, against

any patient, Hospital employee, member of the Medical Staff, or any other health care worker of the facility because that person has done either of the following:

(a) Presented a grievance, complaint, or report to any of the following: the facility, an entity or agency responsible for accrediting or evaluating the facility, the Medical Staff, or any other governmental entity.

(b) Has initiated, participated, or cooperated in an investigation or administrative proceeding related to the quality of care, services, or conditions at the facility that is carried out by an entity or agency responsible for accrediting or evaluating the facility or its Medical Staff or any other governmental entity.

7.3.2 The proper exercise of the Medical Staff's and Hospital's responsibilities, including, but not limited to, those responsibilities relating to quality assessment and corrective action, does not constitute retaliation and is not precluded by this section.

7.4 Authorizations, Releases, Immunity, Confidentiality, and Indemnity

Applicants, members, Practitioners, and AHPs, by virtue of applying for or accepting membership, clinical privileges, or other permissions to practice, agree to comply with and be bound by the provisions in the Rules addressing authorizations to obtain and release information, releases, immunities, confidentiality, and indemnity. Compliance with those provisions is a condition of appointment to, and continued membership on, the Medical Staff, and a condition to any clinical privilege or other permissions to practice granted.

DIVISION 2: MEMBERSHIP AND PRIVILEGES

ARTICLE 8

MEMBERSHIP QUALIFICATIONS AND RESPONSIBILITES

8.1 General Qualifications

Medicare Conditions of Participation, 42 C.F.R. Section 482.22(c)(4), requires Bylaws to describe the qualifications a candidate must meet in order to be recommended for appointment. Similarly, TJC Standard MS.01.01.01, EP 13, requires Bylaws to include qualifications for appointment to the Medical Staff.

8.1.1 Only Practitioners and APPs who are professionally competent, conduct themselves professionally, and continuously meet the qualifications and requirements for Medical Staff membership and privileges set forth in these Bylaws and other Governing Documents may be granted and may maintain Medical Staff membership and/or privileges.

8.1.2 Only Practitioners who are appointed to the Medical Staff may exercise Medical Staff membership rights and responsibilities, and only to the extent and in the manner described in these Bylaws for the staff status the Practitioner holds.

8.1.3 Only Practitioners who are granted privileges to do so under the processes detailed in these Bylaws may admit or provide services in this Hospital.

8.1.4 No Practitioner is entitled to Medical Staff membership or privileges merely because he or she holds a certain degree; is licensed to practice in any jurisdiction; is a member of any professional organization; is a party to, or a beneficiary of, a contract with the Hospital; is certified by any clinical board; or currently has, or has had, staff membership or privileges at another health care facility.

8.1.5 AHPs are not eligible for Medical Staff membership but may be granted privileges or other permissions to practice pursuant to the processes defined in the Medical Staff's Governing Documents.

8.2 Nondiscrimination

Medical Staff membership or privileges shall not be denied on the basis of sex, gender identity, gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status. Medical Staff membership or privileges shall not be denied on the basis of any physical or mental disability if the applicant meets the standards set forth in the Governing Documents with or without reasonable accommodation.

8.3 Minimum Qualifications

All Medical Staffs have basic standards every member must meet. It is helpful to identify those standards as the minimum necessary to have an application reviewed. In this way, the Medical Staff can avoid reviewing an applicant who fails to meet basic qualifications.

Whether the applicant meets basic qualifications can be determined either by reviewing the application that is submitted or by using a "pre-application," in which applicants fill out an abbreviated form demonstrating they meet the basic criteria before they can receive the complete Medical Staff application.

Each hospital may set its own basic standards. The examples listed below are relatively elevated standards that may not be realistic for some hospitals. This list can be augmented or scaled down depending upon the hospital's needs and constraints, if legal requirements (such as licensure) are met. All basic standards should be capable of objective determination.

In order to have an application accepted for processing, an applicant must meet each of the requirements set forth in this section. A Practitioner who does not meet these minimum qualifications is ineligible to apply for Medical Staff membership, and the application shall not be accepted for processing unless these Bylaws provide that the category to which the Practitioner is applying does not require the qualification to be met. If it is determined at any time during processing that an applicant does not meet all the minimum qualifications, the Medical Staff shall discontinue review of the application. An applicant who does not meet the minimum qualifications is not entitled to the procedural rights set forth in these Bylaws but may request a waiver to a qualification, as detailed in the waiver provisions below.

Some hospitals choose not to require certain staff categories, such as Community Affiliate Staff, Honorary Staff, and Administrative Staff, to meet certain requirements.

The minimum qualifications each applicant must meet include:

8.3.1 Holding one of the following:

(a) A license to practice medicine from the Medical Board of California or the Osteopathic Medical Board of California;

(b) A license to practice dentistry from the Dental Board of California;

(c) A license to practice podiatry from the California Board of Podiatric Medicine; or

(d) [A license to practice clinical psychology by the California Board of Psychology.]

8.3.2 If practicing medicine, dentistry, or podiatry, having a federal Drug Enforcement Administration number, if requesting privileges that involve prescribing.

Some hospitals do not require practitioners to maintain Drug Enforcement Administration (DEA) certificates if they will not have privileges to prescribe scheduled drugs. If a DEA certificate will not be required for all applicants, this subsection should be eliminated from the basic requirements.

8.3.3 For physicians and podiatrists, having completed a residency approved by the Accreditation Council for Graduate Medical Education or the Council on Podiatric Medical Education that provided complete training in the specialty or subspecialty that the Practitioner will practice at the Hospital.

Hospitals with staff members who may have trained prior to residency programs becoming common may wish to delete this or to add a "grandfathering" clause to allow those practitioners already on staff to maintain eligibility for membership.

8.3.4 For dentists, having completed a residency approved by the Commission of Dental Accreditation if the Department in which the dentist is assigned requires such a residency.

Hospitals with staff members who may have trained prior to residency programs becoming common may wish to delete this or to add a "grandfathering" clause to allow those practitioners already on staff to maintain eligibility for membership.

8.3.5 Being certified by a board recognized by the American Board of Medical Specialties or the American Osteopathic Association, the American Board of Foot and Ankle Surgeons, or the American Dental Association's Council on Dental Education and Licensure, as described in further detail in the Board Certification Section below. Such certification must be in the specialty or subspecialty that the Practitioner will practice at the Hospital.

Not all Medical Staffs will require board certification or may require board certification only for physicians. Further, the CMS Conditions of Participation, Section 482.12(a)(7), provides that the Governing Body must "[e]nsure that under no circumstances is the accordance of staff membership or professional privileges in the hospital dependent solely upon certification, fellowship or membership in a specialty body or society." However, the Interpretive Guidelines to this condition state that "this does not mean that a hospital is prohibited from requiring board certification when considering a MD/DO for medical staff membership, but only that such certification must not be the only factor that the hospital considers … After analysis of all of the criteria, if all criteria are met except for board certification, the hospital has the discretion to decide not to select that individual to the medical staff." TJC Standard MS.07.01.01, EP 1, notes that "Medical staff membership and professional privileges are not dependent solely upon certification, fellowship, or membership in a specialty body or society." The exemption provisions found in the Rules provide the opportunity for hospitals to waive the board certification requirement. The experience of Medical Staffs that have

adopted board certification requirements suggest that CMS and TJC allow board certification as a minimum qualification, as long as it is not the only qualification required.

8.3.6 Being eligible to receive Medicare and Medicaid payments.

Medicare and Medi-Cal eligibility are important considerations, especially as relates to call-coverage requirements and excluded providers. This precondition to membership is not legally mandated, but in most cases, participation in these programs is essential for hospital reimbursement.

8.3.7 Having liability insurance or equivalent coverage, including nose or tail coverage, meeting the standards [approved by the Medical Staff and the Governing Body] [set by the Governing Body].

Hospitals may include the requirements in any document, such as rules and policies; some hospitals prefer the requirements be established by the Governing Body.

8.3.8 Meeting the clinical activity requirements specified by the Department as necessary to demonstrate current competence for the privileges requested.

8.3.9 Being located close enough (office and residence) to the Hospital to provide continuous care to his or her patients and to fulfill any emergency call requirements. The distance to the Hospital may vary depending upon the Medical Staff category and privileges that are involved and the feasibility of arranging alternative coverage, and may be defined in the Rules.

Some hospitals establish proximity by using mileage parameters; others prefer to use an average travel time. Using a travel time is more difficult to monitor due to traffic delays. It's important to relate proximity to both home and office because of emergency call responsibilities.

8.3.10 If requesting privileges only in departments operated under an exclusive contract, be a member, employee, or subcontractor of the group or person that holds the contract.

8.4 Additional Qualifications

In addition to meeting the minimum qualifications described above, each applicant and member must:

8.4.1 Document his or her:

(a) Adequate experience, education, and training in the requested privileges;

(b) Current professional competence;

(c) Good judgment; and

(d) Adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that patients can reasonably expect to receive the generally-recognized professional level of quality and safety of care for this community. If the Medical Staff receives information suggesting that the applicant cannot meet this standard, it will sequester this information until it has completed its initial review of the application and the Medical Executive Committee is prepared to make a recommendation on the application.

The Americans with Disabilities Act (ADA) may apply to hospital credentialing decisions. The primary concern is that the ADA can be interpreted to prohibit requesting any information regarding physical or mental disabilities and considering that information until after a decision has been made regarding whether the applicant is otherwise qualified for privileges. Therefore, hospitals should limit their inquiries during the initial application phase to only whether the applicant can perform the privileges requested, with or without reasonable accommodation, without posing a danger to patients. Once the practitioner has been granted privileges, the Medical Staff can discuss what types, if any, of reasonable accommodation are necessary.

That said, TJC-accredited hospitals should be aware of the requirements of MS.06.01.05, EP 6, which includes the following note:

"The applicant's ability to perform privileges requested must be evaluated. This evaluation is documented in the individual's credentials file. Such documentation may include the applicant's statement that no health problems exist that could affect his or her practice. Documentation regarding an applicant's health status and his or her ability to practice should be confirmed. Initial applicants may have their health status confirmed by the director of a training program, the chief of services, or the chief of staff at another hospital at which the applicant holds privileges, or by a currently licensed Doctor of Medicine or Osteopathy approved by the organized medical staff. In instances where there is doubt about an applicant's ability to perform privileges requested, an evaluation by an external and internal source may be required. The request for an evaluation rests with the organized medical staff."

Hospitals should consult with counsel regarding credentialing decisions that may involve consideration of whether an applicant can, in fact, practice safely with or without a reasonable accommodation.

8.4.2 Demonstrate an ability and commitment to:

(a) Adhere to the lawful ethics of his or her profession;

(b) Work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and

(c) Participate in and properly discharge Medical Staff responsibilities.

8.4.3 If applying after previously holding membership and/or privileges, or if applying for reappointment, pay all outstanding dues, fees, and/or assessments, if any, from the prior or current appointment.

This is an optional provision. Some Medical Staffs have difficulty enforcing dues or fees provisions; this paragraph makes payment a qualification for membership. This means that if the practitioner does not pay, he or she will not be eligible to even apply for membership and privileges.

8.5 Board Certification

Some hospitals and Medical Staffs may require board certification as a qualification for membership. Experience has shown that a simple statement requiring board certification is insufficient to address the complexities of the requirement. Therefore, we have a more detailed discussion here, as well as provisions regarding when the requirement may be waived in the Rules and Regulations.

8.5.1 "Specialty board," as used in this section, means a national specialty board of, or recognized by, the American Board of Medical Specialties or the American Osteopathic Association, the American Board of Foot and Ankle Surgeons, or the American Dental Association's Council on Dental Education and Licensure.

This Model identifies some of the more common certifying boards; hospitals and Medical Staffs may also identify other acceptable certifying boards.

8.5.2 Unless the individual qualifies for an exemption to this requirement pursuant to the guidelines set forth in the Rules and Regulations, a Practitioner applying for appointment or reappointment to the Medical Staff and/or for the granting or extension of clinical privileges must, at the time of application, be certified by the specialty board pertaining to the Practitioner's clinical privileges.

See earlier comment regarding board certification requirements and the Medicare Conditions of Participation.

8.5.3 Unless the member qualifies for an exemption to this requirement pursuant to the guidelines set forth in the Rules and Regulations, all Medical Staff members are required to maintain board certification throughout their membership on the Medical Staff. Medical Staff members must obtain recertification from the specialty board pertaining to the Practitioner's clinical privileges if recertification is required in order to maintain board certification. Failure of a Practitioner to maintain board certification shall result in the automatic termination of his or her Medical Staff membership and privileges. A Practitioner whose Medical Staff membership and privileges are terminated for failing to maintain board certification is not entitled to the hearing and appeal rights in these Bylaws.

Some hospitals only require board certification for initial applicants. The first sentence above should be deleted in such cases.

See earlier comment regarding maintaining board certification. Some hospitals only require board certification for initial applicants; some require that board certification be continuously maintained throughout membership; and some require members to comply with the ABMS member boards' "Maintanence of Certification" requirements. Medical Staffs should modify this section as appropriate to reflect their requirements.

8.5.4 If a Practitioner's membership and privileges are subject to termination for failure to attain or maintain board certification, the Medical Executive Committee, in its sole discretion, subject only to the approval of the Governing Body, may extend the date of termination of the Practitioner's membership and privileges for up to six weeks if the Medical Executive Committee determines that such extension is necessary for the health and wellbeing of patients at the Hospital. The Medical Executive Committee's decision not to extend a Practitioner's membership and/or privileges, or to extend them for less than six weeks, is not subject to the hearing and appeal rights in these Bylaws.

8.5.5 Board certification must correspond to the clinical privileges requested and training program completed. An applicant or member need not be certified in a general specialty for which he or she is requesting privileges if he or she is certified in a subspecialty for which he or she is also requesting privileges.

8.6 Waiver

Waiver provisions reflect the reality that, on occasion and for the purpose of promoting patient health and wellbeing, the Medical Staff and Hospital will need to grant privileges to a practitioner who does not meet a standard qualification. That said, waivers should be disfavored, as they can make mandatory qualifications discretionary, which then can give rise to hearing rights. They also have been used as a basis for claiming economic credentialing and discrimination, and may be used to support negligent credentialing claims. Before granting a waiver, hospitals and Medical Staffs should consult with legal counsel.

Any applicant who does not satisfy one or more of the qualifications or criteria identified in this Article or in any document describing the criteria for membership or privileges may request that the qualification or criteria be waived, subject to the following:

8.6.1 It is the Medical Staff and Governing Body's intent that waivers to any eligibility criteria be granted rarely. Waivers are never granted for qualifications that are required by law or accreditation standard.

8.6.2 Waivers of any eligibility criteria are disfavored and are granted only in extreme circumstances when necessary to address an identifiable patient care need and only if the waiver is found to be in the best interests of the Hospital and its patients' health and wellbeing. The needs or circumstances of the applicant are irrelevant to such determination.

8.6.3 The Governing Body, with a recommendation from the Medical Executive Committee, is the sole determiner of whether a waiver is in the best interest of the Hospital and its patients' health and wellbeing.

Hospitals and Medical Staffs must avoid making recommendations or decisions on the basis of the anticipated economic impact that an applicant's practice may have on other practitioners. Such consideration is impermissible in California and carries significant legal risk.

8.6.4 A determination that a waiver is, or is not, in the best interest of the Hospital and its patients' health and wellbeing is not a determination as to whether the Practitioner is otherwise qualified to hold membership or privileges, and does not entitle the Practitioner to the hearing and appeal rights in these Bylaws.

8.6.5 Once the Board determines that a waiver is in the best interests of the Hospital and its patients, the Practitioner requesting the waiver bears the burden of demonstrating exceptional circumstances and that his or her qualifications are equivalent to, or exceed, the criterion in question.

8.6.6 A determination to grant a waiver does not mean that appointment will be granted, only that processing of the application can begin.

8.6.7 A determination to grant a waiver in a particular instance is not intended to set a precedent.

8.7 General Responsibilities of Membership

Except as otherwise provided in these Bylaws, each Medical Staff member and Practitioner with privileges must continuously meet all of the following responsibilities:

8.7.1 Provide patients with quality of care meeting the professional standards of the Medical Staff.

8.7.2 Abide by the Governing Documents of the Medical Staff and the Hospital.

8.7.3 Abide by all applicable laws and government regulations and comply with applicable accreditation standards.

8.7.4 Discharge in a responsible and cooperative manner the Medical Staff, department, section, committee and service functions for which he or she is responsible.

8.7.5 Complete and document history and physicals in a timely manner consistent with these Bylaws and other Governing Documents.

8.7.6 Appropriately inform patients and obtain consent, in a manner consistent with Hospital and Medical Staff requirements.

8.7.7 Prepare and complete, in a timely and accurate manner, the medical and other required records for all patients to whom the Practitioner in any way provides services in the Hospital, in the manner consistent with Hospital policy and procedure.

8.7.8 Abide by the ethical principles of his or her profession.

8.7.9 Refrain from unlawful fee splitting or unlawful inducements relating to patient referral.

8.7.10 Refrain from harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff member, volunteer, or visitor) based upon the person's sex, gender identity, gender expression, age, religion, race, creed, color, national origin, sexual orientation, genetic information, military or veteran status, political affiliations or activities, marital status, or any other legally-protected status, or the person's health status, ability to pay, or source of payment.

8.7.11 Refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a Practitioner or Allied Health Professional who is not qualified to undertake this responsibility or not adequately supervised.

8.7.12 Provide for appropriate coverage of his or her patients.

8.7.13 Coordinate individual patients' care, treatment and services with other Practitioners and Hospital personnel, including, but not limited to, seeking consultation whenever warranted by the patient's condition or when required by the Rules or policies and procedures of the Medical Staff or applicable Department.

DNV-GL Standard MS.18 requires that the Bylaws define the circumstances and criteria under which consultation or management is required.

8.7.14 Actively participate in, and regularly cooperate with, the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous organization-wide quality measurement, assessment, and improvement; peer review, including providing information during corrective action investigations and testimony during hearings; utilization management; quality evaluation; Ongoing and Focused Professional Practice Evaluations and related monitoring activities required of the Medical Staff; and in discharging other such functions as may be required from time to time.

8.7.15 Upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care, or review of the care, of specific patients.

8.7.16 Communicate with appropriate Department officers and/or Medical Staff Officers when he or she obtains credible information indicating that a fellow Medical Staff member may have engaged in unprofessional or unethical conduct or may have a

health condition which poses a significant risk to the well-being or care of patients, and then cooperate as reasonably necessary toward the appropriate resolution of any such matter.

8.7.17 Accept responsibility for participating in proctoring in accordance with the Rules and policies and procedures of the Medical Staff.

8.7.18 Complete continuing professional education that meets all licensing requirements and is appropriate to the Practitioner's specialty.

8.7.19 Adhere to the Medical Staff Standards of Conduct as described in the Governing Documents so as not to adversely affect patient care or Hospital operations.

8.7.20 Work cooperatively with other members, Hospital staff, and Hospital administration so as not to adversely affect patient care or Hospital operations.

8.7.21 Participate in emergency service coverage and consultation panels as allowed and required by the Medical Staff or Hospital.

The model Rules that accompany these Bylaws recommend that hospitals develop rules to address emergency room call responsibilities. These responsibilities vary significantly from hospital to hospital. It is imperative that each hospital develop call provisions, and it is strongly recommended that they be included in the Rules to enhance the Medical Staff's ability to enforce the obligations.

8.7.22 Cooperate with the Medical Staff in assisting the Hospital to meet its uncompensated or partially-compensated patient care obligations.

8.7.23 Comply with any rules relating to any training program for health care Practitioners and professionals that the Hospital may sponsor or participate in, including residency programs.

8.7.24 Participate in patient and family education activities as determined by the Department or Medical Staff Rules, or the Medical Executive Committee.

8.7.25 Notify the Medical Staff office in writing promptly, and no later than five calendar days, following any investigations into, or action taken regarding, the member's license, Drug Enforcement Administration registration, board certification, or privileges at other facilities; any changes in liability insurance coverage; any report filed with the National Practitioner Data Bank or licensing board; any arrest or charge for any alleged criminal act with the exception of a traffic violation that does not rise to the level of either a misdemeanor or felony; or any other action or change in circumstances that renders the information previously provided out-of-date or that could affect his/her qualifications for Medical Staff membership and/or clinical privileges at the Hospital.

8.7.26 Continuously meet the qualifications for and perform the responsibilities of membership as set forth in the Governing Documents. A member may be required to demonstrate continuing satisfaction of any of the requirements of

these Bylaws upon the reasonable request of the Medical Executive Committee. This shall include, but is not limited to, submitting to mandatory physical or mental health evaluation and mandatory drug and/or alcohol testing, the results of which shall be reportable to the Medical Executive Committee, the Well-Being Committee, and/or the Professional Conduct Committee.

This requirement is repeated elsewhere in these Bylaws; however, it is an important point that is worth making again.

8.7.27 Discharge such other obligations as may be lawfully established from time to time by the Medical Staff or Medical Executive Committee.

8.8 Conduct Expectations

Medical Staffs should adopt a comprehensive policy that specifies what constitutes appropriate and inappropriate behavior, and how the Medical Staff will address reports of inappropriate behavior. An overview of such a policy is described in the Rules.

8.8.1 The Medical Staff expects Practitioners and AHPs to work cooperatively to create a cohesive, harmonious, and professional environment that respects the entire care team and supports a high level of patient care. The desired care environment will require from each Medical Staff member and AHP teamwork, mutual respect, and a personal commitment to the Medical Staff's and Hospital's behavior expectations.

8.8.2 By applying for, or accepting, membership and/or privileges, each Practitioner and AHP acknowledges and agrees that appropriate conduct and behavior is critical to the delivery of quality patient care, to the Hospital's orderly functioning, and to the Hospital's and Medical Staff's ability to meet their obligations to patients, Practitioners, staff, and the community.

8.8.3 By applying for, or accepting, membership and/or privileges, each Practitioner and AHP acknowledges and agrees that he or she will comply with any Medical Staff rules or policies delineating behavior expectations; will communicate professionally with all individuals in the Hospital, and will not engage in any unacceptable and/or inappropriate conduct, as defined in any Governing Document, while at the Hospital; will not tolerate hostile or threatening behavior against any individual at the Hospital; and will not retaliate against any individual at the Hospital who reports the Practitioner or Allied Health Staff member to the Hospital or Medical Staff regarding the Practitioner or Allied Health Staff member's behavior or clinical practice.

8.8.4 If a Practitioner or Allied Health Staff member has concerns or complaints about any of the following, he or she will address them in a professional manner to the appropriate Medical Staff officer, Department Chair, Department manager, nursing/staff supervisor, administrator, or Governing Body representative:

- Patient care;
- Performance or behavior of a Medical Staff member, Allied Health Staff member, or employee;
- Hospital facilities, operations, policies, governance, administration, action or inaction; or
- Medical Staff operations, governance, Bylaws, Rules and Regulations, policies or procedures, processes, or action.

8.8.5 Each Practitioner and AHP acknowledges and agrees that behavior that falls below the Medical Staff's standards can adversely affect patient care and Hospital operations and may be grounds for corrective action.

8.8.6 Reports of a Practitioner's or Allied Health Staff member's failure to meet these standards or to comply with any other Medical Staff policy and procedure addressing behavior shall be addressed in the manner outlined in the relevant Medical Staff Rules and Code of Conduct.

ARTICLE 9

MEMBERSHIP STATUS

9.1 Categories of Membership

9.1.1 Each Medical Staff member shall be assigned to a Medical Staff category based on his or her qualifications. The member shall have the prerogatives and responsibilities detailed for the membership category in these Bylaws.

9.1.2 A member may be assigned to a different membership category by the Medical Executive Committee either during appointment or at reappointment if a change in qualifications occurs. A change in Medical Staff category is not in and of itself grounds for a hearing under these Bylaws.

9.1.3 The staff categories are: [fill in]

Not all of the categories described below will apply to every hospital. Hospitals can choose which apply and list them here.

9.2 Description of Prerogatives and Responsibilities

TJC MS.01.01.01, EP 15, requires that the Medical Staff Bylaws include a description of the roles and responsibilities of each category of practitioner on the Medical Staff. The sections that follow fulfill this requirement.

9.2.1 Members' prerogatives are based on the membership category they hold and are delineated in the description of each staff category. The available prerogatives and their meaning include the following:

(a) Admit patients, if granted privileges to do so.

Notwithstanding this provision, the Medical Staff privileging forms must specify whether an individual practitioner has been granted admitting privileges or not.

(b) Eligible for clinical privileges: Exercise those clinical privileges that have been approved.

(c) Vote on any Medical Staff matter, including Bylaws amendments, officer selection, and other matters presented at any general or special staff meetings and on matters presented at department meetings.

(d) Hold office in the Medical Staff and in the department to which he or she is assigned.

(e) Serve on committees.

(f) Vote on committee matters.

9.2.2 In addition to the requirement to continuously comply with the basic responsibilities applicable to all members set forth in the Membership Qualifications and Responsibilities Article, members are expected to carry out additional responsibilities based on the membership category they hold. Those responsibilities are delineated in the description of each staff category, and may include:

(a) Medical Staff functions: Contribute to, and participate equitably in, staff functions, as described in the Governing Documents or at the request of a Department Chair or other officer, including: contributing to quality improvement, risk management and utilization management activities; serving in Medical Staff and department offices and on Hospital and Medical Staff committees; participating in and assisting with the Hospital's medical education programs; proctoring other Practitioners; and fulfilling such other staff functions as may reasonably be required.

(b) Consulting with other Medical Staff members consistent with his or her delineated privileges.

(c) Emergency room call: Serving on the on-call roster and accepting responsibility for providing care to any patient requiring on-call coverage in his or her specialty, in accordance with rules approved by the Medical Executive Committee and the Governing Body.

(d) Attend meetings: Attend at least the minimum number of Medical Staff [and department] meetings specified in the Medical Staff Bylaws or department rules.

(e) Pay fees/dues: Pay application fees, dues, and assessments in the amounts specified in the rules.

9.2.3 In addition to the above, other prerogatives or responsibilities may be identified in each staff category. Prerogatives and responsibilities also may be subject to limitation, as described in the Governing Documents.

9.3 Active Staff

9.3.1 Qualifications

Each Medical Staff must decide what activity is necessary for Active Staff membership and whether courtesy members must have some minimum level of activity in order to maintain membership. The numbers in these Bylaws are examples only.

(a) The Active Staff consists of members of the Medical Staff who are involved in at least [____ patient contacts] at the Hospital during the two-year appointment term and who have been members in good standing on the Provisional Staff for at least [12 months], [or who

demonstrate, by way of other substantial involvement in Medical Staff or Hospital activities, a genuine concern and interest in the Hospital].

Some hospitals choose to allow practitioners who are not clinically active, but who provide service to the hospital in other ways, Active Staff status. We note, however, that other staff categories may be better suited for these practitioners and recommend that only committed, clinically active practitioners be granted Active Staff status. Only Medical Staffs that cannot easliy recruit members to participate in leadership positions should grant Active Staff status to practitioners who are not clinically active at the hospital but show commitment to the organization.

(b) Active Staff members must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article of these Bylaws.

9.3.2 Prerogatives. Active staff members may:

(a) Admit patients.

(b) Be eligible for clinical privileges.

(c) Vote.

(d) Hold office.

(e) Serve on committees.

(f) Vote on committee matters.

9.3.3 Responsibilities. Active Staff members hold the following responsibilities:

(a) Medical Staff functions.

(b) Consulting.

(c) Emergency room call.

(d) Attend meetings.

(e) Pay fees/dues.

9.4 Courtesy Staff

Medical Staffs have begun consolidating staff categories. Here, rather than separate "consulting staff" and "courtesy staff" categories, we have recommended a single, combined category. Medical Staffs can, of course, create additional categories to meet their needs, delineating the qualifications, prerogatives, and responsibilities as appropriate.

9.4.1 Qualifications

(a) The Courtesy Staff consists of members of the Medical Staff who are involved in at least one patient contact at the Hospital during the two-year appointment term and who have been members in good standing on the Provisional Staff for at least [12 months]. Courtesy Staff members with fewer than _____ patient contacts during the two-year appointment term must also be an active staff member at another accredited hospital.

The last sentence above is optional.

(b) Courtesy Staff members must meet each of the minimum qualifications and additional qualifications detailed in Membership Qualifications and Responsibilities Article.

9.4.2 Prerogatives. Courtesy staff members may:

(a) Admit patients.

(b) Be eligible for clinical privileges.

(c) Serve on committees.

This is optional.

(d) Vote on committee matters.

This is optional.

9.4.3 Responsibilities. Courtesy Staff members hold the following responsibilities:

(a) Medical Staff functions.

(b) Consulting.

(c) Emergency room call.

This is optional.

(d) Attend meetings.

This is optional.

(e) Pay fees/dues.

9.5 Community Affiliate

This staff category is for members who only refer patients to the Hospital and do not hold privileges.

9.5.1 Qualifications

(a) The Community Affiliate Staff consists of members of the Medical Staff who desire to be associated with the Hospital, but do not intend to practice at the Hospital.

(b) Community Affiliate Staff members must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article, except they do not need to:

(i) Hold a DEA number.

(ii) Be board certified.

Some hospitals may want these practitioners to be board certified.

(iii) Be eligible to receive Medicare and Medicaid payments, or qualify as an Ordering, Referring, and Prescribing provider for Medicare and Medicaid; however, they may not be excluded from Medicare or Medicaid.

(iv) Meet the location requirements.

(v) Pledge to continuous care.

9.5.2 Prerogatives. Community Affiliate Staff members may:

(a) Refer patients to the Hospital for admission and care, but may not admit or provide clinical services at the Hospital.

(b) Refer patients to the Hospital's diagnostic facilities and order diagnostic tests.

(c) Communicate with the clinical staff about the care of patients who they refer; visit those patients, and review the medical records and test results for those patients, but may not admit patients, attend patients, write orders for inpatients, input information into the medical record, perform consultations, assist in surgery, or otherwise participate in the management of clinical care to patients at the Hospital.

(d) Serve on committees.

This provision is optional. If the Medical Staff finds value in allowing Community Affiliate Staff members to serve on committees, or to both serve and vote on committees, then this provision should be kept. If the Medical Staff does not want to allow Community Affiliate Staff members to serve or vote on committees, this provision should be deleted.

(e) Vote on committee matters.

This provision is optional. If the Medical Staff finds value in allowing Community Affiliate Staff members to serve on committees, or to both serve and vote on committees, then this provision should be kept. If the Medical Staff does not want to allow Community Affiliate Staff members to serve or vote on committees, this provision should be deleted.

(f) Attend Medical Staff meetings and department meetings, without vote.

(g) Attend educational activities.

9.5.3 Responsibilities. Community Affiliate Staff members hold the following responsibilities:

(a) Pay fees/dues.

This is optional.

9.6 Telemedicine Staff

9.6.1 The Telemedicine Staff consist of members who solely provide telemedicine services to patients at the Hospital.

(a) Telemedicine Staff members must meet each of the minimum qualifications and additional qualifications detailed in Membership Qualifications and Responsibilities Article, except they do not need to:

(i) Hold a DEA number, unless they request prescribing privileges.

(ii) Be board certified.

Some hospitals may want these practitioners to be board certified.

(iii) Meet the location requirements.

(iv) Pledge to continuous care.

(b) Notwithstanding the above, Telemedicine Staff members may be exempted from some or all of the minimum qualifications and additional qualifications if they are credentialed through the Telemedicine Staff Membership And Clinical Privileges provisions found below.

Some hospitals and Medical Staffs permit a more "streamlined" version of credentialing of telemedicine providers.

9.6.2 Prerogatives. Telemedicine Staff members may:

(a) Be eligible for telemedicine clinical privileges.

(b) Serve on committees.

This is optional.

(c) Vote on committee matters.

This is optional.

(d) Attend Medical Staff meetings and department meetings, without vote.

(e) Attend educational activities.

9.6.3 Responsibilities. Telemedicine Staff members hold the following responsibilities:

(a) Medical Staff Functions.

(b) Pay fees/dues.

9.7 Provisional Staff

9.7.1 Qualifications.

(a) The Provisional Staff consists of members of the Medical Staff who have been appointed to the Medical Staff after applying as an initial applicant and who do not hold, at the time of appointment, other staff status on the Medical Staff.

(b) Provisional Staff members must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article.

9.7.2 Prerogatives. Provisional Staff members may:

(a) Admit patients.

(b) Be eligible for clinical privileges.

(c) Serve on committees.

This is optional.

(d) Vote on committee matters.

This is optional.

9.7.3 Responsibilities. Provisional Staff members hold the following responsibilities:

(a) Medical Staff functions.

(b) Consulting.

(c) Emergency room call.

(d) Attend meetings.

(e) Pay fees/dues.

9.8 Temporary Staff

The "Temporary Staff" status takes the place of the "Locum Tenens Affiliate" status in previous models.

9.8.1 Qualifications

(a) The Temporary Staff consists of Practitioners who have been granted privileges to fulfill an important patient care need under the "Temporary Privileges" section in the Privilege Delineation Article of these Bylaws, and who are not currently applying for membership.

(b) Temporary Staff must meet each of the minimum qualifications and additional qualifications detailed in the Membership Qualifications and Responsibilities Article, except they do not need to:

(i) Be board certified.

Some hospitals may want these practitioners to be board certified.

(ii) Meet the location requirements.

9.8.2 Prerogatives. Temporary Staff Practitioners may:

(a) Admit patients.

(b) Be eligible for clinical privileges.

9.8.3 Responsibilities. Temporary Staff Practitioners hold the following responsibilities:

(a) Medical Staff functions.

(b) Consulting.

(c) Emergency room call.

(d) Pay fees/dues.

9.9 Graduate Staff

In the prior model, this category was referred to as "House Officers." However, a more accurate term would be to recognize that these practitioners are not practicing through the training program, but rather are "moonlighting," meaning they must have membership and privileges to practice.

9.9.1 Qualifications

(a) The Graduate Staff consists of members who (i) have completed at least one residency program, but are currently a resident or fellow in a training program, and (ii) are practicing at this Hospital within their existing specialty.

(b) The Graduate Staff do not have to be board certified.

9.9.2 Prerogatives. Graduate Staff may:

(a) Admit patients.

(b) Be eligible for clinical privileges.

(c) Serve on committees.

This provision is optional. If the Medical Staff finds value in allowing Graduate Staff members to serve on committees, or to serve on committees, then this provision should be kept. If the Medical Staff does not want to allow Graduate Staff members to serve on committees, this provision should be deleted.

(d) Vote on committee matters.

This provision is optional. If the Medical Staff finds value in allowing Graduate Staff members to serve on committees, or to vote on committees, then this provision should be kept. If the Medical Staff does not want to allow Graduate Staff members to vote on committees, this provision should be deleted.

(e) Attend Medical Staff meetings and department meetings, without vote.

(f) Attend educational activities.

9.9.3 Responsibilities. Graduate Staff members hold the following responsibilities:

(a) Medical Staff functions.

