SoHum Health

733 Cedar Street
Garberville, CA
95542(707) 923-3921

MEDICAL STAFF BYLAWS

ADOPTED by the Medical Staff on: **July 11, 2024**

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Medical Staff Bylaws

INTRODUCTION

These Bylaws constitute a structure for the self-governance of the Medical Staff of Southern Humboldt Community Healthcare District. Through the Bylaws, the Rules and Regulations and the Supplemental Attachments, the Medical Staff will address its responsibilities regarding the quality of medical care, the orderly resolution of Medical Staff issues, the conduct of specific Medical Staff functions, and the Medical Staff accountability to the District governing body.

DEFINITION OF TERMS

Administrator means the person appointed by the governing body to act on its behalf in the overall management of the District. An Administrator designee means a person responsible directly to the Administrator.

Allied Health Professional (AHP) means a non-physician provider, including a Clinical Psychologist, Nurse Practitioner, Physician Assistant or Doctor of Optometry licensed as who may provide medical care within their California license and scope of practice.

AHP Staff means the organization of AHPs, who are not eligible for medical staff membership, but have been approved by the MEC and the Governing Body to provide a medical level of care.
Chief of Staff means the chief officer of the Medical Staff.

Committee of the Whole (CW) means the executive body of the Medical Staff that carries out the legal and District responsibilities as defined in these Bylaws and state law for the Medical Staff.

Date of receipt means the date any special notice or other communication was delivered personally; or if such special notice or communication was sent by US mail, it shall mean 48 hours after the special notice or communication was deposited in a post office, mailbox, substation, or mail chute, or other like facility regularly maintained by the United States Postal Service, in a sealed envelope, with postage paid, addressed to the person on whom it is to be served, at the office address as last given by that person on any document provided to the Administrator or its designee.

Distant Site Entity means a hospital or critical access hospital, person, group or facility that uses a credentialing or privileging program that meets or exceeds Medicare standards.

District means Southern Humboldt Community Healthcare District.

Good Cause Good cause may include, but is not limited to, violation of District policy, failure to perform Medical Staff duties, professionalism concerns, or conduct inconsistent with Medical Staff responsibilities.

Governing body means the Southern Humboldt Community Healthcare District Board of Directors. As appropriate to the context and consistent with the District Bylaws, it may also mean any governing body committee or individual authorized to act on behalf of the governing body.

Hospital means the Southern Humboldt Community Healthcare District Jerold Phelps Community Hospital.

Limited license practitioner means a practitioner who is not a Doctor of Medicine or Osteopathy.

Medical Staff means the organizational component of the District that includes all physicians (MD or DO), dentists (D.D.S. or D.M.D.), and podiatrists (D.P.M.), who have been granted recognition as

members pursuant to these Bylaws.

Medical Staff year means the period from January 1 to December 31.

Medico-Administrative Officer means a practitioner, employed by or otherwise serving the District on a full or part-time basis, whose duties include certain responsibilities that are both administrative and clinical in nature. Clinical responsibilities, as used herein, are those responsibilities that require a practitioner to exercise clinical judgment with respect to patient care, including the supervision of professional activities of practitioners under his or her direction.

Member means any physician, dentist, or podiatrist who has been granted membership on the Medical Staff and may also refer to any non-physician provider granted membership on the AHP Staff, pursuant to the terms of these Bylaws.

Non-Physician Provider means an individual, other than a licensed Doctor of Medicine or osteopathy, Doctor of Dental Surgery or dental medicine, or Doctor of Pe~~o~~diatric Medicine, who exercises independent judgment within the areas of the non-physician provider's competence and the limits established by the governing body, the Medical Staff, and the applicable state practice acts. A non-physician provider may be a Clinical Psychologist, Nurse Practitioner, Physician Assistant or Optometrist and may be granted membership on the AHP Staff A qualified non-physician provider renders direct or indirect medical care under the supervision or direction of a Medical Staff member possessing clinical privileges to provide such care in the District facilities.

Physician means an individual with a M.D. or D.O. degree who is currently licensed to practice medicine in the State of California.

Practitioner means a health care professional licensed to practice one of the professions eligible for membership on either the Medical Staff or AHP Staff and may include an applicant.

Prerogative means a participatory right granted to a member, by virtue of staff category or otherwise, that is exercisable subject to and in accordance with the conditions imposed by these Bylaws and Supplemental Attachments, as well as by other District and Medical Staff rules, regulations, or policies.

Privileges or **clinical privileges** means the permission granted to a member provide patient care services, including but not limited to, the right to render specific diagnostic, therapeutic, medica~~l~~, dental, podiatric, or surgical services and includes access to those resources, including equipment, facilities, and hospital personnel which are necessary to effectively exercise those privileges.[1] All clinical privileges are limited by licensure and legal restrictions on scope of practice, as appliable to the practitioner.

Special notice means a written communication sent by certified mail return receipt requested.
Supplemental Attachments means those documents, in addition to these Bylaws and the Rules and Regulations, that govern the Medical Staff. Supplemental Attachments are identified in Article 11 of these Bylaws.

Telehealth, also known as telemedicine or virtual health is the use of telecommunications and information technologies to provide health assessment, treatment, diagnosis, intervention, consultation, clinical supervision, education, and information across distances. For purposes of these Bylaws, "Telemedicine" refers to that subset of telehealth services determined by the Medical Staff and the Governing body to be appropriately delivered to Hospital patients by members or AHP practitioners who

[1] Title 22, §70701(a)(4)

have been granted the right to exercise Clinical Privileges via telehealth modalities via telehealth. This term includes:

Distant site: A location where a health care professional provides medical services that is different from the location of the patient at the time the service is provided via telemedicine.

Distant Site Entity A hospital or critical access hospital, person, group or facility that uses a credentialing or privileging program that meets or exceeds Medicare standards.

Originating site: 0 The originating site is the location of a patient at the time the service is provided via telemedicine.

Telemedicine Professionals means the specific subset of members of the Medical Staff or AHP Staff who only exercise clinical privileges via telehealth modalities for the patients of the District, and may be credentialed by the Distant Site Entity if the requirements set forth in these Bylaws are met.

Article I. NAME AND PURPOSES

1.1 ORGANIZATIONAL NAME

The name of the Medical Staff organization is the Southern Humboldt Community Healthcare District (SHCHD) Medical Staff (the "Medical Staff"). The SHCHD Allied Health Professional Staff organization is referred to as the "AHP Staff".

1.2 MEDICAL STAFF MISSION AND RESPONSIBILITY

The Medical Staff organization has been established to assure the provision of high-quality health care to the citizens of Southern Humboldt who seek services from Southern Humboldt Community Healthcare District. Towards accomplishing this end the Medical Staff shall:

1.2.1 Assure that all patients treated in any of the facilities or departments of the District in receive a level of professional care at or above a level of quality consistent with generally accepted standards that are attainable within the District's means and circumstances.

1.2.2 Oversee the professional and legal structure for medical staff operations, the operations of the AHP Staff, including but not limited the processes of credentialing, privileging, corrective actions and other forms of peer review.

1.2.3 Support professional education and community health education.

1.2.4 Initiate and enforce the rules that guide the conduct of practitioners pursuant to the authority delegated to it by the governing body in the Governing Board Bylaws pursuant to state and federal law.

1.2.5 Assist the governing body and administration with resolving health care issues of mutual concern to the Medical Staff and District governance.

1.2.6 Keep the governing body fully informed of Medical Staff activities, needs and patient care changes which impact the Community as a whole through monthly reports submitted by the Administrator or the Chief of Staff.

1.2.7 Participate in the District's quality improvement program.

Article II. MEDICAL STAFF ORGANIZATION

2.1 ORGANIZATION OF MEDICAL STAFF SERVICES

Medical Staff members shall conduct Medical Staff affairs as a Committee of the Whole ("CW"). The CW will carry out all functions of the Medical Staff including but not limited to Medical Staff Organization, Medical Staff membership, Admission and care of Patients, and developing and updating the medical Staff Bylaws that are required by state law, these Bylaws, the Governing Board Bylaws, and as deemed appropriate by the Medical Staff and CMS standards. The CW may appoint ad hoc task forces to address specialized Medical Staff issues.

2.2 DUTIES OF THE COMMITTEE OF THE WHOLE

The CW shall perform the duties specified in state law, the Bylaws and specified in 2.1 of the Medical Staff Rules and Regulations.

2.3 MEETINGS

The CW shall meet as often as necessary, but no less than once in each two-month period. Meeting notices shall be sent to all CW members no less than 24 hours before any meeting of the CW.

2.4 MEETING ATTENDANCE

Active Staff members and Provisional Active Staff members are expected to attend department, committee, CW and Medical Staff meetings~~, however, there are no specific meeting attendance requirements~~. All non tele-health active staff shall attend a minimum of two Medical Staff meetings each calendar year. Members of the Medical Staff who are in the Active Staff and Provisional Active Staff categories have the right to vote. Associate Members, Telemedicine Members, Associate Provisional Members and Courtesy Members may attend CW meetings without vote unless the vote is related to credentialing, privileging, or peer review of an Allied Health Professional. AHP Staff may attend CW meetings without the right to vote, unless otherwise designated. At each CW meeting, the AHP Staff present may designate one member to represent AHP Staff and be entitled to vote on issues that affect AHP Staff. Issues the designated AHP Staff member would be eligible to vote on, including but not limited to would be the determination of AHP core clinical privileges, education and training requirements for AHP Staff, and policies and procedures.

Article III. STAFF CATEGORIES

3.1 GENERAL PROVISIONS

3.1.1 Practitioners shall be assigned to one of the following categories on the Medical or AHP staffs: Active, Provisional Active, Associate, Provisional Associate, Telemedicine or Courtesy.

3.1.2 Each practitioner shall be assigned to a Medical or AHP staff category based upon the criteria contained in these Bylaws and the Supplemental Attachments, as well as the rules and regulations and all other policies of the Medical Staff. Each time membership is granted or renewed, their staff category shall be assessed to determine whether the applicant meets the staff category qualifications.

3.1.3 The prerogatives and responsibilities of each membership category are general in nature and may be subject to limitation by special conditions attached to a particular individual membership or by action of other sections of these bylaws, rules and regulations or Supplemental Attachments.

3.1.4 The members of each Medical or AHP staff category shall carry out the duties defined in the Bylaws, Supplemental Attachments, Rules and Regulations, and all policies of the Medical Staff.

3.1.5 Action may be initiated to change the staff category of a member or terminate the membership of any member who fails to meet the qualifications or fulfill the duties described in these Bylaws, Rules and Regulations and Supplemental Attachments.

3.1.6 Changes in staff category, clinical privileges or membership shall not be grounds for a hearing, unless required by law.

3.2 ACTIVE STAFF

3.2.1 Qualifications

The Active Staff shall consist of members who:

(a) Exhibit satisfactory performance for at least twelve months as a Provisional Staff member;

(b) Meet the qualifications of membership on either the Medical Staff or AHP Staff;

(c) Commit to support the District's patient care programs;

(d) Regularly admit or are otherwise regularly involved in the care of at least fifteen (15) patients per year at the Hospital as measured by patient contacts, which are defined as admissions, consultations, procedures (inpatient or outpatient), and/or evaluations and services performed in the Emergency Department.

3.2.2 Prerogatives

(a) Active Staff members may exercise only those privileges specifically granted within District inpatient and outpatient programs, including the admission of patients to the Hospital;

(b) Active Medical Staff members may attend meetings, with the right to vote;

(c) Active AHP Staff may attend meetings, without the right to vote, unless the vote is related to credentialing, privileging, or peer review of an Allied Health Professional. Medical Staff Peer review activities shall include conflict-of-interest safeguards to ensure impartial review. Members shall not participate in review of matters in which they have a personal or professional conflict of interest.

(d) Physicians who are Active Staff members may hold positions of leadership;

(e) Active Staff members may serve on committees. All other members may serve on committees, with or without vote, as specified in Section 2.4 or as otherwise specified by the CW.

3.2.3 Responsibilities

Active Staff Members shall:

(a) Fulfill all responsibilities of membership: and,
(b) Actively assist the Medical Staff and Hospital, as requested.

3.3 ASSOCIATE STAFF

3.3.1 Qualifications

The Associate Staff shall consist of members who:

(a) Exhibit satisfactory performance for at least twelve months as a Provisional Staff member;
(b) Meet the qualifications of Medical or AHP staff membership;
(c) Commit to support the District's patient care programs; and
(d) Are an Active Staff member at another healthcare organization.

3.3.2 Prerogatives

Associate Staff Members may:

(a) Exercise only those privileges specifically granted within District inpatient and outpatient programs, including the admission of patients to the Hospital; and,
(b) Attend meetings, with no right to vote.

3.3.3 Responsibilities

Associate Staff Members shall:

(a) Fulfill all responsibilities of membership;
(b) Maintain Active staff membership at another health care organization; and
(c) Provide, upon request, clinical activity and quality data reports, and other peer review documentation outlining the outcome of each case reviewed from the hospital(s) where the member actively practices to allow for validation of competency for membership and any privileges requested., as well as ongoing professional practice evaluation or focused professional practice evaluation.

3.4 COURTESY STAFF

3.4.1 Qualifications

The Courtesy Staff shall consist of member who:

(a) Meet the qualifications of Medical or AHP staff membership; and,
(b) Are an Active Staff member at another healthcare organization.

3.4.2 Prerogatives

Courtesy Staff members may:

(a) Order laboratory and radiologic tests and observe procedures performed by Active or Associate members, but may not otherwise hold clinical privileges; and
(b) Attend meetings, with no right to vote.

3.4.3 Responsibilities

Courtesy Staff Members shall:

(a) Fulfill all responsibilities of membership;
(b) Maintain Active medical staff membership at another health care organization;
(c) Provide, upon request, clinical activity and quality data reports, and other peer review documentation outlining the outcome of each case reviewed from the hospital(s) where the member actively practices to allow for validation of competency for membership and any privileges requested and
(d) Attend meetings, with no right to vote.

3.5 PROVISIONAL STAFF

3.5.1 Qualifications

The Provisional Staff shall consist of members who:

(a) meet the qualifications of Medical or AHP staff membership, and who have been

members for no longer than twenty-four (24) months;

(b) Meet the qualifications of Medical Staff or AHP Staff membership;

(c) Commit to support the District's patient care programs;

3.5.2 Prerogatives

Provisional Staff members may:

(a) Admit and care for patients only if granted clinical privileges to do so;

(b) Attend meetings;

(c) Provisional Active Medical Staff have the right to vote, while Provisional Associate Medical Staff have no right to vote;

(d) Provisional AHP Staff, of any staff category, may not vote unless the vote is related to credentialing, privileging, or peer review of an Allied Health Professional; and

(e) All Provisional Staff may serve on committees as requested by the CW, but may not hold positions of leadership;

3.5.3 Responsibilities

Provisional Staff members shall:

(a) Complete proctoring requirements;

(b) Fulfill all responsibilities of membership; and

(c) Actively assist the Medical Staff and Hospital, as requested;

3.5.4 Competency Validation of Provisional Staff Members

(a) Each Provisional Staff member shall undergo a period of Focused Professional Practice Evaluation (FPPE) (Proctoring) as described in these Bylaws. The purpose of this provisional period shall be to evaluate the member's proficiency in the exercise of clinical privileges initially granted, and overall eligibility for continued staff membership and advancement within staff categories. Evaluation of Provisional Staff members shall follow the frequency and format determined by the CW to be appropriate in order to adequately evaluate the Provisional Staff member including, but not limited to, concurrent or retrospective chart review, mandatory consultation, and/or direct observation. Appropriate records shall be maintained.

(b) The CW shall determine the Provisional Staff member may advance to another staff category when the Provisional Staff member meets all of the qualifications for advancement; has discharged all of the responsibilities, including completion of all required proctoring; and has not exceeded or abused the prerogatives of the Provisional Staff category.

(c) A Provisional Staff member shall remain in the Provisional Staff category for a minimum of ~~three (3) months and up to~~ twelve (12) months. the governing body may extend the provisional status (after recommendation from the Chief of Staff) if further evaluation is necessary for a total period of twenty-four (24) months following appointment to the provisional staff.

(d) Failure to meet all of the qualifications for advancement within twenty-four (24) months shall result in disqualification for reappointment. Where proctoring is not timely completed only for specified clinical privileges, those clinical privileges shall automatically terminate. A Provisional Staff member is not entitled to the procedural rights of appeal as set forth in the Fair Hearing Process, unless required by law.

3.6 TELEMEDICINE STAFF

3.6.1 Practitioners who render a diagnosis or otherwise provide clinical care and

treatment to a patient at this Hospital by telemedicine, Telemedicine Professionals, are subject without exception to the Medical Staff credentialing and privileging processes in the Bylaws and Rules & Regulations.

3.6.2 In order to qualify for telemedicine privileges, the Telemedicine Professional must meet all of the requirements set forth in the Medical Staff Bylaws and Rules & Regulations for privileges.

3.6.1 Notwithstanding any contrary provision in these Bylaws, the Rules & Regulations or Supplemental documents, the Medical Staff may provide recommendations related to applications for initial appointment or reappointment utilizing "credentialing by proxy," which is a process allowing reliance upon credentialing and privileging information provided by a Distant Site Entity only if the following provisions are met:

(a) the Governing Body has approved a process, based upon the recommendation of the Medical Staff;

(b) the Governing Body has an agreement with the Distant Site Entity for the provision of telemedicine services that satisfies the requirements of federal and state law, including but not limited to the following:

(i) The Distant Site Entity is either a Medicare participating hospital, or an entity which is a contractor of services to the District and furnishes contracted telemedicine services in a manner that permits the District to comply with all applicable Conditions of Participation;

(ii) The Distant Site Entity credentials and privileges its practitioners who are Telemedicine Professionals in a manner that meets or exceeds Medicare standards and is consistent with §482.12, §482,22 and §485.616 of Title 42 of the Code of Federal Regulations;

(iii) Each Telemedicine Professional is privileged at the Distant Site Entity to provide the telemedicine services;

(iv) Each Telemedicine Professional providing telemedicine services to the District's patients holds a license to practice medicine in the State of California;

(v) Each Telemedicine Professional holds professional liability insurance in the amounts required by these Bylaws for all clinical privileges exercised in relation to the patients of the District;

(vi) The Distant Site Entity agrees to enter into a peer review sharing agreement consistent with Bus. & Prof. Cod e§809.08 and further agrees to share peer review information with the District's Medical Staff, upon request, maintaining all protections available, including but not limited to Evidence Code §1157;

(vii) The Distant Site Entity shall provide to the Medical Staff of District:

1) On at least an annual basis, a current list of the Telemedicine Professionals providing telemedicine services to the District's patients and the clinical privileges held by each Telemedicine Professional at the Distant Site Entity;

2) Notice when program details (e.g., the practitioners providing services, or their privileges) have changed;

3) At the time of initial appointment or reappointment, all

practitioner data elements necessary for the Medical Staff of the District to complete required queries of the applicable state licensing board for each applicant physician or practitioner, and the National Practitioner Data Bank for each applicant physician;

4) Notice no later than 24 hours after the Distant Site Entity becomes aware that an action has been taken, or a recommendation made regarding a Telemedicine Professional for which a report may be required pursuant to Business & Professions Code sections 805, 805.01, 805.8 and/or the National Practitioner Data Bank.