(b) Consulting.

(c) Emergency room call.

(d) Pay fees/dues.

9.10 Committee Staff

This is an optional category and intended to offer a staff status if a Medical Staff needs practitioners to fulfill committee and other functions.

9.10.1 Qualifications

(a) Committee Staff shall consist of members who do not hold privileges, but who are appointed to the staff in order to participate in Medical Staff functions.

(b) Committee Staff are not required to meet any of the minimum or additional qualifications identified in these Bylaws, but must hold a current California license as a Practitioner.

9.10.2 Prerogatives. Committee Staff may:

(a) Serve on committees.

(b) Vote on committee matters.

(c) Attend Medical Staff meetings and department meetings, without vote.

(d) Attend educational activities.

9.11 Administrative Staff

9.11.1 Qualifications

(a) The Administrative Staff consists of California-licensed Practitioners who are not eligible for other staff category and who are retained by the Hospital or appointed by the Medical Staff to perform on-going medical administrative activities.

(b) Administrative Staff do not have to meet any of the minimum qualifications or additional qualifications for membership, other than to be currently licensed Practitioners.

(c) Because Administrative Staff appointment is conditioned on the Practitioner's position with the Hospital or Medical Staff, the termination of that position shall result in the automatic termination of staff status, without any hearing and appeal rights described in these Bylaws.

9.11.2 Prerogatives

(a) Serve on committees.

(b) Vote on committee matters, if the right to do so is specified by the Medical Executive Committee at time of appointment or within the committee description.

Alternatively, these members can simply be given the right to vote on any committee on which they serve.

(c) Attend Medical Staff meetings and department meetings, without vote.

(d) Attend educational activities.

9.12 Honorary Staff

Some hospitals adopt "Retired Staff" and "Honorary Staff" as different categories. Hospitals seem to be moving toward combining the status to have fewer staff statuses to manage.

9.12.1 Qualifications.

(a) The Honorary Staff consists of members who either (i) have a record of previous service to the Hospital, have retired from the active practice of medicine and, in the discretion of the Medical Executive Committee, are in good standing at the time of initial application for membership on the Honorary Staff; or (ii) are recognized for outstanding or noteworthy contributions to the medical sciences.

(b) Honorary Staff do not have to meet any of the minimum qualifications or additional qualifications for membership.

9.12.2 Prerogatives. Honorary Staff members may:

(a) Serve on committees.

(b) Attend Medical Staff meetings and department meetings, without vote.

(c) Attend educational activities.

ARTICLE 10

PROCEDURES FOR APPOINTMENT AND REAPPOINTMENT

10.1 General

10.1.1 Unless otherwise provided in this Article and in the Privilege Delineation Article, "applicant" shall refer to Practitioners applying for appointment, reappointment, and/or privileges.

10.1.2 The process for granting Allied Health Staff status and privileges or other permissions to practice to AHPs shall be detailed in the Rules and Regulations.

10.1.3 Practitioners may apply for appointment to the Medical Staff by completing an application. Practitioners are appointed to the Medical Staff and/or are granted privileges only after the processes delineated in this Article and the Privilege Delineation Article are completed. Except as otherwise described in these Bylaws, only the Governing Body has the authority to appoint members and to grant privileges. All decisions regarding appointment and the granting of privileges shall be made using the criteria and standards for membership and clinical privileges set forth in the Medical Staff's Governing Documents. Such decisions shall be objective and evidence-based and shall, where appropriate, reflect the general competencies required by the applicable accrediting body.

TJC allows the Chief Executive Officer to, under certain circumstances, grant temporary privileges. There have been isolated anecdotal reports that CMS has, in the past, cited hospitals who allow this, citing the Condition of Participation that suggests only the Governing Body determines whether to grant privileges (see 42 C.F.R. Section 482.12(a)(2)). CMS reportedly has backed away from that position as it applies to temporary privileges. As will be discussed further below, hospitals and Medical Staffs should consult legal counsel regarding who has authority to grant temporary privileges.

TJC Standard MS.06.01.05 requires that the decision to grant or deny a privilege be through a process that is objective and evidence based.

TJC also has incorporated "general competencies" into its credentialing and privileging standards (see the Introduction to MS.06.01.01). Although the Bylaws do not have to reflect these competencies, TJC-accredited hospitals should ensure that their processes comply.

10.1.4 Initial applicants who, at the time of application or at any time during which the application is being processed, have an accusation against their license in which the licensing body is requesting revocation, limitation, or suspension of the license shall not be eligible to apply for appointment, reappointment, or privileges until the licensing action has been resolved.

This is an aggressive approach to credentialing. Sometimes, a Medical Staff will have an initial applicant who is currently subject to a Medical Board accusation which has not yet been resolved. These applicants present challenges, as it is difficult to truly determine their qualifications while the accusation is outstanding. Here, we suggest a way that does not require the Medical Staff to parse these issues; instead, the initial applicant is simply ineligible. A Medical Staff could expand this limitation to apply to reappointment applications as well; however, in those instances, the Medical Staff usually has an opportunity to evaluate the practitioner based on his or her performance during the previous appointment.

Notably, these approaches have not been tested in California courts.

10.1.5 Any history of revocation, suspension, restriction, or other disciplinary or corrective action by any state licensing authority, professional organization, certification board, peer review body, or health care entity (including an IPA, HMO, PPO, health plan, or private payor) regarding a Practitioner's license, certificate, membership or clinical privileges, whether contested or voluntarily accepted, may constitute grounds for denial of the applicant's application for appointment or reappointment for membership and clinical privileges or practice prerogatives. The Medical Staff shall consider the nature and gravity of the charges or allegations and any resulting disciplinary or corrective action; however, the fact of the revocation, suspension, restriction or other disciplinary or corrective action shall independently be sufficient grounds for finding the denial to be reasonable and warranted. The provisions in this paragraph apply only to action taken for reasons related to that aspect of a Practitioner's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

Again, this is an aggressive approach. However, because it is not an automatic action (it may be grounds for denial but does not automatically result in ineligibility or denial), these provisions may withstand legal scrutiny. This approach has not been tested in California courts.

10.2 Obligations of Applicants

10.2.1 Agree to Comply with Governing Documents.

By applying to this Medical Staff for membership and/or privileges, whether initial appointment or reappointment, Practitioners agree that they have read the Medical Staff Bylaws and Rules and Regulations, and that they:

(a) Agree that they will abide by the Medical Staff Governing Documents in effect throughout their term of appointment, and

(b) Acknowledge that the granting of membership and/or privileges is expressly conditioned on their continued compliance with the Medical Staff Governing Documents in effect throughout their term of

appointment or privileges, and that failure to comply may result in corrective action.

10.2.2 Complete Application Required

(a) Each applicant has the obligation to provide a complete application to the Medical Staff for consideration. An application will not be considered complete unless the application form has been filled in completely, all questions on the application form have been answered, all supporting documentation has been supplied, all entries and attachments are legible, understandable, and substantively responsive on every point of inquiry, and necessary information has been verified from primary sources. Once this occurs, an application shall be considered preliminarily complete and may be processed further as described below.

Using the "preliminarily complete" designation leaves open the possibility that the Medical Staff will require additional information before the application will be considered complete.

(b) If, at any time during the processing, any individual or committee with responsibility for review of the application determines that additional information from or regarding the applicant is needed in order to evaluate the application, the application will be considered incomplete until that information is supplied. If the requested information or materials are in the exclusive possession of another person or entity, the applicant must take the necessary measures to obtain them or to arrange for them to be submitted to the Medical Staff directly by the source. If the applicant fails to provide the information requested within 30 days after being informed of the need for additional information, or within a later deadline if one is specified in writing to the applicant, then the application will be deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.

This approach places the burden squarely on the applicant to produce the information necessary for the Medical Staff to make an informed recommendation regarding his or her application. The failure to provide that information means that the Medical Staff cannot make an informed recommendation regarding appointment or denial, meaning the application is incomplete. If the application remains incomplete for a period of time, the Medical Staff can consider the application voluntarily withdrawn. Under limited circumstances, the withdrawal of an application may require a report to the licensing board or the National Practitioner Data Bank. However, because the withdrawal was voluntary and did not result from a final proposed action or recommendation, the Medical Staff may be able to assert that the practitioner is not entitled to hearing rights under state and federal law, or the Bylaws. However, we recommend that Medical Staffs consult with legal counsel prior to determining whether a hearing is required.

10.2.3 Burden of Producing Information

(a) At all times, applicants for appointment, reappointment, and privileges have the burden of demonstrating to the Medical Staff and the Governing Body that they qualify for membership, Allied Health Staff status, or the requested privileges. Applicants have the burden of producing accurate and adequate information for a thorough evaluation of the applicant's qualifications and suitability for the requested status or privileges, resolving any reasonable doubts about these matters and satisfying requests for information. Failing to sustain this burden, providing false or misleading information, and making significant omissions of information shall each individually be grounds for denial of the application or the request.

(b) Applicants, at all times during the processing of their applications, have the burden of updating and correcting any information they have provided as part of the application process. An applicant must inform the Medical Staff in writing within 14 days of any change in the information previously provided, regardless of its source. Failure to inform the Medical Staff in writing of changes to the information previously provided may result in the denial of the application or request.

(c) If the Medical Executive Committee determines it appropriate, the burden to produce information for any individual applicant may include submission to a physical or mental health examination and/or mandatory drug and alcohol testing at the Practitioner's expense, and the submission of the results of the examination to the Medical Executive Committee or designee. The application shall be incomplete until the examination results are submitted to the Medical Executive Committee. If the results are not submitted within the time frame set by the Medical Executive Committee, which shall be no less than 30 days from the date of the request, then the application shall be deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.

See earlier comment.

10.3 Processing of Membership/Privileges Applications

TJC Standard MS.01.01.01, EPs 14, 15, 26, and 27, require that the Medical Staff Bylaws include the basic steps of the credentialing, recredentialing, privileging, re-privileging, appointment, and reappointment processes. The details beyond the "basic steps" can be placed in other documents. However, experience has shown that separating the provisions of the credentialing process into two different documents can result in redundancy, conflict, and confusion – as well as requiring end users to consult two different documents when faced with a question regarding the process. Moreover, these provisions tend to rarely be amended, so they do not benefit from the different amendment processes that apply to policies or Rules. Therefore, this version of the Model Bylaws houses a more comprehensive approach to credentialing and recredentialing.

10.3.1 General

All applications for appointment and reappointment shall be processed in the manner described in the Medical Staff's Governing Documents, including the Governing Body Action Section of these Bylaws.

10.3.2 Applications

(a) Applicants may request an application for membership and/or privileges through the Medical Staff Services Administration. The application form shall be approved by the Medical Executive Committee and the Governing Body. The content of applications shall be described in the Medical Staff Rules and Regulations. Completed applications shall be submitted as directed and must be accompanied by the application fee.

Medical Staffs should include with each application a cover letter explaining how to submit the application. Medical Staffs may have electronic portals instead.

(b) By submitting an application, the applicant has agreed to be bound by the Governing Documents and all the responsibilities and agreements described within throughout both the application period and, if granted, throughout his or her term of Medical Staff membership, privileges, or Allied Health Staff status. In addition, the applicant:

(i) Signifies his or her willingness to appear for interviews regarding his or her application for appointment.

(ii) Authorizes Medical Staff and Hospital representatives to consult with persons or entities who have been associated with the applicant or who otherwise may have information bearing on the applicant's competence and qualifications or that is otherwise relevant to the pending review, and authorizes such persons to provide all information that is requested orally and in writing.

(iii) Consents to the inspection and copying by Medical Staff and Hospital representatives of all records and documents that may be relevant or lead to the discovery of information relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

(iv) Certifies that he or she will report any subsequent changes in the information submitted on the application form to the Medical Staff Services Administration and the Chief Executive Officer.

(v) Releases from any and all liability the Medical Staff and the Hospital and its representatives for their acts performed in connection with evaluating the applicant.

(vi) Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to Medical Staff or Hospital representatives.

(vii) Authorizes and consents to Medical Staff and Hospital representatives providing other System Members and other health care entities, professional societies, licensing boards and other organizations concerned with provider performance and the quality of patient care with relevant information the Medical Staff or Hospital may have concerning him or her, and releases the Medical Staff and Hospital and their representatives from liability for so doing, including, but not limited to, claims arising from laws forbidding restraint of trade.

(viii) Consents to undergo, and to release the results of, a physical or mental health examination by a health care professional acceptable to the Medical Executive Committee, as well as to undergo, and release the results of, drug and alcohol testing, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

(ix) Signifies his or her willingness to abide by all the conditions of membership, as stated in the Bylaws and other Governing Documents.

For purposes of this Article the term "Hospital representative" includes the Governing Body, its individual Directors or Trustees and committee members; the Chief Executive Officer, Hospital employees, the Medical Staff, all Medical Staff Leaders and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

10.3.3 Verification of Information

(a) After the applicant has submitted the application, the Medical Staff shall determine whether the application has been filled out in its entirety and whether all requested documentation, including fees, have been provided. If any information has not been provided, the application will be considered incomplete. The Medical Staff will inform the applicant of what information is missing and that the applicant has 30 days to provide the missing information. If the applicant fails to provide the information within the deadline, then the application shall be deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.

See earlier comment.

(b) Once an application that has been filled out in its entirety and all requested documentation and fees have been provided, the Medical Staff or its designee shall verify the information, including, but not limited to, licensure status, training and education, current proficiency with respect to the Hospital's general competencies (as applicable to the privileges requested), health status, other evidence submitted in support of the application, professional liability action history, confirmation that the Practitioner is the same individual identified in the credentialing documents (by viewing a current, valid picture Hospital ID card or a valid state or federal agency picture ID card), and at least two written verifications of peer references. The Hospital's authorized representative also shall query the National Practitioner Data Bank, and the Medical Staff shall query the licensing board and the Office of Inspector General Exclusion list. The Medical Staff shall have policies and procedures describing the process for verifying information, as well as which information requires primary source verification and from what sources verification may be obtained.

TJC Standard MS.06.01.03, EP 6, and DNV-GL Standard MS8, SR.1, requires primary source verification, where feasible, of certain information. These details do not need to be in the Bylaws or Rules; we recommend allowing flexibility to put in policies.

(c) If the Medical Staff cannot verify the information, or finds inconsistencies when attempting to verify the information, it shall so inform the applicant. The applicant shall have 30 days to correct the information or explain the inconsistencies to the satisfaction of the Medical Staff. Failure to correct or provide a satisfactory explanation shall result in the application being deemed incomplete and voluntarily withdrawn. Withdrawn applications will not be processed further and do not entitle the applicant to the hearing rights in these Bylaws.

See earlier comment.

(d) After the information provided has been verified, the application may be deemed preliminarily complete and submitted to the department for further processing.

10.3.4 Department Review

This applies to hospitals with departments.

Upon receipt, the Department Chair or Department Committee shall review the application and supporting documentation, may personally interview the applicant, and may request that the applicant provide additional information. Based upon the criteria for appointment or reappointment (as applicable) described in the Governing Documents, the Chair shall transmit to the Credentials Committee on the prescribed form a written report with recommendations as to staff appointment and clinical privileges. The Department Chair or Department Committee may instead request that the Medical Staff defer action on the application but must provide reasons for this request.

10.3.5 Credentials Committee Action

For hospitals with credentials committees.

The Credentials Committee shall review the application, the supporting documentation, the department's report and recommendations, and other such information available to it that may be relevant to its consideration. The Credentials Committee or a subcommittee may personally interview the applicant and may request that the applicant provide additional information. The Credentials Committee shall then transmit to the Medical Executive Committee on the prescribed form a written report with recommendations as to staff appointment, department/section affiliations, and clinical privileges. The Credentials Committee may instead request that the Medical Staff defer action on the application but must provide reasons for this request.

10.3.6 Medical Executive Committee Action

(a) After receipt of the Department and Credentials Committee report and recommendations, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee

may defer its recommendation in order to obtain or clarify information or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation.

(b) After confirming it has sufficient information to make a recommendation, the Medical Executive Committee shall formulate a preliminary recommendation as to whether the applicant meets the relevant criteria specified in the Governing Documents regarding appointment, reappointment, and privileges. If the preliminary recommendation is favorable, the Medical Executive Committee shall then assess the applicant's health status and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff or Allied Health Staff.

(c) Thereafter, the Medical Executive Committee will formulate a written report with final recommendations to the Governing Body, as follows:

(i) Favorable Recommendation: Favorable recommendations shall be promptly forwarded to the Governing Body together with the application form, its accompanying information, and the reports and recommendations of the Department and Credentials Committee as to staff appointment, department and section affiliations, clinical privileges to be granted, and any special conditions to be attached to the appointment.

(ii) Adverse Recommendation: When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the Practitioner by Special Notice, and he or she shall be entitled to such procedural rights as may be provided in these Bylaws. The Governing Body shall be generally informed of, but shall not receive, detailed information, and shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his or her procedural rights.

10.3.7 Governing Body Action

(a) On Favorable Medical Executive Committee Recommendation: Giving great weight to the Medical Executive Committee's recommendation, and in no event acting in an arbitrary or capricious manner, the Governing Body shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond. If the Governing Body's action is itself grounds for a hearing under the Hearings and Appeals Article of these Bylaws, the Chief Executive Officer shall promptly inform the

applicant by Special Notice, and he or she shall be entitled to the procedural rights as provided in these Bylaws.

This standard is consistent with Business and Professions Code Section 809.05(a): "The governing bodies of acute care hospitals have a legitimate function in the peer review process. In all peer review matters, the governing body shall give great weight to the actions of peer review bodies and, in no event, shall act in an arbitrary or capricious manner."

(b) Without Benefit of Medical Executive Committee Recommendation: If the Governing Body does not receive a Medical Executive Committee recommendation within 270 days of the application being deemed complete, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Governing Body. If the recommendation is grounds for a hearing under the Hearings and Appeals Article of the Bylaws, the Chief Executive Officer shall give the applicant Special Notice of the adverse decision and of the applicant's right to request a hearing. The applicant shall be entitled to the procedural rights found in the Hearings and Appeals Article before any final adverse action is taken.

This provision should be invoked only rarely, when the Medical Executive Committee has failed to act after being requested to do so.

This (270 days) is an optional time frame; however, nine months should be enough time for an application to make it to the Governing Body.

(c) After Procedural Rights: If the Medical Executive Committee's recommendation is adverse and entitles the applicant to a hearing under these Bylaws, the Governing Body shall take final action in the matter only after the applicant has exhausted or has waived his or her procedural rights. Action taken after the applicant has exhausted or has waived his or her procedural rights shall be consistent with the Appeal Procedure provisions in the Hearings and Appeals Article and shall be the Governing Body's final action.

(d) Expedited Review: The Governing Body may use an expedited process for appointment, reappointment, or when granting privileges when criteria for that process are met. The expedited process involves the Governing Body delegating its appointment authority to a committee of at least two voting members of the Governing Body; however, any final decision of the committee must be subject to ratification by the full Governing Body at its next regularly scheduled meeting. Expedited processing is not available if the Practitioner or member submits an incomplete application or if the Medical Executive Committee's final recommendation is adverse in any respect or has any limitations. The following situations are evaluated on a case-by-case basis and usually result in ineligibility for the expedited

process; a determination that expedited process shall not be used is not grounds for a hearing under these Bylaws:

Similar to the comment above regarding the potential limitation on the manner in which temporary privileges are granted, Medical Staffs should consult legal counsel to determine whether the expedited Governing Body approval process is consistent with CMS requirements.

(i) There is a current challenge or a previously successful challenge to the Practitioner's licensure or registration;

(ii) The Practitioner has received an involuntary termination of Medical Staff membership at another organization;

(iii) The Practitioner has received involuntary limitation, reduction, denial, or loss of medical privileges;

(iv) There has been a final judgment adverse to the Practitioner in a professional liability action.

TJC Standard MS.06.01.11, EP6, provides that the hospital has discretion to allow expedited review even if there has been an adverse judgment. TJC requires that the hospital must determine if there has been either an unusual pattern, or an excessive number, of professional liability actions resulting in a final judgment against the applicant. Whether to liberalize this standard for purposes of expedited processing is a judgment call. This model opts to leave it at the more rigorous level because of the difficulty in assessing patterns and numbers, and because a single egregious malpractice action would seem to warrant no expedited review, even if there is no pattern or excessive number involved.

10.3.8 Notice of Final Decision

A decision and notice to appoint shall be sent, at a minimum, to the applicant, the Chief of Staff, the department chair, and the administrator. The notice shall include the staff category to which the applicant is appointed; the department and section, if any, to which the Practitioner is assigned; the list of clinical privileges the Practitioner may exercise; and any special conditions attached to the appointment.

10.3.9 Guidelines for Time of Processing

All individuals and groups shall act on applications in good faith and in a timely manner. Except when additional information must be secured, or for other good cause, the Medical Staff shall attempt to process each application within the following time guidelines:

TJC Standard MS.06.01.07 requires hospitals to complete credentialing in a timely manner, and MS.06.01.05, EP 11, requires hospitals to act on completed applications

within the Bylaws-specified time period. DNV-GL Standard MS.11, SR.4 requires that a completed application be "acted on within a reasonable period of time, as specified in the medical staff Bylaws." However, there may be occasions when the credentialing process may take longer than the guidelines provided here (for example, if peer references do not return documentation timely or when questions regarding the practitioner's qualifications arise).

(a) Medical Staff Services Administration review and verification of application: 45 days after the application is deemed preliminarily complete.

(b) Department review and recommendation: 45 days after receiving application from Medical Staff Services Administration.

(c) Credentials Committee review and recommendation: 45 days after receiving the report and recommendation from the Department.

When setting deadlines, consider how frequently the committee meets.

(d) Medical Executive Committee review and recommendation: 45 days after receiving the report and recommendation from the Credentials Committee.

(e) Governing Body action: 45 days after receiving the Medical Executive Committee recommendation, unless the hearing and appeal rights of the Hearings and Appeals Article apply.

(f) Notice to the Practitioner: 45 days after the Governing Body's final decision.

TJC MS.06.01.09 requires the hospital to notify practitioner of the credentialing decision within the time frame specified in the Bylaws.

These time periods are guidelines and are not directives which create any rights for a Practitioner to have an application processed within these precise periods. If action at a particular step in the process is delayed without good cause, the next higher authority may immediately proceed to consider the application upon its own initiative or at the direction of the Chief of Staff or the Chief Executive Officer (however, the provisions in the Section, Governing Body Action, "Without Benefit of Medical Executive Committee Recommendation" apply).

10.4 Intervention

Notwithstanding the above, if at any time during the process the reviewing body has concerns regarding the application, it may refer the matter to, or ask for assistance from, the Chief of Staff or the Medical Executive Committee.

10.5 [Optional] Processing of Telemedicine Membership and Privileges

10.5.1 Notwithstanding the other credentialing and privileging provisions in these Bylaws and other Governing Documents, the Medical Staff and Governing Body may use any one of the following processes to evaluate and grant membership and/or privileges to an applicant who practices only Telemedicine at the Hospital.

(a) The Practitioner's or AHP's application may be processed in the manner described above in the Processing of Membership/Privileges Applications Section above.

(b) The Medical Staff may make its recommendation relying upon information provided by a distant-site hospital(s) at which the applicant is a member of the Medical Staff and has clinical privileges, or a distant-site entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or entity, in order to make a credentialing decision based upon this Hospital's standards. This process may be used only if: (a) the written agreement complies with the requirements detailed in 42 C.F.R. Sections 482.22(a)(3) or (a)(4) and Sections 482.12(a)(8) or (a)(9), and applicable accreditation standards; (b) the Practitioner is privileged at the distant site for those services to be provided to the Hospital; (c) the distant site provides the Hospital with a current list of the applicant's privileges; and (d) the Hospital performs an internal review of the Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse events that result from the telemedicine services provided by the distant-site physician or Practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or Practitioner; or

This model rarely cites specific regulations within the Bylaws (other than licensing and reporting requirements). Here, because CMS's contract requirements for telemedicine provider credentialing are very specific, and because that information does not necessarily need to be detailed in the Bylaws, we recommend simply referring to the legal standard as the guidance required.

TJC Standard MS.13.01.01, EP 1, requires that the distant site hospital or entity be a TJC-accredited organization.

In addition, TJC requires that the shared information include "adverse outcomes related to sentinel events considered reviewable by The Joint Commission." Therefore, TJC-accredited hospitals must add that requirement into this provision.

(c) The Medical Staff may make its recommendation relying on the credentialing and clinical privileging decisions made by a distant-site hospital(s) at which the Practitioner is a member of the Medical Staff and has clinical privileges or the decisions by a distant-site entity providing telemedicine services with which the applicant is affiliated, in accordance with a written agreement with such hospital or entity. This process may be used only if: (a) the written agreement complies with the requirements detailed in 42 C.F.R. Sections 482.22(a)(3) or (a)(4) and Sections 482.12(a)(8) or (a)(9), and applicable accreditation standards; (b) the Practitioner is privileged at the distant site for those services to be provided to the Hospital; (c) the distant site provides the Hospital with a current list of the applicant's privileges; and (d) the Hospital performs an internal review of the Practitioner's performance of these privileges and sends to the distant site information that is useful to assess the Practitioner's quality of care, treatment, and services for use in privileging and performance improvement. At a minimum, this information includes all adverse events that result from the telemedicine services provided by the distant-site physician or Practitioner to the Hospital's patients and all complaints the Hospital has received about the distant-site physician or Practitioner.

TJC Standard MS.13.01.01, EP 1, requires that the distant site hospital or entity must be a Joint Commission-accredited organization.

In addition, The Joint Commission requires that the shared information include "adverse outcomes related to sentinel events considered reviewable by The Joint Commission."

This provision reflects the CMS requirements for "streamlined" or "delegated" credentialing. However, there is a split of opinion regarding whether this approach is permitted under California law.

California Business and Professions Code Section 2290.5 was amended in 2011 specifically to address, among other things, the credentialing of telehealth providers. The timing of the amendments and certain wording referring specifically to the CMS regulations suggest that the intent was to allow hospitals to credential telehealth providers in the manner approved by CMS. But the statute itself states that hospitals may make credentialing decisions "based on medical staff recommendations that rely on information provided by the distant-site hospital or telehealth entity." (Emphasis added.) Therefore, some conclude that the law does not permit Medical Staffs to rely on the distant site/entity's decision. Hospitals should consult legal counsel to determine whether or not to adopt this proposed approach.

10.5.2 If the applicant applies for privileges that exceed those Telemedicine privileges that he or she has at the distant-site hospital or the distant-site entity, the application for those privileges must proceed through the same privileging and credentialing process applicable to non-Telemedicine Staff applicants.

10.5.3 Regardless of which manner of credentialing the Hospital uses for Telehealth Practitioners, it shall independently query the National Practitioner Data Bank, the Practitioner's licensing board, and the Office of Inspector General for all applicants for Telemedicine Privileges.

These remain independent duties for hospitals, regardless of how they credential telemedicine providers.

10.6 Application for Reappointment

All the above provisions in this article, including, but not limited to, the obligations of applicants, the effect of applications, and the manner in which applications are processed, shall apply to applicants for reappointment or renewal of privileges. In addition, the following provisions apply:

10.6.1 Applications

The Medical Staff shall develop an application for reappointment and renewal of privileges, as described in the Rules and Regulations. The Medical Staff shall send applications for reappointment and renewal of privileges to members at least _____ days prior to the expiration of the current appointment or privileges. A complete application must be returned to the Medical Staff at least _____ days prior to expiration.

The time frames for distributing and returning reappointment forms should allow time to complete the required licensing board and National Practitioner Data Bank inquiries, as well as for processing by departments and committees. Medical Staffs should work with the Medical Staff Services Administration to determine the appropriate time frames.

10.6.2 Delinquent Reappointment Applications

Failure to return a complete form by the deadline or to otherwise comply with the provisions in this Article regarding the provision of information may result in the Medical Staff's inability to process the reappointment application prior to the end of the applicant's current appointment term. This shall result in the member's automatic resignation of membership and privileges at the end of his or her current appointment term. In such cases, the applicant will not be entitled to a hearing under these Bylaws. If the resigned member submits a written request for appointment and a complete application within 60 days of the resignation, then the Medical Staff will consider his or her application in the same manner as a reappointment application, and will not require the applicant to serve on the Provisional Staff. In such circumstances, the member also may be considered for temporary privileges, pursuant to the Privilege Delineation Article.

TJC does not permit the extensions of appointments beyond two years. Although an applicant may be "resigned," he or she could reapply directly thereafter.

This is an optional provision that allows the Medical Staff to credential "resigned"

members as reappointments, rather than having to use the initial application processes. It also provides the option of granting temporary privileges.

10.6.3 Peer and Quality Data

In addition to the other criteria for reappointment found in the Governing Documents, the Medical Staff shall consider an applicant's ongoing professional performance review data and other quality data, as well as information regarding the Practitioner's conduct and adherence to Governing Document requirements, as appropriate, when determining whether or not to grant reappointment and privileges. If a Practitioner has performed any privilege too infrequently to allow the Medical Staff to assess current clinical competence, the Medical Staff may impose proctoring or other focused professional practice evaluation requirements; these requirements shall not entitle the Practitioner to a hearing under these Bylaws. Additionally, the Medical Staff shall consider the Practitioner's conduct and compliance with the Governing Documents when making reappointment determinations.

TJC MS.08.01.01 requires Medical Staffs to factor in OPPE information in making decisions regarding the maintaining of an existing privilege.

10.6.4 Participation in Continuing Education

The Medical Staff shall consider an applicant's participation in continuing education when determining whether or not to grant reappointment and privileges.

TJC Standard MS.12.01.01, EP 5, and DNV-GL Standard MS.10.

10.6.5 Verification

The Medical Staff may develop verification processes specific to the consideration of reappointment applications that may differ from the verification process for initial applications. Regardless, the Hospital's authorized representative shall query the National Practitioner Data Bank and the Medical Staff shall query the licensing board and the Office of Inspector General for every reappointment applicant. The Medical Staff also shall confirm current DEA registration.

Credentialing practice does not require primary source reverification of certain historical information that does not change (for example, medical school, residency).

10.7 Duration of Appointments

10.7.1 All new staff members who are granted privileges, other than Telemedicine Staff, shall be appointed to the Provisional Staff. Members shall hold Provisional Staff status for at least 12 months, and no more than 24 months. To move from Provisional Staff status to another staff status with privileges, the Practitioner

must meet the standards detailed in the Governing Documents, including the privileging forms.

Because of Telemedicine Staff's limited prerogatives and responsibilities, they can be exempted from provisional status.

10.7.2 Appointments, reappointments, and the grant of clinical privileges shall be up to a maximum of two years and shall not be extended beyond two years. No Practitioner has the right to a two-year appointment, and appointments may be for periods less than two years.

This provision leaves open the option that, sometimes, a practitioner will be granted a time-limited appointment until the practitioner demonstrates improvement in one or more areas. Hospitals should discuss with their attorneys whether this results in hearing rights.

10.8 Waiting Periods

10.8.1 For Applications Withdrawn as Incomplete

If a Practitioner has had two applications withdrawn for being incomplete within a 12-month period, the Practitioner will be subject to a 12-month waiting period before he or she can submit another application. The Governing Body may waive this waiting period using the same waiver provisions detailed in Membership Qualifications and Responsibilities Article above.

The 12-month period is to prevent the further wasting of Medical Staff resources.

10.8.2 Reapplication After Adverse Membership Decision

(a) A 36-month waiting period before applying for membership or privileges shall apply to the following Practitioners:

(i) An applicant who:

(1) Has received a final adverse decision regarding appointment or the granting of privileges, or

(2) Withdrew his or her application or request for membership or privileges following an adverse recommendation by the Medical Executive Committee or the Governing Body.

(ii) A former member who has:

(1) Received a final adverse decision resulting in termination of Medical Staff membership and/or privileges or other permissions to practice; or

(2) Resigned from the Medical Staff or relinquished privileges or other permissions to practice while an investigation was pending or following the Medical Executive Committee or Governing Body issuing an adverse recommendation or decision.

(iii) Subject to (e) below, a member who has received a final adverse decision resulting in:

(1) Termination or restriction of privileges; or

This varies slightly from the paragraphs above, as it addresses current members who have had some, but not all, of their privileges terminated.

(2) Denial of his or her request for additional privileges.

(b) An action is considered adverse only if it is based on the type of occurrences which might give rise to corrective action. For the purposes of this section, automatic suspensions or terminations under the Automatic Suspension, Terminations, and Limitations provisions of the Corrective Action Article of these Bylaws are not "adverse."

(c) The action is considered final on the latest date on which the application or request was withdrawn; a member's resignation became effective; a member waived his or her right to a hearing to challenge an adverse recommendation or action; or upon exhaustion of all Medical Staff and Hospital hearings and appellate reviews.

(d) Practitioners subject to waiting periods cannot reapply for Medical Staff membership or the privileges affected by the adverse action for at least 36 months after the action became final. After the waiting period, the Practitioner may reapply. The application will be processed like an initial application or request, plus the Practitioner must document that the basis for the adverse action no longer exists, that he or she has corrected any problems that prompted the adverse action, and/or he or she has complied with any specific training or other conditions that were imposed.

(e) Notwithstanding the above, for Practitioners whose adverse action involved the termination, restriction, or denial of some, but not all, held or requested privileges, the waiting period shall apply only to those privileges that were terminated, restricted, or denied.

(f) Notwithstanding the above, for Practitioners whose adverse action included a specified period or conditions of retraining, additional experience, or medical or psychological treatment, the Medical Executive Committee, subject to the Governing Body's approval, may exercise its

discretion to allow earlier reapplication upon completion of the specified conditions and any additional conditions that the Medical Executive Committee determines to be necessary.

10.8.3 Waiver of Waiting Period

The Governing Body may waive the waiting periods under the same circumstances and procedure as described for the waiver of qualifications, described the Membership Qualifications and Responsibilities Article. As in that section, such waivers are disfavored, intended to be granted rarely, and are granted only when necessary to address an identifiable patient care need and only if the waiver is found to be in the best interests of the Hospital and its patients' health and wellbeing. The needs of the individual Practitioner are irrelevant to such determination.

10.9 System Credentialing

10.9.1 System Members may coordinate their credentialing processes and share information regarding applicants.

10.9.2 The System may develop a single application form and may use a centralized verification unit to verify information for System Members.

10.9.3 Upon verification, the application will be processed as detailed in this Article. System Members and their committees may hold joint meetings, or may form joint department or credentials committees, to review applications. Any joint department or credentials committees shall perform the functions of the department and the credentials committees, respectively, as described above, and shall be subject to the same confidentiality and immunity provisions provided in these Bylaws and as provided under state and federal law.

10.9.4 Each System Member's Medical Executive Committee, or its equivalent, shall be responsible for making a recommendation regarding appointment and privileges to the entity's own Governing Body, and each Governing Body shall have sole responsibility for making appointment decisions for its own hospital.

ARTICLE 11

PRIVILEGE DELINEATION

11.1 Exercise of Privileges

Practitioners and APPs may only exercise those privileges that have been granted through the processes delineated in the Governing Documents.

Advanced Practice Professionals (defined in Article 1) are AHPs who practice independently and/or at a medical level of care. As discussed in the comment to that definition, the granting of their authorizations to practice should be through a Medical Staff process. In the past, these authorizations often were referred to as "practice prerogatives" or "service authorizations." However, CMS and TJC both consider any authority to practice at a medical level of care to be a "privilege." Therefore, we refer to APPs applying, and being considered, for privileges in this Article. Medical Staffs can choose to use another term.

11.2 Development of Privileging Criteria

11.2.1 Generally

The Medical Staff, through its departments and committees, and subject to the Governing Body's approval, shall develop criteria for granting initial privileges and reappointment privileges. Those criteria shall be evidence-based and address the general competencies developed by the Medical Staff. Criteria shall be Hospital-specific and may be setting-specific. Criteria may not discriminate between licensees or specialties of Medical Staff members. APPs should, to the extent feasible, participate in the development of criteria for privileges granted to APPs.

Medical Staffs should develop criteria for both appointment and reappointment, which may differ.

Medical Staffs should remember to develop criteria that apply to AHPs who practice at a medical level of care.

11.2.2 New Procedures

Medical Staffs should adopt a policy to address how criteria for new privileges will be developed.

The Hospital may only grant privileges for those procedures that are performed at the Hospital. Requests for clinical privileges to perform either a procedure not currently being performed at the Hospital or a new technique to perform an existing procedure ("new procedure") will not be processed until a determination has been made that the new procedure will be offered by the Hospital and criteria for the clinical privileges have been adopted. The Hospital may develop a process to determine whether sufficient space, equipment, staffing, and financial

resources are in place or available within a specified time frame to support each requested new procedure. Once the Hospital determines that a new procedure will be performed at the Hospital, the Medical Staff may, subject to the Governing Body's approval, develop privileging criteria for new procedures.

Consistent with TJC MS.06.01.01, EP1.

11.2.3 Multi-Specialty Privileges

When a procedure is performed by specialists in different departments, the departments shall collaborate to develop equivalent privileging criteria, while recognizing that practice differences may exist. The Medical Executive Committee has the authority to resolve any significant conflicts or differences in the criteria developed.

11.3 Privilege Delineation

11.3.1 Generally

(a) Each application for appointment and reappointment to the Active, Courtesy, Provisional, or Telemedicine Staff must contain a request for specific privileges. Members and APPs may request additional privileges during their appointment by submitting an application for those privileges.

(b) All requests by Practitioners for privileges shall be processed through the appointment and reappointment procedures described in the Procedures for Appointment and Reappointment Article; requests by APPs shall be subject to the procedures delineated in the Rules.

(c) Privileges shall be granted only to those Practitioners and APPs who satisfy the established criteria, as evidenced by the applicant's current licensure, education, training, experience, demonstrated professional competence, judgment and clinical performance, health status, data from professional practice review by an organization(s) that currently privileges the applicant (if available), the documented results of patient care and other quality improvement review and monitoring, performance of a sufficient number of procedures each year to maintain current clinical competence, and compliance with any other applicable specific criteria detailed in the Governing Documents.

To comply with TJC MS.06.01.05, EP6, and Condition of Participation, 42 C.F.R. Section 482.12(a)(6).

(d) No privileges shall be granted merely because a Practitioner or APP holds a contract with the Hospital or is part of a group that holds a contract with the Hospital.

(e) The Medical Staff may develop processes to authorize Practitioners who are not Medical Staff members or who do not hold other privileges to order outpatient services that are within their scope of practice to order.

DNV-GL Standard MS.12, SR.4a, requires the Bylaws to include a provision to allow practitioners to order outpatient services.

11.3.2 History and Physical

(a) All patients shall receive the same basic medical appraisal. A Practitioner with appropriate privileges shall determine the risk and effect of any proposed treatment or surgical procedure on the general health status of the patient.

(b) Histories and physicals may be performed only by those Practitioners or APPs with privileges to perform them. Any Practitioner who admits patients but does not hold history and physical privileges must assure that a Practitioner or APP with history and physical privileges performs a history and physical in a manner that complies with the Bylaws and any other applicable Governing Document. A Practitioner without history and physical privileges may not supervise an APP's performance of history and physicals.

(c) The admitting Practitioner must assure that every patient receives a history and physical within 24 hours after admission, or, if a history and physical was performed within 30 days prior to admission (or registration if an outpatient procedure) and is in the medical record, that the prior history and physical is updated within 24 hours after admission. Every patient admitted for surgery or other procedure requiring anesthesia services must have a history and physical, or the update to the history and physical, prior to the surgery or procedure requiring anesthesia. No patient shall undergo surgery or a procedure requiring anesthesia services without a history and physical or update consistent with this section in his or her medical record.

(d) History and physicals performed prior to hospitalization may be submitted by practitioners without history and physical privileges, but the update must be performed by someone with history and physical privileges.

The Interpretive Guidelines *to the Medicare Conditions of Participation allow hospitals to accept history and physicals prior to a patient's admission by a physician who does not have history and physical privileges. However, TJC MS.03.01.01, EP 8, provides that history and physicals must be performed by a practitioner who has been granted privileges. Hospitals should determine which approach is most consistent with its obligations.*

11.4 Application to Podiatrists, Dentists, and Oral and Maxillofacial Surgeons

11.4.1 For patients admitted by, or upon order of, a dentist, oral surgeon, clinical psychologist, or podiatrist who is not also a physician, a physician member must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission, or which may arise during hospitalization, which are outside of the admitting Practitioner's lawful scope of practice or clinical privileges.

These practitioners are sometimes referred to as "limited license" practitioners. This term, though, can have multiple meanings (such as the practitioner's license has been limited), none of which are official. Because these non-physicians are independent practitioners with their own scopes of practice, we suggest moving away from the term, "limited license," and just identifying them as "non-physician practitioners."

11.4.2 Where a dispute exists regarding proposed treatment between a physician member and non-physician member based upon medical or surgical factors outside of the scope of licensure of the non-physician member, the treatment will be suspended insofar as possible while the dispute is resolved by the appropriate departments or Chief of Staff.

11.4.3 The findings, conclusions, and assessment of risk must be confirmed or endorsed by a physician member with appropriate privileges prior to major high-risk (as defined by the Medical Staff) diagnostic or therapeutic interventions.

Medical Staffs should identify what procedures are considered major- or high-risk.

11.5 Effect of Contracted Services

11.5.1 The Hospital may enter into contracts or arrangements with Practitioners and/or groups of Practitioners for the performance of clinical and administrative services at the Hospital. All individuals that wish to provide clinical services pursuant to such contracts must apply for, be granted, and maintain membership and privileges in accordance with these Bylaws.

11.5.2 If a contract or arrangement confers the exclusive right to perform specified services to one or more Practitioners or groups of Practitioners (an "exclusive contract"), no other Practitioners except those authorized by the exclusive contract may exercise clinical privileges to perform the specified services while the contract is in effect. As such, only Practitioners authorized under the contract are eligible to apply for the clinical privileges covered by the contract. No other applications will be processed.

11.5.3 Prior to the Hospital entering into any exclusive contract in a specialty area that has not previously been subject to such a contract or arrangement, the Governing Body will initiate a notice-and-comment process consistent with California legal requirements. The Medical Executive Committee shall provide input to the Governing Body as part of this process, and the Medical Staff shall have the

opportunity to provide input directly to the Medical Executive Committee or the Governing Body.

11.5.4 A decision to operate a department or service pursuant to an exclusive contract, or to transfer an exclusive contract to another Practitioner or group of Practitioners, shall result in the automatic termination of privileges covered by the exclusive contract for those Practitioners who are not a party to, subcontractor of, or third-party beneficiary of, the exclusive contract. A Practitioner who does not hold any privileges as a result of this termination shall have his or her membership terminated as well.

11.5.5 The termination or denial of membership and/or privileges as a result of an exclusive contract arrangement shall not entitle any Practitioner to a hearing under these Bylaws.

11.5.6 A Practitioner who holds privileges in connection with a contract shall be subject to the terms of that contract, as well as to the Medical Staff Governing Documents. If the contract and the Governing Documents conflict, the terms of the contract will prevail, except that contracts may not grant Medical Staff membership or privileges to any individual and contracts may not reduce any hearing rights granted for an action that must be reported to the Practitioner's licensing board under Business and Professions Code Section 805 or to the federal National Practitioner Data Bank. The Practitioner shall be entitled to the hearing rights in these Bylaws only if actions taken fall within the definition of grounds for hearing detailed in the Hearings and Appeals Article of these Bylaws.

Practitioners cannot contract away their rights to hearings under Business and Professions Code Section 809.

11.5.7 Practitioners who serve under contracts to provide only administrative services are not required to apply for Medical Staff membership and privileges. If a Practitioner's contractual duties involve formal liaison with or advising the Medical Staff, Hospital Administration, or the Governing Body about Medical Staff activities or performance, the Hospital shall consult with the Medical Executive Committee and provide it reasonable opportunity to review and comment on the scope of responsibilities and the qualifications of the proposed candidate. The Hospital also shall, at least bi-annually, provide the Medical Executive Committee with a reasonable opportunity to provide input to the Hospital regarding the performance of those contracted Practitioners.

This provision is recommended to provide a formal means of garnering Medical Staff input into hospital contracting decisions that directly impact the Medical Staff.

11.6 Temporary Privileges

11.6.1 Temporary privileges may be granted by the Governing Body, pursuant to its own procedures, upon recommendation of the Chief of Staff, as follows:

TJC allows the Chief Executive Officer to, under certain circumstances, grant temporary privileges. There have been isolated anecdotal reports that CMS, has, in the past, cited hospitals who allow this, citing the Condition of Participation that suggests only the Governing Body determines whether to grant privileges (see 42 C.F.R. Section 482.12(a)(2)). CMS reportedly has backed away from that position as it applies to temporary privileges. Hospitals and Medical Staffs should consult legal counsel or contact TJC, DNV, or CMS directly to determine what process to adopt for approving temporary privileges.

(a) To applicants for initial appointment who have submitted a complete application. To be eligible for temporary clinical privileges, an applicant must: (i) have had no current or previously successful challenges to licensure or registration, (ii) have not been subject to involuntary termination of Medical Staff membership at another organization, and (iii) have not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges at another health care facility.

(b) To non-applicants, to meet an important patient care need, including the following:

(i) The care of a specific patient, where care could not be provided by a current member or where the patient has rejected care from current members;

(ii) When necessary to prevent a lack of services in a needed specialty area;

(iii) Proctoring, where it is not feasible to have current members proctor; or

(iv) When serving as a locum tenens for a member or APP, and temporary privileges are necessary to assure continuity of care.

TJC simply says, "important patient care need," and DNV-GL says, "urgent patient care need." This model provides further explanation of what that means.

DNV-GL MS.13, SR.5, provides the following: If the organization provides medical staff services through use of locum tenens or similar temporary medical service that may be used for a period not to exceed six months; the medical staff will define within the medical staff Bylaws the process regarding the approval of physicians and other practitioners providing such services. The medical staff will complete the required credentialing and privileging requirements defined by the medical staff.

These Bylaws provide that any practitioner providing services for more than 120 days under the temporary privileges process should be credentialed through the full Medical Staff process; however, the

DNV-GL standard suggests that, for DNV-accredited hospitals, a separate process may be developed in the Bylaws.

11.6.2 The following information will be verified prior to the granting of any temporary clinical privileges:

(a) Current licensure (including any peer review or other actions reported to the licensing board),

(b) Relevant training or experience,

(c) Current competence,

(d) Ability to perform the privileges requested,

(e) Current professional liability coverage acceptable to the Hospital, and

(f) Results of a query to the National Practitioner Data Bank and the Office of Inspector General.

TJC requires that this be verified only for applicants awaiting approval, and that only current licensure and current competence be verified for temporary privileges granted to meet an important care need. We suggest that best practice is to verify all the factors listed for all temporary privilege requests.

Additionally, DNV-GL MS.13 requires this for all temporary privilege determinations. It also requires that the Medical Staff receive professional references (MS.13, SR3d) and "database profiles from AMA, AOA, NPDB, and OIG Medicare/Medicaid Exclusions" (MS.13, SR.3e).

This is required by DNV-GL, but not TJC; regardless, it is good practice.

11.6.3 Grants of temporary clinical privileges will not exceed 120 days.

(a) For non-applicants, the individual may exercise temporary privileges for a maximum of 120 days, consecutive or not, anytime during the 24-month period following the grant of privileges, subject to the following conditions:

(i) The individual must notify the Medical Staff Administration at least 15 days prior to exercising these privileges (exceptions for shorter notice periods may be considered for good cause); and

(ii) The individual must inform the Medical Staff Administration of any change that has occurred to the information provided on the application form for temporary privileges.

This approach may be new to some Hospitals. It allows Hospitals to benefit from having a locum tenens or other temporary practitioner available

repeatedly on short notice, without having to temporarily recredential the practitioner for each limited practice period.

11.6.4 By requesting temporary privileges, the individual agrees to be bound by the Bylaws and other Governing Documents, including, but not limited to, the provisions addressing authorizations, releases, immunities, and confidentiality.

11.6.5 Individuals granted temporary privileges shall be subject to the proctoring and supervision requirements specified in the Governing Documents, and shall act under the supervision of the Department Chair of the Practitioner's specialty.

11.6.6 There is no right to temporary privileges. Temporary privileges will not be granted if a Practitioner does not meet the qualifications for temporary privileges. If there is insufficient information regarding the applicant's qualifications, character, judgment, or ability to exercise the privileges requested, the matter will be deferred until the application can be fully processed.

The decision to grant temporary privileges should be deferred if there is unfavorable information or reasonable doubts as to an applicant's suitability for the Medical Staff. Under California law, the denial or termination of temporary privileges for a medical disciplinary cause or reason must be reported to the Medical Board of California and gives rise to a hearing right. Therefore, deferral to full credentialing, rather than denial, is the appropriate way to address temporary privilege questions.

11.6.7 Temporary privileges shall terminate when expired or, in the case of applicants to the Medical Staff, if the applicant withdraws his or her application. Temporary privileges also may be suspended or terminated in the manner described in the Corrective Action Article of these Bylaws. Practitioners whose temporary privileges are suspended or terminated shall be entitled to the hearing and appeal rights of these Bylaws only if the action is considered Grounds for Hearing as defined in Hearings and Appeals Article of these Bylaws.

11.6.8 Upon the termination of temporary privileges, the Department Chair or Chief of Staff shall assign a Medical Staff member to assume responsibility for the Practitioner's patients. The wishes of the patient shall be considered in choosing a replacement.

11.7 Disaster Privileges

Disaster privileges may be granted when the Hospital's disaster plan has been activated and the organization is unable to handle the immediate patient needs. The following provisions apply:

11.7.1 Disaster privileges may be granted on a case-by-case basis by the Chief Executive Officer, based upon recommendation of the Chief of Staff, or, in his or her absence, the recommendation of the responsible Department Chair, upon presentation of a valid government-issued photo identification issued by a state or federal agency and at least one of the following:

(a) A current picture identification card from a health care organization that clearly identifies professional designation;

(b) A current license to practice;

(c) Primary source verification of licensure;

(d) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT), the Medical Reserve Corps (MRC), the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), or other recognized state or federal response organization or group;

(e) Identification indicating that the individual has been granted authority by a government entity to provide patient care, treatment, or services in disaster circumstances; or

(f) Confirmation by a licensed independent practitioner currently privileged by the Hospital or by a staff member with personal knowledge of the volunteer practitioner's ability to act as a licensed independent practitioner during a disaster.

TJC EM.02.02.13 provides detail about the privileging of Practitioners in disasters.

11.7.2 Persons granted disaster privileges shall wear identification badges denoting their status as non-members having only disaster privileges.

11.7.3 Primary source verification of licensure occurs as soon as the disaster is under control or within 72 hours from the time the volunteer licensed independent practitioner presents themselves to the Hospital, whichever comes first. If primary source verification of a volunteer licensed independent practitioner's licensure cannot be completed within 72 hours of the practitioner's arrival due to extraordinary circumstances, the Hospital documents all the following:

(a) Reason(s) it 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; and

(c) Evidence of the Hospital's attempt to perform primary source verification as soon as possible.

11.7.4 If, due to extraordinary circumstances, primary source verification of licensure of the volunteer licensed independent practitioner cannot be completed within 72 hours of the practitioner's arrival, it is performed as soon as possible. However, primary source verification of licensure is not required if the volunteer licensed

independent practitioner has not provided care, treatment, or services under the disaster privileges.

TJC EM.02.02.13

11.7.5 The responsible Department Chair or the Chief of Staff shall oversee the performance of each volunteer practitioner, and shall arrange for appropriate concurrent or retrospective monitoring of the activities of practitioners granted disaster privileges.

11.7.6 Based on the Medical Staff's oversight of each practitioner granted disaster privileges, the Chief Executive Officer, upon recommendation of the Chief of Staff, [or in his or her absence, the recommendation of the responsible department chair,] shall determine within 72 hours of the practitioner's arrival if granted disaster privileges shall continue.

Volunteers who are not licensed independent practitioners may be permitted to provide disaster services as described in the Rules or other Governing Documents.

11.8 Emergency Situations

In the event of an emergency, any Medical Staff member or credentialed Allied Health Professional shall be permitted to do everything reasonably possible within the scope of their licensure, regardless of the privileges granted, to save the life of a patient or to save a patient from serious harm. The member or AHP shall promptly yield such care to a member with the appropriate privileges when one becomes available.

11.9 Transport and Organ Harvest Teams

TJC permits practitioners who are not members of the Medical Staff and who have not undergone Medical Staff credentialing to provide patient care services as members of a transport or organ harvest team.

Under California law, such a team member must hold a current California license to practice medicine.

Properly licensed practitioners who, individually or as members of a group or entity, have contracted with the Hospital to participate in transplant and/or organ harvesting activities may act within the scope of their agreement with the Hospital.

ARTICLE 12

LEAVES OF ABSENCE AND RESIGNATION

12.1 Leaves of Absence

Members may request a leave of absence which, except for military leaves of absence, requires approval by the Medical Executive Committee. During the period of the leave, the member shall not exercise privileges at the Hospital, and membership rights and responsibilities shall be inactive; however, the obligation to pay dues and assessments, if any, shall continue unless waived by the Medical Executive Committee.

12.1.1 Military Leave of Absence

(a) Requests for leaves of absence to fulfill military service obligations shall be granted upon notice to the Medical Executive Committee.

(b) Reactivation of membership and clinical privileges previously held shall be granted upon request, except that the following may apply:

(i) If the leave of absence has been for more than two years, the member shall be required to submit a reappointment application;

(ii) If the request for reactivation occurs in less than two years but after the expiration of the member's current appointment term, the member may be required to update information in his or her credentials file, which may be done by submitting a reappointment application form.

12.1.2 In cases where reactivation from a military leave of absence is requested after the expiration of the member's current appointment term, the member shall be treated as if he or she had been continuously appointed to the Medical Staff for purposes of determining staff status and eligibility for officer or other positions.

12.1.3 Notwithstanding the above, the Medical Staff may take appropriate measures to ensure the current clinical competence of any member requesting a reinstatement from a military leave of absence.

Federal law requires employers to restore those who have served in the military to the job and benefits they would have attained if they had not been absent due to military service. Medical Staff members are not employees (except in very limited circumstances); however, the same rationale may apply. Even so, the Medical Staff should implement appropriate safeguards to ensure that patients are protected.

12.1.4 Reinstatement from Non-Military Leaves of Absence

(a) Non-military leaves cannot exceed two years. Failure to request reinstatement at the end of the leave shall be deemed a voluntary

resignation of membership and privileges, which does not entitle the Practitioner to the hearing rights in these Bylaws.

Medical Staffs can choose other periods, we suggest not more than two years.

(b) Requests for reinstatement shall be considered following the same process as the review of reappointment applications. The member must provide information regarding his or her professional activities during the leave of absence and may be required to provide additional information to demonstrate current clinical competence.

(c) Even if a member has not yet requested reinstatement from a leave, he or she must submit a reappointment application in a timely manner, prior to the expiration of his or her current appointment term, or his or her membership and privileges shall expire. In such cases, the Practitioner must apply to the Medical Staff as an initial applicant, but at the Medical Executive Committee's discretion, may be placed in a staff status other than Provisional Staff.

12.2 Resignation

12.2.1 Manner of Resignation

A resignation of membership and/or some or all privileges shall be in writing and signed by the Practitioner. If a date is not specified in the written document, then the resignation will be considered effective upon receipt.

12.2.2 Good Standing

This provision is optional.

(a) Prior to the effective date of resignation, a Practitioner must complete all medical records; pay any outstanding dues, fees, or assessments; and appropriately discharge or transfer responsibility for the care of any hospitalized patient. Failure to do so will result in the Practitioner being deemed to have been out of good standing at the time of resignation. This designation may be transmitted to querying health care entities.

(b) If the Practitioner is scheduled for inpatient or call responsibilities prior to resignation, the Practitioner must either: (a) specify a date for resignation that goes into effect after the fulfillment of those responsibilities, or (b) arrange alternative coverage. Failure to fulfill or ensure coverage for call or other scheduled responsibilities shall result in the Practitioner being deemed out of good standing at the time of resignation, and this designation may be transmitted to querying health care entities.

DIVISION 3: QUALITY AND PEER REVIEW

ARTICLE 13

PRACTITIONER PERFORMANCE EVALUATIONS

13.1 General

The Medical Staff is responsible to the Governing Body for the adequacy and quality of patient care services provided at the Hospital, and the Governing Body has ultimate responsibility for those services. To fulfill its responsibility, the Medical Staff will develop processes, subject to the Governing Body's approval, for the evaluation of care provided by Medical Staff members and others with privileges. Those processes will be consistent with state and federal legal and accreditation requirements. Decisions regarding the granting, renewing, and termination of membership or privileges shall be, among other things, detailed, current, accurate, objective, and evidence-based. Ongoing performance evaluation and monitoring will be designed to assure timely identification of matters that may require correction. Concerns regarding professional performance or conduct will be addressed pursuant to the Investigation Article, Corrective Action Article, and the Hearings and Appeal Article of these Bylaws.

This wording is consistent with the language in Health and Safety Code Section 1250(a) and Title 22, California Code of Regulations, Section 70703(a).

13.2 Focused Professional Practice Evaluation for New Privileges

Focused professional practice evaluations (FPPE) and ongoing professional practice evaluations (OPPE) are TJC requirements. If a hospital is not TJC accredited, it can use different terms for these processes. This section refers to the standard proctoring for new privileges, regardless of the term used.

13.2.1 All initial grants of clinical privileges, whether at the time of appointment, reappointment, or during the term of an appointment, will be subject to a focused professional practice evaluation (FPPE). That evaluation shall include proctoring, and may include chart review, monitoring, external review, and other forms of review.

13.2.2 The Medical Staff, subject to the Governing Body's approval, shall develop the policies and processes it determines necessary to implement FPPE for new privileges. Each Department, subject to the Medical Executive Committee's and Governing Body's approval, shall be responsible for developing FPPE criteria for new applicants and for privileges granted during appointment. In addition, the Medical Staff shall develop criteria for FPPE for conduct at the Hospital.

Having FPPE criteria for behavior for new members is optional, but valuable. It demonstrates to new members that the Medical Staff takes its conduct expectations seriously, and it creates measurable data that the Medical Staff can review to determine compliance.

13.2.3 When a Practitioner or APP completes FPPE requirements, the Department shall convey this information to the Medical Executive Committee.

13.2.4 If a Practitioner or APP fails to complete the FPPE requirements for any privilege during his or her Provisional Staff status period due to lack of clinical activity, then that privilege shall expire. If all of the Practitioner's or APP's privileges expire, then his or her membership shall automatically terminate. Under these circumstances, the Practitioner and APP shall not be entitled to any hearing and appeal provisions under these Bylaws.

Hospitals can choose to adopt a different deadline, such as within two years.

13.2.5 If a Practitioner or APP who has been granted a new privilege in the middle of his or her appointment fails to complete the FPPE requirements for that privilege within two years after being granted the privilege due to lack of clinical activity, then that privilege shall expire. Under these circumstances, the Practitioner and APP shall not be entitled to any hearing and appeal provisions under these Bylaws.

Hospitals can choose to adopt a different deadline.

13.2.6 If a Practitioner fails to satisfactorily complete FPPE due to a medical disciplinary cause or reason, then the Practitioner will be referred to the Medical Executive Committee for further consideration.

In such cases, there may be corrective action that could result in an 805 report and hearing right.

13.3 Ongoing Professional Practice Evaluation

As noted above, OPPE is a TJC requirement. However, even hospitals that are not TJC accredited should adopt processes to evaluate members and APPs, regardless of what it is termed.

13.3.1 All persons with privileges shall be subject to ongoing professional practice evaluations.

13.3.2 The Medical Staff and Hospital shall develop clearly defined processes that facilitate the evaluation of each Practitioner's professional practice. Such evaluation shall include evaluation of the Practitioner's interpersonal conduct at the Hospital. Each Department, subject to the Medical Executive Committee's approval, shall be responsible for determining the type of data to be collected.

As mentioned with FPPEs for behavior above, this is optional, but valuable.

13.3.3 Information resulting from the ongoing professional practice evaluation is used as part of the determination of whether to continue, limit, or revoke any existing privilege.

13.4 Focused Professional Practice Evaluation for Cause

13.4.1 The Medical Staff shall develop criteria to be used for evaluating the performance of Practitioners and APPs when issues affecting the provision of safe, high quality patient care are identified.

(a) The decision to assign a period of performance monitoring is based on the evaluation of a Practitioner's current clinical competence, practice behavior, and ability to perform the requested privilege.

(b) An FPPE for cause process is not intended to be an investigation, as that term is defined in these Bylaws.

The issue of when an investigation begins is significant – hospitals must report to the National Practitioner Data Bank (NPDB) a Practitioner who resigns during an investigation; if the Practitioner resigns after notice of a pending investigation (or during the investigation), the hospital must report to the Practitioner's licensing board. In 2015, a revised NPDB Guidebook provided that the NPDB interprets the word "investigation" expansively and is not limited to how the term is defined in Medical Staff Bylaws. In certain instances, an FPPE "for cause" may be considered an investigation under the NPDB's interpretation, as described in the Guidebook. Hospitals should consult with counsel whenever a Practitioner resigns during a "for cause" FPPE to determine whether any reporting obligations exist.

13.4.2 The Medical Staff shall clearly define the performance monitoring process and shall include each of the following elements:

(a) Criteria for conducting performance monitoring.

(b) Method for establishing a monitoring plan specific to the requested privilege.

(c) Method for determining the duration of performance monitoring.

(d) Circumstances under which monitoring by an external source is required.

Per TJC Standard MS.08.01.01, EP 3.

13.4.3 The processes also shall identify the triggers that indicate the need for performance monitoring and the criteria that determine the type of monitoring to be conducted.

13.4.4 The FPPE for cause process may result in the following:

(a) A determination that the FPPE should be concluded without further action;

(b) A determination that the Practitioner or APP should be subject to a plan that specifies non-restrictive measures designed to improve performance; or

(c) A referral to the Medical Executive Committee for investigation or corrective action.

13.5 Fitness for Practice Evaluations

At any time, the Medical Executive Committee may require a Practitioner or Allied Health Staff member to submit to a medical or psychological examination, including blood, urine or other biological or physiological testing, and to allow the Medical Executive Committee (and the Wellbeing Committee, if the Medical Executive Committee chooses) to inspect the records of the examination. The Medical Executive Committee shall provide in writing to the Practitioner or Allied Health Staff member a brief description of the reasons for the requirement and identify a deadline for compliance.

13.6 Informal Remediation

The following two sections (Informal Remediation and Progressive Measures) are optional but are useful in reminding Medical Staffs that there are intervening options available prior to initiating more formal corrective action. The intervening measures may result in positive changes in the Practitioner, without requiring formal action.

At any time when warranted, the Medical Staff may employ informal remediation to address matters related to a Practitioner or Allied Health Staff member's clinical or professional performance. The Medical Staff officers, departments, and committees may counsel, educate, or issue letters of warning or censure without initiating formal corrective action. Such 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 officer, department, or committee. Any informal actions, monitoring, or counseling shall be documented in the Practitioner or Allied Health Staff member's file. The activities shall be reported to the Medical Executive Committee, but Medical Executive Committee approval is not required. These activities are not a restriction of privileges or grounds for the hearing or appeal rights under these Bylaws. Notwithstanding the availability of informal remediation, the Medical Staff may initiate investigations and/or take corrective action against a Practitioner without first initiating informal remediation.

13.7 Progressive Measures

The Medical Staff may develop progressive measures to address matters related to a Practitioner or Allied Health Staff member's clinical or professional performance. "Progressive measures" means formal interventions that do not constitute investigations or corrective actions. Examples of progressive measures include, but are not limited to, referrals to anger management courses, medical record keeping courses, and continuing education courses on clinical matters. Such interventions, if used, shall be

documented in the Practitioner's or Allied Health Staff member's file. The progressive measures shall be reported to the Medical Executive Committee, but Medical Executive Committee approval is not required for such measures. Progressive measures are not a restriction of privileges or grounds for the hearing or appeal rights under these Bylaws. Notwithstanding the availability of progressive measures, the Medical Staff may initiate investigations and/or take corrective action against a Practitioner without first initiating progressive measures.

Examples of these measures include collegial interventions and professional behavior interventions.

ARTICLE 14

INVESTIGATIONS

Medical Staff Bylaws often include investigations and corrective actions in a single article. We suggest placing them separately as a reminder that: (1) when possible, investigations should precede corrective action, and (2) investigations do not always result in corrective action. In other words, investigations and corrective actions should not be conflated together.

14.1 Grounds for Investigation

The Medical Staff may initiate an investigation into any Practitioner or APP when reliable information from any source indicates that the Practitioner or APP has done anything that is reasonably likely to have been, or to be:

Medical Staffs can choose to develop a different process for investigations and corrective actions for APPs; however, the process developed here is designed to promote fairness and the discovery of factual information.

14.1.1 Detrimental to patient safety or to the delivery of quality patient care within the Hospital;

14.1.2 Unethical or illegal;

14.1.3 Contrary to the Medical Staff Governing Documents;

14.1.4 Intimidating or harassing to staff, colleagues, patients, or other persons at the Hospital;

14.1.5 Below applicable professional standards;

14.1.6 Disruptive of Medical Staff or Hospital operations; or

CHA's Model Bylaws have long included acknowledgement that disruption of hospital operations should be actionable. For DNV-accredited hospitals, this is included as a requirement of Standard MS.14.

14.1.7 An improper use of Hospital or Medical Staff resources.

14.2 Initial Review

14.2.1 Whenever information suggests that an investigation is warranted, the Chief of Staff or his or her designee [and/or the Chief Medical Officer] may, on behalf of the Medical Executive Committee, immediately perform an initial review and conduct whatever interviews may be indicated. The information developed during this initial review shall be presented to the Medical Executive Committee, which shall decide whether to initiate a formal investigation.

14.2.2 If the information includes claims of unlawful harassment or discrimination by a Practitioner or APP, the Chief of Staff or his or her designee [and/or the Chief Medical Officer] and representatives from the Hospital, which may include an attorney or other advisor, shall perform an initial review. The reviewers shall attempt to complete the initial fact-gathering process within five days, and within seven days shall decide whether to refer the matter to the Medical Executive Committee for further investigation or corrective action. If the matter is referred to the Medical Executive Committee, the information gathered during the initial review shall be provided to the Medical Executive Committee.

14.3 Initiation of Investigation

The Medical Executive Committee may initiate an investigation upon receiving information suggesting that grounds for an investigation exists. Except as provided in these Bylaws, only the Medical Executive Committee has the authority to initiate an investigation as defined in these Bylaws. The Chief of Staff shall inform the Chief Executive Officer or his or her designee whenever an investigation is initiated and shall continue to keep the Chief Executive Officer or his or her designee fully informed of all action taken. If the investigation involves a patient complaint that constitutes a "patient grievance" pursuant to the Hospital's grievance policy, the Medical Executive Committee shall cooperate with the Hospital in its process for the resolution of patient grievances.

The Medicare Conditions of Participation require Hospitals to have a process to address patient grievances. Hospitals and Medical Staffs should ensure that their investigatory processes do not conflict with each other when a matter involves a patient grievance.

14.4 Investigative Procedure

Once the Medical Executive Committee initiates an investigation, it will proceed with the understanding that the fundamental purpose of the investigation is to discover facts in order to determine truth. To achieve this, the following will occur:

This statement may provide guidance to the Medical Staff.

The following process helps to achieve the fundamental purpose of the investigation and to instill fairness into the process.

14.4.1 The Medical Executive Committee will inform the Practitioner or APP that it has initiated an investigation. The notice will include a brief description of the reasons for the investigation, will identify the body that is performing the investigation, and will inform the Practitioner or APP that he or she will have an opportunity to provide information to the investigative body pursuant to these Bylaws.

14.4.2 The Medical Executive Committee will identify a body to perform the investigation. The investigatory body may be the Medical Executive Committee as a whole, a subcommittee of the Medical Executive Committee, an ad hoc committee, a Medical Staff Officer or Department Chair, or other body that the Medical Executive Committee determines is appropriate to perform the investigation. The Medical Executive Committee will provide the investigatory

body with appropriate direction for its assignment. Insofar as feasible, the members of the investigatory body may not be in direct economic competition with the individual being investigated; may not be professionally associated with or a relative of the individual being investigated; and may not have an actual bias, prejudice, or conflict of interest that would or could prevent the individual from fairly and impartially investigating the matter.

14.4.3 The investigatory body will evaluate whatever information it determines is reasonably likely to achieve the goal of discovering facts to determine truth. This may include, without limitation, reviewing relevant documents and patient records; conducting interviews; engaging outside consultants, subject to the Medical Executive Committee's approval; and requiring the Practitioner or APP to submit to a physical or mental health examination and/or mandatory drug and alcohol testing at the Practitioner's or APP's expense, subject to the Medical Executive Committee's approval. The investigatory body may require the Practitioner or APP to submit information as part of the investigation, including patient medical records.

14.4.4 The investigatory body shall provide the Practitioner or APP the opportunity to provide information to the body in a manner that the investigatory body determines appropriate. This may include the provision of written information to the investigatory body, attendance at an interview with the investigatory body, or both. Interviews shall not include the presence of attorneys and shall not be considered a "hearing" as the term is used in these Bylaws.

14.4.5 The investigatory body will attempt to complete its investigatory tasks within 30 days; however, the investigatory body may take additional time as long as it keeps the Medical Executive Committee informed of its progress.