5) Notice no later than thirty (30) days after the Distant Site Entity becomes aware of adverse events, claims, settlements, judgments, arrests, patient complaints, or corrective actions or a leave of absence regarding a Telemedicine Professional;

(viii) Each Telemedicine Professional covered by the agreement, including new practitioners who are added from time-to-time shall:

1) Acknowledge their participation in the agreement;

2) Agree to maintain unrestricted, unencumbered clinical privileges at the Distant Site Entity for any privileges to be exercised or the District's patients;

3) Agree to exercise professional judgment consistent with the standards of their profession and to comply with federal and state laws, including those related to informed consent, when engaging in telemedicine;

4) Provide a signed authorization and release containing the following provisions:

a) Providing permission for the Medical Staff of Southern Humboldt Healthcare District, or its representative, and <Distant Site> to share credentialing documents, verifications, data and peer review information between Southern Humboldt Healthcare District and <Distant Site>, as they determine to be relevant to the evaluation of the Telemedicine Professional's competence and/or conduct, and request for telemedicine privileges.

b) Agreeing to abide by the Medical Staff Bylaws, Rules & Regulations and Supplemental documents of the Medical Staff of the District;

c) Agreeing to participate in peer review as requested by the District or its Medical Staff.

d) Agreeing to notify the Medical Staff of Southern Humboldt Healthcare District when no longer providing telemedicine services.

5) Should the Telemedicine Professional refuse to provide the signed authorization and release, as provided above, the

Telemedicine Professional's application for Clinical Privileges shall be determined incomplete, withdrawn from consideration and no hearing or appeal rights shall be afforded in such instance.

(ix) The Medical Staff, as the Originating Site, shall:

1) Maintain a list of the Distant Site Clinical Privileges of each Telemedicine Professionals;
2) Track appointment and reappointment dates for each Telemedicine Professional;
3) Confirm the Telemedicine Professional's license to practice medicine in California is current and unencumbered;
4) Query the NPDB of each Telemedicine Professional, in connection with initial appointment or reappointment;
5) Assist the District in gathering professional practice evaluation information of each Telemedicine Professional providing telemedicine services to the District's patients and in sending the Distant Site Entity such information for use in the periodic appraisal of each Telemedicine Professional. At a minimum, this information shall include all adverse events that result from the telemedicine services provided by the distant-site physician or practitioner to the District's patients and all complaints the District receives about the distant-site physician or practitioner;
6) Notify the Distant Site Entity as soon as possible and no later than 24 hours after the District, or its Medical Staff take an action or make a recommendation regarding a Telemedicine Professional for which a report may be required pursuant to Business & Professions Code §805.
7) Notify the Distant Site Entity Notice no later than thirty days after the District becomes aware of adverse events, claims, settlements, judgments, arrests, patient complaints, or corrective actions, or a leave of absence regarding a Telemedicine Professional;

(x) Telemedicine Professionals who do not qualify for credentialing by proxy may be credentialed and privileged by the Medical Staff and Governing Body.

Article IV. MEMBERSHIP

4.1 NATURE OF MEMBERSHIP

A practitioner, including one who has a contract with the District to provide medical care, can provide patient care to patients of the District only if the practitioner is a member of the Medical Staff or AHP Staff or has been granted clinical privileges in accordance with these Bylaws, Supplemental documents, Rules and Regulations, and policies of the Medical Staff. Appointment to the Medical or AHP staffs shall confer only such privileges and prerogatives as are granted by the Governing Body.

4.2 MEMBERSHIP ON THE MEDICAL AND AHP STAFFS

4.2.1 Medical Staff membership and the granting of clinical privileges shall be extended only to physicians, dentists or podiatrists who are professionally competent and continuously meet the qualifications, standards, and requirements set forth in these Medical Staff Bylaws and Supplemental Attachments.

4.2.2 AHP Staff membership and the granting of clinical privileges shall be extended only to Clinical Psychologists, Nurse Practitioners, Physician Assistants and Optometrists who are determined to be professionally competent and continuously meet the qualifications, standards and requirements set forth in these Bylaws, Supplemental Attachments, Rules and Regulations and policies applicable to the Medical and AHP staffs.

4.2.3 No person shall be entitled to membership on the Medical or AHP staffs merely because that person holds a certain degree or is licensed to practice in the state of California or any other jurisdiction.

4.2.4 No person will be entitled to membership on the Medical or AHP staffs solely because that person is a member of a professional organization, is certified by any clinical specialty board, or because such person had, or presently has membership, privileges or practice prerogatives at this or any other health care organization.

4.2.5 Appointment to, and membership on the Medical or AHP staffs shall confer only such clinical privileges or practice prerogatives as have been specifically granted by the governing body in accordance with these Bylaws.

4.2.6 Membership on the Medical or AHP staffs or the granting of clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, surgery center or other outpatient service facility, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this hospital.

4.2.7 Applicants to the AHP Staff shall be credentialed in the same manner as applicants to the Medical Staff and the credentials files of any employed member shall be maintained separately from any employment file, which is maintained by Human Resource Department.

4.3 MINIMUM QUALIFICATIONS FOR MEDICAL AND AHP STAFF MEMBERS

Applicants for membership on the Medical or AHP staffs must meet the following membership standards:

4.3.1 Licensure/Certification:

(a) **Physicians & Surgeons** must hold a valid and unsuspended license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California and for initial applicants, the practitioner’s license must not be

subject to any term of probation or other restriction.

(b) **Dentists** must hold a valid, unrestricted, and unsuspended license to practice dentistry and/or dental surgery issued by the Dental Board of California in order to be appointed to the Medical Staff.

(c) **Podiatrists** must hold a valid, unrestricted, and unsuspended license to practice podiatry issued by the California Board of Podiatric Medicine in order to be appointed to the Medical Staff.

(d) **Clinical Psychologist:** Must hold a valid, unrestricted, and unsuspended license to practice psychology issued by the California Board of Psychology in order to be appointed to the AHP Staff.

(e) **Nurse Practitioner:** an advanced practice registered nurse who possesses additional advanced practice educational preparation and skills in physical diagnosis, psychosocial assessment, and management of health-illness needs in primary care, and/or acute care, and who either (1) successfully completed a nurse practitioner education program approved by the Board; or (2) holds National certification[2] and is licensed by the California Board of Registered Nursing. A NP must hold both valid, unrestricted and unsuspended licenses as a registered nurse and as a Nurse Practitioner issued by the California Board of Registered Nursing (BRN) in order to be appointed to the AHP Staff.

(f) **Physician Assistant:** a licensed and skilled health care professional, trained to provide patient evaluation, education, and health care services, having passed the Physician Assistant National Certifying Examination (PANCE). A PA must hold a valid, unrestricted and unsuspended license issued by the California Physician Assistant Board (CAB) in order to be appointed to the AHP Staff.

(g) **Optometrist:** Must hold a valid, unrestricted and unsuspended license issued by the California State Board of Optometry in order to be appointed to the AHP Staff.

4.3.2 **Participation in Governmental Programs:**

(a) Applicants must be and remain eligible to participate in Medicare, Medicaid and other federally sponsored health programs.

(b) No applicant may apply who has been excluded by any federal or state agency, including but not limited to OIG exclusion, exclusion by Medicare, Medicaid, or from participation in any federal or state health care program, no may an initial applicant have any such action pending.

4.3.3 Professional Competence and Conduct:

(a) Each applicant must meet the minimum standards for:

(i) experience, education and training;

(ii) current clinical competence;

(iii) good judgment;

(iv) current adequate physical and mental status so as to demonstrate to the satisfaction of the medical staff that they are professionally and ethically competent and that patients treated by them can reasonably expect to receive quality medical care;

(v) adherence to the ethics of their respective professions;

(vi) the ability to work cooperatively with others so as not to adversely

[2] 16 Code Cal. Regs.§1480, subsection (o) defines NP and (n) defines National Certification; .§1482 defines training necessary to be licensed.

affect patient care;

(vii) confidentiality as required by law and these bylaws; and

(viii) the willingness to participate in and properly discharge those responsibilities determined by the Medical Staff.

(b) CME:

Upon appointment or reappointment, each applicant shall provide proof of completion of continuing education hours, in at least the minimum amount required by law for license renewal, the majority of which shall be related to the applicant's area of practice and request for privileges.

(c) Prescribing Authority:

(i) Each applicant who is authorized by law to prescribe and seeks Clinical Privileges to do so must have a current, unrestricted federal DEA registration, and no initial applicant must have a pending adverse action by the DEA. Schedules 2, 2N, 3, 3N, 4 and 5 are required.

(ii) Nurse Practitioners must also have a furnishing number issued by the BRN.

(iii) Providers whose specialty does not involve prescribing and/or who solely work remotely, are not required to provide a DEA certificate of registration, but in such case may not prescribe controlled substances.

(d) Other licensure/certification:

Each applicant must possess any current, valid and unrestricted special certification as required by requested clinical privileges, e.g. fluoroscopy.

(e) Adequate Professional Liability Insurance:

Every applicant must have and maintain professional liability insurance coverage in the amounts not less than $1,000,000/$3,000,000.

(f) Compliance with Infection Control:

Every applicant must meet the requirements of all Hospital and Medical Staff infectious and communicable disease policies and requirements, as well as local, state, and federal public health orders, laws, or regulations, including, but not limited to: screening, immunization and vaccinations; proof of vaccinations; hand hygiene; masks and other personal protective equipment; social distancing; and testing. Those applicants who seek Clinical Privileges to provide solely telemedicine services and are not physically present in the hospital may be excepted from this requirement unless compliance is otherwise required by local, state, or federal public health orders, laws, or regulations.

(g) No initial applicant may have record of revocation, suspension, restriction, or probation of licensure in any state which became final within the past ten (10) years; record of admonishment, citation, or reprimand from a licensing board or certification agency within the past five (5) years; or have any such action currently pending.

(h) No applicant may have record, from any time period, of conviction, no contest plea or guilty plea of a felony, nor such charge be pending in addition to subsection (g), above, no applicant may have a pending charge and no applicant may have a record of a misdemeanor conviction, no contest plea, guilty plea or civil monetary penalties, within the past ten (10) years, related to:

(i) the provider's professional practice;

(ii) other health care matters (including third-party reimbursement);

(iii) violence; or

(iv) self-use, misuse, inappropriate prescribing, improper distribution, or inappropriate furnishing of DEA scheduled drugs (Schedules I through V).

(i) No initial applicant may have record of a denial, revocation, summary suspension, termination, restriction, limitation, loss, reduction or relinquishment of medical staff membership, clinical privileges, employment or participation in any hospital, health plan or other health care entity, for a medical disciplinary cause or reason, that has become final within the past seven (7) years. Nor may any initial applicant have any such action or recommendation pending. An action is deemed final after the practitioner has completed any applicable fair hearing and appeal at that other entity and does not include any judicial proceeding that may be brought to challenge that action.

(j) No initial applicant may have had a leave of absence, withdrawal, abandonment, or resignation of membership, clinical privileges, employment or participation in any hospital, health plan or other health care entity, after the applicant received notice of investigation or discipline, within the past ten (10) years.

4.4 MINIMUM QUALIFICATIONS FOR MEDICAL STAFF MEMBERS

4.4.1 Every initial applicant to the Medical Staff must provide evidence of Board Certification:

(a) current board certification by a member board of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), American Board of Dental Specialties (ABDS), American Board of Oral and Maxillofacial Surgery (ABOMS), American Board of Podiatric Medicine (ABPM), American Board of Foot and Ankle Surgery (ABFAS), or other board accepted by the MEC; **or**

(b) current enrollment in a graduate medical education program which, upon successful completion, shall result in board admissible eligibility in the specialty area for which the applicant seeks clinical privileges; **or**

(c) current board eligibility in the specialty area for which the applicant seeks clinical privileges. The applicant must become board certified within the time frame specified by their specialty after completion of their formal education and/or training.

(d) Applicants for reappointment must maintain board certification if it was required at the time of initial appointment.

(e) The board certification requirement may be waived for good cause by the CW and governing body.

(f) Failure to obtain or maintain board certification may~~shall~~ result in automatic termination of Medical Staff membership and clinical privileges and may~~shall~~ not afford the member the hearing or appeal rights specified in these Bylaws, unless required by law.

4.4.2 For physicians practicing in the Emergency Department:

(a) The purpose of ABEM board certification is to objectively and independently confirm that physicians who complete an Emergency Medicine residency demonstrate core knowledge, skills, and abilities needed to practice Emergency Medicine at the highest standards. It is also expected that physicians practicing in Emergency Medicine will maintain continuing certification to demonstrate clinically oriented and highly relevant (COHR) knowledge and skill in the practice of Emergency Medicine.

(b) The CW and governing body may, in their sole discretion, recommend and grant clinical privileges to physicians who are not ABEM certified if they demonstrate COHR knowledge, skill and ability to practice Emergency Medicine and also provide certificates of completion of courses such as PALS, ACLS, ATLS, or other similar courses, or the completion of 25 CME (Continued Medical Education) hours per year or 50 CME hours per 2 years in a specified content area of Emergency Medicine, in satisfaction for the granting of clinical privileges.

4.5 MINIMUM QUALIFICATIONS FOR AHP STAFF MEMBERS

4.5.1 Clinical Psychologists:

(a) may provide only such care and treatment as is within the scope of their education, training, licensure and scope of permitted practice by the State, the Medical Staff and the governing body.

(b) may perform consultations requested by a member of the Medical Staff. The clinical psychologist may evaluate patients through interviews, observation and/or psychological testing, assess patients' mood, behavior and mental abilities, consult regarding chemical dependency issues and apply current research findings and methodologies in making diagnoses and recommending treatment. Such evaluation, assessment and/or treatment shall be properly reflected in a patient's medical record.

(c) may evaluate a patient for involuntary detainment under California law.[3]

(d) may not admit or discharge patients, except in tandem with a member of the Medical Staff who remains responsible for the patient.

(e) shall consult with a member of the Medical Staff whenever a patient's condition is beyond the competence, scope of practice, or authority of the clinical psychologist.

(f) has no prescribing authority.

(g) practices under the general supervision of the Medical Staff.

4.5.2 Nurse Practitioners (NPs):

(a) may provide only such care and treatment as is within the scope of their education, training, licensure and scope of permitted practice by the State, the Medical Staff and the governing body.

(b) function under the General Supervision of the Medical Staff;

(c) will practice pursuant to Standardized Procedures and be responsible to at least one designated supervising physician who shall be available at all times either in person, by phone, or by electronic communication, as is reasonable for the circumstance and as specified in the Standardized Procedures. Standardized Procedures shall specify the scope of supervision required for performance of standardized procedure functions.[4]

(d) Shall order Schedule II-II controlled substances in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the NP's Standardized Procedure relating to controlled substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner providing the order. The NP's

[3] Section 5150 et seq. of the Welfare and Institutions Code.
[4] 16 CCR §1474(b)(7).

Standardized Procedures shall provide for a method of periodic review which shall occur at least at the time of reappointment.[5]

(e) if the NP is furnishing drugs or devices pursuant to Standardized Procedures, a Qualified Supervising Physician is limited to supervising no more than four NPs at a given time.[6]

(f) Notwithstanding subdivisions (b-d), NPs who have satisfied further additional training and experience requirements may be certified by the California Board of Registered Nursing for an expanded scope of practice, to work without Standardized Procedures for a specified list of functions. Such NP is known as a "103 NP." No individual may function as a 103 NP without first obtaining specific authorization granted by the CW and governing body.

(g) must have H&Ps, consult notes, procedure notes (including Code notes), DNR, death certificates, and discharge notes co-signed by a Qualified Supervising Physician.

(h) shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or the condition of a patient is beyond the scope education, training or practice of the NP.

(i) must verbally inform all new patients, in a language understandable to the patient, that the NP is not a physician and surgeon. For purposes of Spanish language speakers, the nurse practitioner shall use the standardized phrases “enfermera especializada” or “enfermero especializado.” The NP must further advise patients that they have the right to see a physician and surgeon on request, and the circumstances under which they must be referred to see a physician and surgeon.[7]

4.5.3 Physicians Assistants (PA):

(a) may provide only such care and treatment as is within the scope of their education, training, licensure and scope of permitted practice by the State, the Medical Staff and the governing body.

(b) work under the supervision of at least one Qualified Supervising Physician to provide medical care and guidance needed by a patient.

(c) act as an agent for the Qualified Supervising Physician and so the orders given and tasks performed by a PA shall be considered the same as if they had been given and performed by the Qualified Supervising Physician.[8]

(d) when assisting a doctor of podiatric medicine , the PA shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.[9]

(e) authority to practice is documented in a Practice Agreement as defined by California law, which shall:

(i) define those medical services, tasks and procedures the PA is authorized to perform, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the PA’s competence, including peer review, and review of the

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[5] 16 Cal. Code Regs., §1474(b); Bus.& Prof. 2725(c).

[6] No physician and surgeon shall supervise more than four nurse practitioners at one time who are furnishing drugs or devices. (Bus. & Prof Code §2836.1)

[7] 16 CCR§1487.

[8] 16 C.C.R. §1399.541.