14.5 Conclusions

14.5.1 At the conclusion of its investigation, the investigatory body shall create a report, which it shall submit to the Medical Executive Committee (if the investigatory body was not the Medical Executive Committee). The report shall summarize the investigatory body's activities during the investigation and shall include its findings and conclusions. The report may include recommendations to the Medical Executive Committee, but the Medical Executive Committee is not required to adopt any investigatory body recommendation.

14.5.2 Before acting on any report, the Medical Executive Committee shall confirm that the Practitioner or APP had the opportunity to provide information to the investigatory body in the manner described above.

14.5.3 As soon as practicable after the conclusion of the investigation, the Medical Executive Committee shall do one of the following:

(a) Determine that no corrective action should be taken and, if the Medical Executive Committee determines there was no credible evidence for the

complaint in the first instance, clearly document that finding in the Practitioner's file;

(b) Refer the matter back to the investigatory body, with guidance regarding additional investigation that the Medical Executive Committee has determined is necessary;

(c) Defer action to a reasonable time; or

(d) Impose corrective action in the manner described in the Corrective Action Article.

14.6 Notification of Investigation to System Members

This notification provision is broad and includes notification of recommendations that are not yet final actions. Hospitals and Medical Staffs should consult with counsel before notifying any entity about a corrective action recommendation or action.

Whenever the Medical Executive Committee initiates an investigation under this Article, it may notify other System Members where the individual also practices or has privileges that an investigation has been initiated and the basis for the investigation. The Medical Executive Committee also may provide any other information it determines to be appropriate regarding the investigation to other System Members, but will take measures to protect the integrity of the investigation and will not provide preliminary or draft investigatory reports to other entities. The Medical Staff and Hospital will ensure that any information shared complies with Hospital policies regarding patient confidentiality and, at a minimum, with HIPAA and California's laws regarding confidentiality. Any notification should take place within 10 days of the initiation of the investigation, if possible.

14.7 Information Received from Other Entities

If the Hospital or Medical Staff is informed that a Practitioner or Allied Health Staff member is subject to an investigation at another entity, that information will be referred to the Medical Executive Committee for evaluation to determine whether an investigation is warranted by this Medical Staff pursuant to these Bylaws.

14.8 Joint Investigations

This Medical Staff may join with other System Members to jointly investigate an individual who practices at or has privileges with each of the System Members involved in the investigation. In such event, the Medical Executive Committee may delegate the investigation to a joint investigatory body. The joint investigatory body must comply with the investigation provisions detailed in this Article, except that it may engage outside consultants and require mental or physical evaluations without the Medical Executive Committee's approval, as long as a majority of the executive committees of the System Members participating in the investigation agree that the engagement or evaluation is necessary.

Engaging outside consultants often incurs costs that the Hospitals and/or the Medical Staffs are responsible for. Earlier in these Bylaws is a provision that requires Medical Executive Committee approval before an investigatory body engages consultants. The rationale for this is to manage

resources. Here, because a joint investigation involves more than one Medical Executive Committee, we suggest that a majority of the Medical Executive Committees involved must give approval before engaging a consultant. This provision is optional, and Medical Staffs can choose to remove it or, alternatively, to specify that each Medical Executive Committee must give approval before the joint investigatory body can engage an outside consultant.

14.9 Medical Executive Committee Authority

Despite the status of any investigation, including any joint investigation, the Medical Executive Committee shall, at all times, retain authority and discretion to take whatever action may be warranted by the circumstances, including summary action.

ARTICLE 15

CORRECTIVE ACTION

15.1 Grounds for Action

15.1.1 Regardless of whether or not an investigation has taken place, or is taking place, the Medical Executive Committee at all times has the authority to impose corrective action when grounds for action exists. The grounds for corrective action include when the Medical Executive Committee has reasonably verified that events that would constitute grounds for investigation, as identified above, have, in fact, occurred.

15.1.2 When appropriate, the Medical Staff should make reasonable attempts at informal remediation or progressive measures, or to conduct a formal investigation, before initiating corrective action; however, such measures are not mandatory conditions to corrective action, which may be initiated whenever circumstances reasonably appear to warrant it.

15.2 Authority to Impose Action

15.2.1 By accepting membership and/or privileges, the Practitioner accepts the authority of the Medical Executive Committee to recommend and/or impose corrective action pursuant to these Bylaws. Each Practitioner agrees that he or she will comply with any requirements the Medical Executive Committee imposes on the Practitioner as corrective action once that action is considered a final action or if the action is a summary action. Failure to comply with the requirements of corrective final actions or summary actions shall, in and of itself, be grounds for additional corrective action, including termination of membership and privileges. Invoking the hearing rights under these Bylaws shall not be considered a failure to comply with any corrective action requirement, and no Practitioner shall be penalized for asserting his or her hearing and appeal rights.

15.2.2 Nothing within this article shall preclude Department Chairs or committees from issuing informal written or oral warnings that do not constitute corrective action under these Bylaws.

15.3 Effective Dates of Action

15.3.1 Unless the Medical Executive Committee designates otherwise, a non-summary corrective action that does not give rise to a hearing right under these Bylaws shall be considered final and effective upon the Governing Body's affirmation of the action.

Because such actions are not restrictive, Medical Staffs can modify this provision so that they are final upon the Medical Executive Committee's approval.

15.3.2 Unless the Medical Executive Committee designates otherwise, summary action shall be effective immediately upon imposition.

15.3.3 Corrective action that gives rise to a hearing right under these Bylaws but is not a summary action shall be considered final and effective only after the Practitioner has exhausted or waived his or her hearing rights and only if the action is adopted by the Governing Body.

15.4 Examples of Corrective Action

The Medical Executive Committee has the authority to impose corrective action it determines is likely to achieve peer review goals and is appropriate under the circumstances. Examples of such action include, but are not limited to:

15.4.1 Issuing a letter of guidance, counsel, warning, or reprimand;

15.4.2 Referring to an appropriate committee, such as the Well-Being Committee or Professional Standards Committee;

15.4.3 Imposing terms of probation for continued appointment;

15.4.4 Requiring non-restrictive monitoring or retrospective proctoring;

15.4.5 Requiring additional training or education;

15.4.6 Recommending reduction, suspension (including summary suspension), or other restriction of membership or clinical privileges, including mandatory consultation, concurrent proctoring, or co-admission; or

15.4.7 Recommending revocation of membership or clinical privileges.

15.5 Additional Steps

15.5.1 The Medical Executive Committee shall provide notice of the corrective action to the Practitioner. When the action gives rise to a hearing under these Bylaws, the notice shall comply with the notice requirements detailed in the Hearing and Appeals Article. When appropriate, the Medical Executive Committee shall identify and inform the member of any terms or conditions that must be met before the corrective action is lifted.

15.5.2 Whenever the Medical Executive Committee, Department Chair, or Committee chair issues a written letter of guidance, counsel, warning, or reprimand, whether as formal corrective action or otherwise, the Practitioner or Allied Health Staff member shall have the right to submit a written response, which shall be placed in his or her file.

15.5.3 Whenever the Medical Staff takes or recommends an action for a medical disciplinary cause or reason, or based on the Practitioner's professional competence or professional conduct, that adversely affects, or could adversely

affect, the health or welfare of a patient, it shall confer with the Hospital administration and with counsel, if any, to determine whether the Medical Staff and Hospital have any reporting obligations under California Business and Professions Code Sections 805 or 805.01, or to the National Practitioner Data Bank.

"Medical disciplinary cause or reason" is the standard used to determine whether an action must be reported to the licensing board; "professional review actions," as described in this section, is the standard used to determine whether something must be reported to the NPDB.

15.6 Summary Action

15.6.1 Grounds for Summary Action

The Medical Staff may immediately and summarily suspend or restrict a Practitioner's or Allied Health Staff member's privileges whenever the failure to take that action may result in an imminent danger to the health of any individual.

This language reflects the standard in Business and Professions Code Section 809.5.

15.6.2 Summary Actions, Defined

A "summary action" is a suspension or other restriction of privileges that goes into effect before the Practitioner has the opportunity to exercise the hearing and appeal rights in these Bylaws, if any apply.

15.6.3 Procedures for Imposition of Summary Actions

(a) The Medical Staff authorizes each of the following to impose a summary action on a Practitioner, if grounds for summary action exist: the Medical Executive Committee; the Chief of Staff; the Chair of the Department where the Practitioner holds privileges; the Chief Executive Officer, and the Chief Medical Officer [or any officer of the Governing Body].

The Medical Staff may authorize who may impose a summary restriction/suspension. California Business and Professions Code Sections 809.5(a) and (b).

(b) Unless otherwise stated, the summary action shall be effective immediately upon imposition. The summary action may be limited in duration and remain in effect for the period stated or may be of indeterminate length.

(c) The person or body who imposed the summary action shall provide oral notice to the Practitioner within one working day after imposition, and Special Notice in writing within three working days after imposition. The written notice shall include a brief statement of facts demonstrating that the summary action is reasonable and warranted because it is reasonable

to believe that a failure to take the action summarily could result in an imminent danger to the health of any individual. The statement of facts shall also include a summary of one or more particular incidents giving rise to the assessment of imminent danger. This initial notice is in addition to, and not a substitute for, the written notice required under the hearing and appeal procedures in these Bylaws.

This notice is not legally required but is recommended for promoting fairness within the process. Additionally, having the Medical Staff articulate the rationale for the summary suspension early in the process helps ensure that the action is taken thoughtfully and in compliance with legal standards.

(d) If the Medical Executive Committee was not the body who imposed the summary action, the person or body who imposed it will provide the Medical Executive Committee with oral notice of the summary action within one working day after imposition and with a copy of the same Special Notice provided to the Practitioner within three working days after imposition. Such notice shall also be considered a request to initiate an investigation and/or corrective action under these Bylaws.

(e) Patients affected by a summary action shall be assigned to another member by the Department Chair or Chief of Staff. The wishes of the patient and affected Practitioner shall be considered, where feasible, in choosing a substitute member.

15.6.4 Procedures for Ratification of Summary Action

Within one week after a summary action has been imposed, the Medical Executive Committee or a subcommittee appointed by the Chief of Staff shall meet to review and consider the action. Upon request, the member may attend and make a statement, on such terms and conditions as the Medical Executive Committee may impose, concerning the events leading to the summary action. No Medical Executive Committee meeting, with or without the member, shall constitute a "hearing" within the meaning of the Hearings and Appellate Reviews provisions of these Bylaws. After the meeting, the Medical Executive Committee will continue, modify, or terminate the summary action. It shall give the Practitioner Special Notice of its decision within two working days of the meeting.

15.6.5 Imposition of Summary Action by Governing Body

(a) If no one authorized to take summary action in the Procedures for Imposition of Summary Actions Section is available to take summary action, the Governing Body (or its designee) may immediately suspend a Practitioner's privileges if failure to summarily suspend those privileges is likely to result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) made reasonable

attempts to contact the Chief of Staff and the Chair of the Department to which the member is assigned before acting.

The language of this section provides that the Governing Body may "summarily suspend," rather than "summarily restrict" a Practitioner's privielges. The rationale for this wording is that the authorization allowing the Governing Body to act (found in Business and Professions Code Section 809.5(b)) specifically says the Governing Body may "immediately suspend," and does not include the word, "restrict."

(b) Such summary action is subject to ratification by the Medical Executive Committee. If the Medical Executive Committee does not ratify the summary action within two working days, excluding weekends and holidays, the summary action shall terminate automatically.

15.7 Governing Body Right to Intercede

15.7.1 The Governing Body has ultimate responsibilities over the care provided at the Hospital and must act to protect the quality of care provided to patients and ensure the competency of the Medical Staff.

15.7.2 If the Medical Executive Committee fails to investigate or to take corrective action contrary to the weight of the evidence, the Governing Body may direct the Medical Executive Committee to initiate an investigation or disciplinary action, but only after consultation with the Medical Executive Committee.

This language reflects the legal standard found in Business and Professions Code Section 809.05(b).

"Consultation" may include, but is not limited to, written correspondence with the Medical Executive Committee via the Chief of Staff, an in-person meeting with the Medical Executive Committee, or an in-person meeting with the Chief of Staff or his or her designee, as the Medical Executive Committee's representative. As part of the consultation, the Governing Body shall identify the Practitioner against whom action is requested, shall summarize the basis for the request for action, may identify the action or actions requested, and shall include a deadline for action.

15.7.3 If the Medical Executive Committee fails to take action in response to that Governing Body's direction, the Governing Body may initiate corrective action after providing written notice to the Medical Executive Committee of the intent to initiate action. The Governing Body shall provide notice of the corrective action to the Practitioner and to the Medical Executive Committee. When the action gives rise to a hearing under these Bylaws, the notice shall comply with the notice requirements detailed in the Hearing and Appeals Article.

This language reflects the legal standard found in Business and Professions Code Section 809.05(c).

15.7.4 Nothing in this subsection shall limit the Governing Body from taking summary action consistent with Imposition of Summary Action by Governing Body Section of this Article when the failure to take immediate action may result in imminent danger to the health of any person.

15.8 Automatic Suspension, Termination, and Limitation

TJC Standard MS.01.01.01, EP 28, requires the Bylaws to include the indications for automatic suspension of membership or privileges, and EP 31 requires the Bylaws to include the process for automatic suspension of membership or privileges. The provisions here meet those standards and go further in discussing automatic terminations.

15.8.1 General Terms

(a) In the circumstances described in the Events Resulting in Automatic Action Section below, a Practitioner's or AHP's privileges or membership may be automatically terminated, suspended, or limited as described. If a Practitioner or AHP accumulates a total of 90 days of automatic suspension in a 12-month period, his or her membership and privileges shall be automatically terminated.

The Medical Staff may adopt a different number, such as 120 days.

Although automatic terminations do not usually lead to reporting obligations under Business and Professions Code Section 805, or required reports to the National Practitioner Data Bank, there are circumstances under which an automatic action will require a report. In those circumstances, the Medical Staff may also have to provide the practitioner with a hearing right prior to the termination going into effect. Medical Staffs should consult legal counsel whenever it appears that an automatic termination is imminent in order to assess whether reporting obligations or hearing rights will be triggered.

(b) Except as otherwise provided below, an automatic termination, limitation, or suspension of appointment and privileges will be effective immediately upon actual or Special Notice to the individual. Notice also shall be provided to the Medical Executive Committee, Chief Executive Officer, and Governing Body.

(c) Patients affected by an automatic suspension shall be assigned to another member by the Department Chair or Chief of Staff. The wishes of the patient and affected Practitioner shall be considered, where feasible, in choosing a substitute member.

(d) A Practitioner whose membership or privileges have been automatically terminated, suspended or limited shall not be entitled to procedural rights afforded under the Hearing and Appeal Article of these Bylaws unless the Medical Staff determines that the Practitioner is entitled to such rights

pursuant to Business and Professions Code Section 809 et seq., or under the Health Care Quality and Improvement Act.

(e) When the Practitioner or AHP is not entitled to the Hearing and Appeal provisions of these Bylaws for an automatic termination, limitation, or suspension, the Medical Executive Committee may provide the Practitioner or AHP with an opportunity to meet with the Medical Executive Committee in any forum or manner that it deems appropriate. Such meeting shall not be considered a hearing and shall not be conducted as a hearing under these Bylaws. The issue before the Medical Executive Committee shall be limited solely to the question of whether or not grounds existed for the automatic termination, suspension, or limitation. The Medical Executive Committee shall immediately rescind any termination, suspension, or limitation that was based on a material mistake of fact as to the basis for such action. If the Medical Executive Committee rescinds an automatic termination, suspension, or limitation based on a material mistake of fact, that automatic termination, suspension, or limitation shall not be grounds for a civil action for damages against the Hospital, Governing Body, Medical Staff, or Medical Staff members.

15.8.2 Events Resulting in Automatic Action

In addition to the other circumstances described elsewhere in these Bylaws as resulting in automatic suspension, termination, or limitation, the following circumstances shall lead to automatic suspension, termination, or limitation:

(a) Licensure

(i) Revocation, Suspension, or Expiration. Whenever a member's license or other legal credential authorizing practice in this state is revoked, suspended or expired, Medical Staff membership and privileges shall be automatically revoked as of the date such action becomes effective.

(ii) 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, any privileges which are within the scope of such limitation or restriction shall be automatically limited or restricted in a corresponding manner as of the date such action becomes effective and throughout its term.

Some Medical Staffs may choose to impose an automatic suspension or termination, rather than police the limits of the license restriction.

(iii) Probation. Whenever a member is placed on probation by the applicable licensing or certifying authority, his or her membership

status and 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.

(b) Drug Enforcement Certificate

(i) Revocation, Suspension, or Expiration. Whenever a member's Drug Enforcement Administration certificate is revoked, limited, suspended or expired, 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 [OR: the member's privileges shall be suspended].

If having a valid DEA certificate is a qualification for membership, then not having one should lead to suspension and then, if not corrected, termination.

(ii) Probation. Whenever a member's Drug Enforcement Administration 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.

(c) Medical Records

Medical Staff members and AHPs are required to prepare, maintain, and complete accurate medical records within the time frame prescribed by the Governing Documents. Failure to do so shall result in an automatic suspension after notice is provided. The suspension shall apply to the Medical Staff member's right to admit, treat, or provide services to new patients in the Hospital; however, members may admit and treat new patients in life-threatening situations. Members and AHPs also shall be allowed to continue to care for patients the Medical Staff member already has admitted or is treating until that patient is discharged. The suspension shall continue until the medical records are completed or until the Practitioner or AHP accumulates sufficient suspension days to result in an automatic termination. Nothing in the foregoing shall preclude the Medical Executive Committee from also implementing monetary fines or a reduction of non-clinical privileges for delinquent medical records.

It is reasonable to permit members suspended for medical record delinquencies to provide services in limited situations, for a limited period of time.

Some Medical Staffs find that imposition of fines or demotion of benefits (e.g., preferred parking spots) are more effective in dealing with medical record deficiencies.

(d) Failure to Maintain Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall result in automatic suspension of membership and all privileges. Failure to maintain professional liability insurance for certain procedures shall result in the automatic suspension of privileges to perform those procedures. The suspension shall be effective until appropriate coverage is reinstated, including coverage for the time period for which coverage had lapsed, or until the Practitioner or AHP accumulates sufficient suspension days to result in an automatic termination.

(e) Failure to Pay Dues or Fines

Failure to pay required dues or fines within 30 days after written warning of delinquency shall result in an automatic suspension of membership and privileges. The Practitioner or AHP shall remain suspended until he or she either pays the delinquent dues or accumulates sufficient suspension days to result in an automatic termination.

(f) Failure to Comply with Government and Other Third-Party Payor Requirements

If a member ceases to be a Medicare or Medi-Cal provider for any reason, the member shall be automatically [suspended][removed from all emergency call activities]. The Medical Executive Committee shall be empowered to determine that compliance with certain specific third-party payor, government agency, or professional review organization rules or policies is essential to Hospital and/or Medical Staff operations. In such cases, a Practitioner who fails to comply with such requirements shall be automatically suspended and shall remain suspended until the Practitioner or AHP either comes into compliance with these requirements or accumulates sufficient suspension days to result in an automatic termination.

If the Bylaws require members to maintain eligibility to participate in Medicare/Medi-Cal, then there should be a corresponding provision for automatic suspension if such eligibility is lost. Additionally, DNV-accredited hospitals must include such a provision. (See DNV-GL Standard MS.12, SR 7.)

(g) Failure to Maintain Board Certification

Failure to maintain board certification, if applicable, throughout the appointment period shall result in the automatic suspension of privileges. The Practitioner or AHP shall remain suspended until board certification is achieved, or until he or she accumulates sufficient suspension days to result in an automatic termination.

Not all Hospitals will require board certification. Those that do might not require continuous maintenance of certification, or if they do, will address it at reappointment, rather than in the middle of an appointment. This provision is only applicable if the Medical Staff intends to suspend Practitioners mid-appointment if they do not maintain board certification.

(h) Arrests or Convictions

A conviction, plea of guilty, or plea of no contest shall result in an automatic relinquishment of medical staff membership and privileges if the matter pertains to a felony or misdemeanor involving any of the following: (a) Medicare, Medicaid, or other federal or state governmental or private third-party payer fraud or program abuse; (b) controlled substances, other than marijuana; (c) sexual assault, battery, or rape; (d) child pornography; (e) moral turpitude; or (f) child, dependent adult, or elder abuse.

Some Hospitals will include this type of provision; others will choose not to. Listed here are the types of offenses that may reflect on the Practitioner's character or fitness to practice.

Additionally, some Hospitals may choose to broaden this provision by automatically suspending Practitioners who have been arrested, charged, or indicted (but not yet convicted) for these offenses. This approach has both the advantage and disadvantage of removing discretion from the Medical Staff when addressing members who have been charged with serious offenses. On the one hand, the Medical Staff will not have to commit resources to weigh the effect the alleged criminal conduct (if true) has on patients or on Hospital operations; on the other, some Medical Staffs may be uncomfortable with suspending Practitioners who have not yet been found guilty of the alleged crime.

(i) Failure to Provide Information

An individual's failure to provide information pertaining to his or her qualifications for appointment or clinical privileges in response to a written request from the Credentials Committee, the Medical Executive Committee, or any other Medical Staff committee shall result in the automatic suspension of appointment and clinical privileges. The Practitioner or AHP shall remain suspended until he or she either provides the information to the satisfaction of the requesting party or accumulates sufficient suspension days to result in an automatic termination.

In some cases, this may result in a report to the licensing body and/or the NPDB. Hospitals should consult with counsel whenever a Practitioner is suspended or terminated for failing to provide information.

(j) Failure to Satisfy Special Attendance and Related Peer Review Requirements

Failure without good cause to, when requested by a Medical Staff committee, submit to mental or physical examinations, execute a release as required, or appear at any type of meeting shall result in the automatic suspension of the individual's privileges. The determination whether such failure is without good cause shall rest solely in the discretion of the Medical Executive Committee. The automatic suspension shall remain in effect until the individual either complies with the request in issue or

accumulates sufficient suspension days to result in an automatic termination.

In some cases, this may result in a report to the licensing body and/or the NPDB and may trigger a hearing right. Hospitals should consult with counsel whenever a Practitioner is suspended or terminated for not obtaining an examination, submitting a release, or satisfying a special appearance requirement.

(k) Failure to Complete Mandatory Orientation or Training

Hospitals require Practitioners and AHPs to complete training on a number of subjects, such as electronic medical records, HIPAA compliance, and infection control. This section imposes an automatic suspension when the Practitioner fails to do so.

Failure without good cause, as determined solely by the Medical Executive Committee, to complete in a timely manner any mandatory orientation or training required by the Hospital, the Governing Documents, or the Medical Executive Committee shall result in the automatic suspension of the member's Medical Staff privileges until such time as either the individual has successfully completed the required orientation or training or the Practitioner's or AHP's membership and privileges are automatically terminated. For the purposes of this section, "mandatory training" does not include training ordered as part of an individual determination regarding a Practitioner's competency, such as training ordered as part of an FPPE plan or as a corrective action.

Training is sometimes required on an individual basis as part of an FPPE or corrective action. In those cases, if a Practitioner fails to participate, the appropriate next step is for the Medical Executive Committee to determine whether other corrective action is warranted, rather than an automatic suspension (which, in these cases, would blur the line between peer review and administrative actions).

(l) Exclusive Contracts

(i) If the Hospital closes or continues the closure of a department or service pursuant to an exclusive contract, or if the Hospital transfers an exclusive contract, then the privileges covered by the exclusive contract shall automatically terminate if the Practitioner is not a party to, a subcontractor under, or a third-party beneficiary of the contract.

(ii) If a Practitioner is no longer a party to, a subcontractor under, or a third-party beneficiary of a contract to provide services to a closed department or service under an exclusive arrangement, the

Practitioner's privileges to provide such services shall be automatically terminated.

(m) Telemedicine

This provision applies only if using a delegated credentialing process.

If a Practitioner has telemedicine privileges granted through the processes detailed in the Processing of Telemedicine Membership and Privileges Section of the Procedures for Appointment and Reappointment Article, those privileges shall automatically terminate if: (a) the Practitioner no longer has the same privileges at the distant site hospital or entity that the Practitioner has been granted at this Hospital; or (b) if the distant site hospital or entity informs the Hospital that it has terminated or recommended the termination of the Practitioner's privileges and/or membership. If a Practitioner has telemedicine privileges granted through the processes detailed in Processing of Telemedicine Membership and Privileges Section of the Procedures for Appointment and Reappointment Article, those privileges shall be automatically suspended if the distant site hospital or entity informs the Hospital that it has suspended the Practitioner's privileges.

This approach – where the privileges at this hospital are terminated only upon the recommendation of termination by the distant site hospital or entity – is broad, and can be limited. However, because the hospital often has little direct oversight of the Practitioner, it may wish to proactively terminate whenever it receives such information. Hospitals should consult with legal counsel as to whether such automatic action would result in any reporting obligations or hearing and appeal rights.

15.9 Notification of Recommendation or Action to System Members

This notification provision is broad and includes notification of recommendations that are not yet final actions. Hospitals and Medical Staffs should consult with counsel before notifying any entity about a corrective action recommendation or action.

15.9.1 Whenever the Medical Staff or Hospital takes or recommends corrective action against an individual, the Medical Staff and Hospital may notify other System Members where the individual also practices, has privileges, or is applying for privileges, of: (a) the action recommended or taken; (b) the basis for the recommendation or action; (c) whether the individual has a right to challenge the action through a hearing; and (d) whether the individual has requested a hearing to challenge the action. The Medical Staff or Hospital also may share any other information it determines to be appropriate regarding the action with other System Members.

15.9.2 The Medical Staff and Hospital will ensure that any information shared complies with Hospital policies regarding patient confidentiality and, at a minimum, with HIPAA and California's laws regarding confidentiality. Any notification should take place within 10 days of the action or event, if possible.

15.10 Information Received From Other Entities

If the Hospital or Medical Staff is informed that a Practitioner or AHP is subject to a corrective action recommendation or action at another entity, that information will be referred to the Medical Executive Committee for investigation. If a Practitioner or AHP has been summarily restricted at a System Member, the Chief of Staff will, within one day of receiving notice, determine whether a summary action is justified at this Hospital pursuant to these Bylaws. If the Chief of Staff imposes a summary action, it will be reviewed in the same manner as other summary actions.

ARTICLE 16

HEARINGS AND APPEAL

The hearing and appeal provisions in these Bylaws are designed to comply with the requirements of California Business and Professions Code Section 809 et seq., as well as California case law. They also are designed to help Medical Staffs comply with the hearing standards of the federal Health Care Quality Improvement Act which, if met, can support the Hospital's immunity protections under federal law. Finally, these provisions are designed to promote efficient hearing processes.

Because publicly-owned Hospitals may have due process responsibilities beyond those reflected in this Model, those Hospitals and their Medical Staffs should consult with counsel before adopting or modifying their hearing and appeals processes.

16.1 Scope of Article

16.1.1 Throughout this Article, the term "Practitioner" applies to physicians, podiatrists, dentists, and psychologists who are applicants, members, and/or hold privileges to or on the Medical Staff.

16.1.2 The hearing and appeal procedures set forth in this Article do not apply to AHPs, including APPs [except for clinical psychologists], regardless of whether or not a corrective action must be reported to the AHP's licensing board.

Some Medical Staffs classify clinical psychologists as members; others classify them as AHPs. Regardless, they are entitled to hearing rights under Business and Professions Code Section 809. For hospitals that designate psychologists as AHPs, the highlighted language must be added.

16.1.3 This Article applies only to actions or recommendations taken for a medical disciplinary cause or reason and that require a report to the Practitioner's licensing board pursuant to Business and Professions Code Section 805 or to the National Practitioner Data Bank. If the Hospital or Medical Staff takes other actions or recommendations that adversely affect a Practitioner's ability to practice at the Hospital for more than 14 consecutive days, then the Practitioner may be entitled to the administrative review provisions described in the Rules and Regulations. However, no Practitioner is entitled to a hearing under this Article or to an administrative review in the Rules and Regulations if they are subject to an automatic suspension or automatic termination under these Bylaws, or if they are denied or terminated for failing to meet the minimum or general qualifications found in Bylaws Article 9.

Hospitals and Medical Staffs may want to adopt separate provisions to address restrictions that do not give rise to a hearing under Business and Professions Code Section 809 et seq., but that may create a common-law hearing right. Those hearing procedures do not have to be in the Medical Staff Bylaws, and instead can be included in the Rules and Regulations.

16.1.4 Individual Evaluations v. Requests to Review Rules and Requirements

The hearing and appeal rights established in these Bylaws are strictly "judicial" rather than "legislative" in structure and function. The triers of fact and hearing officer have no authority to adopt or modify rules and standards or to decide questions about the merits or substantive validity of any Governing Document. However, the Medical Executive Committee, in conjunction with the Governing Body may, in its discretion, entertain challenges to the merits or substantive validity of Governing Documents and decide those questions. If the only controversy is whether a Governing Document is lawful or meritorious, the Practitioner is not entitled to a hearing or appellate review. In such cases, the Practitioner must submit his or her challenges first to the Governing Body and only thereafter may he or she seek judicial intervention.

16.1.5 Substantial Compliance

Technical, non-prejudicial, or insubstantial deviations from the procedures set forth in these Bylaws shall not be grounds for invalidating the action taken.

16.2 Initiation of Hearing

16.2.1 Governing Body Action

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

When the Medical Staff fails to act in peer review matters, the Governing Body has the right to do so. If its actions give rise to a hearing right, then the Governing Body, rather than the Medical Staff, should have the authority to manage the hearing. This paragraph makes that responsibility explicit.

16.3 Grounds for Hearing

Except as otherwise specified in these Bylaws, any one or more of the following actions or recommendations shall constitute grounds for a hearing, but only if the final imposition of

the action would require the Hospital to file a report under California Business and Professions Code Section 805 or to the National Practitioner Data Bank:

(a) Denial of initial appointment or reappointment to the Medical Staff;

(b) Denial of requested clinical privileges;

(c) Suspension of Medical Staff membership and/or privileges for more than 14 consecutive days;

(d) Restrictions, including suspension and mandatory proctoring, imposed on privileges or membership for a cumulative total of 30 days or more during any 12-month period;

(e) Termination of Medical Staff membership and/or privileges;

(f) Any other disciplinary action or recommendation that must be reported to a Practitioner's licensing board under Business and Professions Code Section 805 or to the National Practitioner Data Bank.

No other recommendation or action will entitle a Practitioner to a hearing detailed in this Article. Voluntary restrictions, leaves of absence, and resignations are not disciplinary actions or recommendations, and do not entitle a Practitioner to a hearing under these Bylaws, regardless of whether or not they must be reported to the licensing board or the National Practitioner Data Bank.

California Business and Professions Code Section 809.1(a) provides that "[a] licentiate who is the subject of a final proposed action of a peer review body for which a report is required to be filed under Section 805" shall be entitled to notice and a hearing. Although resignations and voluntarily accepted restrictions must, under certain circumstances, be reported under Section 805, they do not constitute a "final proposed action" and, therefore, do not give rise to hearing rights.

16.4 Notice of Recommendation or Action

When an adverse action or adverse recommendation has been taken or made, the Chief of Staff shall promptly give the Practitioner Special Notice of the recommendation or action and of the right to request a hearing pursuant to this Article. The Notice of Recommendation or Action shall include the following information:

(a) A description of the recommendation or action;

(b) A brief statement of the basis for the recommendation or action;

(c) Whether the action, if adopted, must be reported under Business and Professions Code Section 805, and/or the National Practitioner Data Bank;

This is not required but should be included.

(d) A statement that the Practitioner has the right to request a hearing on the recommendation or action within 30 days of receipt of the notice, and that failure to request such a hearing in a timely manner shall result in the waiver of the right to a hearing; and

Hospitals should not change this deadline. To obtain the immunities available under the Health Care Quality Improvement Act, Medical Staffs should allow Practitioners at least 30 days to request a hearing.

(e) A summary of the Practitioner's rights under this Article and a copy of this Article.

Providing a copy of the Article is optional, but advisable.

16.4.2 Mediation

At any time before or after making a corrective action recommendation, the Medical Staff may offer the Practitioner the opportunity to mediate the dispute. The mediation shall be conducted in the manner described in the Rules and Regulations. The Practitioner agrees that requesting mediation tolls all the deadlines in this article other than the deadline to request a hearing within 30 days after receiving a Notice of Recommendation or Action described above.

16.4.3 Request for Hearing

(a) The Practitioner must submit any request for hearing in writing, addressed to the Medical Executive Committee with a copy to the Chief Executive Officer or his/her designee. The request must be received by the Medical Staff Administration within the deadline. The Practitioner shall state in writing within the request his or her intentions with respect to attorney representation.

(b) In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. In such cases, the Medical Staff's recommendation or action shall be considered by the Governing Body at its next meeting. The Governing Body shall give the recommendation great weight but may exercise its independent judgment in determining whether or not to adopt the recommendation or action.

16.4.4 Notice of Hearing and Notice of Charges

After receiving a request for hearing, the Chief of Staff will schedule the hearing and, at least 30 days prior to the hearing, provide to the Practitioner by Special Notice:

(a) The time, place, and date of the hearing;

(b) A list of the witnesses expected to testify at the hearing on the Medical Executive Committee's behalf, and

To take advantage of the immunity under the Health Care Quality Improvement Act, this should be included in the Notice of Hearing.

(c) The reasons for the final proposed action taken or recommended, including the acts or omissions with which the Practitioner is charged. This notice shall include a list of patient records (if applicable), and information supporting the recommendation. The notice may be supplemented or amended at any time, including during the hearing, so long as the additional material is relevant to the recommendation or the Practitioner's qualifications and the Practitioner has had a sufficient opportunity (at a minimum, 30 days) to review and respond to this additional material. No prior notice is required if the amendment removes any reasons for the final proposed action taken or recommended, including any of the acts or omissions identified.

This is an optional, but useful, provision.

16.4.5 Commencement of Hearing

The hearing shall begin no later than 60 days, and no sooner than 30 days, after receipt of the Practitioner's request for the hearing, and be completed within a reasonable time, unless the Hearing Officer issues a written decision finding that the Practitioner failed to comply with the document and witness list exchanges in a timely manner, or consented to the delay. The parties may agree in writing to set an alternative hearing date outside of this time frame, or the Hearing Officer may set an alternative hearing date upon a motion from either party or upon the Hearing Officer's own motion. A hearing is deemed to have commenced at the beginning of the voir dire of the Hearing Officer.

This 60-day outer-limit is required by Business and Professions Code Section 809.2. In practice, it is difficult to achieve.

The Business and Professions Code does not provide guidance as to what constitutes the beginning of a hearing; this is proposed to provide guidance.

16.5 Appointment of Trier of Fact and Hearing Officer

16.5.1 Trier of Fact

Medical Staff Bylaws generally refer to a "hearing committee" or "judicial review committee." As the law and practice of hearings has evolved, these terms no longer encompass the variety of fact-finders available in this process. Therefore, we refer to these committees and the arbitrator as the "triers of fact," which is the term used in Business and Professions Code Section 809.2 and is a more efficient way of referencing these bodies throughout this article.

In its sole discretion, the Medical Executive Committee shall select either a Judicial Review Committee, a Dedicated Review Panel, or an Arbitrator to serve as the trier of fact (the "Trier of Fact") at the hearing. The Medical Executive Committee shall inform the Practitioner of its decision at least thirty days prior to the hearing. The Trier of Fact shall have such powers as are necessary to discharge its responsibilities.

(a) Judicial Review Committee

(i) When the Medical Executive Committee elects to use a Judicial Review Committee as the Trier of Fact, the Chief of Staff shall appoint its members. Such appointment shall include designation of the Chair. A Hearing Officer who is not a Judicial Review Committee member shall preside over the hearing. The Judicial Review Committee shall carry out all the duties assigned to the Trier of Fact.

See further discussion regarding Hearing Officers, below.

(ii) The Judicial Review Committee shall be composed of at least three members of the Medical Staff who are in good standing and of good ethics. More than three members can be appointed to the Judicial Review Committee; in such cases, the hearing may continue if any Judicial Review Committee member resigns or is removed from the panel as long as at least three committee members remain. Preference shall be given to Active Staff members, but the Chief of Staff may appoint members from any staff category. If it is not feasible to appoint Medical Staff members, the Chief of Staff may appoint Practitioners who are not Medical Staff members. The Judicial Review Committee members shall gain no direct financial benefit from the outcome of the hearing, shall not be in direct economic competition with the Practitioner, and shall not have acted as accusers, investigators, fact finders, initial decision makers, or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a Medical Staff member from serving as a member of the Judicial Review Committee.

This language is the equivalent of appointing one or more alternates but gives all Judicial Review Committee members equal ability to deliberate and vote. In other words, no member believes him or herself to be superfluous to the process.

(iii) The Judicial Review Committee shall include at least one member who shall have the same healing arts licensure as the Practitioner and, where feasible, shall include an individual practicing the same specialty as the Practitioner. The failure to include an

individual practicing the same specialty as the Practitioner shall not be grounds to invalidate the outcome of the hearing.

16.5.2 Dedicated Hearing Panel

A "Dedicated Hearing Panel" is a relatively new concept. Traditionally, hearings have been held before panels made up of volunteers from the Medical Staff. Although this keeps the hearing peer-focused, it often results in delays and longer proceedings, arising from the difficulty of scheduling members who generally can only sit on the committee in the evenings, and who may have call or other professional or personal requirements. The Dedicated Hearing Panel addresses these concerns by contracting with committee members to attend the hearings during consecutive days, much like a courtroom proceeding. This allows the hearing to be completed much more efficiently and quickly, generally benefiting both the Medical Staff and the Practitioner. There is an added financial cost to the Medical Staff, but that is often made up for in the efficiencies of the process.

(a) When the Medical Executive Committee elects to use a Dedicated Hearing Panel as the Trier of Fact, the Chief of Staff shall appoint its members. Such appointment shall include designation of the Chair. A Hearing Officer who is not a Dedicated Hearing Panel member shall preside over the hearing. The Dedicated Hearing Panel shall carry out all the duties assigned to the Trier of Fact.

See further discussion regarding Hearing Officers, below.

(b) Dedicated Hearing Panel members must be willing to commit six or more hours per day on consecutive days, with the exception of weekends and holidays (unless otherwise stipulated by the parties) for the purpose of hearing evidence, engaging in deliberations, and reaching a decision.

(c) The Dedicated Hearing Panel must be comprised of at least three Practitioners. More than three members can be appointed to the Dedicated Hearing Panel; in such cases, the hearing may continue if any Dedicated Hearing Panel member resigns or is removed from the panel, as long as at least three committee members remain. The Dedicated Hearing Panel members need not be members of the Medical Staff but must be of good reputation and must either currently be practicing in their discipline or have practiced in their discipline within the last two years. The Dedicated Hearing Panel shall include at least one member who shall have the same healing arts licensure as the Practitioner and, where feasible, shall include an individual practicing the same specialty as the Practitioner.

This language is the equivalent of appointing one or more alternates but gives all Judicial Review Committee members equal ability to deliberate and vote. In other words, no member believes him or herself to be superfluous to the process. All of this is optional but provides guidance as to who qualifies to sit on the panel.

(d) The Dedicated Hearing Panel members shall gain no direct financial benefit from the outcome of the hearing, shall not be in direct economic competition with the Practitioner, and shall not have acted as accusers, investigators, fact finders, initial decision makers or otherwise actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude anyone from serving as a member of the Dedicated Hearing Panel.

16.5.3 Arbitrator

(a) When the Medical Executive Committee elects to use an arbitrator as the Trier of Fact, the Medical Executive Committee and the Practitioner may stipulate to the arbitrator who shall serve, subject to voir dire. Otherwise, the arbitrator shall be selected using the process detailed in this article. By applying for and/or accepting membership or privileges on this Medical Staff, the Practitioner agrees this process is acceptable. The arbitrator shall meet the same qualifications as the Hearing Officer, as detailed in this article. The arbitrator shall carry out all the duties assigned to the Hearing Officer and to the Trier of Fact. If an arbitrator is appointed, no additional Trier of Fact or Hearing Officer shall be appointed, and all references in these Bylaws to the Trier of Fact or Hearing Officer duties and responsibilities shall be read as the arbitrator's duties and responsibilities. The arbitrator shall be selected as follows:

Business and Professions Code Section 809.2 provides that if the hearing is held before an arbitrator, the arbitrator must be "selected by a process mutually acceptable to the" Practitioner and Medical Staff. Settling on a "mutually acceptable process" can, in contentious hearings, be time-consuming and result in delay. This model suggests inserting a "mutually acceptable" process in the Bylaws, to which the Practitioner must agree if he or she chooses to apply to and practice at the Hospital. This approach, however, has not yet been adjudicated or approved by California courts.

This (the arbitrator shall meet the same qualifications as the Hearing Officer) is optional but is more likely to result in an arbitrator with sufficient knowledge and experience with Medical Staff law.

(i) Within 21 days of requesting a hearing, the Practitioner must send to the Medical Executive Committee a list of at least three attorneys whom he or she would accept as Arbitrator. If the Practitioner fails to provide a list, then the Medical Executive Committee shall initiate the Arbitrator selection process as if it had rejected the Practitioner's list of nominees as provided below.

(ii) The Medical Executive Committee may select the Arbitrator from the Practitioner's list. If the Medical Executive Committee

does not accept any of the Arbitrator nominees identified by the Practitioner, the Medical Executive Committee must provide the Practitioner a written list of at least three potential Arbitrators within 10 days after rejection of the Practitioner's list.

(iii) The Practitioner shall have 10 days from his/her receipt of the Medical Executive Committee's list to select an Arbitrator from the list. If the Practitioner fails to either select an Arbitrator or to reject all the names on the list within that time, then the Medical Executive Committee may select any person on its list as the Arbitrator.

(iv) If the Practitioner timely rejects the Medical Executive Committee's list, then the Practitioner and the Medical Executive Committee shall each designate one name from their respective lists. The persons designated shall, within five days, select an Arbitrator who shall be appointed subject to voir dire. If the persons designated fail to select an Arbitrator timely, the process shall be repeated with other names selected from the parties' respective lists until an Arbitrator is selected.

(v) If, for any reason, the person so identified is not available, cannot otherwise serve, or, after voir dire, is unacceptable to both the Medical Executive Committee and the Practitioner, the same process set forth in this section will be followed until an Arbitrator is selected and agrees to serve.

(b) If the failure or refusal of the Practitioner to agree to an Arbitrator makes it impracticable to commence the hearing within the time frames set forth above, the time for commencement of the hearing shall be extended to thirty days after an Arbitrator is selected.

(c) Nothing in the above sections shall be construed as limiting the ability of the Practitioner and Medical Executive Committee to select an arbitrator through a different mutually acceptable process.

16.5.4 Payment and Confidentiality of Patient Information

Payment of panel members is not required and, with regard to Judicial Review Committee members, is controversial. Some Medical Staffs contend that such service should be voluntary as part of Medical Staff "citizenship." However, hearings can become complicated and time-consuming, and both fairness and expediency support allowing such payments in order to help assure the panel will remain dedicated to the process until its conclusion.

Payment of physicians may have Stark and anti-kickback implications; hospitals should carefully review any payment arrangements to assure compliance.

Additionally, California case law regarding the payment of triers of fact is evolving. Two cases, Haas v. County of San Bernardino *(2002) 27 Cal.4th 1017 and* Yaqub v. Salinas Valley Memorial Healthcare System *(2004) 122 Cal.App.4th 474, together suggested that the possibility that a trier of fact might benefit from future engagements by the medical staff could raise the "appearance of bias," which would disqualify the triers of fact from serving. However, a recently published Court of Appeal decision (*Natarajan v. Dignity Health *(Cal. Ct. App., Oct. 22, 2019, No. C085906) 2019 WL 5387284)) rejected this line of reasoning for privately owned hospitals, at least when it comes to the selection of hearing officers. (Note: At the time this Model was released, the window of time during which the parties in Natarajan could request review by the California Supreme Court was still open; therefore, it is possible that review might be requested and granted, and a California Supreme Court decision could at some point supersede the Court of Appeal decision.)*

Because Natarajan *addresses the payment of hearing officers, not triers of fact, Hospitals and Medical Staffs should discuss with their counsel whether safeguards against the appearance of bias are necessary whenever the Medical Staff unilaterally selects and compensates the trier of fact. Such safeguards could include, for example, requiring trier of fact members to agree that they will not accept appointment as a paid trier of fact member for the Medical Staff for at least three years following the conclusion of the current hearing and appeal process.*

Publicly owned hospitals have different responsibilities than privately-owned hospitals, and publicly owned hospitals should discuss with counsel their responsibilities under Hass *and* Yaqub*. Publicly owned hospitals may want to adopt the waiting period described above in order to avoid the appearance of bias.*

(a) Triers of Fact may be paid by the Hospital, by the Medical Staff, or their fees split between the parties. The Medical Staff will refer all such payment arrangements to the Hospital to ensure legal compliance.

(b) Any Trier of Fact who is not a Medical Staff member shall be required to sign a business associate agreement with the Hospital before serving.

16.5.5 The Hearing Officer

Hearing officers are optional under Business and Professions Code Section 809, and Medical Staffs can instead appoint a "presiding officer" from the hearing committee. However, given that hearings have become very legalistic under California law, our position is that Medical Staffs should always appoint a hearing officer (unless using an arbitrator) to act as the presiding officer. Moreover, hearing officers should be familiar with Medical Staff law and hearings. This model provides guidance regarding hearing officer qualifications.

(a) The Medical Executive Committee shall appoint a Hearing Officer to preside at the hearing before a judicial review committee or a dedicated

hearing panel. 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 Practitioner 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, shall not be in direct economic competition with the Practitioner, and must not act as a prosecuting officer or as an advocate.

As required by Business and Professions Code Section 809.2(b).

(b) The Medical Executive Committee will attempt to appoint a Hearing Officer that is acceptable to the Practitioner. In the event that the Medical Executive Committee and the member cannot agree on the Hearing Officer, the Medical Executive Committee may unilaterally appoint a Hearing Officer who meets the Hearing Officer qualifications described in these Bylaws.

The California Society for Healthcare Attorneys maintains a list of qualified hearing officers. Hospitals and Medical Staffs should always independently vet the qualifications of the any hearing officer before engagement; however, this list is a good place to start.

Notably, California case law regarding the payment of Hearing Officers is evolving. Two cases, Haas v. County of San Bernardino *(2002) 27 Cal.4th 1017 and* Yaqub v. Salinas Valley Memorial Healthcare System *(2004) 122 Cal.App.4th 474, together suggested that the possibility that a Hearing Officer might benefit from future engagements by the medical staff could raise the "appearance of bias," which would disqualify the Hearing Officer from serving. However, a recently published Court of Appeal decision (*Natarajan v. Dignity Health *(Cal. Ct. App., Oct. 22, 2019, No. C085906) 2019 WL 5387284)) rejected this line of reasoning for privately owned hospitals. (Note: At the time this Model was released, the window of time during which the parties in* Natarajan *could request review by the California Supreme Court was still open; therefore, it is possible that review might be requested and granted, and a California Supreme Court decision could at some point supersede the Court of Appeal decision.)*

Publicly owned hospitals have different responsibilities than privately-owned hospitals, and publicly owned hospitals should discuss with counsel their responsibilities under Hass *and* Yaqub. *Publicly owned hospitals may want to adopt the waiting period described above in order to avoid the appearance of bias.*

(c) 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, and 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. These rulings shall be consistent with legal authority and the provisions of this Article.

(d) When no attorney accompanies a party to the proceedings, the Hearing Officer shall have the authority to interpose and rule on appropriate objections throughout the course of the hearing. The Hearing Officer shall not, however, have the authority to override or revise the Representation section of this Article.

(e) 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 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.

(f) The Hearing Officer may participate in the deliberations of the committee and be a legal advisor to it, but the Hearing Officer shall not be entitled to vote. The Hearing Officer may assist in preparation of the Trier of Fact's report and recommendations.

16.5.6 Voir Dire

The Practitioner and the Medical Executive Committee shall be entitled to a reasonable opportunity to question and challenge the impartiality of Trier of Fact members and the Hearing Officer. Challenges to the impartiality of any Trier of Fact member or the Hearing Officer shall be ruled on by the Hearing Officer.

Although it may appear odd for the Hearing Officer to rule on his or her own impartiality, Business and Professions Code Section 809.2(c) specifically provides this.

16.6 Prehearing Process

16.6.1 General Procedures:

The pre-hearing and hearing processes shall be conducted in an informal manner that is consistent with Business and Professions Code Section 809 et seq. Formal rules of evidence or procedure shall not apply.

16.6.2 Witness List

(a) If either side to the hearing requests in writing a list of witnesses, then at least 10 days before the hearing the parties shall exchange lists of witnesses expected to testify. The list shall include a brief description of the subject(s) about which the witness is expected to testify. The failure to disclose the identity of a witness at least 10 days before the

commencement of the hearing shall constitute good cause for a continuance.

(b) The witness list of either party may be amended or supplemented any time during the course of the hearing. If an addition of a witness to the list occurs after the commencement of the hearing, this shall be good cause for a 10-day continuance prior to the introduction of the additional witness's testimony.

This may cause disruption if the hearing is scheduled to occur on consecutive days; however, Business and Professions Code Section 809.2(f) provides that the failure to disclose the identity of a witness at least 10 days before the commencement of the hearing is good cause for a continuance.

(c) If the hearing officer allows evidence to be presented on rebuttal, the hearing officer may, in his or her authority to promote an efficient and fair process, find that witnesses who were not previously on the witness list may be presented on rebuttal without requiring 10 days advance notice.

As noted above, the failure to disclose the identity of a witness at least 10 days before the hearing is good cause for a continuance; however, it often is hard to predict who may need to be called as a rebuttal witness. This provision allows the hearing officer the option of determining that the witness may be called without a continuance.

It is unclear whether the provision in Business and Professions Code Section 809.2(f) that failing to identify a witness is "good cause" for a continuance would permit the hearing officer to exercise his or her discretion not to grant a continuance for rebuttal witnesses.

16.6.3 Provision of Relevant Information

(a) Each party shall have the right to inspect and copy, at its own expense, any documentary information or other evidence relevant to the charges which the other party has in its possession or under its control, as soon as practicable after the party's request for inspection. The requests for discovery shall be fulfilled as soon as practicable. 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 Practitioners or AHPs, other than the Practitioner under review.

(b) The Hearing Officer shall consider and rule upon any dispute or controversy concerning a request for access to information and may impose any safeguards for the protection of the peer review process and as justice requires. When ruling upon requests for access to information and

determining its relevancy, the Hearing Officer shall consider, among other factors, the following:

(i) Whether the information sought may be introduced to support or defend the charges.

(ii) The exculpatory or inculpatory nature of the information sought, if any; i.e., whether there is a reasonable probability that the result of the hearing would be influenced significantly by the information if received into evidence.

(iii) The burden imposed on the party in possession of the information sought, if access is granted.

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

(c) As a condition of membership, the Practitioner agrees that all documents and information disclosed at any time during the peer review process, including information disclosed as part of the hearing process, will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. Any inappropriate use by the Practitioner of information disclosed by the Medical Executive Committee during the hearing shall be grounds for the Trier of Fact to find that the Practitioner has committed flagrant or repeated noncompliance with this Article in a manner that prejudices the other party and constitutes a waiver of hearing rights, leading to a termination of the hearing in the Medical Staff's favor. It also shall be grounds for additional corrective action against the Practitioner.

This provision is optional. Practitioners may have incentives to use peer review information received during this process in other proceedings (such as civil court proceedings), or to disclose information publicly. This provision makes doing so grounds to terminate the hearing in the Medical Staff's favor. Such a consequence has not been evaluated by California courts, and Hospitals should consult with counsel before requesting this remedy during a hearing.

(d) Prior to receiving any documents, the Practitioner must provide a written representation that his or her counsel or other representative and any experts expected to testify have executed any agreements necessary to protect Protected Health Information contained in any documents provided.

Although Medical Staffs may share confidential patient information with its members as part of peer review, it cannot directly share that information with the Practitioner's counsel. Practitioners should share that information only if they have a HIPAA-compliant Business Associate Agreement with their attorneys.

(e) No party will have any right to discovery beyond the above information. Civil discovery provisions shall not apply. No confidential information will be provided regarding other Practitioners or Allied Health Staff.

(f) At the request of either party, the parties must exchange all documents and other evidence that will be introduced at the hearing. The documents must be exchanged at least 10 days prior to the hearing. A failure to comply with this rule shall constitute good cause for a continuance.

(g) Before a Practitioner, or any person acting on the Practitioner's behalf, may contact any Hospital employee, Medical Staff member, or Allied Health Staff member whose name is on the Medical Executive Committee's witness list or other document exchanged during the pre-hearing process, the Practitioner must: (i) notify the Chief of Staff in writing of his or her intent to contact the individual, (ii) agree in writing to respect any decision by the individual not to discuss the matter with the Practitioner or the Practitioner's representative, and (iii) not contact the individual until seven days after the Medical Executive Committee (or, in the case of a Hospital employee, the Medical Executive Committee and a representative of the Human Resources department jointly) sends the potential witness a letter informing him or her that any decision to, or not to, discuss the matter with Practitioner is voluntary and will not impact the individual's employment or member status. The Medical Executive Committee will send that letter to the individual, with a copy to the Practitioner, within seven days after receiving the required notice and written agreement from the Practitioner. If the Practitioner behaves in a manner that may be considered harassing to the witness, that shall be grounds for the Trier of Fact to find that the Practitioner has committed flagrant or repeated noncompliance with this Article in a manner that prejudices the other party and the Hearing Officer or the Trier of Fact may take appropriate action, up to and including action pursuant to the Conduct of Hearing Section.

This provision is optional and should be further discussed before adoption. Hospitals and Medical Staffs may also want to consult legal counsel before adopting. The provision is intended to protect potential witnesses from harassment but should not be used to interfere with a Practitioner's preparation for a hearing.

16.6.4 Pre-Hearing Conference

This is optional but is useful to have procedural matters addressed prior to the hearing itself.

(a) The Practitioner and the Medical Executive Committee shall exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing

as possible, so that decisions concerning such matters may be made in advance of the hearing.

(b) The Hearing Officer may require the Practitioner and the Medical Executive Committee (or a representative of each) to participate in a pre-hearing conference, which the parties and Hearing Officer shall endeavor to hold no later than two days prior to the hearing.

(c) At the pre-hearing conference, the Hearing Officer will attempt to resolve all procedural questions, including any objections to exhibits or witnesses.

(d) Objections to any prehearing decisions may be succinctly made at the hearing, typically outside of the presence of the Trier of Fact, and shall be preserved for consideration in any appellate review proceeding.

16.6.5 Stipulations

The parties will use their best efforts to develop and agree upon stipulations to provide for a more efficient hearing.

16.7 The Hearing

16.7.1 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, including failure to comply with the Bylaws or Rules and Regulations of the Medical Staff. Accordingly, the Practitioner is entitled to representation at the hearing as follows:

(a) The Practitioner and the Medical Executive Committee may stipulate to allow greater participation by attorneys in the hearing than the provisions below describe. Otherwise, the provisions below will control.

(b) If the Practitioner wishes to be accompanied at the hearing by an attorney, he/she shall give notice of such intent in the written Request for Hearing. If the Practitioner changes his or her mind regarding attorney representation at the hearing, he or she must notify the Medical Executive Committee of this change as soon as possible. If the notification occurs within 30 days prior to the start of the hearing, or after the start of the hearing, this shall be good cause for the Medical Executive Committee to be granted a continuance and the Hearing Officer shall, upon request from the Medical Executive Committee, grant the Medical Executive Committee a continuance.

(c) The Medical Executive Committee representative shall not be accompanied by an attorney at the hearing if the Practitioner is not accompanied by an attorney. However, regardless of whether the Practitioner elects to have attorney representation at the hearing, each

party has the right to engage legal counsel to assist in preparing for a hearing or an appellate review.

(d) Attorneys for either party may accompany their clients in the hearing sessions in order to represent and advise their clients. Attorneys shall not examine witnesses, shall not address the Trier of Fact, and shall not make oral statements in the hearing.

This subsection 16.7.1(d) should not be adopted by publicly-owned hospitals.

For those hospitals that are not publicly owned, this is a purely optional provision. California law does not require attorney representation (much less participation) at hearings. However, the Health Care Quality Improvement Act provides (among other things) immunity from liability to professional review bodies and certain individuals for taking professional review actions if the hospital complies with certain statutory provisions.

Among those provisions is the requirement to provide adequate notice and hearing to a Practitioner who is subject to a professional review action. A health care entity can be deemed to meet the notice and hearing requirements if the hearing includes certain provisions described in the statute, including the right to representation by an attorney or other person of the physician's choice. However, the 9th Circuit Court of Appeal decision in Smith v. Ricks, 31 F.3d 1478 (1994), provides that an attorney need only be present at the hearings to meet the HCQIA standard. Importantly, failing to adopt the notice and hearing details described in the statute does not, itself, constitute a failure to provide adequate notice and hearing.

Before adopting this provision, hospitals and Medical Staffs should consult with legal counsel.

(e) Whether or not attorneys are present in the hearing pursuant to this Article, the Practitioner and the Medical Executive Committee may be represented at the hearing by a Practitioner licensed to practice medicine, podiatry, dentistry, or psychology in the State of California, who is not also an attorney at law.

(f) The Hearing Officer shall not allow the presence of attorneys at the hearing to be disruptive or cause a delay in the hearing process.

16.7.2 Burdens of Presenting Evidence and Proof

(a) At the hearing, the Medical Executive Committee shall have the initial duty to present evidence in support of its action or recommendation.

(b) An initial applicant shall bear the burden of persuading the Trier of Fact, 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 not produced upon request of the Medical Staff during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

(c) Except as provided above for initial applicants, the Medical Executive Committee shall bear the burden of persuading the Trier of Fact by a preponderance of the evidence that its action or recommendation is reasonable and warranted. In meeting this burden, the Medical Executive Committee shall not be limited to presenting only that information available to it at the time it imposed or recommended the action, but rather may present any relevant information (within the limits discussed elsewhere in this article) available to it at the time of the hearing.

Medical Staff Bylaws should not limit the Medical Executive Committee's case to only that information known to it at the time it made the recommendation. The standard in Business and Professions Code Section 809.3 is whether "the action or recommendation is reasonable and warranted," (emphasis added) not whether it was reasonable and warranted. This is consistent with the patient protection goals of peer review – it is perverse to have a standard that would limit the Medical Executive Committee's ability to rely on information that demonstrates that the Practitioner may pose a threat to patients simply because it was discovered after the Medical Executive Committee made its recommendation.

(d) The Medical Executive Committee is not required to prove each and every charge or issue in front of the Trier of Fact in order for its actions and/or recommendations to be found reasonable and warranted.

This optional statement provides guidance to the Trier of Fact.

(e) "Reasonable and warranted" means within the range of alternatives reasonably open to the Medical Executive Committee under the circumstances, and not necessarily that the action or recommendation is the only measure or the best measure that can be taken or formulated in the Trier of Fact's opinion.

16.7.3 Record of Hearing

A court reporter shall make a record of the hearing proceedings and, if deemed appropriate by the Hearing Officer, the pre-hearing proceedings. The cost of the court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the requesting party. The Practitioner is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record. The Hearing Officer 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.

16.7.4 Rights of Both Sides at the Hearing

(a) At a hearing, both sides will have the following rights, subject to reasonable limits determined by the Hearing Officer:

(i) To call and examine witnesses, to the extent they are available and willing to testify;

(ii) To introduce exhibits;

(iii) To cross-examine any witness on any matter relevant to the issues;

(iv) To receive all information made available to the Trier of Fact; and

(v) To submit a written argument that may include proposed findings, conclusions and recommendations to the Trier of Fact after the conclusion of the hearing sessions.

(b) If the Practitioner does not testify, he or she may be called by the Medical Executive Committee or the Trier of Fact, or both, and questioned as if the Practitioner was under cross examination.

16.7.5 Conduct of Hearing

(a) The Trier of Fact may question witnesses, request the presence of additional witnesses, and/or request documentary evidence, all of which must occur during the hearing sessions, subject to objections by either party, which shall be resolved by the Hearing Officer.

Optional provision.

(b) Upon motion of either party or the Hearing Officer, the Trier of Fact may terminate the hearing if it finds that either party has:

In Mileikowski v. West Hills Hospital and Medical Center et al*., 45 Cal. 4th 1259 (2009), the California Supreme Court determined that a hearing officer may not unilaterally terminate a hearing, because such a decision is tantamount to a decision on the merits, which should only be made by the hearing committee.*

(i) Exhibited flagrant or repeated noncompliance with this Article in a manner that prejudices the other party or results in repeated delays to the hearing process,

(ii) Egregiously interfered with the orderly conduct of the hearing, or

(iii) Failed to appear at the hearing.

(c) If the motion to terminate is based on the Practitioner's failure to appear at the hearing, the Trier of Fact shall find that the Practitioner has waived his or her hearing rights if he or she has failed to appear at the hearing, unless the Practitioner can prove that an unforeseen and unanticipated emergency prevented him or her from attending.

(d) A finding that the termination results from the Practitioner's noncompliance or egregious conduct shall result in a finding that the Practitioner has waived his or her right to a hearing.

(e) The Hearing Officer shall be permitted to advise the Trier of Fact regarding his or her recommendation regarding the disposition of the motion. Evidence of, or a finding that, a party intended to prejudice the other party, delay the hearing process, or interfere with the orderly conduct of the hearing is not necessary to support or grant the motion to terminate the hearing.

(f) The party against whom the terminating sanctions have been ordered may appeal the terminating order to the Governing Body. The appeal must be requested within 10 days of the terminating order, and the scope of the appeal shall be limited to reviewing the appropriateness of the terminating order. The appeal procedure shall be in accordance with the appeal provisions of this Article. If the Governing Body, using its independent judgment but giving great weight to the Trier of Fact's determination, finds that the order to terminate the hearing is unwarranted, the Trier of Fact shall reconvene and resume the hearing.

16.7.6 Admissibility of Evidence

(a) Except as provided below, judicial rules of evidence and procedure relevant to the conduct of the hearing, examination of witnesses, and presentation of evidence shall not apply to a hearing conducted under this Article. Except as provided in 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.

(b) Notwithstanding the above, (1) the attorney-client privilege and the privilege for confidential marital communications shall apply during the hearing; (2) the physician-patient privilege and the psychotherapist-patient privilege shall apply during the hearing, but only if the Practitioner is the patient; and (3) evidence of mediation, compromise, or offers of settlement, as well as any conduct or statements made in negotiation thereof, is inadmissible to prove either parties' opinion regarding the strength or weakness of evidence supporting the corrective actions or recommendations. Communications that confirm that mediation or settlement discussions were mutually accepted and pursued may be disclosed and admitted as proof that otherwise applicable time frames

were tolled or waived or to demonstrate the good faith of the parties in their attempts to resolve the matter.

In the case of Smith v. Selma Community Hospital, 164 Cal.App. 4th 1478 (2008)*, the Court of Appeal found (among other things) that evidence regarding settlement discussions was admissible due to the broad rules of admissibility found in that Medical Staff's Bylaws. This is addressed here by allowing such discussions to be admissible in very narrow circumstances, and not to reflect on the strength of either party's case.*

16.7.7 Presence of Trier of Fact

All the members of the Trier of Fact must be present throughout the hearing and deliberations unless both parties agree that any one member need not attend a particular hearing session or committee meeting. In unusual circumstances when a Trier of Fact member must be absent from any part of the proceedings, he or she shall not be permitted to participate in the deliberations or the decision unless and until he or she confirms that he or she has read the entire transcript of the portion of the hearing from which he or she was absent.

Medical Staffs should rarely agree to allow a Trier of Fact member to be absent from a hearing session, especially as the Medical Staff generally has the burden of proof and benefits from putting on its case directly to the Trier of Fact.

16.7.8 Failure to Appear

Under no circumstances shall the hearing be conducted without the presence of the Practitioner. Failure without good cause of the Practitioner to personally attend and proceed at such a hearing shall be deemed to constitute voluntary acceptance of the recommendations or actions involved.

16.7.9 Postponements and Extensions

Postponements and extensions of time may be requested by either party, the Trier of Fact, or the Hearing Officer, but will be permitted only upon either stipulation by both parties, or by the Hearing Officer on a showing of good cause. Extensions of time necessary to appoint the Trier of Fact or Hearing Officer shall be deemed good cause so long as both parties are proceeding in good faith.

16.8 Hearing Conclusion, Deliberations, and Decision

Within 30 days after final adjournment of the hearing, or 15 days if the Practitioner is currently under summary suspension, the Trier of Fact shall render a decision which shall be accompanied by a written report; this decision and report shall be delivered to the Medical Executive Committee, the Chief Executive Officer or his/her designee, and by Special Notice to the Practitioner. The report and decision shall include the Trier of Fact's findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Unless the hearing was before an arbitrator, the final decision of

the Trier of Fact must be sustained by a majority vote of the committee. Both the Practitioner and the Medical Executive Committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the Trier of Fact shall be subject to the rights of appeal or review as described in these Bylaws.

16.9 Appeal Procedure

Under Health and Safety Code Section 32150 et seq., district hospitals are required to provide an appellate review process. TJC Standard MS.10.01.01, EP 5, also requires accredited hospitals to provide a mechanism to appeal adverse decisions. For non-district, non-TJC accredited hospitals, this is optional but recommended.

16.9.1 Time for Appeal

Within 30 days after receiving the decision of the Trier of Fact, either the Practitioner or the Medical Executive Committee may request an appellate review. The appealing party shall submit a written statement concisely stating the specific grounds for appeal. The written request shall be delivered to the Chief of Staff, the Chief Executive Officer, and the other party. If appellate review is not requested within such period, the Trier of Fact's decision shall thereupon become the final recommendation of the Medical Staff. The Governing Body shall consider the decision within 70 days and shall give it great weight.

16.9.2 Grounds for Appeal

The grounds for appeal shall be limited to:

(a) Substantial non-compliance with the procedures required by these Bylaws or applicable law which has created demonstrable prejudice.

(b) The decision was arbitrary, capricious, or unsupported by credible evidence.

16.9.3 Time, Place and Notice

If an appellate review is to be conducted, the Appeal Board, within 30 days after receiving a request for appeal, shall schedule a review date and cause each side to be given notice (with Special Notice to the Practitioner) of the time, place, and date of the appellate review. The appellate review shall commence within 60 days from the date such notice is provided; however, when a request for appellate review concerns a member who is under suspension which is then in effect, the appellate review should commence within 45 days from the date the request for appellate review was received. The time for appellate review may be extended by the Appeal Board for good cause.

16.9.4 Appeal Board

(a) The Governing Body may sit as the Appeal Board, or it may appoint an Appeal Board which shall be composed of not less than three members of the Governing Body.

(b) 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, investigation, or recommendation on the same matter.

(c) The Appeal Board may engage an attorney to advise it in the proceeding. If an attorney is selected, and if the Appeal Board so chooses, he or she may act as a presiding officer and shall have the authority, subject to the direction of the Appeal Board, to issue rulings on any procedural matter that arises during the appeal process, as well as any other authority granted by the Appeal Board. Alternatively, the Appeal Board may appoint a hearing officer to preside over the hearing, with the authority to rule on any procedural matter that arises during the appeal process, as well as any other authority granted by the Appeal Board. Regardless of whether the Appeal Board engages an attorney as an advisor or as a hearing officer, that attorney shall not be entitled to vote with respect to the appeal.

The role of an attorney advisor and the role of a Hearing Officer (such as one engaged for the Trier of Fact hearing) are different. If the Hospital engages an attorney to advise the Appeal Board, communications between the attorney and the Appeal Board should be subject to the attorney-client privilege.

However, some Hospitals choose not to engage external counsel as a legal advisor, but rather prefer to engage an attorney as a hearing officer instead.

(d) The Appeal Board shall have such powers as are necessary to discharge its responsibilities.

16.9.5 Appeal Procedure

(a) The proceeding by the Appeal Board shall, at the discretion of the Appeal Board, either be a de novo hearing or an appellate hearing based upon the record before the Trier of Fact.

(b) If the proceeding is an appellate hearing based on the record before the Trier of Fact, the Appeal Board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available during the hearing in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the hearing. Alternatively, the Appeal Board may remand the matter to the Trier of Fact for the taking of further evidence and for decision.

(c) Each party shall have the right to present a written statement in support of the party's position on appeal. The appellate Hearing Officer may establish reasonable time frames for the appealing party to submit a written statement and for the responding party to respond. Each party has the right to personally appear and make oral argument. The Appeal Board may then, at a time convenient to itself, deliberate outside the presence of the parties.

(d) 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.

16.9.6 Decision

(a) Within 30 days after the adjournment of the appellate review proceeding, the Appeal Board shall render a final decision in writing. Final adjournment shall not occur until the Appeal Board has completed its deliberations.

(b) The Appeal Board may affirm, modify, or reverse the decision, or it may remand the matter for further review by the Trier of Fact or any other body designated by the Appeal Board. If the Appeal Board remands the matter back to the Trier of Fact, it will provide direction to the Trier of Fact for its further consideration and shall set a deadline for the Trier of Fact to complete its further review.

(c) The Appeal Board shall give great weight to the Trier of Fact decision and shall not act arbitrarily or capriciously. The Appeal Board may, however, exercise its independent judgment in determining whether a Practitioner was afforded a fair hearing and whether the Trier of Fact's decision is reasonable and warranted. The Appeal Board's decision shall specify the reasons for the action taken and provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such reasons, findings, and conclusions differ from those of the Trier of Fact.

(d) The Appeal Board shall forward copies of its decision to each party.