[9] Bus. & Prof. Code §3502(b)(2).

practice agreement;

(ii) identifies those drugs, under Schedules II-V, or devices, that the PA may furnish, order or administer, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the PA's competence, including peer review, and review of the practice agreement;

(iii) if the PA is authorized to furnish, order or administer Schedule II controlled substances, the Practice Agreement shall address the diagnosis of the illness, injury, or condition for which the PA may furnish the Schedule II controlled substance;

(iv) document back-up procedures for the immediate care of patients who are in need of emergency care beyond the physician assistant's scope of practice for such times when a Qualified Supervising Physician is not on the premises;[10]

(v) specify the methods for supervision and the continuing evaluation of the competency and qualifications of the PA; and

(vi) shall be signed and dated by the PA and each supervising physician.

(f) A Physician Assistant may:

(i) take a patient history; perform a physical examination and make an assessment and diagnosis therefrom; initiate, review and revise treatment and therapy plans;

(ii) order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services;

(iii) Order, transmit an order for, perform, or assist in the performance of laboratory procedures, screening procedures and therapeutic procedures;

(iv) Recognize and evaluate situations which call for immediate attention of a physician and institute, when necessary, treatment procedures essential for the life of the patient;

(v) Instruct and counsel patients regarding matters pertaining to their physical and mental health. Counseling may include topics such as medications, diets, social habits, family planning, normal growth and development, aging, and understanding of and long-term management of their diseases;

(vi) Initiate arrangements for admissions, complete forms and charts pertinent to the patient's medical record, and provide services to patients requiring continuing care, including patients at home;

(vii) initiate and facilitate the referral of patients to the appropriate health facilities, agencies, and resources of the community;

(viii) administer or provide medication to a patient, or issue or transmit drug orders orally or in writing in accordance with California law and the Practice Agreement. The PA may furnish or order Schedule II or III controlled substances in accordance with the

[10] 16 CCR§1399.545(e).

practice agreement or a patient-specific order approved by the treating or supervising physician and surgeon;[11]

(ix) perform surgical procedures without the personal presence of the supervising physician which are customarily performed under local anesthesia. All other surgical procedures requiring other forms of anesthesia may be performed by a PA only in the personal presence of a supervising physician.

(x) may also act as first or second assistant in surgery under the supervision of a supervising physician. The PA may so act without the personal presence of the supervising physician if the supervising physician is immediately available to the PA. "Immediately available" means the physician is physically accessible and able to return to the patient, without any delay, upon the request of the physician assistant to address any situation requiring the supervising physician's services.[12]

4.5.4 Optometrists:

(a) may provide only such care and treatment as is within the scope of their education, training, licensure and scope of permitted practice by the State, the Medical Staff and the governing body.

(b) must possess a therapeutic pharmaceutical agents' certification in order to use therapeutic pharmaceutical agents and be authorized to diagnose and treat the conditions listed in subdivisions (b) and (d) of Bus. & Prof. Code §3041, including administration of authorized immunizations;

(c) shall consult with an appropriate physician under the circumstances specified in Bus. & Prof. Code §3041;

(d) shall consult with a member of the Medical Staff whenever a patient's condition is beyond the competence, scope of practice, or authority of the optometrist;

(e) practices under the general supervision of the Medical Staff.

4.6 DEMONSTRATED PERFORMANCE

Upon the reasonable request, but no later than five (5) days after the request of the CW, a member may be required to demonstrate satisfactory compliance with any of the basic responsibilities of the Medical Staff Bylaws. A member may be required to provide information and/or to make a special appearance before the CW to discuss the compliance with all or any of the above Medical Staff responsibilities. Notice shall be given at least three (3) days prior to the requested special appearance and shall include a general indication of the issue involved. Failure of a member to appear, unless excused by the CW upon a showing of good cause, shall be a basis for corrective action

4.7 LACK OF MINIMUM QUALIFICATION

4.7.1 An applicant, or member, who does not meet the minimum qualifications set forth above, is ineligible for appointment or reappointment to the Medical Staff or AHP staff and such application shall not be accepted for review.

4.7.2 If it is determined during the evaluation process that an applicant does not meet the minimum qualifications, the review of such application shall be discontinued.

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[11] Bus. & Prof. Code §3502.1

[12] Subsections 1-10 listed in Cal. Code Regs. Tit. 16, § 1399.541

4.7.3 An applicant who fails to meet minimum qualifications is not entitled to the procedural rights of hearing or appeal as set forth in the Fair Hearing Process in Article 9. But a practitioner may submit comments to the Chief of Staff and a request for reconsideration for the specific qualification that disqualified the application. These comments shall be reviewed by the Committee of the Whole (CW).

4.7.4 Waiver of Qualifications

Insofar as is consistent with applicable laws and governing body policies, the Chief of Staff, after consulting with the CW, has the discretion to deem a practitioner to have satisfied any qualification, providing that the practitioner has demonstrated the possession of substantially comparable education, experience, or other qualification and it is determined that the waiver is in the best interests of the District. A waiver may be granted by the governing body after consultation with the Chief of Staff. There is no obligation to grant any such waiver, and practitioners have no right to have a waiver considered and/or granted. A practitioner who is denied a waiver or consideration of a waiver shall not be entitled to any hearing and appeal rights under these Bylaws and Supplemental Attachments.

4.7.5 Every applicant shall provide a complete Application for Appointment including all requested documentation. (See Medical Staff Appointment Process, A Supplemental Attachment to the Southern Humboldt Community Healthcare District Medical Staff Rules & Regulations for further details, including but not limited to Article 1.) An application which is incomplete in any manner or form will not be forwarded to the Medical Staff for review and is not entitled to the procedural rights of appeal as set forth in the Fair Hearing Process.

4.8 NONDISCRIMINATION

Membership to Medical Staff or AHP Staff or privileges shall not be denied on the basis of sex, race, age, creed, religion, color, national origin, or any physical or mental impairment if, after any necessary reasonable accommodation, the applicant is able to comply with the Bylaws and supplemental attachments of the Medical Staff and District Bylaws.

4.9 BASIC RSPONSIBILITY

Each practitioner exercising clinical privileges and all members shall continuously meet all of the following basic responsibilities:

4.9.1 Provide patients with care at or exceeding the generally recognized professional level of quality and endeavor to provide cost-effective, non-futile medical care.

4.9.2 Retain responsibility, within the practitioner's area of professional competence, for the continuous care and supervision of each District patient to which the practitioner is providing services. If there is an interruption in the care provided by a practitioner, the practitioner must arrange for a suitable replacement that can 1) assure continuous care of the patient, 2) holds unrestricted similar clinical privileges and 3) has agreed to provide backup coverage for the practitioner's patients. This includes assuring there is coverage for any AHP Staff under the member's supervision.

4.9.3 Abide by 1) all applicable laws and regulations of governmental agencies and 2) comply with applicable CMS and state standards, the Medical Staff Bylaws, Rules and Regulations, as well as Supplemental Attachments and all other reasonable and lawful policies and/or standards of the Medical Staff/District. This includes timely providing information, including that required for reappointment to the Medical Staff.

4.9.4 Regularly participate, cooperate and support the Medical Staff and District in activities intended to provide, monitor and improve patient care. Such activities include but are

not limited to: emergency service, on-call responsibilities, backup functions, evaluation, measurement, assessment, peer review, Ongoing Professional Practice Evaluation (OPPE), Focused Professional Practice Evaluation (FPPE), proctoring, new provider orientation, infection control compliance, communicable disease screening and procedures, immunization requirements, utilization management, and pharmacy and therapeutics utilization and other activities as may be required by the Medical Staff from time to time.

4.9.5 Prepare and complete in a timely manner all patients', medical records.

4.9.6 Cooperate with the implementation of electronic methods of communicating and executing daily business, such as the use of electronic records, providing a current e-mail address, and agreeing to accept electronic service of communications at the email address provided to the Medical Staff.

4.9.7 Keep as confidential and secure all patient protected health information, medical records, peer review information, Hospital and District confidential information and passwords.

4.9.8 Complete continuing medical education (CME) that meets all licensing requirements and is appropriate to the practitioner's specialty.

4.9.9 Aid in any education of other practitioners or healthcare personnel as requested by the Medical Staff.

4.9.10 Refrain from unlawful fee splitting or unlawful inducements relating to patient referrals.

4.9.11 Refrain from any:

(a) disruptive behavior (including, but not limited to physical or verbal behavior that would be characterized by a reasonable person as inappropriate, intimidating, hostile, belittling, degrading, derogatory, demeaning, mocking profane or offensive and may include repeated refusal to abide by basic requirements);

(b) harassment;

(c) retaliation or attempted retaliation (including, but not limited to reprisals or threat of reprisal to those who complain about or report potentially improper conduct or actions); or

(d) unlawful discrimination (based upon the person's age, sex, religion, race, creed, color, national origin, health status, ability to pay, or source of payment);

(e) against any person (including any patient, District employee, District independent contractor, Medical Staff member, volunteer, or visitor).

4.9.12 Refrain from delegating the responsibility for diagnosis or care of patients to any practitioner who is not qualified to undertake this responsibility or who is not adequately supervised.

4.9.13 Seek consultation whenever warranted by the patient's condition or when required by these Bylaws and the Rules and Regulations.

4.9.14 Abide by the lawful ethical principles of the medical profession;

4.9.15 Provide information from the practitioner's office records or from outside sources as necessary to facilitate the continuity and provision of care, or upon request for review of the care of specific patients.

4.9.16 Immediately communicate with appropriate Medical Staff officers when obtaining credible information indicating that another member of the Medical Staff or AHP Staff may have engaged in unprofessional or unethical conduct or may have a physical or mental condition that poses a significant risk to the wellbeing of patients. The practitioner shall cooperate, as necessary, toward the appropriate resolution of any such

matter.

4.9.17 Accept responsibility for participating in proctoring of members of the Medical and AHP staffs in accordance with these Bylaws and the Supplemental Attachment on Credentialing and Privileging.

4.9.18 Work cooperatively with other members of the Medical and AHP staffs, nurses, District administrative staff, and others so as not to adversely affect patient care or District operations.

4.9.19 Cooperate with the Medical Staff in assisting the District to meet its uncompensated or partially compensated patient care obligations.

4.9.20 Continuously inform the Medical Staff of any significant changes in the information relative to the appointment and reappointment documents.

4.9.21 Immediately inform the Medical Staff of any changes to demographic information including, but not limited to current address, phone number, fax number and email address.

4.9.22 Meet, at all times, the qualifications for membership on the Medical Staff or AHP Staff, as applicable and as set forth in these Bylaws.

4.9.23 Immediately notify the Medical Staff of any pending action or action, accusation or investigation taken by:

(a) Government authorities, including but not limited to CMS, OIG, DEA, FBI, law enforcement or a licensing authority;

(b) Any healthcare organization, including but not limited to a hospital, medical staff, health plan, medical group for medical disciplinary cause or reason as that term is defined in California law;

Failure of a practitioner to meet any of the basic responsibilities listed above may be grounds for informal or formal corrective action.

4.10 DURATION OF APPOINTMENT

Initial appointments to the Medical or AHP Staffs shall as specified in Section 3.5.4(c). Reappointments to the Medical or AHP staffs shall be for a period of no more than 24 months.

4.11 LEAVE OF ABSENCE

Members may obtain a voluntary leave of absence from the Medical Staff by following the procedures specified in the Medical Staff Appointment Process, which is a Supplemental Attachment to the Rules and Regulations and incorporated by this reference. A leave cannot exceed an absence of more than two (2) years. Reinstatement at the end of the leave must also follow the procedures set forth in the Medical Staff Appointment Process.

Article V. MEDICAL STAFF OFFICERS

5.1 OFFICER DESIGNATIONS

There shall be the following general officers of the Medical Staff:

5.1.1 Chief of Staff

5.1.2 Vice Chief of Staff

5.2 QUALIFICATIONS

Officers must be members of the Active Medical Staff at the time of nomination and election and they must remain members in good standing during their terms of office. At the discretion of the active Medical Staff members, failure to maintain such status may create a vacancy in the office involved.

5.3 NOMINATIONS

Nominations for the office of Vice Chief of Staff may be made from the floor by any member of the CW at the last meeting of the Medical Staff year. When there are two~~three~~ or more candidates for the office and no candidate receives a majority, there shall be successive balloting, whereby the name of the candidate receiving the fewest votes will be omitted from each successive slate until one candidate obtains a majority vote.

5.4 ELECTION

Upon approval of a majority of the active Medical Staff members present at the CW meeting, the current Vice Chief of Staff will be advanced to the office of Chief of Staff and a new Vice Chair will be elected. If the existing Vice Chief of Staff fails to receive a majority vote to advance to Chief of Staff, the above nomination procedures shall be followed. Officers will take office on the first day of the Medical Staff year.

5.5 TERM OF ELECTED OFFICER

The Chief of Staff and the Vice Chief of Staff each shall serve a one-year term. Each officer shall serve until the end of his or her term or until a successor is elected, unless the officer dies, resigns or is removed from office.

5.6 REMOVAL OF ELECTED OFFICER

A Medical Staff officer may be recalled from office for failure to carry out the duties of the office. Except as otherwise provided, removal of a Medical Staff officer may be initiated by a petition signed by at least 50 percent of the members of the Medical Staff eligible to vote for officers. Removal shall be considered at a special meeting called for that purpose. Removal shall require a majority vote of the active Medical Staff members

5.7 FILLING VACANCIES

Vacancies created by resignation, removal, death, or disability shall be filled as follows: The Vice Chief of Staff shall fill a vacancy in the office of Chief of Staff. A vacancy in the office of Vice Chief of Staff shall be filled by special election held in general accordance with these Bylaws.

5.8 CHIEF OF STAFF DUTIES

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

5.8.1 Enforce the Medical Staff Bylaws and Supplemental Attachments.

5.8.2 Call and preside at CW meetings and be responsible for the agenda preparation of all meetings of the CW.

5.8.3 Appoint Medical Staff ad hoc, liaison, or multidisciplinary committees and designate the chairs of these committees.

5.8.4 In the interim between CW meetings, perform those responsibilities of the CW that in the opinion of the Chief of Staff must be accomplished prior to the next regular or special meeting of the CW.

5.8.5 Perform such other functions as may be assigned to the office by these Bylaws and Supplemental Attachments or the CW.

5.8.6 Consult with the Administrator regarding medico-administrative matters.

5.8.7 Serve on liaison committees with the governing body and administration.

5.8.8 Regularly report to the governing body on the performance of Medical Staff functions and communicate to the Medical Staff any concerns expressed by the governing body.

5.9 VICE CHIEF OF STAFF DUTIES

The Vice Chief of Staff shall perform the duties of secretary/treasurer of the CW. This office shall also perform such other duties as the Chief of Staff may assign. In the absence of the Chief of Staff, the Vice Chief of Staff shall assume all duties and authority of the office.

Article VI. COMMITTEES

6.1 GENERAL

6.1.1 CW Responsibilities

The CW serves as the executive body of the Medical Staff. The CW will address all the functions often associated with standing Medical Staff committees. The CW may appoint members to ad hoc task forces and by law the CW must appoint members to the Interdisciplinary Practice Committee (IPC). All Medical Staff committees or task forces will conduct their business in accordance with the following procedures.

6.1.2 Appointments

Appointments to the CW are addressed in Section 6.4 of these Bylaws and not subject to the approval of the Chief of Staff. The chief of staff will appoint all Medical Staff members to the IPC and any Medical Staff task force. The appointments may include any category of Medical Staff member. As appropriate, appointments may include non-physician providers, District administration, representatives of the community, and anyone with special expertise.

6.1.3 Removal of Committee or Task Force Member

A member who ceases to be in good standing, suffers a significant limitation of privileges, or any other good cause may be removed by the Chief of Staff. A member may also be removed if, after review of the circumstances which prompts consideration of removal, the Chief of Staff in his exclusive review finds good cause.

6.1.4 Records of Meetings

Minutes of the CW and ad hoc task force meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the recommendations, conclusions, or actions adopted by the CW or ad hoc task force. The chairperson of the committee or task force shall review and signify by signature that the minutes are an accurate representation of the proceedings of the meeting.

6.1.5 Quorum

A quorum will consist of the voting members present for CW meetings. For all other meetings, a quorum shall consist of 33 percent of the voting members but in no event less than two voting members. Medical Staff Bylaws changes and elections of the Chief of Staff and Vice Chief of Staff Officer positions shall require a minimum of 3 voting members for approval.

6.1.6 Manner of Action

Except as otherwise specified, the actions 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. Committee action may be conducted by telephone conference that shall be deemed to constitute a meeting for the matters then discussed.

6.1.7 Rules of Order

Unless otherwise specified, meetings shall be conducted according to Rosenberg's Rules of Order; however, technical failures to follow such rules will not invalidate action taken at such a meeting.

6.1.8 Hospital Representation

The CEO/Administrator or designee shall be a member without vote of the CW and may serve on any task force of the Medical Staff.

6.2 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIATION IN DISTRICT DELIBERATIONS

The Medical Staff may discharge duties delegated to it by the District relating to licensure, certification, disaster planning, facility and services planning, and physical plant safety by providing Medical Staff representation on District committees established to perform such functions.

6.3 COMBINED OR JOINT COMMITTEE MEETINGS

The members of the CW collectively or individually may participate in combined or joint committee meetings with staff members from other healthcare entities, the county Medical Society or other groups deemed appropriate by the Chief of Staff and the governing body. Precautions shall be taken to assure that confidential Medical Staff information is not inappropriately disclosed. Participation in external meetings is contingent upon access to and approval authority of all minutes prepared in conjunction with any such meetings by the District Medical Staff representative.

6.4 COMMITTEE OF THE WHOLE COMPOSITION

The CW shall be composed of the Medical Staff officers listed in these Bylaws. One AHP member shall be selected by the CW to serve, who shall not vote ~~unless the vote is~~ unless the vote is related to credentialing, privileging, peer review of an Allied Health Professional, regarding the determination of service authorizations, peer review of an AHP or whether AHP employment is in the best interest of the communities served by the Hospital. Other members of the AHP Staff may attend CW meetings, without the right to vote unless the vote is related to credentialing, privileging, or peer review of an Allied Health Professional. In addition to the Administrator, other administrative representatives and/or governing body representatives may serve, without vote, on the CW if approved by the CW.