(e) If the Governing Body sat as the Appeal Board, the Appeal Board's decision shall be deemed the Governing Body's final decision. If a committee sat as the Appeal Board, then it shall submit its decision to the Governing Body for final action. The Governing Body shall adopt the Appeal Board's decision as its own, which shall become the Governing Body's final decision, unless the Governing Body, on its own motion and exercising its independent judgment, finds that the Practitioner was not afforded a fair hearing in compliance with these Bylaws. In such cases, the matter will be referred back to the Trier of Fact for further proceedings.

(f) The final decision of the Governing Body shall be effective immediately and shall not be subject to further review.

16.10 Additional Provisions

16.10.1 Right to One Hearing and One Appeal Only

Except in circumstances where a new hearing is ordered by the Governing Body or a court, no Practitioner shall be entitled to more than one evidentiary hearing and one appellate review on any particular adverse action or recommendation, or on any matter that has resulted in an adverse action or recommendation.

16.10.2 Exhaustion of Remedies

If an adverse action is taken or recommended, the Practitioner must exhaust the administrative remedies afforded by these Bylaws before resorting to legal action.

16.11 Joint Hearing

Hospitals and other health care entities, such as medical groups, often "share" Practitioners. It is not uncommon that more than one health care entity will take action against a shared Practitioner at the same time, especially if the entities are System Members. In such cases, these entities may find that having a single, joint hearing, rather than separate hearings, results in greater efficiencies and better decision-making. Practitioners also can benefit from this arrangement, as it limits the cost of participating in multiple hearings.

Joint hearing provisions like this one, however, have not been scrutinized by California courts. It is unclear how a court would rule if they were ever challenged. Therefore, these provisions include "safeguards" designed to improve their likelihood of being upheld, including (a) a joint hearing is held only if the Practitioner agrees to it; and (b) the agreed upon hearing procedures must be compliant with Business and Professions Code Section 809 et seq., and with the Health Care Quality Improvement Act.

16.11.1 General Provisions

(a) If (1) the Hospital has an information sharing agreement with another health care entity(ies), as provided in the Rules, (2) the Hospital or Medical Staff takes adverse action or makes an adverse recommendation against a member on the same or similar grounds as an adverse action or adverse recommendation undertaken by that other health care entity(ies), and (3) such adverse action or adverse recommendation provides hearing rights to the member at both the Hospital and the other health care entity(ies), then the Hospital's Medical Executive Committee, the other health care entity(ies), and the Practitioner may agree to hold a single, joint hearing process to address the actions and recommendations at the Hospital and the other health care entity(ies) ("Joint Hearing Process"). If the Practitioner does not agree to the Joint Hearing Process, a Joint Hearing Process will not be held and the Hospital and the other health care

entity(ies) will hold individual hearings pursuant to their own Bylaws or policies.

Not all health care entities have or are "peer review bodies" under California law. Therefore, they may not be able to take advantage of the same discovery or immunity protections that apply to peer review bodies. Before entering into sharing agreements, and especially before participating in joint hearings as provided under this section, Hospitals should take into account how this process may impact the security of their own confidential peer review information.

(b) To the extent that any of the hearing provisions, including the Joint Hearing Process provisions, in the Hospital Medical Staff Bylaws and the other health care entity(ies)'s Bylaws or policies differ, the Medical Executive Committees and the other health care entity(ies) shall jointly determine which entity's hearing provisions shall govern the Joint Hearing Process. At the very least, the agreed upon provisions must comply with the hearing procedures found in California Business & Professions Code Section 809 et seq., and with the Health Care Quality Improvement Act. In the event the Medical Executive Committee and other health care entity(ies) are unable to agree on which Bylaws' hearing procedures, including the Joint Hearing Process procedures, will apply to the hearing, then no Joint Hearing Process will be held and the Hospital and the other health care entity(ies) will hold individual hearings pursuant to their own Bylaws or policies.

(c) If a Joint Hearing Process is held, it shall commence at such time as the parties agree in writing to have a single, joint hearing.

(d) Notwithstanding which hearing provisions are agreed upon, if a hearing conducted as part of the Joint Hearing Process is held before a Judicial Review Committee, the Judicial Review Committee shall have at least one participating and voting member from this Medical Staff and at least one participating and voting member from the each of the other health care entity(ies).

16.11.2 Independent Rights

(a) The Hospital and each of the other health care entity(ies) shall be considered separate parties in the Joint Hearing Process and may be separately represented in a manner permitted by the hearing provisions selected for the Joint Hearing Process.

(b) The Hospital and the other health care entity(ies) each independently shall have the rights and responsibilities granted to parties in these proceedings, including, but not limited to, the rights to voir dire potential panel members and hearing officers, to call and cross examine witnesses, and to make arguments before the Trier of Fact.

(c) The Hospital and the other health care entity(ies), in their own discretion, may agree to be jointly represented by a single representative.

16.11.3 Separate Appellate Rights

The Joint Hearing Process does not, and is not intended to, include any appeals or appeal rights relating to the decision of the Trier of Fact. Notwithstanding the preceding sentence, in instances in which a Joint Hearing Process is held, the Hospital and the other health care entity(ies)'s governing bodies may elect, in their sole and absolute discretion, to hold any appellate oral arguments in joint session.

16.11.4 Compliance With Applicable Law and Regulation

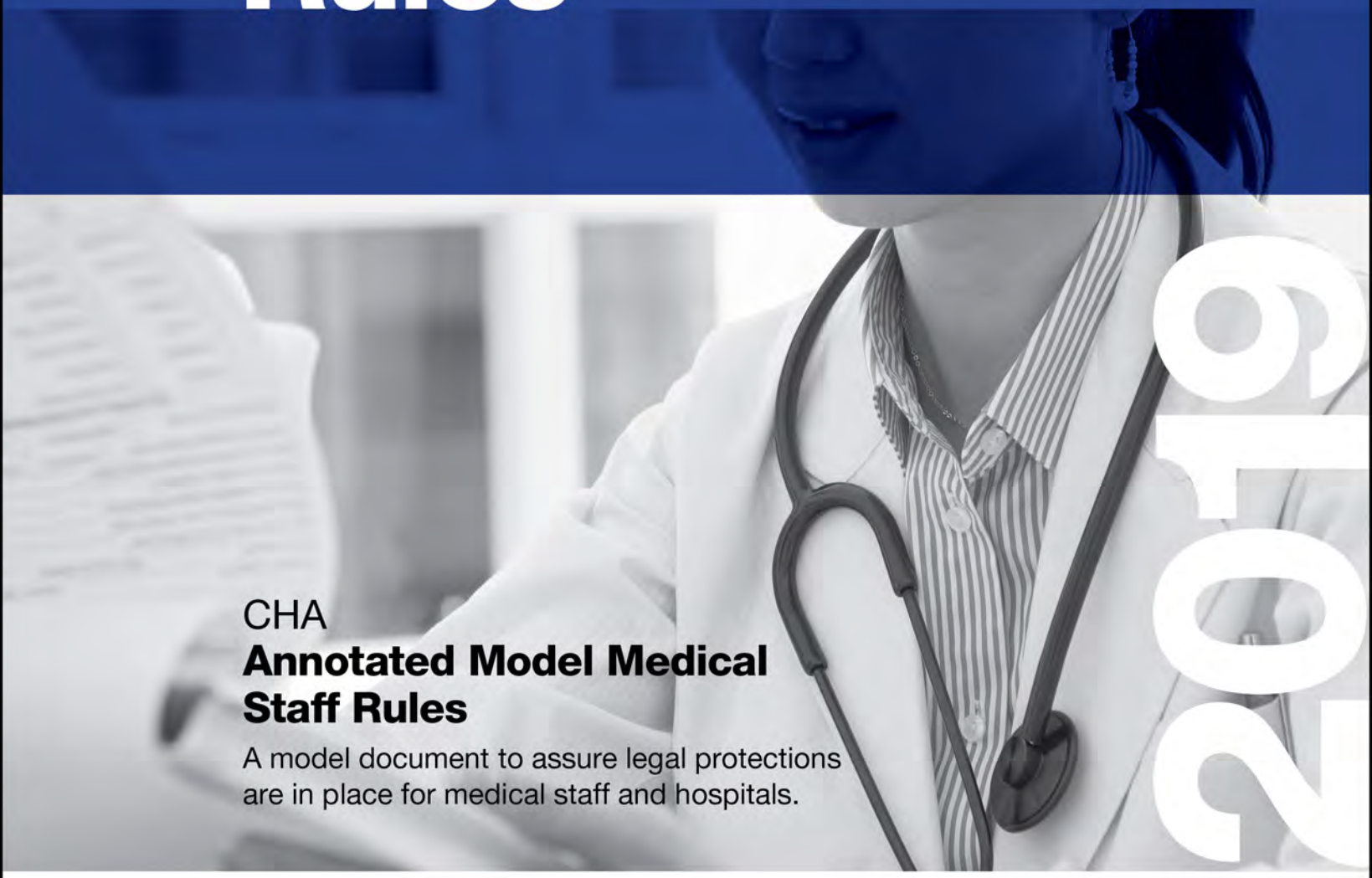
(a) If a Joint Hearing Process is held, the Hospital and the other health care entity(ies) will take appropriate actions to confirm compliance with state and federal laws and regulations governing the privacy and security of personal protected health information.

Each time a Medical Staff opts to use a Joint Hearing Process, it should review the patient confidentiality (including HIPAA and CMIA) implications and take appropriate actions to ensure compliance.

(b) A Joint Hearing Process (and appellate oral arguments held in joint session, if any) shall be deemed to satisfy all procedural requirements pursuant to Business & Professions Code Section 809 et. seq., as to both the Hospital and the other health care entity(ies).

Again, it is our position that a joint hearing does meet these requirements; however, this has not yet been tested in court.

Medical Staff Rules



2019

CHA

Annotated Model Medical Staff Rules

A model document to assure legal protections are in place for medical staff and hospitals.

Arent Fox, LLP

Includes commentary

CALIFORNIA HOSPITAL ASSOCIATION

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Mental Health Law Manual
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This publication is provided as a service to the hospital members of the California Hospital Association. Hospitals are encouraged to use the model document as a template to create hospital-specific bylaws and rules.

These CHA *Model Medical Staff Bylaws and Rules* are intended as a resource to our members to assist them in developing their own Medical Staff Bylaws and Rules. While we have made every effort to achieve compliance with California law, Medicare Conditions of Participation, and The Joint Commission accreditation standards, they are not intended as legal advice, nor is there any representation that the documents are in fact compliant with all of these requirements. Because The Joint Commission remains the predominant accrediting organization for California hospitals, the CHA *Model Medical Staff Bylaws and Rules* have not been specifically tailored to other accrediting bodies standards. Users of these resource documents are advised to consult their own legal counsel to guide and advise them as to the legal implications and requirements for compliance in development of their own Medical Staff Bylaws, Rules, and associated policies and procedures.

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MODEL MEDICAL STAFF RULES INTRODUCTION

Medical Staff Rules and Regulations are very facility-specific, as they often include processes that the Hospital or Medical Staff has developed as working best for that particular institution. Therefore, the content that one hospital includes in their Rules will differ from another. These Model Rules are not intended to be all-inclusive; rather, they include matters that the Model Medical Staff Bylaws references as being in the Rules.

Throughout this document, text appearing in black are the Model Rules; text appearing in red is commentary on those Rules.

Most hospitals will need to supplement these Model Rules with their other facility-specific rules pertaining to patient care and treatment, which must be tailored to each hospital's own resources and policies. The following is a list of topics that typically appear in facility-specific rules (although these matters also can be addressed in policies and procedures instead):

- ☐ Admission and Attendance Policies
- ☐ Consent
- ☐ Consultations
- ☐ Dental Patients
- ☐ Disasters
- ☐ Discharges
- ☐ Emergency Call
- ☐ Emergency Room
- ☐ Hospital Formulary
- ☐ Laboratory
- ☐ Medical Education
- ☐ Medical Records
- ☐ Orders
- ☐ Pathology
- ☐ Podiatric Patients
- ☐ Reportable Conditions, Deaths, Autopsies
- ☐ Surgery
- ☐ Withholding/Withdrawing Life Support

RULE 1

APPLICATION FORM

1.1 Pursuant to the Medical Staff Bylaws Procedures for Appointment and Reappointment Article, the content of the application for appointment and privileges shall include, but need not be limited to, the following:

1.1.1 An agreement that the applicant will abide by the Governing Documents.

1.1.2 A request for information pertinent to the applicant's qualifications, including, but not limited to, information regarding the applicant's:

a. Licensing,

b. Education (including participation in continuing medical education),

c. Specialty training,

d. Experience,

e. Abilities and current competencies,

f. Professional affiliations,

g. Proffered references (including the names and addresses of professional peers — when possible from the same professional discipline as the applicant — who will be able to attest in writing to the applicant's relevant qualifications, experience, abilities and current competencies), and

h. Relevant health status.

1.1.3 A request for information regarding professional liability, licensing, and related matters, including involvement in professional liability actions; the requested information shall include, but not be limited to:

a. All pending professional liability actions and all professional liability final judgments or settlements involving the applicant;

b. Previously completed or currently pending challenges involving professional licensure, certification or registration (state or district, Drug Enforcement Administration), or the voluntary relinquishment of licensure, certification or registration;

c. Voluntary or involuntary termination, limitation, reduction or loss of Medical Staff or medical group membership and/or clinical privileges at any other hospital or health facility or entity;

d. Any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and

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

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

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

This provision is optional.

RULE 2

DEPARTMENTS

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

[List Departments/Services here]

This Rule applies to departmentalized Medical Staffs. Some hospitals have many departments, while smaller hospitals may not have any. If the Medical Staff is not organized into departments, this Rule should be deleted.

RULE 3

STANDARDS OF CONDUCT

3.1 Purpose

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

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

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

TJC Standard LD.03.01.01 requires Hospital leaders to develop a Code of Conduct that defines acceptable behavior and behaviors that undermine a culture of safety. This Model provides suggested definitions; however, Medical Staffs and Hospital leaders should work to harmonize the defintions across the facility.

3.2 Definitions

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

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

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

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

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

b. Submission to, or rejection of, such conduct by an individual impacts the evaluation of the individual's professional competence or job performance; or

c. Such conduct reasonably interferes with an individual's performance or creates an intimidating, hostile, or offensive work environment.

3.3 Examples of Inappropriate Conduct

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

3.3.1 Verbal abuse: Verbal abuse includes, but is not limited to, vulgar, profane, or demeaning language, or shouting, sarcasm, or criticism directed at an individual that has the intent or effect of lowering the recipient's reputation or self-esteem. It is often intimidating to the recipient and can cause the recipient or others around him or her to become ineffective in performing their responsibilities (e.g., the individuals become afraid or unwilling to question or to communicate concerns, or to notify or involve either the involved Practitioner or others when problems occur). While constructive criticism is valued and appreciated, the kind of conduct described in this paragraph is disruptive when it reaches beyond the bounds of fair professional comment or negatively impacts staff morale.

3.3.2 Noncommunication: Noncommunication includes refusal or failure to communicate with others where that refusal or failure adversely impacts the provision of care to patients or Medical Staff or Hospital operations. Noncommunication may cause important information to not be clearly communicated and may take the form of incomplete or ambiguous communication that requires others to divert patient care resources to obtain follow-up clarification. Specific forms of noncommunication include, but are not limited to, failing or refusing to take or return phone calls, pages, texts, or other communications related to patient care; repeatedly or intentionally providing ambiguous orders and/or failing to clarify orders; failing to respond to requests from the Medical Staff for information; and refusing or failing to participate in peer review and/or quality improvement.

3.3.3 Inappropriate communication: Inappropriate communication includes using medical records or other inappropriate venues to criticize the Hospital or its employees, Medical Staff members, or AHPs; or making false statements regarding the Hospital or Medical Staff, or about patient care, to patients, visitors, other Practitioners, or members of the public. The Hospital and Medical Staff provide internal mechanisms for relaying concerns regarding patient care matters; Medical Staff members and AHPs are encouraged to use those when patient care or other concerns are identified. Notwithstanding the above, reports to government agencies with oversight over the

Hospital or to entities that accredit the Hospital do not constitute inappropriate communication.

Although such communication often is disruptive and should be considered inappropriate behavior, hospitals and Medical Staffs must take care that they do not take action, or even appear to take action, against a practitioner because he or she voiced complaints about the Hospital or Medical Staff. Doing so may put the facility at risk for retaliation claims. If the Hospital or Medical Staff needs to take action on the basis of inappropriate communication, it should discuss with counsel first.

3.3.4 Failure to comply: Failure to comply includes willfully or negligently failing to comply with the Governing Documents. Failure to comply places the Medical Staff or the facility in jeopardy with respect to licensing or accreditation requirements, complying with other applicable laws, or meeting other specific obligations to patients, potential patients, and facility staff. Specific examples include:

a. Failing to cooperate in the peer review process (e.g., failing to meet with committee members, to answer reasonable questions relevant to the evaluation of patient care, or to provide information relevant to the evaluation of patient care).

b. Failing to provide information necessary to process the facility's or a patient's paperwork. The facility, its patients, and their families have a right to expect timely and thorough compliance with all requirements of the facility, third-party payors, regulators, etc., as necessary to assure smooth functioning of the facility and that patients receive the benefits to which they are entitled.

c. Violating confidentiality rules, including disclosing confidential peer review information outside the confines of the formal peer review process. If Practitioners are concerned about the quality of care provided by a Practitioner or by the facility, they should report it using the internal reporting mechanisms or by elevating the report up the chain of command within the institution. Notwithstanding the above, reports to government agencies with oversight over the Hospital or to entities that accredit the Hospital do not constitute a failure to comply.

d. Refusing to comply with established protocols and standards, including, but not limited to, utilization review standards. Where deviation from established protocols and standards is necessary in the best interests of the patient, the Practitioner or AHP should be able to account for the deviation and, in appropriate circumstances, work cooperatively and constructively toward any necessary refinements of protocol or standards.

e. Failing to participate in, or meet, Medical Staff obligations when doing so obstructs or significantly impairs the ability of the Medical Staff to perform its delegated responsibilities.

f. Repeatedly abusing or ignoring scheduling policies or reporting late for scheduled appointments, surgeries, and treatments, resulting in unnecessary

delays in, or hurrying of, patient care services being rendered to any patient of the facility.

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

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

3.3.7 Combative behavior: Combative behavior includes, but is not limited to, behavior that repeatedly verbally or physically challenges legitimate and generally-recognized authority or generally-recognized lines of professional interaction and communications, or behavior that reflects an inability to acknowledge or to deliver constructive comments and criticism. Combative behavior does not include challenges to authority that are presented in a professional and constructive manner.

3.3.8 Dishonesty: Dishonesty includes, but is not limited to, intentionally recording false information in medical records or inappropriately back-dating medical record entries; providing false information to peer reviewers or Medical Staff Leaders; submitting knowingly false grievances, complaints, or reports; and making knowingly false allegations against a staff member, Medical Staff member, other professional, or Hospital administration or administrators.

3.3.9 Abusive use of media, including social media: Abusive use of media, including social media, includes, but is not limited to, using media or social media platforms to intimidate or harass any person affiliated with the Hospital, including patients and their families; to falsely and maliciously discredit Hospital employees, contractors, or Medical Staff members; to post confidential health care information about patients; to share confidential or peer review information about the Hospital, its employees or contractors, or Medical Staff members; or to post inaccurate information about the Hospital or its Governing Body members, administration, administrators, employees, contractors, Medical Staff members, or AHPs.

3.3.10 Harassment and sexual harassment: Harassment and sexual harassment includes conduct as defined in this Rule.

3.4 Conduct Expectations

3.4.1 All Practitioners and AHPs are expected to engage in appropriate behavior and to refrain from unacceptable and inappropriate conduct. Practitioners and Allied Health Staff members must address any concerns or complaints about Hospital-related matters, including those listed below, in a professional manner to the appropriate Medical Staff Leader, Department manager, nursing/staff supervisor, administrator, or Governing Body representative:

a. Patient care;

b. Medical Staff member, Allied Health Staff member, or employee performance or behavior;

c. Hospital facilities, operations, policies, governance, administration, or action; or

d. Medical Staff operations, governance, Governing Documents, processes, or action.

3.4.2 If a Practitioner or AHP engages in inappropriate conduct in a manner that (a) is disruptive to Hospital operations, (b) negatively impacts, or potentially could negatively impact, patient health and wellbeing, or (c) suggests that the Practitioner or AHP no longer meets the qualifications or responsibilities of membership or privileges, the Practitioner or AHP may be subject to action under this rule and/or corrective action under the Bylaws, including, but not limited to, summary action or termination.

3.4.3 The Medical Staff recognizes that, on occasion, there may be instances where a Practitioner or AHP's conduct falls outside the literal description of expected behavior but is not disruptive. There also are circumstances where the exigencies of a situation may result in crossing over the lines of acceptable behavior. In most instances involving isolated events, corrective action may not be called for. However, repeated or egregious incidents, as judged by the Medical Staff, is subject to such corrective action as deemed necessary to effectively address the particular circumstances, up to and including termination.

3.5 Procedures

The process that follows is just one example of how a Medical Staff can address violations of the conduct standards. This approach incorporates the Professional Conduct Committee – a committee created to address conduct issues – but another committee can be designated instead. There is no one-size-fits all approach; however, all procedures should include the following elements:

- *Reporting*
- *Evaluation of reports*
- *Ranking of verified reports*
- *Interim corrective measures (if appropriate)*
- *Escalation of actions (as appropriate)*

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

3.5.2 Evaluation

a. The evaluating body shall seek appropriate documentation of each incident of alleged inappropriate conduct. Such documentation should include:

1. Date, time, and location of the reported behavior.

2. A factual description of the behavior.

3. The circumstances that precipitated the event.

4. The name and medical record number of any patient or patient's family member who was involved in or witnessed the event.

5. The names of other witnesses to the event.

6. The consequences, if any, of the behavior as it relates to patient care or safety, or Hospital personnel or operations.

7. Any action taken to intervene in or remedy the event, including the names of those intervening.

8. A record of any action taken to address the situation prior to the Medical Staff's evaluation, including the date, time, place, action and name(s) of those taking such an action.

b. The evaluating body will seek information regarding the alleged incident from the Practitioner or AHP at issue. That input can be in the form of a written statement or an oral statement obtained and documented by the evaluating body.

c. The evaluating body will evaluate anonymous reports to the degree possible.

d. The evaluation shall take place within 14 calendar days from receipt of a report of inappropriate conduct.

3.5.3 Action

a. **Unfounded/Unconfirmed Report:** If the evaluating body determines the report is unfounded or is unable to be confirmed, it shall include a statement regarding this finding with the report. The report shall be maintained in the

Medical Staff member's file with the original complaint. The evaluating body will notify the individual who initiated the report of the decision.

b. **Confirmed Report:** If the evaluating body confirms the report, it shall refer it to the Medical Executive Committee or to the Professional Conduct Committee (the "designated committee") to determine what, if any, actions should be taken. Any actions will depend on a number of variables, including, but not limited to:

This Model is an example of a simplified process for addressing confirmed reports of inappropriate behavior. Many Medical Staffs choose to adopt a more sophisticated process. Especially in larger staffs, the more sophisticated processes may be useful in addressing variations and degrees of inappropriate behavior.

1. Degree of disruptiveness,

2. Number of incidents (i.e., pattern of disruptive behavior over time), and

3. Length of time between incidents of disruptive behavior, if multiple incidents have occurred.

c. **Plan for Addressing Disruptive Behavior:** The designated committee will develop a plan for addressing the inappropriate behavior, which will be included in the individual's credentials file. The plan shall include item (1) below, and may include any portion or all of items (2) and (3) below:

1. The designated committee shall send a letter to the individual that describes the inappropriate conduct, explains that the behavior is in violation of the Standards of Conduct, notes any patient care or Hospital operations implications, explains why the behavior in question is inappropriate, directs the individual to comply with the Standards of Conduct in the future, invites the individual to respond, and makes clear that attempts to confront, intimidate, or otherwise retaliate against the individuals who reported the behavior in question is a violation of this Rule and grounds for further disciplinary action. A copy of this Rule shall be included with the letter. Documentation of both the letter and the individual's response, if any, shall be included in the individual's file.

2. The Chief of Staff, Chief Executive Officer, or the designated committee, and any other number of appropriate participants from the Medical Staff and Governing Body, shall schedule a meeting with the individual to discuss the inappropriateness of his or her behavior and require that such behavior cease. During the meeting, the individual will be advised that he or she is required to comply with the Bylaws and the Standards of Conduct. A follow-up letter documenting the content of the discussion and any specific actions the offending individual has agreed to perform shall be sent to the individual. The individual will be invited to respond. This letter and any response will be included in the individual's file.

3. The plan may incorporate additional components, including, but not limited to:

   i. Warning the individual that failure to abide by the terms of the Standards of Conduct shall be grounds for disciplinary action including, but not limited to, suspension and/or termination of Medical Staff membership.

   ii. Requiring the individual to agree to specific corrective actions aimed at eliminating that individual's disruptive behavior. Suggested actions are counseling, leave of absence, written apologies, courses or programs specific to the behavior trait, or requiring the individual to sign a behavior modification contract. The Chief of Staff, Chief Executive Officer or designated committee shall document any corrective action and require the individual to sign his or her acceptance of this plan. The plan may clearly delineate the consequences for the individual not successfully completing the agreed upon corrective action.

   iii. In appropriate circumstances, the plan may provide for immediate suspension and/or action to terminate Medical Staff membership without need of further warning or counseling.

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

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

3.5.6 Consequences of a Member's Failure to Comply with the Standards of Conduct: Depending on the factors involved and whether or not the recommendation or action is one that is identified as "Grounds for Hearing," the Practitioner or AHP may be entitled to the hearing rights found in the Hearing and Appeals Article of the Medical Staff Bylaws, the Administrative Hearings Rule in these Rules, or the Allied Health Practitioner Rule in these Rules.

RULE 4

IMMUNIZATION AND COMMUNICABLE DISEASES

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

RULE 5

WAIVERS TO BOARD CERTIFICATION

This Rule applies only if the Medical Staff requires board certification as part of its minimum qualifications. As noted in the comments to the Medical Staff Bylaws, some hospitals only require board certification for initial applicants, some require that board certification be continuously maintained throughout membership, and some require members to comply with the ABMS member boards' "Maintanence of Certification" requirements. Medical Staffs should modify this section as appropriate to reflect their requirements.

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

5.1 Time Limited Exemptions

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

5.1.1 A Practitioner who has taken the board certification exam but has not yet been informed of the results. In such cases, the exemption expires no more than three months after the Practitioner has taken the exam.

5.1.2 A Practitioner who has graduated from his or her residency or fellowship program within 12 months of applying for membership and/or privileges. In such cases, the exemption expires no more than 12-months after the Practitioner has graduated.

5.1.3 A Practitioner whose specialty board requires a minimum number of years of practice before eligibility to take the examination. In such cases, the exemption expires no more than 15 months after the Practitioner becomes eligible to take the exam, or no later than seven years after the Practitioner has completed his or her relevant residency or fellowship program, whichever comes first.

5.1.4 A Practitioner who, as determined by the Medical Executive Committee, has experienced extraordinary circumstances in the 18-month period prior to the board certification deadline or the date of the board certification examination or renewal examination. In such cases, the exemption shall expire no more than 15 months after the board certification deadline or expected examination date. Examples of "extraordinary circumstances" include the death of a close family member (spouse, child, parent, or sibling); divorce and/or custody proceedings; and serious illness or disability requiring significant treatment or hospitalization, as documented by a California-licensed physician. "Extraordinary circumstances" do not include, among other things, prior board examination failure or relocation of practice. The Medical Executive Committee's

decision that the extraordinary circumstances exception does not apply is not subject to the hearing and appeal rights in the Governing Documents.

5.2 Permanent Exemptions

Practitioners who fall within the following categories may receive permanent exemptions from the board certification requirements, as long as the Practitioners can demonstrate current clinical knowledge and competency to the Medical Executive Committee's and Governing Body's satisfaction.

5.2.1 A member who has been continuously on staff since _____ and was not board certified at the time this Rule was adopted.

Some Medical Staffs "grandfather" in members who have been on staff for a specified period of time and are not board certified.

5.2.2 Practitioners whose sub-specialty did not, at the time of their training, have a sub-specialty board or formal residency programs, and therefore, the Practitioners have never been eligible to sit for the sub-specialty board certification examinations. In such cases, the Practitioner may be exempted from the sub-specialty certification requirement but must still be certified in their original specialty.

5.2.3 Practitioners who are ineligible for board certification due to graduation from a foreign training program.

RULE 6

EMTALA: QUALIFIED MEDICAL PERSONS/MEDICAL SCREENING EXAMS

Hospitals subject to the Emergency Medical Treatment and Labor Act (EMTALA) must comply with 42 C.F.R. Section 489.24(a) and describe in Bylaws or Rules those categories of non-physician professionals who may perform medical screening exams (referred to in EMTALA as "qualified medical persons").

Hospitals should also develop comprehensive policies for complying with EMTALA, as referenced here.

6.1 Qualified Medical Persons

The Hospital has developed policies and procedures to comply with its obligations under the Emergency Medical Treatment and Labor Act (EMTALA). Pursuant to those policies, the following categories of non-physician professionals are designated as qualified medical persons (QMP) who may perform medical screening examinations to determine the existence of an emergency medical condition or labor, as long as those professionals have been granted the privileges to do so.

6.1.1 Physician Assistant

6.1.2 Nurse Practitioner

6.1.3 Certified Nurse Midwife (limited to assessing a pregnant woman and fetus)

6.1.4 A registered nurse (limited to assessing a pregnant woman), if that registered nurse has been determined by the Labor and Delivery Nurse Manager to be qualified and experienced in obstetrical nursing, if the nurse has been granted limited practice prerogatives by the Medical Executive Committee to perform these exams, and if the nurse follows standardized procedures approved by the Medical Staff.

These are examples of possible QMPs; hospitals can limit this list, but should not expand without discussing with counsel.

6.2 Non-Emergency Requests

When the request of an individual presenting to the emergency department makes clear that the medical condition is not of an emergency nature, a registered nurse who has been determined by the ER Nurse Manager to be qualified and experienced in emergency nursing and who follows standardized procedures approved by the Medical Staff may provide the screening examination.

6.3 In All Circumstances

When the QMP performing the screening examination is uncertain about the nature of the patient's condition or the existence of an emergency or labor, a physician from either the Emergency Department or Labor and Delivery shall perform the screening examination.

RULE 7

CONFLICTS OF INTEREST

7.1 Conflicts of Interest Policy

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

Together with the Governing Body and Hospital administration, the Medical Staff should develop one or more conflict of interest policies to apply to the staff. These policies may differ, depending on the needs of the staff. For example, some policies may automatically disqualify persons who hold certain conflicts from office, such as ownership interests in competing entities. Others may be less restrictive. In any event, this section is intended to provide a minimum of what should be included in the policy.

a. Define what constitutes an actual or potential conflict of interest;

b. Require all candidates for Medical Staff office or Department or Section office to disclose in writing, at least 20 days prior to the election, actual or potential conflicts of interest to the Medical Executive Committee and to the Chief Executive Officer;

c. Require that the candidate disclosure statements be distributed with ballots for the election;

d. Require all committee members to disclose in writing to the Medical Executive Committee and the Chief Executive Officer actual or potential conflicts of interest prior to appointment;

e. Require Medical Staff Leaders and committee members to update their written disclosure whenever the information changes while they are in office or serving on a committee;

f. Require Medical Staff Leaders and committee members to recuse themselves from decisions for which they have an actual conflict of interest; and

g. Include provisions addressing how disagreements regarding whether or not a Medical Staff Leader or committee member should be recused shall be resolved.

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

7.2 Disclosure of Interest Form

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

RULE 8

CONFLICT MANAGEMENT PROCESSES

8.1 Medical Staff Disputes

8.1.1 In the event of conflict between the Medical Executive Committee and the Medical Staff regarding a proposed or adopted Rule or policy, or other issue of significance to the Medical Staff, the Medical Staff can submit a petition requesting initiation of the conflict management process signed by at least [insert percentage] of members eligible to vote. The petition must identify up to [five] Medical Staff members eligible to vote that shall serve as petitioners' representatives. Each page of the petition where signatures appear must include a description of the nature of the dispute.

Each Medical Staff should evaluate and establish an appropriate threshold for initiating the conflict management by a petition of the Medical Staff. The number should be sufficiently high so that the interests of individuals or a disgruntled few are not controlling the processes. But it also needs to be set in recognition that in small medical staffs, the interests of a few may represent the prevailing view of the Medical Staff. Finally, the number should be reasonable – i.e., not so high that the provisions can never be invoked.

8.1.2 Upon verification of the petition, the Chief of Staff shall convene a meeting with one or more of the petitioners' representatives and an equal number of Medical Executive Committee members. The representatives of both the Medical Executive Committee and the petitioners shall exchange information relevant to the conflict and shall work in good faith to resolve differences in a manner that respects the positions of the Medical Staff, the leadership responsibilities of the Medical Executive Committee, and the safety and quality of patient care at the Hospital.

8.1.3 Resolution of the conflict requires a majority vote of the Medical Executive Committee's representatives at the meeting, and a majority vote of the petitioner's representatives at the meeting. Unresolved differences regarding Governing Documents shall be addressed as described in the Governing Document Article of the Bylaws. All other unresolved matters shall be brought to the Medical Staff for discussion at the next Medical Staff meeting.

Medical Staffs can, if they choose, add another step to this process and require the proposed resolution to be sent back to the Medical Executive Committee for ratification before it is final. In that case, the following should be added after the first sentence: "Proposed resolutions approved in this manner require ratification by the Medical Executive Committee prior to implementation; therefore, the proposed resolution will be sent to the Medical Executive Committee for consideration. The Medical Executive Committee will give great weight to the proposed resolution adopted at the meeting between the Medical Executive Committee's and the petitioners' representatives. If the Medical Executive Committee does not ratify the proposed resolution, the issue will be considered unresolved."

8.1.4 Nothing in this section shall limit the ability of Medical Staff members to communicate with the Governing Body on a rule, regulation, or policy adopted by the Medical Staff or the Medical Executive Committee. The Governing Body determines the method of communication.

Per TJC Standard MS.01.01.01, EP 10.

8.2 Disputes with the Governing Body

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

Although California law only refers to a conflict resolution process for matters related to Medical Staff self-governance, TJC Standard LD.02.04.01 requires the hospital to develop an ongoing process for managing conflict among "leadership groups" and to implement the process when a conflict could adversely affect patient safety or quality of care. Therefore, this model broadens the application of the conflict resolution process. However, TJC no longer includes EPs that provided more detail regarding the process. The proposal here is one way, but not the only way, to address conflicts.

8.2.1 Either the Medical Executive Committee or the Governing Body may invoke the meet and confer process, or the process may be invoked by a written petition signed by at least 50 percent of Medical Staff members eligible to vote. The purpose of the petition must be included on every page where signatures appear.

8.2.2 The matter may be referred to the Joint Conference Committee described in the Medical Staff Rules, or, upon request of at least two thirds of members of the Medical Executive Committee or two thirds of members of the Governing Body, the meet and confer will be conducted by a meeting of the full Medical Executive Committee and the full Governing Body.

8.2.3 A neutral mediator acceptable to both the Governing Body and the Medical Executive Committee may be engaged to further assist in dispute resolution upon the request of:

a. At least a majority of the Medical Executive Committee plus two members of the Governing Body; or

b. At least a majority of the Governing Body plus two members of the Medical Executive Committee.

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

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

RULE 9

AUTHORIZATIONS, RELEASES, IMMUNITY, CONFIDENTIALITY, AND INDEMNITY

9.1 Duration of Application

9.1.1 Applicants, members, Practitioners, and AHPs, by applying for or accepting Medical Staff membership, Allied Health Staff status, clinical privileges, or other practice prerogatives, authorize and agree that the provisions set forth in this Rule commence when an individual requests an application and that these provisions apply and remain in effect for all time, whether or not an application for membership or privileges is provided or considered, and whether or not membership or any privileges are granted, denied, suspended, limited, or terminated, for any reason.

9.1.2 For the purposes of this Rule only, references to "members" and to AHPs includes persons who had Medical Staff membership or Allied Health Staff status at any time, regardless of whether or not they continue to be Medical Staff members or hold Allied Health Staff status.

9.1.3 The authorizations, immunities, indemnity, releases, and confidentiality provisions in this Article apply to all actions taken or declined pursuant to the Governing Documents. "Action" for the purpose of this article includes, without limitation, any act of communication, consideration, report, recommendation, disclosure, rule-making, or adjudication taken, or declined to be taken, pursuant to the Medical Staff Governing Documents or otherwise in furtherance of the Hospital's or Medical Staff's responsibilities, duties, and obligations.

9.2 Authorizations

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

9.2.1 The Hospital and Medical Staff may solicit from any person or entity any information that may be relevant to the Practitioner's or AHP's qualifications, fitness, character, or ability to meet the standards of the Medical Staff.

9.2.2 The Hospital and Medical Staff may provide to any heath care organization (including, but not limited to, any medical group, hospital, medical foundation, training facility, professional school, or health care payor) or licensing agency information that may be relevant to the Practitioner's or AHP's professional qualifications, fitness, character, or ability to meet the standards of that organization.

9.3 Confidentiality and Sharing of Information

9.3.1 General Rule of Confidentiality

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

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

b. Therefore, all Medical Staff records and information, including, but not limited to the following, shall, to the fullest extent permitted by law, be confidential, regardless of the source of the information: department, section, and committee records, minutes, and files; applications and privileging forms and the evaluations of those forms; internal policies; information learned during any Medical Staff, department, section, or committee meeting; and other records. These documents, in whatever form, shall be maintained as Medical Staff committee records and not become part of a patient medical record or Hospital record. Access to, use of, and dissemination of confidential information and records shall be made only where expressly required by law or as otherwise provided in the Governing Documents.

c. Committee members and persons attending any Medical Staff meeting may be required, as a condition or service or attendance, to sign a statement regarding their obligations to keep records and information confidential. Regardless of whether such a statement is required, the confidentiality provisions in the Governing Documents apply.

9.3.2 Permitted Use and Disclosure of Confidential Information

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

a. As permitted or required by Hospital or Medical Staff Governing Documents;

b. As needed to fulfill the obligations of the Hospital or Medical Staff, as determined by those individuals charged with overseeing those obligations;

c. Upon approval of the Chief of Staff, to respond to requests for information from other peer review bodies or health care entities;

d. In compliance with an information sharing agreement with another health care entity;

e. To share with System Members to facilitate the review of an applicant or member of the affiliated entity's Medical Staff or Allied Health Staff, or to facilitate systemwide performance improvement and quality assurance activities;

f. For any other purpose designed to assist the Hospital or Medical Staff in either of their functions, either upon approval of the Chief of Staff or upon approval of the Chief Executive Officer, after the Chief Executive Officer provides notice to the Chief of Staff explaining the reasons for the use or disclosure;

g. As required by law (including court order) or accreditation requirement, as determined by the Medical Executive Committee, the Chief Executive Officer, or the Governing Body.

9.3.3 Individuals Who May Access Information

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

a. Medical Staff Officers, for the purpose of fulfilling any of their duties;

b. Committee members, for the purposes of conducting their specific committee functions;

c. The Chief Executive Officer, Chief Medical Officer, and the Governing Body;

d. The Medical Staff Services Administration personnel;

e. Risk Management and Quality Improvement department personnel, so long as such access is both necessary and consistent with their administrative functions;

f. Other persons designated by the Chief of Staff as needing access to ensure the fulfillment of the Medical Staff's and the Hospital's obligations.

This "catch all" would include, for example, outside experts or legal counsel.

9.3.4 Sharing Peer Review Information With Other Peer Review Bodies

This provision allows the Medical Staff to comply with Business and Professions Code Section 809.08, which requires Medical Staffs to share peer review information with requesting peer review bodies under certain circumstances. The statute limits the requirement to "licentiates," which is limited in the statute to physician and surgeons, podiatrists, clinical psychologists, marriage and family therapists, clinical social workers, professional clinical counselors, and dentists. The language here would apply to all practitioners and Advanced Practice Professionals covered by the Bylaws.

Along with the statutory requirements for peer review information sharing, many Medical Staffs want to share information about physicians that they believe will help other entities make good credentialing decisions; this section permits this but does not require it.

a. Whenever the Medical Staff receives a request from a peer review body for information regarding an individual who was subject to corrective action under the Bylaws for a medical disciplinary cause or reason, the Medical Staff will, subject to the conditions in paragraph (b), provide the peer review body with a written summary of the relevant peer review information or with the peer review records.

b. The Medical Staff may, within its discretion and on a case-by-case basis, condition its release of any peer review information on first receiving: (i) a release from the individual that is acceptable to the Medical Staff, and/or (ii) a peer review sharing agreement agreeable to the Medical Staff and signed by the requesting peer review body, and that includes an indemnification provision.

c. "Relevant peer review information" or "peer review record" includes, but is not limited to, allegations and findings, explanatory or exculpatory information submitted by the individual, any conclusions made, any actions taken, and the reasons for those actions, to the extent not otherwise prohibited by applicable federal or state law. The information shall not identify any person except the individual identified in the request.

This language is from Business and Professions Code Section 809.08(a).

d. This section does not limit the Medical Staff's ability to share and disclose peer review information to any entity or person, as long as it is done in a manner consistent with the other Confidentiality and Sharing of Information provisions in the Governing Documents.

9.3.5 Peer Review Information Sharing Agreements

The Hospital may execute information sharing agreements with other health care entities to facilitate the sharing of information. Notwithstanding any other provision in the Governing Documents, except for provisions regarding the protection of Wellbeing Committee information and substance abuse treatment information, Medical Staff records may be shared pursuant to the terms of an information sharing agreement so long as the agreement includes provisions to promote the protection of the shared Medical Staff records and the agreement has been approved by the Medical Executive Committee and the Chief Executive Officer.

Not all health care entities have or are "peer review bodies" under California law. Therefore, they may not be able to take advantage of the same discovery or immunity protections that apply to peer review bodies. Before entering into the sharing agreements permitted under this section, Hospitals should take into account the security of their own confidential peer review information and draft any agreements accordingly.

9.3.6 Wellbeing Committee and Substance Abuse Treatment Information

a. Notwithstanding any other provision in this Rule, information regarding a Practitioner or AHP maintained by the Wellbeing Committee shall not be shared unless: (i) required by law, (ii) the Practitioner or AHP provides written permission to share the information maintained by the Wellbeing Committee, or (iii) the Medical Executive Committee votes to disclose the information.

This is an optional provision and only limits the sharing of information maintained by the Wellbeing Committee. It does not limit the sharing of information maintained by the Medical Executive Committee or by Department chairs, such as referrals to the Wellbeing Committee noted in Medical Executive Committee minutes, or Medical Executive Committee records of reports from the Wellbeing Committee. Medical Staffs can adopt rules that do not permit the sharing of any Wellbeing Committee-related information (including information found in the Medical Executive Committee minutes or held by Department chairs), or, alternatively, can choose to treat Wellbeing Committee information the same as other peer review information and not provide this expanded protection.

b. Prior to sharing any mental health records or substance abuse treatment records, the Medical Staff shall consult with legal counsel to determine the manner in which the information may be provided to third parties.

Certain California and federal laws provide increased protection to mental health and substance abuse treatment information. Prior to sharing such information, Medical Staffs should consult with legal counsel to determine what, if any, additional steps should be taken. The California Hospital Association California Health Information Privacy Manual *provides useful information about these issues.*

9.3.7 Breach of Confidentiality and Misuse of Information

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

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

This provision is optional. It has not been evaluated by California courts, and hospitals and Medical Staffs may want to discuss with legal counsel prior to adopting this approach.

9.3.8 Practitioner and Allied Health Staff Access and Correction

a. A Practitioner or Allied Health Staff member shall be granted access to his or her own credentials file, subject to the following provisions:

1. The Practitioner or AHP shall give notice of a request to review the file to the Chief of Staff (or his or her designee) at least five business days before the requested date for review.

2. The Medical Staff may require the Practitioner or AHP to sign a statement prior to having access to the credentials file confirming that the information reviewed is confidential and may not be disclosed outside of the peer review process, that the Practitioner understands that retaliation against any individual who provided information to the Medical Staff is strictly prohibited, and that any retaliation will be grounds for corrective action.

3. The Practitioner or AHP may review and receive a copy of only those documents provided by or addressed personally to the Practitioner or AHP. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, and complaints, shall be made available to the Practitioner and AHP, in writing, by the designated officer of the Medical Staff within a reasonable period of time (not to exceed two weeks). Such summary shall disclose the substance, but not the source, of the information summarized. A copy of the summary shall be kept in the credentials file.

4. Per federal restrictions, National Practitioner Data Bank reports will not be provided. Practitioners may perform their own query for information from the National Practitioner Data Bank.

5. The Practitioner or AHP's review of the information and summary shall take place in the Medical Staff office, during normal work hours, with an officer or designee of the Chief of Staff present.

6. In the event the Hearings and Appeals provisions of the Bylaws are invoked, the Practitioner shall have access to his or her credentials file in a manner consistent with Hearings and Appeals Article.

b. A Practitioner or Allied Health Staff member may be permitted to request correction of information as follows:

1. After review of his or her file, a Practitioner or AHP may address to the Chief of Staff a written request for correction of information in the credentials file. Such request shall include a statement of the basis for the action requested.

2. The Chief of Staff shall review the request within 30 days and shall recommend to the Medical Executive Committee whether to make the correction as requested. The Medical Executive Committee shall make the final determination of whether to make the correction.

3. Good cause for correction exists only if the information is demonstrably factually inaccurate or has been placed in the wrong file. Good cause does not exist if the Practitioner or AHP simply disagrees with the information, or the information is old, or the Medical Staff was unable to validate the information. In instances where the Medical Staff evaluated a complaint or report regarding a Practitioner or AHP but was unable to substantiate it or found it to be unsubstantiated, the Medical Staff shall attach a statement to the complaint or report reflecting the findings of the evaluation. The original complaint or report shall not be deleted from the Practitioner's or AHP's file.

It is very important that exonerations of unsubstantiated complaints be included in the practitioner's file, for both accuracy and fairness.

We recommend against removing unsubstantiated reports, however, for

several reasons: (a) whether or not a report has been substantiated often requires a judgment call, which may differ from person to person (such as in "he-said, she-said" circumstances); (b) sometimes, complaints cannot be substantiated because the complainant is no longer available; in those cases, the complaint may still be useful to the medical staff in later determining whether patterns of behavior exist; and (c) if someone is making unwarranted complaints against practitioners, it is important to keep track of that behavior as well.

4. The Practitioner or AHP shall be notified within seven days, in writing, of the Medical Executive Committee's decision.

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

9.4 Immunity and Releases

9.4.1 Applicants, Practitioners, and AHPs, by applying for, or accepting, Medical Staff membership, Allied Health Staff status, clinical privileges, or other permissions to practice, acknowledge and agree that the Hospital, the Medical Staff, each Medical Staff member, any representative of the Hospital or Medical Staff, and all third parties are exempt from liability to a Practitioner or AHP for damages or other relief for any action taken or declined, as described in the Rules, or for providing information to the Hospital or Medical Staff. This immunity shall also apply to actions taken or declined that occur after an application is denied or is withdrawn, or after the individual no longer holds membership or Allied Health Staff status. Nothing in the Governing Documents shall be deemed to waive or limit any immunity provided by federal or state law.

9.4.2 Applicants, Practitioners, and AHPs, by applying for, or accepting, Medical Staff membership, Allied Health Staff status, clinical privileges, or other permissions to practice, release from liability to the fullest extent under the law the Hospital, the Medical Staff, each Medical Staff member, and any representative of the Hospital or Medical Staff for any action taken or declined, as described in the Rules. This release of liability shall remain in effect for all time and shall also apply to actions taken or declined that occur after an application is denied or withdrawn, or after the individual no longer holds membership or Allied Health Staff status.

9.4.3 As a condition of continued membership or privileges, or of continued processing of an application, an individual applicant, Practitioner, or AHP must, when requested by a Medical Staff Committee or Officer, execute any general or specific releases that may be required by any entity for the purpose of obtaining additional information regarding the Practitioner's qualifications, fitness, character, or ability to meet the standards of the Medical Staff. Failure to execute such a release within 14 days after requested to do so shall result in an automatic suspension of Medical Staff membership (as detailed further in the Automatic Suspension, Termination, and Limitation provisions of the Corrective

Action Article of the Bylaws) or a finding that the applicant's application is incomplete and deemed voluntarily withdrawn.

Hospitals and Medical Staffs can adopt a different deadline, as long as it is fair.

9.5 Indemnity

This indemnity clause is tailored to meet the standards of California Corporations Code Section 5238 for not-for-profit entities.

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

a. As a member of, or witness for, a Medical Staff, Department, committee, or hearing committee;

b. As a member of, or witness for, the Hospital Governing Body or any Hospital task force, group or committee; and

c. As a person providing information to any Medical Staff or Hospital group, officer, Governing Body member, or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a Medical Staff member or applicant.

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

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

RULE 10

ADMINISTRATIVE HEARINGS

10.1 Eligibility

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

Business and Professions Code Section 809 and the NPDB requires fair hearings only in limited circumstances – essentially, when reporting is required. However, California common law suggests that hearings might be required whenever a decision is made to deny or restrict a particular individual's opportunity to practice at a hospital, even if such decisions do not require the hospital to report the practitioner. Examples of this may include a practitioner who is terminated for sexually harassing an administrator; a practitioner who is denied reappointment for failing to comply with policies, but not in a way that necessarily impacts patient care; or a practitioner who is suspended for a medical disciplinary cause or reason, but for less than 14 days.

In such cases, the Hospital may want to offer the practitioner a modified hearing, such as the one described here.

Hospitals should consult with counsel whenever denying, terminating, or restricting a practitioner as a result of an individual review, regardless of reason. California case law still requires a "nexus" to patient care before such actions can be taken, so even administrative actions should take this into consideration.

10.1.1 Does not require the Hospital to file a report with the licensing body pursuant to Business and Professions Code Section 805 or with the National Practitioner Data Bank;

10.1.2 Is not based on the Practitioner's failure to meet a minimum qualification for membership or a qualification for specific privileges;

10.1.3 Does not result from the "Automatic Suspension, Termination, and Limitation" section of the Corrective Action Article of the Medical Staff Bylaws; and

10.1.4 Is not based on any ground that the Medical Staff Bylaws declares does not give rise to a hearing.

10.2 Administrative Hearing Procedure

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

Governing Body or its designee will have the responsibilities otherwise granted to the Medical Executive Committee or Chief of Staff.

When the Medical Staff fails to act in peer review matters, the Governing Body has the right to do so. If its actions give rise to a hearing right, then the Governing Body, rather than the Medical Staff, should have the authority to manage the hearing. This paragraph makes that responsibility explicit.

10.2.1 Administrative Hearings need not follow the Hearing and Appeal Article of the Medical Staff Bylaws and instead shall comply with the process described in this Rule; however, the Medical Staff may, but is not required to, use the following sections and provisions in the Hearing and Appeals Article of the Medical Staff Bylaws to guide Administrative Hearings:

a. Scope of Article,

b. Mediation,

c. Arbitrator,

d. Prehearing Process,

e. The Hearing,

f. Appeal Procedure,

g. Additional Provisions, and Joint Hearing

Because these hearings are not governed by Business and Professions Code Section 809 et seq., there is flexibility in how they can be organized. The Administrative Hearing Process adopts some, but not all, of the processes found in the Bylaws process.

10.2.2 The Medical Staff shall provide the Practitioner with notice of the action or recommendation. The notice shall also inform the Practitioner that he or she has 30 days in which to request an Administrative Hearing. The notice shall include a copy of this Rule and the sections of the Hearing and Appeals Article described above.

10.2.3 The Practitioner must submit any request for hearing in writing, addressed to the Medical Executive Committee with a copy to the Chief Executive Officer or his/her designee. The request must be received by the Medical Staff Services Administration within the deadline. The Practitioner shall state, in writing within the request, his or her intentions with respect to attorney representation.

10.2.4 In the event the Practitioner does not request a hearing within the time and in the manner described, the Practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved. In such cases, the Medical Staff's recommendation or action shall be considered by the Governing Body at its next meeting. The Governing Body shall give the recommendation great weight, but may exercise its independent judgment in determining whether or not to adopt the recommendation or action.

10.2.5 If the Practitioner requests a hearing within the time and in the manner described, the Medical Executive Committee will provide him or her with a notice of the reasons that form the basis for the action or recommendation within 60 days after receiving the

request for hearing. The notice may be supplemented or amended at any time, even during the hearing, so long as the additional material is relevant to the recommendation or the Practitioner's qualifications and the Practitioner has a sufficient opportunity (at a minimum, 30 days) to review and respond with additional information.

This is an optional, but useful, provision.

10.2.6 The Medical Executive Committee shall endeavor to schedule the hearing to begin within 90 days after receiving the request for hearing, but no sooner than 30 days after sending the Notice of Reasons. The Medical Executive Committee will send the Practitioner notice of the time, date, and location of the hearing at least 30 days prior to the hearing date.

Because these hearings are not governed by Business and Professions Code Section 809 et seq., the Medical Staff can select more workable time frames for starting the hearing.

10.2.7 The administrative hearing shall be held in front of an arbitrator selected in the manner described in the "Arbitrators" section in the Hearing and Appeals Article of the Medical Staff Bylaws.

10.2.8 Failure of the Practitioner to attend any hearing session shall be deemed a waiver of his or her hearing rights, unless the Practitioner can prove to the satisfaction of the arbitrator that an unforeseen and unanticipated emergency prevented him or her from attending.

RULE 11

MEDIATION

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

11.1 Purpose

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

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

11.2 Request

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

11.3 Deadlines

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

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

11.4 Selection and Process

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

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

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

11.5 Confidentiality

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

11.5.1 Communications that confirm that mediation was mutually accepted and pursued may be disclosed as proof that otherwise applicable time frames were tolled or waived. Any such disclosure shall be limited to that which is necessary to confirm mediation was pursued, and shall not include any points that are substantive in nature or address the issues presented.

11.5.2 The fact of the mediation may be disclosed to demonstrate the good faith of the parties in their attempts to resolve the matter; however, this shall not include any points that are substantive in nature or address the issues presented.

RULE 12

COMMITTEES

This Rule presents a comprehensive array of committees, which might be appropriate for a large hospital. Smaller hospitals will want to combine committee functions as much as possible. Except as noted below, all committee activities may be performed by a single committee (such as a Medical Executive Committee), or by the staff or a department acting as a committee of the whole. However, where activities are conducted under the committee of the whole approach, care must be taken to observe formalities and to maintain confidentiality.

To eliminate the necessity of extensive renumbering, the Medical Staff can simply check the box for those committees they wish to adopt. The corresponding appendix will be applicable only if the box is checked.

The appendices describe, for each committee, the suggested composition, the duties, and the meeting frequency. Except when otherwise noted, there is a great deal of discretion involved in deciding who may serve on committees, although there are some specific legal requirements respecting the composition of the Infection Control Committee, Institutional Review Committee, and the Interdisciplinary Practice Committee. Please keep in mind that the Model Bylaws provide that, unless otherwise stated in the Governing Documents, each Medical Staff member who serves on a committee does so with a vote. Other members may or may not vote, depending on what is provided in the Governing Documents.

12.1 Committees

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

Per Bylaws Section 4.4, the default in this Model is that the Chief of Staff, the Chief Executive Officer, and the Chief Medical Officer serve on all committees, without vote. If the Medical Staff does not want these offices to serve on any particular committee, or if the Medical Staff wants them to serve with vote, this should be specifically identified in the provisions below.

Check below if applicable	*See Appendix*
☐ Bioethics Committee	12A
☐ Bylaws Committee	12B
☐ Cancer Committee	12C
☐ Credentials Committee	12D
☐ Department Committees	12E
☐ Emergency Services Committee	12F
☐ Infection Prevention Committee	12G

□	Institutional Review Board	12H
□	Interdisciplinary Practice Committee	12I
□	Joint Conference Committee	12J
□	Pharmacy and Therapeutics Committee	12K
□	Professional Conduct Committee	12L
□	Quality Improvement Committee	12M
□	Utilization Review Committee	12N
□	Wellbeing Committee	12O

Appendix 12A

Bioethics Committee

1. Composition

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

2. Duties

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

a. Providing assistance and resources for decisions which have bioethical implications. The Bioethics Committee shall not, however, be a decision maker in any case.

b. Educating members within the Hospital community concerning bioethical issues and dilemmas.

c. Facilitating communication about ethical issues and dilemmas among members of the Hospital community, in general, and among participants involved in bioethical dilemmas and decisions, in particular.

d. Retrospectively reviewing cases to evaluate bioethical implications and providing policy and education guidance relating to such matters.

e. Proposing guidelines for decision making in cases that have bioethical implications.

3. Meetings and Reporting

The Bioethics Committee shall meet as often as necessary, but at least [*fill in frequency*]. The Committee shall report to the Medical Executive Committee.

Medical Staffs can choose how frequently this committee meets.

Appendix 12B

Bylaws Committee

The Bylaws Committee is not a required committee; however, it adds value in fulfilling the TJC requirement that the Bylaws and Rules reflect current practice. Regardless of which committee ultimately fulfills this function, the committee should include someone familiar with the current Bylaws and Rules.

1. Composition

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

2. Duties

The duties of the Bylaws Committee include:

a. Reviewing the Medical Staff Bylaws, Rules, and forms promulgated by the Medical Staff and its departments on an as-needed basis, but at least once every two years;

This is not required by law or accreditation standard but is good practice to assure the Bylaws are currently compliant with legal and accreditation standard.

b. Evaluating suggestions for modification of the Medical Staff Bylaws, as well as the Rules and forms promulgated by the Medical Staff and its departments;

c. Submitting recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices; and

d. Assuring that the Bylaws and Rules comply with applicable laws, regulations, and accreditation standards, and that they adequately and accurately describe the current structure of the Medical Staff, including, but not limited to:

1) Establishing and enforcing criteria and standards for Medical Staff membership and clinical privileges, as well as the mechanisms for doing so;

2) Establishing and enforcing clinical criteria and standards to oversee and manage quality improvement and assessment, utilization review, and other Medical Staff activities, including procedures for meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records; as well as procedures for evaluating and revising such activities;

3) The mechanism for terminating Medical Staff membership;

4) The fair hearing and appeal procedures;

5) Provisions for assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff and in a manner that is consistent with the Hospital's nonprofit tax-exempt purposes;

6) Provisions respecting the Medical Staff's ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and

7) Provisions requiring a physical examination and medical history to be completed within the time frames established by state hospital licensing regulations and federal Medicare law.

3. Meetings and Reporting

The committee will meet as requested by the Bylaws Committee Chair or Chief of Staff, but at least [*fill in frequency*], and reports to the Medical Executive Committee.

Medical Staffs can choose how frequently this committee meets. We recommend that the committee meet at least once annually to review the Bylaws.

Appendix 12C

Cancer Committee

Hospitals that are certified by the Commission on Cancer of the American College of Surgeons must have a Cancer Committee. Cancer-certified hospitals should review the standards required to maintain this certification and should modify this Appendix to reflect the requirements for composition, responsibilities, and meeting frequency to meet those standards.

For other hospitals, a Cancer Committee is optional, and those hospitals have discretion in deciding the committee's composition, duties and meeting frequency.

1. Composition

The Cancer Committee shall be multi-disciplinary, with the goal of including members from the specialties of surgery, internal medicine, gynecology, pediatrics, diagnostic and therapeutic radiology, pathology, and family practice. The committee must also include representatives of Hospital administration, nursing, social services, rehabilitation and the cancer registry.

2. Duties

The duties of the Cancer Committee are to:

a. Make certain that educational programs address major cancer issues.

b. Evaluate the quality of care given patients with cancer and report as necessary to assure that the results of such evaluations are incorporated into the Hospital-wide quality assessment and improvement systems.

c. Supervise the cancer data system.

d. Appoint Cancer Committee members to act as registry physician advisors.

e. Educate Hospital and Medical Staff members and patients about cancer prevention, detection and treatment.

3. Meetings and Reporting

The committee shall meet as often as necessary, but at least [*fill in frequency*]. It shall report to the Quality Improvement Committee.

Medical Staffs can choose how frequently this committee meets, unless the Hospital is certified by the Commission on Cancer of the American College of Surgeons.

Appendix 12D

Credentials Committee

A Credentials Committee is not required but performs an important function. In a non-departmentalized hospital, this committee is primarily responsible for overseeing all credentialing review. In a departmentalized hospital, this committee coordinates the review among departments and makes certain that minimum standards are met by all applicants.

Regardless of whether a separate Credentials Committee performs the credentialing function, Title 22, California Code of Regulations, Section 70703(d), requires that a committee (which could be a dedicated credentials committee, or another committee, such as, a quality committee or the Medical Executive Committee) perform the credentialing function.

1. Composition

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

2. Duties

The duties of the Credentials Committee include:

a. Following the process described in the Medical Staff Bylaws and other standards set forth in the Governing Documents, evaluating or coordinating the evaluation of the qualifications of all applicants for Medical Staff appointment, reappointment, or changes in staff categories.

b. When requested, providing input into questions from Departments regarding the development of privileging criteria.

c. Receiving recommendations from the Interdisciplinary Practice Committee regarding privileges for Advanced Practice Professionals.

3. Meetings and Reporting

The Credentials Committee shall meet as often as necessary, but at least quarterly. The Committee shall report to the Medical Executive Committee.

Title 22, California Code of Regulations, Section 70703(d), requires that the executive committee and the governing body receive reports regarding credentialing "as frequently as necessary and at least quarterly;" therefore, this committee should meet at least quarterly. Medical Staffs can adopt a more frequent meeting schedule.

Appendix 12E

Department Committees

Department Committees are not required, but they can be very helpful in fulfilling the departmental responsibilities for departments that have too many members to function effectively as a committee of the whole. If the department is very small, there may be no point in having a separate committee.

1. Composition

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

Depending on Department size and member availability, this can be limited to active staff.

2. Duties

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

3. Meetings and Reporting

Each Department Committee shall meet as often as necessary, but at least [*fill in frequency*]. Department Committees shall report to the Medical Executive Committee.

Medical Staffs can choose how frequently this committee meets.

Appendix 12F

Emergency Services Committee

The Emergency Service Committee is an optional committee that some hospitals find useful. If there is a separate Emergency Department that has an Emergency Department Committee, a separate committee may be unnecessary, although medical staffs may want to appoint non-emergency department members to the committee to help address the emergency needs of the community and the problems that arise in arranging emergency back-up services. The Medical Staff has complete flexibility in designing the committee's composition, duties, and meeting frequency.

1. Composition

The Emergency Services Committee shall be composed of [at least five active staff members, including at least one representative of the emergency physicians' contract group. A representative of Hospital administration and an emergency department nurse appointed by the Chief Nursing Officer shall be appointed as voting members].

2. Duties

Consistent with any Hospital agreement for emergency medical care services, the Emergency Services Committee shall develop, implement and maintain a plan for emergency care based on community needs and the capabilities of the Hospital. The plan shall consider what steps must be implemented to: (a) assure that adequate appraisal, advice, or initial treatment shall be rendered to individuals who present themselves at the emergency department requesting examination or treatment for a medical condition, or elsewhere on Hospital property requesting examination or treatment for an emergency medical condition, and (b) that the Hospital maintains a sufficient call panel to provide specialty services on an emergency basis.

3. Meetings and Reporting

The Emergency Services Committee shall meet as often as necessary, but at least [*fill in frequency*]. The Committee reports to the Quality Improvement Committee.

Medical Staffs can choose how frequently this committee meets.

Appendix 12G

Infection Prevention Committee

A separate Infection Prevention Committee (also known as an "infection control committee" is optional, but Title 22, California Code of Regulations, Section 70703(d), requires the Medical Staff to perform infection control functions. Additionally, hospitals are required by Section 70739 to have infection control programs, the oversight of which is performed by a "multi-disciplinary committee which shall include representatives from the medical staff, administration, nursing department and infection control personnel." Having that committee be a Medical Staff committee allows it to retain the discovery protections provided to Medical Staff committees under California law.

1. Composition

a. The Infection Prevention Committee shall be composed of [at least five active staff members, including one representative from each department and one physician whose primary specialty is infectious disease. In addition, the infection control officer, a nurse whose responsibilities primarily involve infectious disease, and the pharmacy director shall be voting members. The employee health nurse, a representative of nursing administration, the operating room supervisor, the director of central supply, and a representative of Hospital administration shall be ex officio members without vote.]

b. [Representatives from housekeeping, laundry, dietetic services, and engineering and maintenance shall be invited to attend on a consultative and ad hoc basis].

2. Duties

The Infection Prevention Committee shall:

a. Develop and oversee the Hospital's infection prevention and control program and the staff's treatment of infectious disease.

b. Engage in surveillance and review activities for the clinical use of antimicrobials at the Hospital.

c. Evaluate, approve, and monitor surveillance activities.

d. Approve action to prevent or control infections and the infection potential among patients and Hospital personnel.

e. Review infections originating in the Hospital and evaluate ways to prevent or reduce the risk of future occurrence.

f. Assure that the results of infection control studies and reviews are incorporated into the Hospital's educational programs and into the Hospital's quality assessment and improvement activities.

g. Review and approve all policies and procedures relating to infection surveillance, prevention, and control activities throughout the Hospital at least once every two years.

h. Work with administration to ensure that any facility improvement plans include current infection control principles.

i. Ensure that the Hospital's prevention and control program links with external support systems and with communitywide agencies as they relate to reduction of risk from the environment.

j. Ensure that appropriate resources are available for infection control activities.

k. Have the Chair or his or her designee be available for on-the-spot interpretation of applicable infection prevention and control policies and rules.

3. Meetings and Reporting

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

Title 22, California Code of Regulations, Section 70703(d), requires that the executive committee and the governing body receive reports regarding infection control "as frequently as necessary and at least quarterly;" therefore, this committee should meet at least quarterly. Medical Staffs can adopt a more frequent meeting schedule.

Appendix 12H

Institutional Review Board

1. Composition

Hospitals that allow the use of any investigational drugs or devices or have any federally-funded research need an Institutional Review Board (IRB) that can carry out the duties assigned by the federal government for protecting human subjects. These committees do not have to be Medical Staff committees; however, California courts have recognized that if IRBs are created as medical staff committees, they are entitled to the California discovery and other protections available to medical staff committees. Hospitals should evaluate the risks and benefits of having an IRB as a Medical Staff committee.

The provisions in the rule comply with the detailed federal regulations that apply to these committees, but they are not all-inclusive. Because hospitals involved in certain types of research must comply with the federal regulations, hospitals maintaining an IRB are advised to review the applicable laws and regulations and develop their own detailed guidelines.

The Medical Staff may have more than one Institutional Review Board (IRB). Each IRB shall have the following composition:

The composition paragraphs below come directly from the Federal Common Rule requirements for IRBs, as revised effective July 2018. They should not be altered unless the Common Rule is revised.

a. Each IRB shall have at least five members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members (professional competence), and the diversity of its members, including race, gender, and cultural backgrounds and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. The IRB shall be able to ascertain the acceptability of proposed research in terms of institutional commitments (including policies and resources) and regulations, applicable law, and standards of professional conduct and practice. The IRB shall therefore include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a category of subjects that is vulnerable to coercion or undue influence, such as children, prisoners, individuals with impaired decision-making capacity, or economically or educationally disadvantaged persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these categories of subjects.

b. Each IRB shall include at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

c. Each IRB shall include at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated with the institution.

d. No IRB may have a member participate in the IRB's initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB.

e. An IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of issues that require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB.

2. Duties

The IRB shall:

a. Comply with federal regulations governing IRBs.

b. Adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, as applicable.

c. Provide appropriate oversight and review of research activities, as described in the IRB's written procedures.

d. Exercise its authority, as described in the IRB's written procedures.

e. Develop a policy for identifying when a quorum is present, which must comply with federal regulations governing IRBs. The quorum provisions in other Governing Documents shall not apply to the IRB.

Federal regulations governing IRBs have specific quorum requirements relating to the review of proposed and continuing research.

f. Develop a policy for identifying and acting upon conflicts of interests.

g. Maintain records in a manner consistent with federal regulations governing IRBs.

3. Meetings

The IRB shall meet as often as needed, but at least as often as described in the IRB's written procedures.

Appendix 12I

Interdisciplinary Practice Committee

1. Composition

Hospitals extending clinical privileges (including standardized procedure privileges) to nurses and physician assistants must have an Interdisciplinary Practice Committee that has a membership with equal representation of nurses and physicians plus, if possible, representation from other professions that are allowed to practice in the hospital. This committee should be a Medical Staff committee in order to qualify for the immunities from liability and the protections against discovery available for Medical Staff committees under California law. This committee also may be responsible for credentialing Allied Health Professionals at the time of appointment and reappointment, rather than the Credentials Committee.

The committee's composition is dictated by Title 22, California Code of Regulations, Section 70706(b). Hospitals should not make changes to this list without first reviewing the regulation or consulting counsel.

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

One or more clinical psychologists is required only if the hospital has a psychiatric unit and one or more clinical psychologists on the medical staff.

2. Duties

a. Policies and Procedures. The IPC shall develop policies and procedures for the conduct of its business, including, but not limited to, the following:

The following requirements reflect, with some modification, the requirements of Title 22, California Code of Regulations, Section 70706(c).

1) Provision for securing recommendations from the medical staff in the medical specialty or clinical field of practice under review, and from Advanced Practice Professionals who practice in the clinical field or specialty under review.

2) Method for the approval of standardized procedures in accordance with statutory requirements, in which affirmative approval of the Chief Executive Officer and a majority of the physician members and a majority of the registered nurse members would be required, and that prior to such approval, consultation shall be obtained from medical staff and nurses in the medical and nursing specialties under review.