6.5 PHYSICIAN SUPPORT COMMITTEE

In accordance with state law, this ad hoc committee shall serve as a resource to assist Medical Staff members when there are concerns regarding potential chemical, substance abuse, mental illness or physical illness. Given the very limited size of the Medical Staff and the mode of operation as a Committee of the Whole, this committee will consist of members from the Humboldt-Del Norte County Medical Society Physician Support Committee ("the consortium"). Annually, the Medical Staff will appoint, or reappoint a member of the Medical Staff as its representative of the consortium. Any concerns will be directed to the Chief of Staff who shall, as appropriate, enlist the help of the Medical Society's resources. Reports of the activities and recommendations relating to these functions shall be made to the CW and governing body as frequently, as necessary, and at least quarterly.

6.6 HUMBOLDT-DEL NORTE CONSORTIUM FOR CME

The Medical Staff recognizes the Humboldt-Del Norte Medical Society as a provider of Continuing Medical Education. Annually, the Medical Staff may appoint or reappoint a Medical Staff member to act as our representative for the consortium.

6.7 THE INTERDISCIPLINARY PRACTICE COMMITTEE

6.7.1 Responsibilities

(a) The need for and appropriateness of services provided by AHPs;

(b) The qualifications and credentials of AHPs who are eligible to initially apply for and continue to provide services in the hospital;

(c) Approval of Standardized Procedures, Practice Agreements, Clinical Privilege forms pertaining to AHP practice and any other documents regarding the practice of AHPs in the hospital;

(d) Whether the efficiency and effectiveness of services performed by AHPs are consistent with the standards of quality medical care and within their scope of practice; and

(e) The current competence of AHPs providing services in the hospital.

6.7.2 Composition

The IPC shall consist of the members of the AHP Staff, the Chief of Staff, the Vice Chief of Staff and the Administrator.

Article VII. CONFIDENTIALITY, IMMUNITY AND RELEASES

7.1 GENERAL

The minutes, files and records of the Medical Staff, its standing and ad hoc committees, including credentials files of members and applicants to this Medical Staff or to the AHP Staff shall, to the fullest extent permitted by law, be considered confidential. Such confidentiality shall also extend to information of like kind that may be provided by third parties. This information shall become a part of the Medical Staff files and shall not become part of any particular patient's file or of the general District records. Dissemination of such information and records shall be made only when expressly required by law, or pursuant to officially adopted policies of the Medical Staff or District. When no officially adopted policy exists, release of material will only be made with the expressed approval of the Chief of Staff, the Administrator, or their designee and any involved Medical Staff member or applicant.

7.2 BREACH OF CONFIDENTIALITY

Effective credentialing, quality improvement, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free, candid, and confidential discussions. Practitioners and others who participate in credentialing, quality improvement, and peer review activities may assume that confidentiality will be preserved and maintained, unless in conflict with applicable state law. Any breach of confidentiality by any person when participating in activities related to credentialing, quality assurance, peer review, or qualifications of individuals for Medical Staff membership and privileges, is outside the appropriate standard of conduct for this Medical Staff or the AHP Staff.

Approved dissemination of confidential information to another health facility, professional society, or licensing authority, or peer review activities will not be considered a breach of confidentiality. If it is determined by the Chief of Staff that a breach of confidentiality has occurred, corrective action will be taken by the CW or referred to the governing body for action if non-members of the Medical Staff or AHP Staff are involved.

7.3 IMMUNITY AND RELEASES

7.3.1 Immunity from Liability for Providing Information or Taking Action

Each representative of the Medical or AHP staffs or District and all third parties shall be exempt from liability to an applicant, member, or practitioner for damages or other relief by reason of providing information to a representative of the Medical or AHP staffs, District, or any other health-related organization. This exemption extends to information regarding an individual who is, or has been, an applicant to or member of the Medical or AHP staffs or who did, or does, exercise privileges or provide services within the District. The exemption also extends to individuals who otherwise participate in Medical Staff or District credentialing, quality improvement, or peer review activities.

7.3.2 Activities and Information Covered

(a) Activities

The immunity provided by this Article shall apply to all acts, communications, reports, recommendations, or disclosures performed or made in connection with District or any other health-related organization's activities. Activities included with the scope of this section include, but are not limited to, the following:

(i) Credentialing, including but not limited to applications for appointment

(ii) Privileging, including but not limited to requests for Clinical Privileges, or specified services

(iii) Periodic reappraisals for reappointment
(iv) Corrective action
(v) Hearings and appellate reviews
(vi) Quality assurance review, including patient care audits
(vii) Peer review
(viii) Utilization reviews
(ix) Morbidity and mortality conferences
(x) Participation on district or committee activities, or acting as a witness providing testimony or information to such committee related to monitoring and improving quality of patient care and appropriate professional conduct.

(b) Information

The acts, communications, reports, recommendations, disclosures, and other information referred to in this Article may relate to a practitioner's professional qualifications, clinical ability, judgment, character, physical and mental health, emotional stability, professional ethics, or other matters that might directly or indirectly affect patient care.

7.4 CUMULATIVE EFFECT

Provisions in these Bylaws and in Medical Staff application forms relating to authorizations, confidentiality of information and immunities from liability shall be in addition to other protections provided by law and not in limitation thereof.

Article VIII. DISCIPLINARY ACTION

8.1 CAUSE AND NOTICE OF ACTION

Any person may provide information to the Medical Staff regarding the conduct, performance, or competence of members of the Medical Staff or AHP Staff. When reliable information indicates a member may have exhibited acts, demeanor, or conduct either within or outside the District that are reasonably likely to be: (1) Detrimental to patient safety or to the delivery of quality patient care within the District, (2) unethical, (3) inappropriate, (4) contrary to the Medical Staff Bylaws or supplemental documents, (5) below applicable professional standards, (6) disruptive of activities of the Medical or AHP staffs or District operations, or (7) an improper utilization of District resources, as determined by the Medical Staff and District board there shall be a proposal for disciplinary action or the request for an investigation.

The proposal for disciplinary action, or the request for an investigation, must be submitted to an officer of the Medical Staff. The request must identify the specific activities or conducts that are alleged to constitute the grounds for proposing an investigation or specific corrective action. The Medical Staff officer shall promptly notify the Administrator of all requests for corrective action and the Medical Staff officer shall continue to keep the Administrator fully informed of actions taken in conjunction with corrective action activities.

8.2 INVESTIGATION

8.2.1 Conducting an Investigation

Upon receipt of a request for corrective action or investigation, the Medical Staff officer shall, in consultation with other members, decide whether to act on the proposal and direct that an investigation be undertaken. If the situation warrants, the medical staff officer may immediately initiate an expedited review without seeking consultation from CW members. The results of the expedited review will be presented to the CW for a decision to initiate a corrective action investigation. If an investigation is undertaken, a Medical Staff officer not connected with the alleged offense or an ad hoc Medical Staff task force may conduct the investigation. If the practitioner being investigated is on the CW, then the practitioner will be removed from the corrective action investigation team. A Medical Staff officer, or a consensus of the CW~~thereof~~, will decide who will conduct the investigation. The investigating process shall, within 30 days of initiation of the investigation, include an interview with the affected practitioner who shall be advised of the reasons for the investigation. The practitioner shall be given an opportunity to comment on the charges. The investigative process shall not be deemed as a "hearing" as that term is used in the Fair Hearing Process. An investigation shall be conducted expeditiously and it will be brought to a conclusion as quickly as a thorough investigation permits, but no later than 90 days after initiation of the investigation.

In a complaint involving patient harassment or discrimination, an expedited review shall be conducted as referenced earlier in Section 8.2.1 of this article. The Administrator or designee shall participate in the expedited review when the Medical Staff officer receives a non-patient complaint from any source regarding harassment or discrimination by a member of the Medical or AHP staffs, the Administrator or designee will participate in an expedited joint review with the assistance of the Medical Staff's retained legal consul.

8.2.2 Written Report

Any investigator shall forward a written report on all investigations to the CW as soon as is practicable after completion of the assignment, following all District policies regarding the release of confidential information. The CW may at any time within its

discretion terminate the investigative process and proceed with action as provided below.

Information obtained in a joint expedited review regarding a complaint of harassment or discrimination may be used, as necessary, to meet District legal obligations when a charge of harassment or discrimination is made. The findings or recommendations of an expedited report must be submitted to the CW within 30 days after completing the investigation(s). If additional time is required to complete the investigation, an interim report shall be forwarded to the CW and it shall specifically request additional time to complete the investigation.

8.3 COMMITTEE OF THE WHOLE ACTION/RECOMMENDATION

8.3.1 As soon as is practicable after the conclusion of the investigative process the CW shall act thereon. Such actions may include the following options:

8.3.2 No corrective action to be taken and, if the CW determines that no credible evidence existed for the complaint, the removal of the complaint and any related information from the member's file. If the CW recommends that no corrective action be taken, such recommendation, together with such supporting documentation as may be required by the governing body, shall be transmitted thereto.

(a) Rejection or modification by the CW of a proposed corrective action by an investigator.

(b) Letters of admonition, censure, reprimand, or warning.

(c) Prepare recommendations for corrective action that are presented to the Governing body for approval. The range of potential recommendations include:

(i) Probation or special limitations or restrictions to be imposed on continued Medical Staff membership or exercise of privileges, including, without limitation, requirements for co-admissions, mandatory consultation, or monitoring.

(ii) Reduction or revocation of privileges.

(iii) Suspension of privileges until completion of specific conditions or requirements.

(iv) Reduction of membership status or limitation of any prerogatives directly related to the practitioner's delivery of patient care.

(v) Suspension of Medical Staff membership until completion of specific condition or requirements.

(vi) Revocation of Medical Staff membership.

(vii) Other actions appropriate to the facts that prompted the investigation.

8.3.3 If the CW recommends an admonition, reprimand, or warning to a practitioner, it shall, at the practitioner's request, grant an interview with the CW. Following the interview, the CW will consider the merits of the information divulged in the interview. If the CW decides to issue an admonition, reprimand, or warning, this shall conclude the matter and notice of the final decision shall be provided to the practitioner, as well as the Administrator and Governing Board.

8.4 INTERVIEWS

Interviews or meetings that are preliminary to corrective action involving a Medical Staff or AHP Staff member shall neither constitute nor be deemed a "hearing," as that term is used in the fair hearing process. They shall be preliminary in nature and shall not be conducted according to the procedural rules applicable to a fair hearing process. The CW shall be required, at the practitioner's request, to grant the practitioner an interview or meeting only when so specified

in the fair hearing process. In all other cases and when the CW has before it an adverse recommendation, it may, but shall not be required to, furnish the member an interview. In the event an interview or meeting is granted, the practitioner shall be informed of the general nature of the circumstance leading to such recommendation or action and may present information relevant thereto. A record of the matters discussed and findings shall be made.

8.5 PROCEDURAL RIGHTS

The Medical Staff does not intend to afford procedural rights to any practitioner unless required by law. Any recommendation by the CW that constitutes grounds for a hearing shall entitle the practitioner to the procedural rights provided in the fair hearing process. In such cases, the Chief of Staff shall give the practitioner written notice of the adverse recommendation and of the practitioner's right to request a hearing in the manner specified.

8.6 OTHER ACTION BY THE GOVERNING BODY

Any action of the governing body that constitutes grounds for a hearing as set forth in the Bylaws of the governing body shall entitle the practitioner to procedural rights incorporating, as much as practicable, the rights provided in the Article 9, Fair Hearing Process. In such cases, the governing body shall give the practitioner written notice of the tentative adverse recommendation and the right to request a hearing.

Should the governing body determine that the CW failure to investigate, or initiate disciplinary action, is contrary to the weight of the evidence, the governing body may direct the CW to initiate an investigation or a disciplinary action after consultation with the CW. In the event that the CW fails to take action in response to a direction from the governing body, the governing body, after notifying the CW in writing, may take action on its own initiative. If such action is unfavorable to the practitioner, or constitutes an admonition, reprimand or warning to the practitioner, it shall become effective as of the final decision of the governing body. If such action is one of those set forth in Article 9, Fair Hearing Process, the governing body shall give the practitioner written notice of the adverse recommendation. The practitioner shall also be advised of the right to request a hearing incorporating, as much as possible, the rights provided in the Fair Hearing Procedure.

8.7 SUMMARY SUSPENSION

8.7.1 Medical Staff Initiation of a Suspension

The Chief of Staff or Vice Chief of Staff may suspend a practitioner's membership status or suspend or restrict a member's privileges if, in their exclusive judgment, the failure to take that action may result in an imminent danger to the health of any individual provided that, if entitled by law the practitioner is subsequently provided notice and hearing rights.[13]

8.7.2 Non-Medical Staff Initiation of a Suspension

The Administrator or the governing body shall also have the authority to suspend a practitioner's membership or suspend or restrict privileges if, in their exclusive judgment the failure to do so would be likely to result in an imminent danger to the health of any individual, provided that the governing body or CEO/Administrator has, before the suspension, made a reasonable attempt to contact the Chief of Staff and Vice Chief of Staff. A suspension or restriction by the governing body or CEO/Administrator that has not been ratified by the CW within two working days after the suspension or restriction shall automatically terminate.

[13] This follows the language of B&P 809.5.

8.7.3 Notice

Summary suspension or restrictions by a Medical Staff officer or the CW shall become effective immediately upon imposition. Prompt written notice shall be given to the practitioner, governing body, Administrator, and others of the Medical Staff as appropriate. The notice of the suspension or restriction given to the practitioner shall constitute a request for corrective action or a corrective action investigation as provided in the procedures set forth in the Supplemental Attachment.

8.7.4 Assignment of Patients

In the event of any suspension or restriction, a Medical Staff officer shall assign the practitioner's patients whose treatment by such practitioner is affected by the summary suspension or restriction to another practitioner. The wishes of the patient shall be considered, where feasible, in choosing a substitute practitioner.

8.7.5 CW Action

After such summary suspension or restriction, the affected practitioner may request a meeting with the CW. The meeting shall be scheduled as soon as reasonably possible. The CW may, at any time, before or after that meeting, modify, continue, or terminate the terms of the summary suspension or restriction order and shall give the practitioner written notice of its decision.

8.7.6 Procedural Rights

Suspensions or restrictions shall remain in effect until completion of the corrective action process and any subsequent hearing and appellate review, unless earlier terminated by the governing body upon recommendation of the CW. The practitioner may request a hearing only if required by law.

8.8 AUTOMATIC DISCIPLINARY ACTION

8.8.1 State Licensure

(a) Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked, suspended, or expired, membership on the Medical Staff or AHP Staff and all Clinical Privileges shall be automatically terminated or suspended as of the date such licensing action becomes effective;

(b) Whenever a practitioner's license or other legal credential authorizing practice in this state is restricted or limited by the applicable licensing or certifying authority, any Clinical Privileges which are in the scope of such restriction or limitation shall be automatically restricted or limited in the same manner as of the date such action becomes effective and throughout its term. To the extent that the restriction or limitation cannot be accommodated because of impracticability or a significant impact on patient safety or hospital operations, the Medical Staff may impose suspension or any other remedy.

(c) Whenever a practitioner's license or other legal credential authorizing practice in this state is placed on probation by the applicable licensing or certifying authority, the practitioner's membership on the Medical Staff or AHP Staff and all affected Clinical Privileges shall become subject to the same terms and conditions of probation at this hospital, as of the date such action becomes effective and continue throughout its term. To the extent that the terms of probation cannot be accommodated because of impracticability or a significant impact on patient safety or hospital operations, the Medical Staff may impose suspension or any other remedy.

(d) Any such automatic termination is not based on a "medical disciplinary cause or reason" as that term is defined in the California Business and Professions Code,

and no report is required to the applicable licensing board. Unless otherwise expressly provided or required by law, the member is not be entitled to hearing or appeal rights specified in Article 9.

8.8.2 DEA Certificate

Whenever a practitioner's Drug Enforcement Administration (DEA) certificate is revoked, suspended or has expired, practitioner shall immediately and automatically be divested of the right to prescribe medications covered by the certificate. A District suspension to prescribe becomes effective upon the DEA effective date and it shall last for at least the term of the DEA suspension. Any such automatic termination is not based on a "medical disciplinary cause or reason" as that term is defined in the California Business and Professions Code, and no report is required to the applicable licensing board. Unless otherwise expressly provided or required by law, the member is not be entitled to hearing or appeal rights specified in Article 9.

8.8.3 Failure to Satisfy Special Appearance Requirement

A member, who fails without good cause, to appear before state and federal authorities or the CW and satisfy the requirements of these Bylaws and Supplemental Attachments, shall automatically be suspended from exercising all or such portion of privileges as specified by the CW. Corrective action may be initiated at the discretion of the CW.

8.8.4 Removal of Medical Records

Unauthorized removal of patient charts/medical records from the District facilities by a member shall result in the automatic suspension of the privileges to admit or treat patients in District facilities. Once the records have been returned to the District, admitting privileges shall resume although corrective action may be initiated at the discretion of the CW. A suspension imposed pursuant to this section which lasts more than sixty (60) days, or cumulatively adds up to more than sixty (60) days in a twelve-month period shall be considered a voluntary resignation from the Medical Staff. Any such action is not based on a "medical disciplinary cause or reason" as that term is defined in the California Business and Professions Code, and no report is required to the applicable licensing board. Unless otherwise expressly provided or required by law, the member is not be entitled to hearing or appeal rights specified in Article 9.

8.8.5 Cancellation of Professional Liability Insurance

Failure to maintain professional liability insurance as required by these Bylaws shall result in automatic suspension of a member's 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 of any acts or potential liabilities that may have occurred or arisen during the period of any lapse in coverage. A suspension imposed pursuant to this section which lasts more than sixty (60) days, or cumulatively adds up to more than sixty (60) days in a twelve-month period shall be considered a voluntary resignation from the Medical Staff. Any such action is not based on a "medical disciplinary cause or reason" as that term is defined in the California Business and Professions Code, and no report is required to the applicable licensing board. Unless otherwise expressly provided or required by law, the member is not be entitled to hearing or appeal rights specified in Article 9.

Article IX. FAIR HEARING PROCESS

9.1 PREAMBLE AND DEFINITIONS

9.1.1 Intra-Organizational Remedies

(a) The intra-organizational remedies and the hearing and appellate review bodies provided for in this document are quasi-judicial in structure and function. No participant in the Fair Hearing Process (FHP) shall have power or authority to hold quasi-legislative, notice and comment type hearings or to make legislative determinations, or determinations as to the substantive validity of Bylaws, rules, regulations or other intra-organizational legislation.