3) Providing for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the medical staff for medical services in the facility.

4) Intended line of approval for each recommendation of the Committee, which shall be consistent with the Governing Documents.

b. Standardized Procedures. The IPC shall:

The following requirements reflect, with minimal modification, the requirements of Title 22, California Code of Regulations, Section 70706.2(a).

1) Identify functions and/or procedures which require the formulation and adoption of standardized procedures under statutory law in order for them to be performed by registered nurses in the facility and initiate the preparation of such standardized procedures.

2) Review and approve all such standardized procedures covering practice by registered nurses in the facility. Standardized procedures can be approved only after consultation with the relevant Medical Staff departments and by affirmative vote of the Chief Executive Officer and a majority of the physician members and a majority of the registered nurse members.

3) Recommend policies and procedures for the authorization of employed registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the IPC or by delegation to the Chief Nursing Officer.

c. Credentialing Allied Health Professionals. The IPC shall:

1) Recommend policies and procedures for expanded role privileges for registered nurses, assessing, planning and directing the patients' diagnostic and therapeutic care.

Title 22, California Code of Regulations, Section 70706.1(a), requires this only for registered nurses; however, the IPC should consider this role for all categories of APPs that include these roles in their scopes of practice.

2) Review AHP applications and requests for privileges and forward its recommendations and the applications to the Medical Executive Committee.

Title 22, California Code of Regulations, Section 70706.1, provides that the "Committee on Interdisciplinary Practice [is] responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges" for advanced practice registered nurses. Some hospitals choose to have the Interdisciplinary Practice Committee also perform this role for other types of AHPs. Another alternative is to have the Interdisciplinary Practice Committee make its recommendation to the Credentials Committee, which then reports to the MEC.

Regardless of the approach selected, hospitals should make sure that the IPC duties align with their Allied Health Professional credentialing provisions (see Rule 13 in this model).

3) Participate in AHP peer review and quality improvement. It may initiate corrective action when indicated against AHPs in accordance with these Rules or other guidelines governing AHPs.

Hospitals should ensure that this aligns with their peer review and quality improvement processes.

4) Serve as liaison between AHPs and the Medical Staff.

d. Education

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

3. Meetings and Reporting

The IPC shall meet as often as necessary, but at least [*fill in frequency*].

Medical Staffs can choose the meeting frequency.

Appendix 12J

Joint Conference Committee

1. Composition

Joint Conference Committees are optional; however, many hospitals maintain the committee since it can help fulfill the TJC requirement for a mechanism to assure effective communication among the Medical Staff, hospital administration and the Governing Body. It also provides a forum to resolve conflicts, as required by TJC, and can fulfill the Business and Professions Code Section 2282.5 "meet and confer" provisions. District hospitals and hospitals governed by the Brown Act should consider whether this committee will be subject to the Brown Act and revise this Section as needed to accommodate these considerations.

Because the committee is optional, there is flexibility regarding composition and other provisions. However, because this is intended to be a forum for equitable dispute resolution, the membership should be designed to provide both the Governing Body and the Medical Staff fair representation.

The Joint Conference Committee shall be composed of eight members: the Chief of Staff, the Vice Chief of Staff, the immediate-past Chief of Staff, the Secretary-Treasurer, three members of the Hospital's Governing Body, and the Chief Executive Officer. All members are voting members. The person serving as the Joint Conference Committee Chair shall alternate annually between the Chief of Staff and one of the Governing Body representatives. The Chief Medical Officer shall attend as a resource person.

Consistent with the Model Bylaws.

2. Duties

The Joint Conference Committee shall:

a. Perform such duties as are described in the Conflict Management Rule.

b. Promote the furthering of understanding of the roles, relationships, and responsibilities of the Governing Body, administration, and the Medical Staff.

c. Serve as a forum for the Governing Body, administration, and the Medical Staff to discuss together any Hospital matters regarding the provision of patient care.

3. Meetings and Reporting

The Joint Conference Committee shall meet at least [*fill in frequency*], or as often as necessary to fulfill its responsibilities, and whenever called to meet under the Conflict Management Rule. Any member of the committee shall have the authority to place matters on the agenda for consideration by the committee. The Joint Conference Committee is directly accountable to the Medical Executive Committee and to the Governing Body.

Medical Staffs and Governing Bodies may choose the meeting frequency; some hospitals may choose to have this committee meet only as necessary to resolve conflicts.

Appendix 12K

Pharmacy and Therapeutics Committee

Title 22, California Code of Regulations, Section 70263(c), requires hospitals to have a pharmacy and therapeutics committee, "or a committee of equivalent composition." Although this regulation does not require that the committee be a Medical Staff committee, Title 22, California Code of Regulations, Section 70703(d), requires medical staffs to fulfill a pharmacy and therapeutic "function." Maintaining the committee as a Medical Staff committee qualifies its proceedings and participants for the immunities from liability and the protections against discovery available for Medical Staff committees under California law.

In addition to the California regulations, the Medicare Conditions of Participation define some of the Medical Staff's roles and responsibilities over pharmacy issues (see 42 C.F.R. Section 482.25).

1. Composition

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

This generally reflects the minimum composition requirement under Title 22; the exception is that the regulation requires only that a pharmacist, and not necessarily the pharmacy director, be on the committee. However, the Interpretive Guidelines to the Medicare Conditions of Participation provide that the pharmacist director's role must include "active leadership of those committees responsible for establishing medication-related policies and procedures."

2. Duties

The Pharmacy and Therapeutics Committee shall:

a. Develop written policies and procedures for establishment of safe and effective systems for procurement, storage, distribution, dispensing, and use of drugs and chemicals.

Reflective of Title 22, California Code of Regulations, Section 70263(c), and Medicare Conditions of Participation, 42 C.F.R. Section 482.25(b)(9).

b. Develop and maintain a formulary of drugs for use throughout the Hospital to assure quality pharmaceuticals at reasonable costs.

Reflective of Title 22, California Code of Regulations, Section 70263(c), and Medicare Conditions of Participation, 42 C.F.R. Section 482.25(b)(9).

c. Review and, as appropriate, update the formulary as needed, and at least annually.

d. Provide oversight for the medication management systems, including identifying risks and implementing processes to reduce risk and improve patient safety.

e. Evaluate reports on medication errors that occur at the Hospital and make recommendations to reduce the occurrence of errors.

f. Evaluate reports on adverse drug reactions and interactions that occur at the Hospital and make recommendations to reduce the occurrence of adverse drug reactions and interactions.

g. Provide education to the Medical Staff and Hospital clinical staff about any changes in the formulary, medical management system, or policies and procedures, as well as on other topics determined appropriate by the Committee.

3. Meetings and Reporting

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

Title 22, California Code of Regulations, Section 70703(d), requires that the executive committee and the governing body receive reports regarding pharmacy and therapeutics "as frequently as necessary and at least quarterly;" therefore, this committee should meet at least quarterly. Medical Staffs can adopt a more frequent meeting schedule.

Appendix 12L

Professional Conduct Committee

1. Composition

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

Many Medical Staffs have created Professional Conduct Committees to oversee Medical Staff and AHP conduct issues. Although any Medical Staff may benefit from specializing this function, this can be especially useful with a large Medical Staff. Practitioner conduct issues are time-consuming and are best managed by individuals who have developed an understanding of the issues and an appreciation for the toll disruptive conduct takes on hospital and Medical Staff operations. Because this committee is not required by law or accreditation requirements, hospitals have flexibility in how they are composed and what their duties are.

2. Duties

The Professional Conduct Committee shall:

a. Monitor Practitioners' and AHP's compliance with the Medical Staff Standards of Conduct;

b. Review incident reports involving Practitioner and AHP conduct;

c. Meet with and counsel individuals who have been referred to the committee by self-referral or by referral from another committee or by a Medical Staff Leader

d. Develop and monitor compliance with corrective action plans;

e. Make recommendations to the Medical Executive Committee for administrative or disciplinary action whenever informal measures are insufficient or ineffective in addressing reported problems; and

f. Perform whatever other tasks might be assigned to it by the Medical Executive Committee or in a Governing Document.

Hospitals should develop comprehensive processes for addressing conduct issues and include detail regarding the Professional Conduct Committee's role.

3. Meetings and Reporting

The committee shall meet as often as necessary, but at least [*fill in frequency*]. The Committee reports to the Medical Executive Committee.

Medical Staffs can choose the meeting frequency.

Appendix 12M

Quality Improvement Committee

1. Composition

California hospital licensure regulations, Medicare Conditions of Participation, and TJC standards require the Medical Staff to provide leadership in measuring, assessing and improving: medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, monitoring of significant departures from established clinical patterns, patients' and families' education, coordination of care with other practitioners and hospital personnel, and the accurate, timely and legible completion of patients' medical records.

These functions generally fit well within the Quality Improvement Committee, which may or may not need subcommittees to help it complete the work, depending upon the volume of cases it must review and the role of the departments in assisting. In some hospitals, some or all of the functions will be assigned to separate committees. In deciding how to structure the committees, the general rule should be to simplify the structure and to consolidate the review as much as possible so that fewer committees will review the same charts for different issues. At the same time, care must be taken so that the expertise needed for the review remains available.

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

This composition is flexible. It should reflect a sufficiently broad expertise to address all the committee's duties.

2. Duties

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

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

a. **Quality Improvement**

1) Develop, review annually, and revise as needed, a quality improvement plan that is appropriate for the Hospital and Medical Staff and that meets accreditation and regulatory requirements. The quality improvement plan may include mechanisms for:

   i. Establishing objective criteria;

   ii. Measuring actual practice against the criteria;

   iii. Analyzing practice variations from criteria by peers;

   iv. Taking appropriate action to correct identified problems;

   v. Following up on action taken; and

   vi. Reporting the findings and results of the audit activity to the Medical Staff, the Chief Executive Officer, and the Governing Body.

2) Utilize at least sentinel event data and patient safety data in measuring and assessing performance improvement.

3) Review and act upon, on a regular basis, factors affecting the quality, appropriateness, and efficiency of patient care provided in the Hospital, including review of surgical and other invasive procedures; mortality; use of medications, including antibiotics; blood and blood components usage; admissions and continued hospitalization; and fulfillment of consultation requirements.

4) Coordinate the findings and results of department, committee, and staff patient care review activities; utilization review activities; continuing education activities; reviews of medical record completeness, timeliness, and clinical pertinence; and other staff activities designed to monitor patient care practices.

5) Submit monthly reports to the Medical Executive Committee on the overall quality, appropriateness, and efficiency of medical care provided in the Hospital, and on the department, committee, and staff patient care review, utilization review and other quality review, evaluation and monitoring activities.

6) Make recommendations to the committees responsible for continuing medical education for the development of appropriate educational programs.

7) On at least an annual basis, evaluate the coordination of patient care and formulate policy recommendations for dietary services, equipment standardization, home health, physical therapy and social services.

8) At least once a year, evaluate and revise as needed the Hospital-wide quality improvement program to assess the effectiveness of the monitoring and evaluation activities and recommend improvement.

b. **Surgical Case Review Duties**

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

1) Selecting appropriate procedures;

2) Preparing the patient for the procedure;

3) Performing the procedure and monitoring the patient; and

4) Providing post-procedure care.

c. **Death and Tissue Review**

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

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

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

2) Review policies governing blood usage.

e. **Medical Records Function**

1) Provide for at least quarterly review of medical records for clinical pertinence and timely completion.

2) Provide for quarterly review by a multidisciplinary team (including Medical Staff members, nursing, health information management service staff and administration) of a sample of records to determine whether they reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and the condition of the patient at discharge.

3) Review summary reports concerning timely completion of medical records.

4) Approve a standardized medical record format and forms to be used in the record.

5) Recommend solutions for problems identified during review, and monitor effectiveness of these interventions.

3. Meetings and Reporting

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

Title 22, California Code of Regulations, Section 70703(d), requires that the executive committee and the governing body receive reports regarding medical records and tissue review (covered by this committee) "as frequently as necessary and at least quarterly;" therefore, this committee should meet at least quarterly. Medical Staffs can adopt a more frequent meeting schedule.

Appendix 12N

Utilization Review Committee

1. Composition

Medical Staffs Bylaws, Rules and regulations are required, pursuant to Title 22, California Code of Regulations, Section 70703(d), to provide for the utilization review function. The Medicare Conditions of Participation, in 42 C.F.R. Section 482.30, also require hospitals to have a utilization review committee that is a "staff committee of the institution" (except in certain, defined circumstances).

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

2. Duties

The Utilization Review Committee shall perform the following functions:

a. General Duties

1) Reviews the Hospital's utilization review plan and acts in a manner consistent with the plan.

2) Oversees review of the medical necessity for admissions, duration of stays, and services furnished, including drugs and biologicals, as further described in the utilization review plan.

3) Addresses over-utilization, under-utilization, and inefficient scheduling and use of resources.

4) Follows patterns of care and recommends focused review as necessary.

5) Works toward maintaining proper continuity of care upon discharge.

6) Communicates pertinent data and results of review to the Medical Executive Committee.

7) Makes recommendations for the utilization of resources and facilities commensurate with quality patient care and safety.

b. Utilization Review Plan

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

The Medicare Conditions of Participation requires hospitals to have a utilization review plan; the Committee should operate in a manner consistent with that plan, but the plan does not need to be detailed in the Rules.

c. **Education**

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

3. Meetings and Reporting

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

Appendix 12O

Well-Being Committee

1. Composition

California hospital licensure regulations require the Medical Staff to have a committee that assists Medical Staff members impaired by chemical dependency and/or mental illness to obtain necessary rehabilitation services. TJC Standard MS.11.01.01 similarly requires medical staffs to implement processes to identify and manage matters relating to individual health.

Although the regulations allow this function to be assigned to any committee, TJC requires that the process be separate from disciplinary actions. Therefore, it is best to assign it to a separate committee that has no responsibility for peer review or involvement in any credentialing or corrective action decision. Some smaller hospitals choose to have "joint" or "community" committees with other local hospitals.

The committee also can help the Medical Staff comply with the Americans with Disabilities Act, which generally restricts when information regarding a physical or mental disability may be obtained from an applicant.

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

2. Duties

a. The Well-Being Committee shall develop processes to educate Medical Staff Members and AHPs about Practitioner and APP health; to address prevention of physical, psychiatric, or emotional illness; and to facilitate confidential diagnosis, treatment and rehabilitation of Practitioners and APPs who suffer from a potentially impairing condition. At a minimum, these processes should include mechanisms for the following:

The following include all the requirements of TJC Standard MS.11.01.01.

1) Educating the Medical Staff and Hospital staff about illness and impairment recognition issues specific to health care professionals.

2) Self-referral by a Practitioner or APP, as well as referral by others while maintaining informant confidentiality.

3) Referral of the Practitioner or APP to appropriate professional internal or external resources for evaluation, diagnosis, and treatment of the condition or concern.

4) Maintenance of confidentiality of the Practitioner or APP seeking referral or referred for assistance, except as limited by applicable law or ethical obligations, or when the health and safety of a patient is threatened.

5) Evaluation of the credibility of a complaint, allegation, or concern.

6) Monitoring the Practitioner or APP until the rehabilitation is complete and periodically thereafter, if warranted.

7) Reporting to the Medical Executive Committee instances in which the Wellbeing Committee has concern that a Practitioner or APP cannot practice safely.

8) Initiating appropriate actions, which may include reporting to the Medical Executive Committee, when a Practitioner or APP fails to complete the required rehabilitation program.

b. The Well-Being Committee may be asked to review the responses from applicants concerning disabilities and recommend what, if any, reasonable accommodations may be indicated in order to assure that the Practitioner or APP will provide care in accordance with the Hospital and Medical Staff's standard of care.

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

3. Meetings, Reporting and Minutes

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

Title 22, California Code of Regulations, Section 70703(d), requires that the executive committee and the governing body receive reports regarding the assistance to impaired members "as frequently as necessary and at least quarterly;" therefore, this committee should meet at least quarterly. Medical Staffs can adopt a more frequent meeting schedule.

RULE 13

ALLIED HEALTH PRACTITIONERS

13.1 Definitions

The term, "Allied Health Practitioner" covers a broad range of professionals; here it is limited as found in the definition in the Bylaws. Hospitals should be careful to ensure that the qualifications of AHPs who practice at the hospital as employees or as contractors, but who are not subject to this Medical Staff credentialing processes, have been appropriately scrutinized by human resources. See also the requirements of TJC Standard HR.01.01.01.

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

The Model tries to avoid duplication; in part because doing so can cause problems if one document is revised and the other is not. Here, duplication from the Bylaws is useful and the provision makes clear that the Bylaws are the controlling document.

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

California law (Title 22, California Code of Regulations, Section 70701) limits Medical Staff membership to physicians, dentists, podiatrists, and clinical psychologists. Allied health practitioners are not permitted to be Medical Staff members. Although both CMS and Joint Commission have broadened their lists of who may serve on the Medical Staff, state law remains a limiting factor.

Not all hospitals allow clinical psychologists to become Medical Staff members. If clinical psychologists are not on the Medical Staff, they are included in the definition of allied health practitioner. List clinical psychologists in this definition only if the Medical Staff grants them membership.

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

The area of allied health professional law is evolving. Whereas previously, allied health professionals tended to be discussed as a large, homogenous group, for the purposes of Medical Staff matters, they more recently have been distinguished into two groups: those who practice at a medical level of care (meaning, they do things that are otherwise the practice of medicine, and are also known as "Advanced Practice Professionals" or APPs) and, therefore, come under the Medical Staff's authority, and those who do not practice at that level. Examples of APPs can include, but are not limited to, chiropractors, clinical psychologists, physician assistants, nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, registered nurse first assistants, clinical nurse specialists, and advanced practice pharmacists. There is, however, no legal definition or legal limit to who may or may not be considered an APP.

Guidance from CMS and TJC suggests that advanced practice professionals should be credentialed and granted privileges through a medical staff process. However, TJC also has an "FAQ" that suggests this is only the case if the APP is also a "licensed independent practitioner" (which they are not in California). TJC also provides in recently revised Standard HR.01.02.01 that physician assistants and advanced practice registered nurses "can be credentialed, privileged, and reprivileged through the medical staff process or an equivalent process." EP 2 explains what constitutes an "equivalent process," which includes, among other things, input from the medical staff to make an informed decision regarding requests for privileges.

Regardless of the TJC's "equivalent process" provision, viewed from a purely logic-based perspective, if an APP is doing the same things as a physician (doing tasks that constitute the practice of medicine, though under some level of supervision or direction), it would be appropriate for the Medical Staff to credential APPs through a similarly-thorough process that includes review at the departmental and committee levels. These Bylaws and the Rules provide for such a process.

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

Under this Rule, AHPs are treated somewhat differently based on whether or not they are Hospital employees.

- *AHPs that are Hospital employees are hired, evaluated, and (if necessary) disciplined by the Hospital through its human resources department. Unless these AHPs are also Advanced Practice Professionals, the Medical Staff does not have authority over Hospital-employed AHPs.*

- *The Hospital's human resources department does not have authority over AHPs who are not Hospital employees; therefore, the Medical Staff fulfills the oversight role (including credentialing, evaluation, and discipline) of AHPs who are not Hospital employees.*

- *Additionally, the Medical Staff must have credentialing and review responsibilities for Advanced Practice Professionals, regardless of whether they are Hospital employees, due to their provision of services at a medical level of care. Provisions in Title 22, California Code of Regulations, Section 70706.1, also suggest that the Medical Staff must be involved in credentialing advanced practice registered nurses and physician assistant, regardless of employment status. Advanced Practice Professionals who are Hospital employees will therefore be subject to both human resources oversight and Medical Staff oversight.*

Because Advanced Practice Professionals practice at a medical level of care, they should be subject to Medical Staff oversight, regardless of whether or not they are employed by the Hospital.

13.2 Designation of Allied Health Practitioners

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

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

Although this is not a legally-mandated standard, hospitals should not recognize categories of AHPs unless there is some oversight by the state or by a private certifying body.

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

13.2.4 At a minimum, the Medical Executive Committee and the Governing Body shall consider the following:

a. Any applicable statutory licensing provisions delineating the scope of practice and prescribed mechanisms for governmental oversight (e.g. California Business and Professions Code; California Code of Regulations), or, if California law does not require professionals in the profession to possess a license, a copy of the standards of the private certifying body of solid national reputation.

b. Evidence that the new category will improve access to, or quality of care at, the Hospital.

c. The effect of the professional on patient charges.

d. Whether the Hospital and Medical Staff can provide necessary oversight and supervision.

13.2.5 The following categories of professionals have been designated as Advanced Practice Professionals eligible for Allied Health Status and privileges:

a.

b.

Hospitals should populate this list with the APPs they recognize. Examples of APPs include:

- *Advanced Practice Pharmacists*
- *Certified Registered Nurse Anesthetists*
- *Certified Nurse Midwives*
- *Clinical Psychologists*
- *Nurse Practitioners*
- *Physician Assistants*
- *Registered Nurse First Assistants*

13.2.6 The following categories of non-APP professionals have been designated as eligible for Allied Health Status and privileges, but do not include those persons who are employed by the Hospital:

a.

b.

Hospitals should populate this list with the other types of AHPs they recognize. This list should only include professions where individuals not employed by the Hospital may, at the request of a Medical Staff member, practice at the Hospital to assist that Medical Staff member. Examples of these practitioners include:

- *Acupuncturists*
- *Audiologists*
- *Perfusionists*
- *Clinical Nurse Specialists*
- *Licensed Clinical Social Workers*
- *Licensed Marriage and Family Therapists*
- *Surgical Nurses*
- *Surgical Technicians*

13.3 Supervising Practitioner

Hospitals could choose to allow certain practitioners, such as Acupuncturists, Advanced Practice Pharmacists, Certified Registered Nurse Anesthetists, Chiropractors, Licensed Clinical Social Workers, and Licensed Marriage and Family Therapists to not have a supervising physician. However, all other advanced practice nurses and physician assistants should have a supervising physician, as they are not permitted to practice independently. PLEASE NOTE: Although some advanced practice nurses other than nurse anesthetists claim to have the authority to act independently, California law does not recognize this and requires these professionals to have some form of supervision (such as standardized procedures).

13.3.1 Except for clinical psychologists, all AHPs who apply for Allied Health Status must identify a Medical Staff member as a supervising practitioner. The supervising practitioner either must be the AHP's employer; have a contractual agreement with the AHP or the AHP's employer for supervision of the AHP's clinical tasks or functions; or work for the same medical corporation or licensed entity as the AHP, and supervision of the AHP is part of the Practitioner's job duties.

The words "Except for clinical psychologists, all AHPs" should be removed if clinical psychologists are eligible for Medical Staff membership, and therefore, are not AHPs.

13.3.2 A supervising practitioner or group which employs or contracts with the AHP agrees to indemnify the Hospital against any expense, loss, or adverse judgment it may incur either as a result of allowing an AHP to practice at the Hospital, or as a result of denying or terminating the AHP's privileges.

13.3.3 The supervising practitioner shall assure that the AHP complies with the Governing Documents.

13.3.4 Supervising practitioners and the AHPs they supervise are responsible for ensuring that the AHP complies with the direction and/or supervision requirements detailed in the standardized procedures, delegation of services agreement, practice protocols, and/or Governing Documents, as applicable.

13.3.5 A supervising practitioner's failure to supervise an AHP in a manner consistent with the standardized procedures, delegation of services agreement, practice protocols, or Governing Documents, as applicable, shall be grounds for corrective action against the supervising practitioner.

13.4 Credentialing Required

13.4.1 All AHPs who (a) are not employees of, or contractors with, the Hospital, but have been granted privileges or practice prerogatives to provide certain clinical services, and (b) are Advanced Practice Professionals, whether employed by the Hospital or not, and have been granted privileges to provide certain clinical services as defined in the Medical Staff Bylaws, must be credentialed through the process described in this Rule, appointed to the Allied Health Staff, and granted privileges or practice prerogatives by the Governing Body before they can practice at the Hospital. These AHPs may only practice those privileges or practice prerogatives granted by the Governing Body pursuant to this Rule.

13.4.2 The Medical Staff Bylaws provisions regarding "General Qualifications," "Additional Qualifications," "General Responsibilities," and "Conduct Expectations," as well as each of the Rules in this document, apply to all AHPs who apply to the Allied Health Staff and/or who are granted privileges or practice prerogatives, as those provisions and Rules might reasonably be applied to AHPs.

13.4.3 The Medical Staff shall develop an application form that, at a minimum, will include the content included in the application for Medical Staff Membership and Privileges.

13.4.4 Each Department shall develop appropriate forms delineating the criteria required for privileges and practice prerogatives for the AHPs who practice in their Departments. For criteria that apply to advanced practice nurses, the Departments shall work with the Interdisciplinary Practice Committee in developing these criteria. All criteria shall be subject to approval by the Medical Executive Committee and the Governing Body.

Per Title 22, California Code of Regulations, Section 70706.1.

13.4.5 Unless the AHP is an employee of the Hospital:

a. An AHP is not an agent of the Hospital or Medical Staff, and neither the AHP, nor the AHP's supervising practitioner, shall claim that the AHP is the Hospital's agent.

b. The Hospital shall have no obligation to, or responsibility for, paying an AHP or for complying with any relevant employment laws, including federal and state income tax withholding laws, overtime laws, and workers' compensation insurance coverage laws.

13.5 Credentialing Process

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

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

Title 22, California Code of Regulations, Section 70706.1, provides that the "Committee on Interdisciplinary Practice [is] responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges" for advanced practice registered nurses. Some hospitals choose to have the Interdisciplinary Practice

Committee also perform this role for other types of AHPs. Another alternative is to have the Interdisciplinary Practice Committee make its recommendation to the Credentials Committee, which then reports to the MEC.

13.6 Nature of Allied Health Staff Membership

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

APPs should be subject to FPPE and OPPE requirements.

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

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

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

13.7 Performance Evaluations, Investigations, and Corrective Action

13.7.1 Employed APPs

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

13.7.2 Performance Evaluations

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

13.7.3 Investigations

a. APPs shall be subject to the Investigation Article of the Medical Staff Bylaws.

b. Non-APP AHPs may be investigated on the same grounds as described in the Investigation Article of the Medical Staff Bylaws; however, the investigation may be authorized by the Department, the Interdisciplinary Practice Committee, or the Medical Executive Committee. The committee that authorizes the

investigation shall use the Investigation Article of the Medical Staff Bylaws as a guide for performing a fair and thorough investigation but is not bound by that process. The investigatory body shall, at a minimum:

1. Provide the AHP the opportunity to provide information to the body in a manner that the investigatory body determines appropriate.

2. Report its findings to the Medical Executive Committee.

13.7.4 Corrective Action

a. By accepting Allied Health Staff status and/or privileges or other practice prerogatives, the AHP accepts the Medical Staff's authority to recommend and/or impose corrective action pursuant to this Rule. Each AHP agrees that he or she will comply with any requirements imposed on the AHP as corrective action once that action is considered a final action or if the action is a summary action. Failure to comply with the requirements of corrective final actions or summary actions shall, in and of itself, be grounds for additional corrective action, including termination of Allied Health Staff status and/or privileges or other practice prerogatives. Invoking the processes in this Rule to challenge corrective actions shall not be considered a failure to comply with any corrective action requirement, and no AHP shall be penalized for asserting those rights.

b. The Medical Executive Committee; the Chief of Staff, the Chair of the AHP's Department, the Chair of the Interdisciplinary Practice Committee, the Chief Executive Officer, or the Governing Body may impose non-summary corrective action on an AHP on the grounds that the AHP has done something that is reasonable likely to have been, or to be:

1. Detrimental to patient safety or to the delivery of quality patient care within the Hospital;

2. Unethical or illegal;

3. Contrary to the Medical Staff Governing Documents;

4. Intimidating or harassing to staff, colleagues, patients, or other persons at the Hospital;

5. Below applicable professional standards;

6. Disruptive of Medical Staff or Hospital operations; or

7. An improper use of Hospital resources.

c. AHPs shall be given notice of the corrective action and a brief description of the reasons for the action.

d. Non-restrictive corrective actions are effective upon imposition; restrictive corrective actions are effective upon approval by the Governing Body. Except as applies to clinical psychologists, marriage and family therapists, and clinical

social workers, the Governing Body may consider and act upon a corrective action recommendation prior to the exhaustion of any hearing rights.

e. AHPs are subject to the "Automatic Suspension, Termination, and Limitation" provisions of the Corrective Action Article of the Medical Staff Bylaws. Additionally, AHPs shall be subject to an automatic suspension if the supervising practitioner's Medical Staff membership or privileges terminate or are suspended, or if the supervising practitioner declines to continue supervision. In such cases, the AHP shall remain on suspension until the supervising practitioner is no longer subject to suspension, until another supervising practitioner is identified, or until the AHP accumulates sufficient suspension days to result in an automatic termination, whichever occurs first.

f. The Medical Executive Committee, the Chief of Staff, the Chair of the AHP's Department, the Chair of the Interdisciplinary Practice Committee, the Chief Executive Officer, the Chief Medical Officer, or any officer of the Governing Body may impose a summary restriction or suspension on any AHP, other than a clinical psychologist, marriage and family therapist, or clinical social worker, whenever any of those individuals or bodies determine that such action is necessary.

g. Summary action may be imposed on a clinical psychologist, marriage and family therapist, or clinical social worker only in compliance with the standards described in the Summary Action provisions of the Corrective Action Article of the Medical Staff Bylaws.

One of the novelties of California Business and Professions Code Section 809, et seq., is that it includes these professionals in its definition of "licentiate," so the "imminent danger" standards of 809.5 apply.

13.8 Challenging Corrective Actions

13.8.1 General Rules

a. If a process to challenge a corrective action is available, the AHP must exhaust that process before resorting to legal action.

b. Technical, non-prejudicial, or insubstantial deviations from the procedures set forth in this Rule shall not be grounds for invalidating the action taken.

c. No AHP is entitled to the hearing and appeals provisions found in the Hearings and Appeals Article of the Medical Staff Bylaws, except as provided below.

d. An employed APP who is disciplined through the Hospital's employment processes, including, but not limited to, termination, is not entitled to challenge that action through the hearing processes described in this Rule. This includes actions the Hospital takes that would, if taken by the Medical Staff, entitle the APP to the hearing process in this Rule.

13.8.2 Advanced Practice Professional

a. Clinical psychologists, marriage and family therapists, and clinical social workers are subject to the Hearings and Appeals Article of the Medical Staff Bylaws.

See above comment.

b. All other APPs are entitled to the following limited hearing process:

Neither California law nor the NPDB requires a hearing process for any other type of AHP; however, TJC provides that a process should be in place for any adverse decision regarding "privileges." As discussed in other contexts, APPs are considered to have "privileges" by TJC and CMS. TJC does not require non-Medical Staff members to have the same process as Medical Staff members, so this process is limited to being TJC compliant, rather than California Business and Professions Code Section 805 compliant.

1. Only adverse decisions regarding reappointment, denial, reduction, suspension, or revocation of privileges are grounds for a limited hearing, and only if those decisions (a) involve a medical disciplinary cause or reason, and (b) would affect the APP's privileges for more than 30 days.

2. The body that imposes the corrective action shall provide notice to the APP of the action and a brief description of the reasons for the action. The notice shall inform the APP that he or she may request a limited hearing under this Rule and that such request must be received by the Medical Staff Services Administration within 15 days of the notice. A copy of this Rule shall be included.

3. If the APP timely requests a limited hearing, the Chief of Staff shall create an ad hoc committee consisting of at least three members in good standing of the Medical Staff or Allied Health Staff, at least one of which shall, if feasible, have the same licensure as the APP who requested the hearing. If it is not feasible to appoint ad hoc committee members from within the staff, the Chief of Staff may select Practitioners or AHPs from outside the Hospital as long as they sign confidentiality and business associate agreements and the Hospital's legal counsel is informed. The members of the ad hoc committee shall be impartial and not have participated in the process that led to the corrective action. Knowledge of the action does not disqualify anyone from serving on the ad hoc committee. The Chief of Staff also shall appoint a hearing officer, which may, but is not required to, meet the qualifications of a Hearing Officer under the Hearings and Appeals Article of the Medical Staff Bylaws.

4. At least 45 days prior to the limited hearing, the Chief of Staff shall provide the APP with the following:

   i. Notice of the date, time, and place for the limited hearing;

ii. The names of the ad hoc committee members;

iii. A brief description of the acts and omissions that led to the corrective action, including a list of medical records, if applicable; and

iv. A copy of any witness statements or other documents the Medical Staff intends to rely on at the limited hearing (except for any documents that may be used for rebuttal).

5. At least 30 days prior to the limited hearing, the APP must provide the Medical Staff with a copy of any witness statements or other documents the APP intends to rely on at the limited hearing. Failure to do so shall give the Medical Staff the right to move to exclude such statements or documents from the limited hearing.

6. The following hearing procedures shall be followed:

i. Neither party shall be represented by an attorney at the limited hearing; however, each party may be represented by a Medical Staff member or Allied Health Staff member of his or her choosing.

ii. Both parties may submit a written statement to the ad hoc committee prior to the limited hearing, subject to any limits that the ad hoc committee may impose. Such statements must be submitted at least 10 days before the hearing, with a copy to the other party.

iii. No witnesses shall be presented at the limited hearing. The APP and a representative of the Medical Staff are entitled to make oral statements to the ad hoc committee, subject to any limits the ad hoc committee may impose. All other information provided to the ad hoc committee shall be in the form of documents or written witness statements. The ad hoc committee may question the APP and the Medical Staff representative.

iv. The limited hearing shall be recorded by a court reporter or by minutes, as determined by the Medical Staff. The cost of any court reporter shall be borne by the Hospital, but the cost of the transcript, if any, shall be borne by the requesting party. The APP is entitled to receive a copy of the transcript upon paying the reasonable cost for preparing the record.

v. The APP shall have the burden of demonstrating to the ad hoc committee by a preponderance of the evidence that the corrective action is not reasonable and warranted.

vi. After the limited hearing with the ad hoc committee, the committee shall determine whether or not the APP met his or

her burden. Within 15 days after the limited hearing, the ad hoc committee shall issue a report stating, at a minimum, its factual findings and its conclusion. The ad hoc committee shall submit its report to the Medical Executive Committee and the APP.

vii. Either party may appeal the decision to the Governing Body within 15 days after receiving the ad hoc committee's report. The appeal will be through written statements; the Governing Body may, in its discretion, permit the parties to present oral statements in front of the Governing Body as well. All presentations, written and oral, shall be subject to the limits and deadlines the Governing Body sets. Giving great weight to the ad hoc committee's report, the Governing Body shall exercise its independent judgment in making a final decision. The Governing Body's decision on the appeal shall be final.

viii. If no party appeals, the Governing Body, giving great weight to the ad hoc committee's report, shall exercise its independent judgment in making a final decision.

13.8.3 All Other AHPs

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

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