(b) Notwithstanding the foregoing, the governing body otherwise may entertain challenges to the substantive validity of intra-organizational legislation and in all proper cases shall hear and decide those questions. Where the substantive validity question is the sole issue, the practitioner may be permitted a direct meeting, in the first instance, with the governing body. The final determination by the governing body shall be a condition precedent to practitioner's right to seek judicial review in a court of law.

9.1.2 Exceptions to Hearing Rights

The procedures described herein do not apply to a practitioner whose application for membership on the Medical Staff or AHP Staff or Clinical Privileges was denied on the basis that the privileges the applicant sought were the subject of an agreement or arrangement providing for exclusive or limited access to a particular service, unless the practitioner is a member of the group which is a party to the agreement or arrangement to provide exclusive or limited access to a particular service. Any such action is not based on a "medical disciplinary cause or reason" as that term is defined in the California Business and Professions Code, and no report is required to the applicable licensing board. Unless otherwise expressly provided or required by law, the member is not be entitled to hearing or appeal rights specified in Article 9.

Such practitioners shall have the right, however, to request that the governing body review the denial. The governing body shall have the discretion to determine:

(a) Whether to review such request;

(b) To determine whether the practitioner may personally appear before and/or submit a statement in support of the practitioner's position.

9.1.3 Exhaustion of Remedies

A practitioner entitled to hearing rights in accordance with California law and to appeal as set forth in these Bylaws must exhaust the intra-organizational remedies afforded by the Bylaws, before resorting to formal legal action.

9.1.4 Definitions

Except as otherwise provided in the Bylaws, the following definitions shall apply:

Responsibility for decision that prompted the hearing decision refers to:

(a) The Medical Staff's Chief of Staff, or authorized officer, who took the action or rendered the decision that afforded hearing rights.

(b) The governing body in all cases where the governing body or authorized officers, directors, or committees of the governing body took the action or rendered the decision which afforded hearing rights.

Notice refers to a written communication delivered personally to the required addressee or sent by United States Postal Service, certified mail, return receipt requested,

addressed to the required addressee at the address as it appears in the records of the District.

Practitioner refers to the practitioner who has requested a hearing pursuant to this document.

Date of receipt of any notice or other communication shall be deemed to be the date such notice or communication was delivered personally to the required addressee. Or, if delivered by mail, such notice or communication shall be deemed received 48 hours after being deposited, postage prepaid, in the United States Postal Service in compliance with 9.1.4(b).

9.2 CAUSE FOR HEARING

9.2.1 Grounds for Hearing

The grounds for hearing specified in these Bylaws are intended to comply with those required by law and not to expand upon such rights. Therefore, a physician and surgeon, podiatrist, dentist or clinical psychologist who is the subject of a final proposed action of a peer review body for which a report is or will be required to be filed under Bus. & Prof. Code section 805 is entitled to a hearing, including when:

(a) An application for clinical privileges and/or membership is denied or rejected for a medical disciplinary cause or reason.

(b) Membership and/or clinical privileges are terminated or revoked for a medical disciplinary cause or reason.

(c) Restrictions are imposed, or voluntarily accepted, on membership or privileges for accumulative total of thirty (30) days or more during any twelve (12) month period for a medical disciplinary cause or reason.

(d) Summary suspension of membership or clinical privileges which remains in effect for more than fourteen (14) days.

9.3 ADVERSE RECOMMENDATIONS

Recommendation of any of the above actions shall constitute an "adverse recommendation" for the purposes of the FHP.

9.4 REQUEST FOR A HEARING

9.4.1 Notice of Action or Proposed Action

Under the FHP, the person or body that has recommended or taken any of the actions constituting grounds for hearing as set forth above, shall provide the affected practitioner with the following:

(a) Notice of an adverse recommendation, or action;

(b) that the action has been or will be reported pursuant to California Business and Professions Code Section 805 and/or to the National Practitioner Data Bank;

(c) a brief statement of the reasons for the action(s);

(d) notice of the applicant's or member's right to request a hearing pursuant to paragraph 9.4.2;

(e) A summary of the rights granted in the hearing pursuant to the Medical Staff Bylaws; and

(f) The right to representation by legal counsel.

9.4.2 Request for Hearing Time Limits

The practitioner shall have thirty (30) days, following the date of receipt of notice to request a hearing. The request for hearing shall be in writing and provided to the Chief of Staff with a copy to the Administrator. In the event the practitioner does not request a hearing within the time and in the manner herein above set forth, the practitioner shall

be deemed to have waived any right to a hearing and to have accepted the recommendation or action involved and it shall thereupon become final.

9.4.3 Times and Place for Hearing

Upon receiving a request for hearing, the Chief of Staff, on behalf of the CW, shall schedule and arrange for a hearing and give notice to the practitioner of the time, place, and date of the hearing. The practitioner may choose to appear in person, by telephone or video conference. The date of the commencement of the hearing shall not be fewer than 30 calendar days from the date of the notice of hearing, or more than 60 calendar days after the receipt of the request for a hearing by the Chief of Staff. However, a practitioner who is under a suspension, which is then in effect, has the right to a hearing as soon as the arrangements can reasonably be made. The date of the hearing for a suspended practitioner shall not exceed 30 calendar days from the date of receipt of the request for hearing by the Chief of Staff.

The date of a hearing may be postponed upon a decision issued by the Chief of Staff based upon good cause and in accord with this FHP.

9.4.4 Notice of Charges or Grounds for Action

If a hearing is requested on a at timely basis, the CW shall provide a written notice stating the reasons for the final proposed action taken or recommended, including the acts or omissions with which the practitioner is charged.

9.4.5 Failure to Appear

Failure of the practitioner, without good cause, to personally appear and proceed and failure of the practitioner to be prepared to proceed at a set hearing time and date shall be deemed to constitute voluntary acceptance of the recommendations or actions involved and it shall thereupon become final.

9.4.6 Continuances

The presiding hearing officer on a showing of good cause may grant continuances, or they may be made upon agreement of the parties.

9.5 HEARING PROCEDURE

9.5.1 Judicial Hearing Officer

When a hearing is requested, the CW shall appoint a Judicial Hearing Officer who shall be an attorney at law and is qualified by experience or training to conduct a fair hearing. The Judicial Hearing Officer shall:

(a) Have no direct financial interest in the outcome of the hearing.

(b) Has not acted as accusers, investigators, fact finders, or initial decision- makers in the matter.

(c) Where feasible, be knowledgeable regarding the appellant practitioner's specialty.

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 and procedure for presenting evidence and arguments during the hearing. The hearing officer shall have the authority and discretion to make all rulings on questions pertaining to matters of law, procedure, or the admissibility of evidence.

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 action, including disciplinary action as seems warranted by the circumstances. The CW and governing body may authorize legal counsel for consultation by the hearing officer, as appropriate.

The hearing officer shall prepare a written report of the findings of the hearings and recommendations for action. The hearing officer will present the report to the CW. A copy of the report will be sent to the governing body.

The hearing officer shall maintain a record of the hearing by one of the following methods:

(a) A certified shorthand reporter present to make a record of the hearing.

(b) A recording of the proceedings.

The cost of attendance of the shorthand reporter shall be borne by the District, but the cost of the transcript, if any, shall be borne by the party requesting it. The hearing officer may order that oral evidence shall be taken only on oath administered by any person entitled to notarize documents in California or by affirmation, under penalty of perjury, to the hearing officer.

The cost of conducting the hearing will be borne by the District.

9.5.2 Pre-Hearing Procedure

(a) At the request of either party, an exchange of witness lists of individuals expected to testify shall be made available to requesting parties. Copies of all documents that are expected to be introduced as part of the hearing shall be made available to requesting parties. If witnesses are added after this list has been provided, it shall be the duty to notify the other party of the change. Failure to disclose the identity of a witness or produce copies of all documents used as part of the hearing at least ten days before the commencement of the hearing shall constitute good cause for a continuance.

(b) It shall be the duty of the practitioner and the Chief of Staff or authorized Medical Staff officer, to exercise reasonable diligence in notifying the hearing officer of any pending or anticipated procedural disputes. Notification should be as far in advance of the scheduled hearing as possible so that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be made at the hearing.

(c) The practitioner shall have the right to inspect and copy, at the practitioner's expense, any documentation relevant to the charges and in possession or under control of the Chief of Staff. The aforementioned individuals will provide the requested information as soon as practicable.

(d) The practitioner shall have the right to inspect and copy, at the practitioner's expense, any documentation relevant to the charges and in possession or under control of the Chief of Staff. The aforementioned individuals will provide the requested information as soon as practicable.

(e) The failure by either party to provide access to such information at least 30 days before the hearing shall constitute good cause for a continuance.

(f) The right to inspect and copy by either party does not extend to confidential information referring to individually identifiable practitioners other than the practitioner involved in the hearing.

The hearing officer shall consider and rule upon any request for access to information, and the hearing officer may impose any safeguards for the protection of the peer review process. When ruling upon requests for access to information and determining the relevancy thereof, the Hearing Officer shall, among other factors, consider at least 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.

(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.

9.5.3 Representation at the Judicial Hearing

The practitioner and District shall be entitled to representation by legal counsel in any phase of the hearing, and the practitioner shall receive notice of the right to obtain representation. In the absence of legal counsel, the practitioner shall be entitled to be accompanied by and represented at the hearing by a practitioner licensed to practice in the State of California who is not an attorney at law. If the practitioner is not so represented by legal counsel, legal counsel shall not represent the District.

9.5.4 Rights of the Parties

Both sides shall have the following rights during the fair hearing process:

(a) To question the qualification and impartiality of the hearing officer to serve in accordance with this FHP procedure.

(b) To call and examine witnesses.

(c) To introduce exhibits or other documents.

(d) To cross-examine or otherwise attempt to impeach any witness who shall have testified orally on any matter relevant to the issues, and otherwise to rebut any evidence.

(e) To be provided with all information made available during the hearing and to the hearing officer.

(f) The practitioner may be called by the body whose decision prompted the hearing and examined as if under cross-examination.

(g) Ruling on any challenge directed at the hearing officer shall be done by a knowledgeable and impartial resource.

9.5.5 Miscellaneous Rules

The rules of law relating to the examination of witnesses and presentation of evidence shall not apply in any hearing conducted under these procedures. Any relevant evidence, including hearsay, shall be admitted by the hearing officer provided the evidence can be characterized as information commonly accepted or used by responsible persons in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law. Each party shall have the right to submit a written statement supportive of each party's respective position. The hearing officer may request a statement to be filed following the conclusion of the presentation of oral testimony. The hearing officer may question witnesses or call additional witnesses as a means of obtaining a full and complete exposition of the relevant facts. The Administrator or designee may attend and observe FHP and CW meetings.

9.5.6 Burdens of Presenting Evidence and Proof

(a) The Chief of Staff or authorized Medical Staff officer shall have the initial burden

to present evidence that reasonably supports the corrective action.

(b) A practitioner shall bear the burden of presenting evidence that clearly allows for an evaluation and resolution of reasonable doubt regarding the applicant's ability and earnestness to perform requested privileges and fitness for Medical Staff membership. Initial applicants shall not be permitted to introduce information not produced upon request of the CW during the credentialing process unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

9.5.7 Adjournment and Conclusion

The hearing officer may adjourn the hearing and reconvene the same at the convenience of the participants without special notice. Upon conclusion of the presentation of oral and written evidence and argument, the hearing shall be closed.

9.5.8 Hearing Officer Decision

Within 30 working days after final adjournment of the hearing (in the event the practitioner is currently under suspension, this time shall be 15 calendar days), the hearing officer shall render a written decision. The decision report shall include findings of fact and any conclusions explaining the connection between the evidence and the decision of the hearing officer. The decision report shall be delivered to the Chief of Staff, the Administrator, and the governing body. At the same time, a copy of the report and decision shall be delivered to the practitioner by certified mail, return receipt requested. The practitioner shall be advised of the appeal rights to the governing body. The decision of the hearing officer shall be considered final, subject only to the right of appeal to the governing body as provided below.

9.6 APPEAL TO GOVERNING BODY

9.6.1 Time for Appeal

Within 30 calendar days after the date of receipt of the CW decision, either the practitioner or the Chief of Staff or authorized Medical Staff officer whose decision prompted the hearing may request an appellate review by the governing body. Said request shall be delivered to the Administrator in writing either in person, or by certified mail, return receipt requested. The request shall include a brief statement of the reasons for the appeal. If such appellate review is not requested within such period, both sides shall be deemed to have accepted the action involved and it shall thereupon become the final action of the Medical Staff.

9.6.2 Grounds for Appeal

The written request for an appeal shall include the grounds for appeal, and a clear and concise statement of the facts that support the appeal. The grounds for appeal from the hearing shall be:

(a) Substantial noncompliance with the procedures that are required by the FHP or applicable law so as to deny a fair hearing.

(b) The decision was not supported by substantial evidence based on the hearing record or such additional information as may be permitted.

9.6.3 Time, Place, and Notice

The governing body shall schedule and arrange for an appellate review. The governing body shall give the practitioner notice of the time, place, and date of the meeting with the parties that are to be included in the appellate review. The date of an appellate review meeting shall not be less than 30 calendar days or more than 60 calendar days from the date of receipt of the request for appellate review. However, when a request for appellate review is from a practitioner who is under suspension then in effect, the

appellate review shall be held as soon as the arrangements may reasonably be made. The review shall not exceed 30 days from the date of receipt of the request for appellate review if the practitioner is under suspension. The time for appellate review may be extended for good cause by the governing body, its chair or its designee.

9.6.4 Appeal Board

When an appellate review is requested, the governing body shall sit as the appeal board. 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 investigation or hearing on the same matter.

9.6.5 Appellate Procedure

The proceedings by the governing body shall be an appellate hearing that is based upon the record of the hearing before the hearing officer. The appeal board may accept additional oral or written evidence, subject to the condition that such evidence could not have been made available to the hearing officer consistent with reasonable diligence. New evidence is subject to the same rights of cross-examination or confrontation provided at the hearing. The governing body may remand the matter to the CW for the taking of further evidence and for decision. Each party shall have the right:

(a) To present a written statement in support of the party's position on appeal,
(b) to appear and respond; and
(c) to be represented by an attorney or any other representative designated by the party.

At the conclusion of the arguments, the governing body may thereupon conduct deliberations, at a time convenient to itself, outside the presence of the appellant and respondent and their representatives.

9.6.6 Decision

Within 30 working days after the conclusion of the appellate review proceedings, the governing body shall render a final decision in writing. The governing body may affirm, modify, or reverse the Hearing Officer's decision, or, in its discretion, remand the matter for further review and recommendation by the CW. Copies of the decision shall be delivered to the practitioner, Chief of Staff, and the Administrator by personal delivery or by certified mail, return receipt requested.

9.6.7 Further Review

Except where the matter is remanded for further review and recommendation the final decision of the governing body following the appeal procedures set forth herein shall be effective immediately and shall not be subject to further review. However, if the matter is remanded to the CW, it shall promptly conduct its review and render its decision to the governing body in accordance with the instructions given by the governing body.

9.6.8 Right to One Hearing

Notwithstanding any other provision of this FHP, no practitioner shall be entitled to more than one hearing and one appellate review on any matter that shall have been the subject of action by either the CW or the governing body or by both.

Article X. GENERAL PROVISIONS

10.1 DUES OR ASSESSMENTS

Active and Provisional Active members of the Medical and AHP staffs may be required to pay annual dues at the beginning of the Medical Staff year. The CW shall have the power to set the amount of annual dues or assessments, if any, for each category of membership. The CW shall determine the manner of expenditure of funds received. At the end of six (6) months, members with unpaid staff dues are reported to the Chief of Staff for further action.

10.2 AUTHORITY TO ACT

Any member who acts in the name of this Medical Staff without proper authority shall be subject to such disciplinary action as the CW may deem appropriate.

10.3 CONSTRUCTION OF TERMS AND HEADINGS

The captions and headings in these Bylaws are for convenience only and are not intended to limit or define the scope or effect of any provision of these Bylaws.

10.4 DISCLOSURE OF INTEREST

All nominees for election or appointment to Medical Staff offices shall disclose in writing to the CW those foreseeable personal, professional or financial affiliations or relationships, which could result in a conflict of interest with their activities or responsibilities on behalf of the Medical Staff. The conflict-of-interest statement shall be sent to the CW at least 20 days prior to the date of election or appointment.

10.5 MEDICAL STAFF ROLE IN EXCLUSIVE CONTRACTING

The Medical Staff shall be notified and may make recommendations to the governing body regarding quality-of-care issues related to exclusive arrangements for physician and/or professional services prior to a decision being made, in the following situations**:**

10.5.1 A decision to execute an exclusive contract in a previously open service;

10.5.2 A decision to renew or modify an exclusive contract in a particular service;

10.5.3 A decision to terminate an exclusive contract in a particular service.

Article XI. ACCESSORY DOCUMENTS

In addition to the Bylaws and Medical Staff Rules and Regulations containing the specific information regarding conduct and requirements expected of all members, the Medical Staff shall be directed by the following Supplemental Attachments:

11.1 Medical Staff Appointment Process; and

11.2 Clinical Privileges Delineation Process.

Upon adoption by the CW and the governing body, such additional documents as occur in this Section are incorporated by reference as part of these Bylaws.

Article XII. AMENDMENTS, FORMATTING AND ADOPTION

12.1 AMENDMENTS

12.1.1 Bylaws

These Bylaws are amended when a majority vote of those voting from the active staff is sustained by the governing body. The member voting shall occur at a CW meeting

12.1.2 Rules and Regulations, Supplemental Attachments

Amendments to the Medical Staff Rules and Regulations, the Supplemental Attachments, and any other documents pertaining to the operation of the Medical Staff are amended when a majority of the voting members of the CW are sustained by the governing body. The member voting shall occur at a CW meeting.

12.2ADOPTION

These Bylaws, upon adoption by the SHCHD Medical Staff, shall replace any previous Bylaws and they shall become effective when approved by the governing body. They shall, when adopted by the Medical Staff and approved by the governing body, be equally binding on the governing body and the Medical Staff, subject, however, to the rights of the governing body to require that these Bylaws be amended.

MEDICAL STAFF BYLAWS ADOPTION AND APPROVAL

Adopted July 11, 2024

Carl K. Hsu, M.D., Chief of Staff

Approved July 25, 2024

Corinne Stromstad, President, SHCHD Board of Directors

SoHum Health

733 Cedar Street
Garberville, CA
95542
(707) 923-3921

MEDICAL STAFF

RULES AND REGULATIONS

ADOPTED by the Medical Staff on: **May 9, 2024**

APPROVED by the Board of Directors on: **June 6, 2024**

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MEDICAL STAFF RULES & REGULATIONS

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MEDICAL STAFF RULES & REGULATIONS

INTRODUCTION

The following Medical Staff rules and regulations serve as a part of the SHCHD Medical Staff Bylaws. As such, the rules and regulations shall be interpreted in a manner to be consistent with the bylaws.

ARTICLE 1 CONDUCT OF MEDICAL CARE

1.1 ADMISSIONS TO DISTRICT SERVICES

1.1-1 General Requirements

a The responsibility for admitting and providing medical care or supervising the care of all patients seeking services in District programs shall be limited to appropriately privileged physicians who are members of the SHCHD Medical Staff.

b A physician assigned to "on call" responsibility will admit or care for patients who have no established relationship with a Medical Staff member and who have an urgent need for medical care. Upon a patient's request, transfer to an appropriate alternative practitioner shall be made consistent with Medical Staff rules (Section 1.2-4 below) as soon as possible.

c Practitioners who have been granted temporary privileges under appropriate Medical Staff procedures may admit or care for patients in all District facilities as deemed appropriate by the practitioner.

d Except for emergencies, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

1.1-2 Suicidal Patients

Suicidal patients are referred to a qualified practitioner or hospital designated as appropriate for such a patient. If referral of the patient is not immediately possible, the following guidelines are followed:

a The patient is admitted to the Hospital with documented suicide precautions.

b Consultation with a psychiatrist is recommended. Further, the attending physician must offer such consultation to the patient or patient's representative.

c To assure the protection of the patient from self-harm, the attending physician shall order, if necessary, observation and application of restraints for the patient. An order for constraints shall be made in accordance with Hospital policy.

1.2 CONTINUOUS MEDICAL COVERAGE

In accordance with the law and SHCHD Medical Staff Bylaws, practitioners will provide uninterrupted medical services by adhering to the following guidelines:

1.2-1 Inpatients (Acute and Skilled Nursing Services)

To provide continuous inpatient care at District facilities, physicians shall be called in the following order: (1) primary physician, (2) physician designated by the primary practitioner as being on-call for the primary physician, and (3) the Chief of Staff.

1.2-2 Emergency Service Patients

Coverage for emergency service patients shall be provided as follows: (1) emergency contract service physician, nurse practitioner or physician assistant, when scheduled, (2) District assigned Medical Staff member, nurse practitioner or physician assistant when scheduled, and (3) the Chief of Staff.

Physicians who are regularly scheduled to work in the Emergency Department will be available to respond within a 30-minute timeframe as dictated by/in the Medical Staff Bylaws, Rules and Regulations which are reviewed and overseen by the District's governing body.

It is the policy of the District to maintain a list of credentialed physicians, nurse practitioners, and physician assistants who are on staff in the Hospital and the Southern Humboldt Community Clinic (SHCC) and available to be on-call and who can respond to the Emergency Department to complete a Medical Screening Examination (MSE) and stabilizing treatment under the following circumstances: (1) when the Emergency Department physician is unavailable due to unforeseen circumstances or becomes incapacitated. (2) when the Emergency Department physician is already caring for a critical patient and is not able to leave the bedside. (3) during a local emergency situation or a community wide disaster when an influx of patients dictates the need for more than one provider to complete a MSE to rule out an Emergency Medical Condition (EMC) and provide stabilizing treatment

1.2-3 District Outpatient Services

Regarding District outpatient services, the practitioner shall maintain continuity of care through appropriate patient scheduling or, in the absence of the primary practitioner, designation of an alternate practitioner to provide or supervise medical services to patients.

1.2-4 Transfer to Another Physician

When care of a patient(s) is transferred from the primary physician to an alternate physician, the primary physician must so state in clear language on the progress and order sheets of the patient's medical record. The primary practitioner must take the additional step of informing the nursing staff of the change in coverage. Nursing staff will notify others as appropriate. Verbal and telephone orders to nursing staff regarding a change in physician coverage must be signed by the transferring physician within 24 hours, if possible.

It is the responsibility of the primary physician to ensure that the alternate physician assuming responsibility for providing care to the transferred patient has the necessary clinical privileges.

1.3 CONSULTATION

The primary practitioner is responsible for requesting consultations when indicated, and for contacting a qualified consultant.

1.3-1 Consultation Guidelines

Except in emergency conditions, the primary physician shall seek a consultation with another qualified physician under the following circumstances:

a. The patient is not a good risk for treatment.
b. The diagnosis is obscure.
c. There is doubt as to the best therapeutic measures.
d. Upon request of the patient or such other individual who is acting for the patient when the condition of the patient precludes such responsibility.

1.3-2 Consultant Qualifications

Consistent with a practitioner's expertise, any District Medical Staff member with Medical Staff privileges can be called for consultation. Non-member consultants must be qualified to give an opinion in the field in which an opinion is being sought. The Medical Staff shall determine the qualifications of a consultant on the basis of the individual's training, experience and competence.

1.3-3 Consultation Documentation.

A complete consultation shall include the following documentation:

a. Evidence of the review of the patient's medical record by the consultant.
b. Pertinent findings on examination of the patient.
c. The consultant's opinion and recommendations.

The consultant's report shall be part of the permanent medical record. When the consultation is obtained by telephone, it is recorded and signed by the physician who receives the telephone consultation. When invasive procedures are involved, consultation notes, except in emergencies, are recorded prior to the performance of the procedure.

1.3-4 Non-Physician Request for Consultation

The Administrator has the right to request a consultation. If the Administrator believes that appropriate consultation is needed and has not been obtained, the Administrator will call this to the attention of the Chief of Staff who will determine the appropriateness of the request for a consultation.

A nurse who believes that appropriate consultation is needed but it has not been obtained shall first call the concern to the attention of the physician caring for the patient. In the absence of appropriate action by the physician, the matter will be referred to the nurse's supervisor, who in turn will refer the matter to the Chief of Staff.

1.4 DISCHARGE AND TRANSFER

Medical Staff members shall follow the guidelines presented below for discharges and transfers from District facilities.

1.4-1 Discharges

a Discharge of patients should occur as soon as medically stable and reasonably practical. When a patient leaves a District inpatient facility against the advice of the primary physician or without proper discharge procedures, a notation of the incident will be made in the patient's medical record by the primary physician. Nursing Service will complete an Against Medical Advice form and a Quality Review form.

b Inpatients shall be discharged only by order of the primary practitioner. A patient may be discharged by telephone order if the primary practitioner has seen the patient that day or an alternate physician or the patient meets predetermined discharge criteria as documented by the primary practitioner.

1.4-2 Inter-Facility Transfers

a No patient will be transferred to an outside facility without approval of the responsible primary District practitioner and the receiving institution. Consent of receiving physician and confirmation by the receiving facility will be obtained by telephone and documented by the transferring practitioner prior to the patient's release. The receiving facility's consent including the time and date thereof, will be documented in the patient's chart. Such documentation shall identify the physician and facility representative who has consented to accept the patient. The transferring practitioner will determine when a patient is appropriate for transfer.

b The patient or the patient's authorized representative will be advised, if possible, of the need and the reason for the transfer and the alternatives, if any, to the transfer. Additionally, the proposed transportation plans and the benefits and risks of the proposed transfer will be divulged to the patient or authorized representative. A note will be made in the patient's medical record regarding the discussion with the patient or patient representative.

c Appropriate transfer forms and/or copies of all medical records shall accompany patients transferred to other facilities for acute or convalescent care to assure adequate continuity of care.

1.5 DISTRICT SERVICES POLICIES AND PROCEDURES

Individual District clinical services develop policies and procedures in collaboration with other district departments and the medical staff. All policies and procedures are discussed at and approved by the CW. When these policies and procedures contain practice guidelines, they must be followed by all practitioners.

1.6 MEDICAL RECORDS

1.6-1 Contents

Physicians responsible for providing overall patient care management or supervision of a patient's care shall provide sufficient data to support the

diagnosis, justify the treatment, document the course and results of treatment and promote continuity of care among health care providers. Specific practitioner provided data to be included in the medical record as per the following table:

Required Medical Record Data	**Inpatient**	**Outpatient**
Emergency care prior to patients' arrival	Y	Y
Record and findings of patient assessment (physical, social, psychological)	Y	Y
Conclusions or impressions drawn from medical history and physical examination	Y	Y
Diagnosis or diagnostic impression	Y	Y
Reason for admission or treatment	Y	
Goals for treatment and treatment plan	Y	Y
Evidence of known Advanced Directive	Y	
Evidence of Informed Consent	Y	Y
Diagnostic and therapeutic orders	Y	Y
Diagnostic and therapeutic procedures and test results	Y	Y
Progress notes made by practitioner and other authorized individuals	Y	Y
Reassessments and revisions of treatment plans	Y	Y
Patient's response to care	Y	Y
All medications ordered, prescribed, or dispensed	Y	Y
Medications administered and any drug reaction	Y	Y
All relevant diagnoses established during course of care	Y	Y
Any referrals and communications from and communications made to external providers or community agencies	Y	Y
Clinical observations	Y	Y
Conclusions at termination of treatment	Y	Y
Discharge instructions to patients and family	Y	Y
Clinical resume and discharge summary, or final progress note, or transfer summary (see section 1.6-8 for details)	Y	Y
A summary list containing significant diagnosis, procedures, drug allergies and medications (established after third visit)	Y	Y

1.6-2 History and Physical

a Admission History and Physical examinations are to be completed within twenty-four (24) hours of admission or registration, and prior to surgery or a procedure requiring anesthesia services.

b If a complete History and Physical examination was performed and recorded within 30 days prior to the patient's admission to the Hospital, a durable, legible copy of the History and Physical report may be provided as part of the Hospital medical record and shall be included in lieu of the admission History and Physical examination. A History and Physical conducted prior to admission to inpatient status must contain the required elements as defined by the Medical Staff. In such instances, an interval history and physical examination must be performed and recorded within twenty-four (24) hours of admission or registration, and prior to surgery or a procedure requiring

anesthesia services. The interval history and physical examination must include all additions necessary to complete the required elements, as well as any changes in the patient's condition and physical findings. If no additions are necessary and no changes are found, the practitioner must so record in the interval note in the medical record.

1.6-3 Progress Notes

Pertinent progress notes shall try to be recorded at the time of observation and they shall be sufficient to clearly establish a record of the progress of a patient undergoing treatment in any District service. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on all acute-care patients. Progress notes for skilled nursing patients shall be in accordance with the law.

1.6-4 Physician's Orders

a Written: Practitioners are encouraged to ensure orders be written clearly, legibly, and completely. Orders that are illegible or unclearly written will not be carried out until clearly understood by the nurse. The order must be signed by the responsible practitioner or alternate practitioner designated by the primary practitioner.

b Verbal. Verbal orders for medications may be received and recorded by a registered nurses, licensed vocational nurses, pharmacist or physician assistant. The person receiving the telephone order shall sign orders dictated over the telephone. The name of the ordering physician must also be noted on the order. The medication ordered must be limited to those approved by the Medical Staff. The ordering practitioner must authenticate the order within 48 hours.

c Verbal orders for diagnostic laboratory, x-ray, dietary, physical therapy and other clinical support services provided by the District may be received by authorized employees for support department when these orders are clearly from a person recognized as an authorized representative of a Medical Staff member.

1.6-5 Standing, Specialty, or Protocol Orders

Standing orders, specialty orders, protocol orders or a practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet in the patient's record, dated and signed by the practitioner. Standing orders shall be reviewed and authenticated by the physician on an annual basis

1.6-6 Authentication

All clinical entries in the patient's medical record shall be legible, accurately dated, timed, and signed by the responsible practitioner.

1.6-7 Final Diagnosis

A final diagnosis shall be recorded for inpatients. The documentation is made without the use of symbols or abbreviations. The entry of the final diagnosis is dated and signed by the responsible practitioner at the time of discharge of all

patients.

1.6-8 Discharge Documentation

Clinical resumes or summaries shall be completed at the time of discharge for all inpatients. The content of the discharge summary shall be sufficient to justify the diagnosis, treatment and end result. The summary should be concise and include the following information:

a. The reason for the hospitalization.
b. Significant findings.
c. Procedure performed and treatments rendered.
d. Consultations.
e. Final diagnosis.
f. The patient's condition at discharge.
g. Instructions to the patient and family, if any.
h. Signature of primary practitioner.

Progress note instead of a clinical resume may be substituted for normal newborns or minor problems requiring less than 48-hour hospitalization. The progress note includes:

a. Patient's condition on discharge.
b. Discharge instructions.
c. Follow up care required.

Internal transfer of a patient from hospital care to skilled nursing care with continuing care provided by the same practitioner may be documented by a progress note.

Transfer summary can be substituted for the clinical resume when a patient is transferred to another practitioner for any reason. The transfer summary shall include:

a. The patient's condition at the time of transfer; and
b. The reason for the transfer

1.6-9 Completion of the Medical Record

Medical record completion shall be in accordance with the following provisions:

a The medical record shall not be permanently filed until it is completed by the primary practitioner or is authorized for filing by the Chief of Staff.

b An inpatient medical record shall be completed promptly and authenticated or signed by the primary practitioner within two weeks following an inpatient discharge. The Director of Medical Records notifies the primary practitioner of incomplete records. The Chief of Staff and the Administrator are also be notified in writing. The practitioner is placed on automatic suspension within four days following notification if delinquent records are not promptly completed.

c Failure to complete an inpatient history and physical within three days following admission to inpatient care by the responsible primary practitioner may lead to automatic suspension of the practitioner.

d Emergency room and outpatient medical records are completed at the time care is provided or within 24 hours of the provision of care. A

dictated history and physical and course of treatment note are acceptable.

1.6-10 Members' Access to the Medical Record

Access to District medical records by Medical Staff members shall be in accordance with the following provisions:

a. A member of the Medical Staff shall be permitted access to a patient's medical records for periods during or before the time the member provides medical services to a patient. In case of return of a patient to the District for medical services, all previous records shall be available for the use of the responsible practitioner.

b. Access to medical records by the Chief of Staff, and the CW shall be permitted for quality-of-care review purposes.

c. Access to all medical records of all patients shall be permitted to members of the Medical Staff for bona fide clinical studies when done in a manner consistent with preserving the confidentiality of personal information concerning the individual patients. The Administrator and CW shall approve all such projects. Subject to the discretion of the Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which the practitioner provided medical services in District facilities.

1.6-11 Release/Removal of Medical Records

The following provisions will govern release and removal of medical records:

a Original records may be removed from District facilities only in accordance with a court order, subpoena, or statute. All records are the property of the District and shall not be taken off premises without permission of the Administrator or designate. Unauthorized removal of original charts from District facilities by a practitioner is grounds for withdrawal of staff privileges for a period to be determined by the CW.

b. Written consent of the patient is required for release of medical information to persons or agencies not otherwise authorized by law, regulation, statute or contract to receive such information.

1.6-12 Utilization Review

Regarding inpatient care, the attending physician shall document the need for continued care as defined in the District utilization review plan for all inpatients. This documentation contains:

a. An adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient evidence for continued hospitalization).

b. The estimated period of time the patient required for inpatient care and plans for care post-discharge.

1.7 DEATHS

1.7-1 Inpatient and Emergency Services

A deceased patient shall be pronounced dead by the primary physician or alternate physician designee within a reasonable time. The body shall not be released until a practitioner has completed a signed and dated entry in the medical record of the deceased. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course had already been adequately documented to within a few hours of death. Policies with respect to release of the body shall conform to local law and District policies.

1.7-2 Autopsies

Medical Staff members should actively attempt to secure permission to do an autopsy in all cases of unusual deaths and of medical-legal and educational interest. Discussion with family for the purposes of education and to obtain permission must be documented in the Physician Progress Notes or the Discharge Summary of the patient's hospital medical record. Results of autopsies are sent, by the pathologist or coroner, to the hospital medical records department. A copy will be forwarded to the attending physician and ordering physician and the Medical Staff Coordinator will be notified that an autopsy has been done. The Medical Staff Coordinator will notify the Medical Staff of the autopsy at the next Medical Staff meeting.

1.7-3 Organ Donation and Transplantation

Medical Staff members must follow hospital policy and procedure in regards to identifying patients who are potential organ donors. This policy was written in conjunction with the contracted tissue and transplantation service and clearly defines donor criteria as well as procedures for referral and obtaining consents. Medical Staff members must assure that the family of each potential donor knows its options in regards to donation. Discussions with the patient and/or family must be documented in the Physician Progress Notes or in the Discharge Summary of the patient's hospital medical record.

1.8 DRUGS AND MEDICATIONS

Drugs and medications administered to patients shall be listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations. Other provisions regarding drugs and medications follow below:

a. Medications brought to the hospital by patients are labeled and stored at the nurse's station. In special cases in which patients are allowed to administer their own medication, District policies established for these cases are followed.

b. Only physicians, physician assistants or the pharmacist may dispense medication from the emergency service. The amounts of medications dispensed must be limited to meet the immediate needs of the patient or until a local retail pharmacy is open. Under no circumstances will more than a seventy-two (72) hour supply be dispensed. Directions for administration must be clearly written on each envelope given to the patient.

c. Medications and I.V. solutions will be renewed as follows:

   i. IV solutions will be reordered every three (3) days in conjunction with I.V. medication renewals. **Exception:** Hyper alimentation and intra lipids are reordered daily.

ii. IV additives and any IV push or IV piggyback medications must be reordered every three (3) days.

iii. Oral anticoagulants, antibiotics, narcotics, or hypnotics must be reordered every five (5) days.

d. Orders that specify total days or doses of therapy are administered as ordered.

e. All prior drug orders are cancelled when the patient is transferred to another District service.

f. Hold orders must specify the date and time of restart. If the date and time are not specified, the order is considered an order to discontinue.

g. A registered nurse that has reason to question the dosage of medication ordered directs such question or doubt to the primary physician. If the nurse still feels that the question has not been resolved, the nurse's supervisor is contacted. The supervisor shall contact the Chief of Staff who considers the nurse's concern.

1.9 DNR ORDERS

1.9-1 Definition and Policy

The definition of DNR is that no cardiopulmonary resuscitation will be performed. It is the policy of the Medical Staff that a physician is not required to give a DNR order. In the event a physician wishes to do so the order must be written in the patient's medical record. The Code Status form is completed for all inpatients with exceptions documented in the progress notes.

1.9-2 DNR Guidelines

The Medical Staff recognizes that certain circumstances exist under which a DNR order is medically justified. The following are suggested guidelines for such an order:

a. When a patient is at the end stage of an irreversible and/or incurable disease process and death is inevitable, a DNR order is medically justified.

b. If an order is written, the physician must discuss the order with the patient and/or family member(s) and indicate such communication in the progress notes of the patient's medical record.

c. The DNR order must be written in the patient's medical record.

1.9-3 DNR Order Time Limits

A DNR order for an acute patient automatically expires seven (7) days from the time that it is entered in the medical record unless renewed in writing by the primary physician. A DNR order for a DP/SNF patient automatically expires thirty (30) days from the time that it was entered in the medical record unless renewed in writing by the primary physician.

ARTICLE 2 COMMITTEES

2.1 COMMITTEE OF THE WHOLE

2.1-1 Role

The CW coordinates and implements the professional and organizational

activities and policies of the Medical Staff as required by law and these Bylaws. It serves in the capacity of a Medical Staff executive committee thereby assuming the responsibilities of an executive committee required by law and convention.

2.1-2 Assigned Responsibilities of the CW

a. Appoint ad hoc task forces and consider and, as appropriate, act on their recommendations.

b. ~~P~~The Chief of Staff should provide liaison between the Medical Staff and the governing body and its designees.

c. Make recommendations to the governing body on matters of a medico-administrative nature.

d. Participate in the development of all District policy, practice, and planning relevant to the Medical Staff.

e. Review and evaluate practitioners' performance for at least but not limited to removal of tissue, infection control compliance, pharmacy and therapeutic utilization, and completeness, timeliness and accuracy of patient medical record entries. As appropriate, establish generic screens to identify problematic situations in the above review and evaluate the results of the screening process.

f. Make specific recommendations to the governing body regarding:
   i. The structure of the Medical Staff.
   ii. A mechanism to evaluate credentials and to delineate individual clinical privileges for members of the Medical Staff.
   iii. A mechanism to determine the suitability of individuals for Medical Staff membership.
   iv. Recommendations for clinical privileges for each eligible individual.
   v. Participation in the District's Quality Assessment and Improvement Program.
   vi. A mechanism by which a Medical Staff member can be terminated.
   vii. A process for fair hearing procedures for Medical Staff members.

g. ~~As required by these Bylaws and state and federal law, investigate and take corrective action, when indicated, regarding a member's ethical conduct or clinical competence~~Proposed change-The Medical Staff, through the Committee of the Whole, shall investigate and take corrective action when indicated regarding a member's clinical competence, professional conduct, or compliance with Medical Staff and District policies, in accordance with applicable Medical Staff policies and fair hearing provisions of these Bylaws .

h. Take steps to develop continuing education activities and programs for the Medical Staff.

i. Review the quality and appropriateness of services provided by contract physicians.

j. Assist Medical Staff members impaired by chemical dependency and/or mental illness to obtain rehabilitation services.

k. Review at least biennially the Bylaws and Supplemental Attachments of the Medical Staff and recommend any revisions therein as may be necessary to meet licensing regulations or changes in Medical Staff procedures or structure.

l. Perform any other functions arising from these Bylaws and related documents assigned by the Governing Board.
m. Approve credentials and privileges of Physician Assistants who provide patient care in District facilities.
n. Conduct in-service training, as appropriate, for District staff.

2.2 INTERDISCIPLINARY PRACTICES COMMITTEE

2.2-1 Role

Develop policies, procedures and oversee implementation of standardized procedures for nursing staff and, as appropriate, other healing arts professionals that are not members of the Medical Staff. The committee shall report to the governing body through the CW.

2.2-2 Responsibilities

a. Perform functions consistent with the requirements of the law.

b. The Interdisciplinary Practice Committee shall be responsible for policies and procedures recommendations that address granting of privileges to registered nurses and other healing arts professionals as appropriate.

c. The committee shall also review credentials and make recommendations to the governing body, through the CW, for granting or rescinding of privileges.

2.2-3 Committee Composition and Meeting Schedule

The committee provides a joint conference mechanism between the Medical Staff, nursing service and non-physician practitioners. The committee shall be composed of the Director of Nursing, Administrator or designee, and an equal number of registered nurses and members of the Medical Staff. Non-physician providers may also serve as members of the committee, as appropriate. The chairperson of the committee shall be a member of the Medical Staff appointed by the Chief of Staff. The committee shall meet on the call of the chairperson.

SoHum Health

733 Cedar Street
Garberville, CA
95542
(707) 923-3921

MEDICAL STAFF

APPOINTMENT PROCESS

Supplemental Attachment to the Rules and Regulations

ADOPTED by the Medical Staff on: **July 11, 2024**

APPROVED by the Board of Directors on: **July 25, 2024**

SoHum Health

APPOINTMENT PROCESS
A Supplemental Attachment to the
Southern Humboldt Community Healthcare District
Medical Staff Rules & Regulations

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SoHum Health

APPOINTMENT PROCESS
A Supplemental Attachment to the Southern Humboldt Community Healthcare District Medical Staff Rules & Regulations

ARTICLE 1. GENERAL PROVISIONS

1.1 GENERAL

1.1-1 Unless otherwise stated, for purposes of this article, all references to "applicant" or "member" shall include practitioners who submit applications for initial appointment and reappointment to the Medical Staff or AHP Staff, as well as requests for clinical privileges, temporary privileges, service authorization, and practice prerogatives. This includes Telemedicine Professional applicants whose credentialing and privileging complies with the Medical Staff bylaws.

1.1-2 By applying for appointment or reappointment to the Medical or AHP staffs or for clinical privileges, service authorization, or practice prerogatives, every applicant acknowledges responsibility to review these Bylaws, applicable Rules and Regulations, as well as all policies of the Medical Staff, and agrees, throughout any period of membership, to comply with applicable professional responsibilities as they exist and as they may be modified from time to time.

1.2 APPLICATIONS

1.2-1 All applications for appointment to the Medical or AHP staff shall be in writing with all requested data completed (or an explanation of why data are unavailable). All entries and required attachments to the application must be legible, comprehensive and substantively responsive on each point of inquiry. To orient the applicant to the requirements, duties, rights, and procedures of a member of the Medical or AHP staffs, a copy of the Bylaws will be given to the applicant undergoing initial appointment.

1.2-2 The application forms are peer review and evaluation documents, an official record of the Medical Staff organization and are afforded all protections pursuant to California Evidence Code section 1157. These forms shall require detailed information related to the qualifications, competence and conduct of an applicant, including but not limited to information concerning:

a. specification of the applicant's clinical specialty, requested Staff category and requested clinical privileges;

b. documentation of the applicant's qualifications, as required by Articles 3 and 4 of the Medical Staff Bylaws;

c. Documentation of all past and current employment, all hospital staff affiliations and any other health care entity affiliation;

d. peer references from at least three (3) individuals who hold a license in the same professional field of licensure as the applicant, at least one of whom is from the same specialty; all of whom shall have observed and worked with the applicant within the past five (5) years, and who have personal knowledge of and are willing to provide information related to the applicant's professional competence and conduct, ethical character and any effects of health status on privileges being requested;

e. the name of the applicant's carrier for professional liability insurance, a "certificate of insurance" covering all Clinical Privileges requested, disclosure of any professional liability claim filed or reported to a carrier, a notice/letter of intent to sue, any settlement or final judgment made in any professional liability case within the past seven (7) years;

1.2-3 The applicant must sign the application, including attestation, certification and acknowledgment that everything in the application is true, correct and complete and is furnished in good faith.

1.2-4 An application is not deemed complete until the applicant has complied with all requests for information, interview, and/or evaluation from the Medical Staff. The applicant shall submit all information requested within fifteen (30~~15~~) days of request from the Medical Staff. If the applicant does not timely submit the information requested, the application or credentialing request(s) shall be deemed incomplete and withdrawn from further processing, and the applicant shall be required to submit a new application or credentialing request(s).

1.3 APPLICATION FOR REAPPOINTMENT

1.3-1 Approximately one hundred and twenty (120) days prior to expiration of their current appointment, each member of the Medical Staff or AHP Staff shall submit an application for reappointment, including any request for addition, renewal or modification of clinical privileges. The application for renewal shall be in writing and on a form prescribed by the Medical Staff. It is expected that, at the time of submission, the applicant will include all information requested in the application.

1.3-2 An application for reappointment to the Medical Staff, for additional or renewal of clinical privileges or practice prerogatives shall be based upon all information known related to the professional competence and conduct of the member, including, but not limited to reappraisal of the applicant's adherence to membership requirements as stated in the Bylaws, Rules and Regulations, Medical Staff policies, and Hospital policies applicable to Medical and AHP staff members. Consideration shall also be given to the practitioner's ethics and conduct, attendance at required staff and department meetings and participation in Medical Staff affairs, compliance with the Medical Staff Bylaws, Rules and Regulations, continuing medical education, cardiopulmonary resuscitation training, utilization of the Hospital's facilities for patients, service on Medical Staff or Hospital committees when requested, cooperation with others working in the Hospital, and general attitude towards patients, the Hospital and the public.

1.3-3 Such reappraisal should also include relevant member-specific information, such as clinical and technical skill, OPPE, FPPE (if any) and current proficiency in the

Hospital's general competencies in light of his/her performance at this Hospital and in other settings, performance improvement activities and, where appropriate, comparisons to aggregate information about performance, morbidity and mortality reviews, judgment and clinical or technical skills, reappraisal of the Hospital's patient care needs and ability to provide adequate support services and facilities for the practitioner.

1.3-4 Where applicable, the results of specific peer review activities shall also be considered. Information provided by another peer review body may also be considered.

1.3-5 The applicant is required to provide detailed information concerning any changes in his/her qualifications since the last appointment, and any other information relevant to his/her qualifications, including that which was not disclosed previously.

The failure of a member of the Medical Staff or AHP Staff to provide a completed application at least sixty (60) days prior to the expiration of current appointment, absent good cause, shall be deemed a voluntary resignation at the end of the current Medical Staff or AHP Staff appointment. The CW may, in its sole discretion and based upon good cause, extend the time by which an application must be completed. There is no right to any such waiver, and a member deemed to have voluntarily resigned pursuant to this section is not entitled to any hearing or appeal rights.

1.3-6 A member who has resigned for failure to submit a reappointment application may reapply as an initial applicant, subject to the same requirements for membership and clinical privileges, including provision of all requested information for evaluation of the application and completion of proctoring, unless waived for good cause by the CW

1.4 MISSTATEMENTS AND OMISSIONS

1.4-1 By signing an application for initial appointment or reappointment, an applicant certifies that the information submitted is true, complete, and correct; is furnished in good faith; and acknowledges his/her understanding that any misstatement or omission shall result in immediate cessation of the processing of the application and no further processing shall occur.

1.4-2 Any misstatement in, or omission from, the application is grounds to stop processing the application. The applicant will be informed in writing of the nature of the misstatement or omission and permitted to provide a written response.

1.4-3 If membership or privileges were granted prior to the discovery of a misstatement or omission, such misstatement or omission may be grounds for termination, as permitted by law.

1.4-4 Action taken pursuant to this Article will entitle the applicant or member to the procedural rights of appeal as set forth in the Fair Hearing Process only when required by law.

1.5 APPLICANT'S BURDEN

1.5-1 In order for the Medical Staff to make a proper recommendation to the governing body concerning an application for appointment or reappointment to the Medical or AHP staffs, the Medical Staff must have in its possession adequate information for an evaluation of the applicant, as measured against the unique professional standards of this Hospital. Accordingly, the Medical Staff will not take action on an application which is not complete.

1.5-2 In connection with an application for appointment, reappointment, or any other credentialing request, the applicant shall have the burden of producing adequate information for proper evaluation of the applicant's qualifications and general competencies with respect to both membership and all requested Clinical Privileges, resolving any reasonable doubts about these matters and satisfying all requests for information.

1.5-3 This burden may include submission to a medical (including, but not limited to blood, urine or other biological testing) or psychiatric/psychological examination, at the applicant's expense, if determined to be appropriate by the CW and based on its sole determination as to the terms and conditions of such examination.

1.5-4 The applicant is responsible to assist in the identification and, as necessary in the solicitation of the requisite number of references, written evaluations and affiliation verifications and may include the requirement that the applicant sign an authorization, release or other document.

1.5-5 By applying for appointment, reappointment, advancement or modification of staff category and/or Clinical Privileges, each applicant agrees to appear for interviews as requested by the CW or governing body.

1.5-6 The applicant's failure to sustain the burden of producing adequate information for proper evaluation of their application with respect to both membership and requested privileges, within the deadlines prescribed by the Medical Staff, shall result in the withdrawal of the application or credentialing request(s). The procedural rights of appeal as set forth in the Fair Hearing Process shall not be available, unless required by law.

1.6 CONTINUING DUTY OF COMPLETENESS

The applicant has an ongoing and continuous duty to keep the application current and complete by informing the Medical Staff, in writing, within twenty four (24) hours of the applicant learning of any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication when such correction, change, modification or addition may substantively change any portion of the application, including but not limited to information which may reflect adversely on current qualifications for membership or privileges. This is a continuing duty of membership on the Medical or AHP staffs.

1.7 EFFECT OF APPLICATION

By signing and submitting an application for initial appointment or reappointment to the Medical or AHP staffs, each applicant:

1.7 -1 authorizes the District Medical Staff and its designee(s) to consult with members of

Medical Staffs at other health organizations or knowledgeable persons who may have information bearing on the professional competence and conduct of the applicant, including, but not limited to, skill, knowledge, training, and judgment, character, ethics, ability to work cooperatively with others, physical and mental capabilities to exercise the requested Clinical Privileges;

1.7 -2 authorizes and requests that all contacts made with external sources provide information requested by the District for evaluation purposes. A request for information from external sources includes the request for and the applicant's authorization for the Medical Staff to inspect and copy records and documents pertinent to the Medical Staff's evaluation of the applicant's request for membership and Clinical Privileges;

1.7 -3 consents to the Medical Staff's disclosure to other hospitals, medical staffs, medical groups and other similar organizations any information regarding the applicant's professional competence or conduct, ethical standing and releases the Medical Staff, the Hospital, District and any of their representatives from liability, to the fullest extent permissible by law for any such disclosure;

1.7 -4 releases from any liability, to the fullest extent permitted by law, all individuals and organizations providing information to the District, Hospital or Medical Staff concerning the applicant;

1.7 -5 releases from any liability, to the fullest extent permitted by law, all representatives of the Medical Staff, Hospital, District, and governing body for their acts performed in connection with evaluating the applicant;

1.7 -6 acknowledges that any procedural rights of appeal as set forth in the Medical Staff Bylaws, rules or policies, including, but not limited to the Fair Hearing Process, must be exhausted prior to seeking outside legal remedies.

ARTICLE 2. MEDICAL STAFF APPOINTMENT PROCESS

2.1 VERIFICATION OF INFORMATION

2.1-1 Upon receipt of a completed application, the Medical Staff shall expeditiously seek to collect and verify:

a. the practitioner requesting approval is the same practitioner identified in the credentialing documents by viewing a valid picture ID issued by a state or federal agency (e.g., drivers' license, passport, etc.);
b. licensure or professional certification; DEA certification; furnishing license and therapeutic pharmaceutical agents certification, as applicable, and any special certifications required by requested clinical privileges;
c. Board certification for applicants to the Medical Staff;
d. Professional liability insurance coverage covering all clinical privileges requested, in the amounts determined by the CW; claims history;
e. Relevant training and experience, including but not limited to peer references, work history, affiliations with other health care entities, quality data such as OPPE/FPPE; and
f. Information from the relevant California licensing board, as well as the National Practitioner Data Bank.

2. 1 - 2 Notwithstanding Section 2.1-1, the Medical Staff may rely upon the credentialing and privileging information provided, consistent with the Medical Staff Bylaws, by a Distant Site Entity which is approved by the Board, upon recommendation of the Medical Staff.

2.1 - 3 An applicant shall be notified of any problems encountered in obtaining the required information. The burden of collecting this information shall be an obligation of the applicant.

2.2 TIME LIMITATIONS

2.2-1 All individuals and groups required to act thereon shall consider applications in a timely and good faith manner. While special or unusual circumstances may constitute good cause and warrant exceptions, the application process shall ordinarily be completed within 90 working days after receipt of all necessary documentation.

2.2-2 In the event of a delay in verifying or receiving information and materials that is outside the control of the Medical Staff, the applicant and Chief of Staff shall be notified.

2.2-3 The application shall remain pending until the Administrator or designee has received the material or the expiration of any deadline for further information;

2.2-4 Applications not completed within four months shall automatically be removed from consideration. The CW may, in its sole discretion, grant a single extension of up to two (2) additional months. Unless the applicant has received notice of a pending investigation, withdrawal of an application does not afford hearing or appeal rights pursuant to the Medical Staff Bylaws.

2.2-5 The time periods specified for the expected application processing is a guideline and shall not create any right for the applicant to have an application processed within specified times.

2.2.6 An application greater than one hundred and eighty days old must be re-signed with the practitioner's attestation as to any changes during the interim period or the fact that there have been no changes. In such circumstances, information obtained greater than one hundred and eighty days must also be re-verified.

2.3 CHIEF OF STAFF ACTION

2.3-1 Upon receipt of a completed application from the Administrator, the Chief of Staff shall review and evaluate the application and supporting documentation in consultation with CW members.

2.3-2 The Chief of Staff and CW shall evaluate each applicant for appointment, reappointment, clinical privileges, service authorization, or practice

prerogatives, and make an objective, evidence-based recommendation, based upon assessment of the applicant in relation to the qualifications and standards set by the Medical Staff and approved by the governing body, as further described in the Bylaws.

2.-3-3 Effect of Chief of Staff Action

a. **Interviews, Further Documentation, Deferral**. Action by the Chief of Staff to interview the applicant, seek further documentation, or defer the application for further consideration will be followed up within a reasonable period of time. Based on the findings and in consultation with the CW, a written recommendation will be prepared by the Chief of Staff. The Chief of Staff shall clearly state the recommended action with respect to membership and requested privileges.

b. **Favorable Recommendation**. If the Chief of Staff recommendation is favorable to the applicant, the recommendation shall include the membership category and clinical privileges to be granted, modified or terminated for Medical or AHP staff. The recommendation may indicate whether the application should be for a specified duration. The Administrator or designee shall promptly forward the application and MECs recommendation, together with all supporting documentation, to the governing body for final decision.

c. **Adverse Recommendation**. When the Chief of Staff recommends an adverse action in respect to the applicant's request for appointment, reappointment or privileges, the Chief of Staff shall also assess and determine whether the adverse recommendation is for a "medical disciplinary cause or reason," meaning 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. All other adverse recommendations are deemed administrative. The applicant shall promptly be given written notice of any adverse recommendation. If the adverse recommendation is for a medical disciplinary cause or reason and the applicant is entitled to hearing rights required by law, notice shall be provided as required in the Bylaws. Where the adverse recommendation affords hearing rights, the governing body shall be informed, but no action shall be taken by the governing body until the fair hearing and appeal procedural rights have been exhausted or waived by the applicant.

2.4 EFFECT OF ACTION BY THE GOVERNING BODY

2.4-1 The governing body shall give great weight to the recommendation from the Chief of Staff and CW. Further, the governing body shall not act in an arbitrary or capricious manner and shall keep in mind its legal responsibilities to act to protect the quality of medical care provided, the competency of the Medical Staff and to ensure the responsible governance of the Hospital.

2.4-2 If the governing body tentatively disagrees with the recommendation from Chief of Staff, the governing body shall first remand the matter back to the Chief of Staff and

the CW, with a written statement of the governing body's concerns and may recommend further action, including but not limited to interviews, gathering of information, etc. The governing body will set a reasonable time limit within which the Chief of Staff in consultation with the CW shall make a subsequent recommendation to the governing body.

2.4-3 If the governing body action remains adverse to the applicant and the governing body's action affords a hearing required by law, the governing body shall promptly notify the applicant, of the right to request a hearing in the manner specified in the Medical Staff Bylaws. The governing body shall also inform the Chief of Staff and CW. If the CW declines to fulfill its role in the Fair Hearing, then the governing body shall assume the role of the CW in fulfillment of the procedures, including the appointment of a Judicial Review Committee. In such case, the adverse decision shall not be final until the applicant has exhausted or waived the procedural rights in the Fair Hearing Process specified in Article 9.

2.4-4 For the purpose of this section, an adverse decision shall be considered final upon waiver by the applicant of any deadlines or upon completion of judicial review:

2.4-5 In the event of unwarranted delay on the part of the Chief of Staff, the governing body may act on an individual's appointment status without the Chief of Staff's recommendation, employing the same type of information usually considered by the Chief of Staff and CW. Prior to taking such action, the governing body will notify the Chief of Staff and CW of its intent and the date prior to which the Chief of Staff and CW may still fulfill their responsibility.

2.5 NOTICE OF FINAL DECISION

Notice of the governing body's final decision shall be given, through the Administrator, to the Chief of Staff, and the applicant. A decision and notice to appoint shall include:

a. The Staff category to which the applicant is appointed.
b. The privileges that may be exercised by the applicant.
c. Any special conditions attached to the appointment.

2.6 REAPPLICATION

2.6-1 Conditions for Reapplication

An applicant or member who has received a final adverse decision, under circumstances listed below, may not reapply for Medical Staff membership and/or clinical privileges for five years from the date of the final adverse decision or the date the application or request was withdrawn. Conditions subject to the five-year requirement are as follows:

a. Denial or rejection of an application for membership or clinical privileges, for a medical disciplinary cause or reason;
b. Withdraws or abandons an application for membership or request for clinical privileges after receiving notice of a pending investigation, or after receiving notice that the application for membership or clinical privileges is denied or will be denied, for a medical disciplinary cause or reason;

c. Termination or revocation of Medical Staff membership for a medical disciplinary cause or reason;
d. Resignation or taking a leave of absence from membership or staff privileges after receiving notice of a pending investigation, or after receiving notice that the application for membership or clinical privileges is denied or will be denied, for a medical disciplinary cause or reason;

2.6-2 Date of Reapplication
The date for reapplication is governed by the date of application withdrawal, date of final adverse decision, or resignation date, whichever is applicable.

2.6-3 Consideration of Reapplication
After the five-year period, the practitioner may submit an application for Medical or AHP staff membership and/or Clinical Privileges. The application shall be processed as an initial application. Such an applicant shall also be required to furnish evidence that the basis for the earlier adverse recommendation or action no longer exists. Satisfactory evidence shall be presented to the Chief of Staff that indicates that the specific cause(s) related to an adverse decision has been satisfactorily addressed. In the absence of satisfactory evidence, the application shall be determined to be incomplete, withdrawn from consideration and no action will be taken.

2.6-4 Waiver of Waiting Period
The governing body, in consultation with the Chief of Staff, may waive the five-year waiting period when the applicant can present compelling evidence that the cause(s) of an adverse recommendation or decision has been remedied.

ARTICLE 3 LEAVES OF ABSENCE

3.1 LEAVE STATUS
At the discretion of the Chief of Staff, a Medical Staff member may obtain a voluntary leave of absence from the Medical Staff. The request for voluntary leave must be submitted in writing to the Chief of Staff. The request will state the reason for the leave and the approximate length of time. The governing body will be advised of the member's leave status. Voluntary leaves which may not exceed two (2) years or the term of staff appointment, whichever comes first. During the leave period, the member shall not exercise clinical privileges in District facilities. Membership rights and responsibilities shall be inactive.

3.2 TERMINATION OF LEAVE OF ABSENCE
At least thirty (30) days prior to returning from leave, the member may request reinstatement by submitting a written request to the Chief of Staff. The request shall include the desired date of return and a summary of relevant activities during leave. The member must establish, to the reasonable satisfaction of the Chief of Staff that the member is able to perform, with or without reasonable accommodations, the clinical activities delineated on their privileges, according to accepted standards of professional performance and without posing a direct threat to patients. The staff member may be subject to monitoring and/or proctoring as determined by the Credentials Committee/Medical Executive Committee upon the recommendation of the member's

Department. Based on the member's activity during the leave period, the Chief of Staff will determine the status of the member's privileges and prerogatives. The Chief of Staff determination will be guided by the reappointment procedures addressed in these Bylaws.

3.3 FAILURE TO REQUEST REINSTATEMENT

A member's failure to request reinstatement, without good cause, shall be deemed a voluntary resignation from the Medical Staff and shall result in automatic termination of membership, privileges, and prerogatives. A member whose membership is automatically terminated shall not be entitled to procedural hearing rights specified in law or the Bylaws. A subsequent request for Medical Staff membership that is received from a member so terminated shall be submitted and processed in the manner specified for applications for initial appointments.

3.4 MILITARY LEAVE

The Chief of Staff upon written notice shall grant a member's request for leave to fulfill a military obligation from the member. The Chief of Staff shall grant reactivation of the membership and privileges previously held by the member. However, the reactivation of the privileges may by subject to monitoring as determined by the Chief of Staff.

SoHum Health

733 Cedar Street
Garberville, CA
95542
(707) 923-3921

MEDICAL STAFF

CLINICAL PRIVILEGE

DELINIATION PROCESS

Supplemental Attachment to Rules and Regulations

ADOPTED by the Medical Staff on: **May 9, 2024**

APPROVED by the Board of Directors on: **June 6, 2024**

SoHum Health

CLINICAL PRIVILEGE DELINEATION PROCESS
A Supplemental Attachment to the
Southern Humboldt Community Healthcare District
Medical Staff Rules & Regulations

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SoHum Health

CLINICAL PRIVILEGE DELINEATION PROCESS
A Supplemental Attachment to the Southern Humboldt Community Healthcare District Medical Staff Rules & Regulations

ARTICLE 1 CLINICAL PRIVILEGES

1.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these Bylaws or Rules, every practitioner including physicians and non- physician providers of the Medical or AHP staffs, shall only be entitled to render care, treatment and services in District facilities consistent with those privileges specifically granted to the practitioner.

1.2 DELINEATION OF PRIVILEGES IN GENERAL

1.2-1 Requests
Each application for appointment and reappointment to the Medical Staff or AHP Staff must contain a request for the privileges desired by the applicant. A request for privileges or modification of privileges must be supported by documentation of training and/or experience supportive of the request.

1.2-2 Basis for Privileges Determination
Requests for Privileges shall be evaluated on the basis of the practitioner's education, training, experience, demonstrated professional competence and judgment. The evaluation will also include the documented results of patient care and other quality improvement review and monitoring activities. Privilege determinations shall also be based on pertinent information concerning clinical performance obtained from other sources, especially other health care settings where the practitioner exercises privileges.

1.3 DELINEATION OF LIMITED LICENSED PRACTITIONERS' PRIVILEGES

1.3-1 Admissions
i. Dentists, podiatrists and clinical psychologists that are members of the Medical Staff may only admit and treat patients by co-admitting each patient with a physician member of the Medical Staff. The physician must have admitting privileges and assume responsibility for the care of the patient's medical condition. The physician member must conduct or directly supervise the admitting history and physical examination (except the portion related to dentistry or podiatry).

ii. Members of the AHP Staff may only care for patients if admitted by a physician. The physician must have admitting privileges and assume responsibility for the care of the patient's medical condition. Members of the

AHP Staff may conduct the admitting history and physical examination only if granted Clinical Privileges to do so.

1.3-2 Medical Appraisal

i. All patients admitted by a dentist or podiatrist for care shall receive the same basic medical appraisal as patients admitted for medical services. A physician member shall determine the risk and effect of any proposed treatment on the general health status of the patient. Dispute between a physician member and a limited licensed practitioner regarding a proposed treatment shall be resolved by seeking appropriate consultation.

ii. A member of the Medical Staff shall oversee the care and treatment provided by a member of the AHP Staff. An AHP shall practice only within the scope of their education, training, competence and within the specific Clinical Privileges recommended by the CW and granted by the governing body.

1.4 TEMPORARY PRIVILEGES

1.4-1 Care of Specific Patients

Temporary clinical privileges may be granted to a practitioner for the care of a specific patient when justified by the needs of the patient and the special qualifications of the practitioner.

1.4-2 Locum Tenens

Temporary clinical privileges may be granted to a practitioner who serves as a locum tenens for a current member of the Medical Staff. A review of the practitioner's credentials will be conducted as indicated below. Locum tenens status shall not exceed six months unless approved by the governing body.

1.4-3 Pending Applications

Temporary clinical privileges may be granted to a practitioner who has completed an application to join either the Medical Staff or AHP Staff. A review of the practitioner's credentials will be conducted as indicated below. A determination to grant temporary privileges shall not be binding or conclusive with respect to an applicant's request for appointment to the Medical Staff. Further, no practitioner has any right to temporary privileges and no hearing or appeal rights are created if temporary clinical privileges are denied.

1.4-4 Process for Granting Temporary Privileges

Request for temporary privileges shall be accompanied by a completed application and supporting documentation. The applicant must be authorized to practice in California. The governing body or its designee may grant temporary privileges to an applicant after receiving favorable information on the following sources:

a. The National Practitioner Data Bank will be queried regarding the applicant's request for temporary privileges.
b. The Chief of Staff will interview the applicant and contact at least one person who has worked with the applicant. The individual contacted should be able to reliably comment on the applicant's current

competence, ethical character, and ability to work with others.

c. Proof of current professional liability insurance.

~~c.~~d. Primary source verification of current licensure in the State,

~~d.~~e. NPBD query results and~~;~~

~~e.~~f. For practitioners who prescribe medication, a current Drug Enforcement Administration (DEA) number.

1.4-5 Granting Temporary Privileges

After the Chief of Staff has collected and evaluated all relevant information regarding the applicant, a recommendation shall be prepared for the governing body's approval. Or, on the recommendation of the Chief of Staff, the Administrator may grant temporary privileges if authorized by the governing body. Temporary privileges will be limited to a total of 120 days in a calendar year.

1.5 EMERGENCY PRIVILEGES

"Emergency" is defined as a condition in which a patient is in imminent danger of serious permanent harm or death and any delay in administering treatment would add to that danger. In the case of an emergency, any practitioner, to the degree permitted by law, and regardless of status of membership on the Medical Staff, AHP Staff or the Clinical Privileges, held shall be permitted to do everything possible to protect a patient from such danger. District personnel shall assist the practitioner, who is treating the patient. When an emergency situation no longer exists, the Chief of Staff shall assign the patient to an appropriate member of the staff if the practitioner treating an emergent condition does not have appropriate privileges for ongoing treatment. Alternatively, the practitioner may, if qualified, request the privileges necessary to continue to treat the patient.

1.6 DISASTER PRIVILEGES

1.6-1 "Disaster" is defined as any officially declared emergency, whether it is local, state, or national. The Chief of Staff, or designee, may grant disaster privileges. In the absence of the Chief of Staff or designee, the Administrator may grant disaster privileges. The granting of disaster privileges shall be on a case-by-case basis at the sole discretion of the individual authorized to grant disaster privileges.

1.6-2 Any practitioner who volunteers to assist the District shall be asked to present a current license to practice, photo identification, and the name and telephone numbers of health care organization at which the practitioner practices.

1.6-3 The Chief of Staff or designee, or the Administrator or designee, shall attempt to contact the facility where the practitioner has recently practiced to verify that the practitioner is in good standing. The Administrator or designee shall also attempt to verify that the practitioner holds a presently valid license to practice. To the extent that such contacts cannot be made in a timely manner given the circumstances, the Administrator or designee may still issue disaster privileges. However, the Medical Staff addresses the verification process as a high priority. As soon as the immediate disaster situation is under control, verification efforts shall resume in the same manner as established for the granting of temporary privileges.

1.6-4 Current professional licensure of those providing care under disaster privileges is verified from the primary source within seventy-two (72) hours, unless extraordinary circumstances prohibit verification, in which case the following is documented:
(i) The reasons verification could not be performed within 72-hours,
(ii) Evidence of demonstrated ability to continue to provide adequate care, treatment,

and services,
(iii) An attempt to rectify the situation as soon as possible.

1.6-5 An initial granting of disaster privileges is reviewed by a person authorized to grant disaster privileges within seventy-two (72) hours to determine whether the disaster privileges should be continued.

1.6-6 Disaster privileges shall be exercised consistent with the District's disaster plan and under the supervision of a Medical Staff member or a District employee. The volunteer practitioner must wear the temporary identification badge established through the identification processes for volunteers during the disaster.

1.6-7 The Chief of Staff or designee(s), to the extent possible will pair the volunteer practitioner granted disaster privileges with another current staff practitioner. This information will be recorded in the emergency credentialing process. The paired practitioner will make every reasonable effort to oversee the professional performance of volunteer practitioner either through direct observation, mentoring, or review of the clinical record. Additionally, the volunteer practitioner will make every reasonable effort to communicate emergency care provided to their paired practitioner or to the Chief of Staff or their designee(s);

1.6-7 The volunteer practitioner's disaster privileges may be terminated at any time without reason or cause, by the Administrator, designee, or the Chief of Staff and shall be terminated when the disaster and/or emergency management plan has been cleared. Denial, restriction or termination of disaster privileges shall not entitle volunteer practitioner to any procedural rights.

ARTICLE 2 PROCTORING

2.1 GENERAL PROCTORING REQUIREMENTS

2.1-1 Proctoring Requirements

i. Except as otherwise recommended by the CW and approved by the governing body, all initial appointees to the Medical Staff and AHP Staff, as well as any members granted new privileges shall be subject to a period of proctoring.

ii. Proctoring may also be imposed when a question arises regarding a practitioner's competency in performing a specific privilege at the hospital The proctoree is responsible for knowing how many cases are to be proctored and in what manner (e.g., concurrent or retrospective). Proctoring is not viewed as a disciplinary measure. It is an information gathering measure. Therefore, it should be imposed only for such period as is reasonably necessary to complete the assessment of the Medical Staff member.

2.1-2 Time Limits

i. Initial Proctoring: The term of initial proctoring shall extend for a minimum

period of six months [1]and for a minimum of ten cases, whichever takes longer. The period of proctoring may be extended for a total proctoring period of not more than 24 months.

ii. FPPE: Requirements for any proctoring outside the initial granting of Clinical Privileges shall be developed by the CW and completed within a reasonable period of time.

2.1-3 Appeals
Proctoring does not ordinarily give rise to the procedural rights described in these Bylaws and rules, and the practitioner shall not be afforded the procedural rights provided in these Bylaws unless required by law.

2.1-4 Monitoring Mechanisms
Proctoring may include direct observation of the practitioner's performance and chart review. Practitioners providing locum tenens coverage are not required to obtain concurrent proctoring if the applicant currently holds active staff privileges of a like nature without monitoring at another facility. Retrospective monitoring will be done through the usual quality assessment process.

During the proctoring period, practitioners must demonstrate they are qualified to exercise the privileges that were granted and they are carrying out the duties of their Medical Staff category.

2.2 COMPLETION OF PROCTORING

Proctoring shall be deemed successfully completed when the practitioner completes the required number of proctored cases within the timeframe established in these Bylaws. The practitioner's professional performance must meet the standard of care of the District for the proctored cases.

2.3 EFFECT OF FAILURE TO COMPLETE PROCTORING

Any practitioner who fails to complete the required number of proctored cases within the timeframe established in the Bylaws and rules shall be deemed to have voluntarily withdrawn his or her request for membership (or the relevant privileges). However, the CW has the discretion to extend the time for completion of proctoring in appropriate cases. Neither a voluntary withdrawal pursuant to this section, or a refusal to grant an extension shall give rise to procedural rights described in these Bylaws , unless required by law.

If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring, the practitioner’s membership and/or Clinical Privileges may be suspended, restricted or terminated, as determined to be appropriate. The practitioner shall be afforded the procedural rights as provided in these Bylaws, if required by law.

The failure to complete proctoring for any specific privilege shall not, by itself, preclude

advancement from provisional staff. If advancement is approved prior to completion of proctoring, the proctoring will continue for the specific privileges. The specific privileges may be voluntarily relinquished or terminated if proctoring is not completed thereafter within a reasonable time. In such instance, a practitioner is entitled to the fair hearing procedural rights only if required by law.