



San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

MEDICAL STAFF BYLAWS & RULES AND REGULATIONS

REVISED ~~JUNE 9~~ JANUARY XX, 2024-2023



San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

MEDICAL STAFF BYLAWS

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President, San Francisco Health Commission



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BYLAWS OF THE MEDICAL STAFF OF LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

PREAMBLE

WHEREAS, Laguna Honda Hospital and Rehabilitation Center is a public hospital organized under the laws of the State of California and the Charter of the City and County of San Francisco; and

WHEREAS, it is recognized that the Medical Staff is responsible for the quality of medical care in the Hospital and must accept and discharge this responsibility, subject to the ultimate authority of the Hospital Governing Body, and that the cooperative efforts of the Medical Staff, the ~~Executive Administrator~~Nursing Home Administrator, and the Governing Body are necessary to fulfill the Hospital's obligations to its Residents;

THEREFORE, the physicians, dentists, clinical psychologists, and podiatrists practicing in this Hospital hereby organize themselves into a Medical Staff in conformity with these Bylaws.

These Bylaws ~~and Rules and Regulations~~ provide the Medical Staff of Laguna Honda with a framework for self-governance to permit the Medical Staff to discharge its responsibilities in matters involving the quality of medical care and the orderly resolution of those purposes. These Bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Governing Body, and relations with applicants to and members of the Medical Staff.

DEFINITIONS

Acting:

~~The terms "Chief of Staff", "Chief Medical Officer", "Executive AdministratorNursing Home Administrator", "Clinical Service Chief", and "Director of Health" shall include any persons designated to act on their behalf in their absence.~~

Affiliated Professional or Affiliated Health Practitioner

Individuals who are credentialed through the Medical Staff, are subject to general Medical Staff oversight, and belong to a professional category not eligible for Medical Staff Membership. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws, and they may not vote on amendments to the Bylaws or Rules and Regulations.

Annual Medical Staff Meeting:

The June Medical Staff Meeting; this is the meeting at which officers are elected for the ensuing period.

Applicant:

Physician, dentist, podiatrist, or clinical psychologist who is applying for Medical Staff membership. To the extent applicable based on the context listed in these Bylaws, this term also applies in relation to individuals who are applying to be an Affiliated Professional.

Assistant Medical Director:

A licensed physician who is appointed by the Chief Medical Officer to assist in administrative matters involving Practitioners and to act on behalf of the Chief Medical Officer in his or her absence.

Chief Medical Officer:

A licensed physician who is appointed by the Hospital ~~Executive AdministratorNursing Home Administrator~~. The Chief Medical Officer is responsible for administrative matters relating to Practitioners at the Hospital, including employment matters, assignments, and other duties as set forth in these Bylaws. In addition, per regulation, within a licensed Skilled Nursing Facility the Chief Medical Officer has responsibilities for the overall quality of care and clinical practice. The Chief Medical Officer is the Medical Director of Laguna Honda Hospital.

Chief of Staff:

The physician elected by the LHH Medical Staff as its Chief Officer. The Chief of Staff ~~shall~~will be responsible for overseeing the organization and activities of the

Medical Staff, the performance improvement process, the credentialing and peer review activities, and other duties as set forth in these Bylaws.

Clinical Service:

The Medical Staff ~~shall~~will have four Clinical Services: Medicine, Physical Medicine and Rehabilitation, Psychiatry, and Outpatient Clinics.

Clinical Service Chief:

The Medical Staff member who is appointed by the Chief Medical Officer, with the concurrence of the Medical Executive Committee, to be responsible for the day-to-day business of a Clinical Service.

Clinical Privileges ("Privileges"):

The permission granted by the Governing Body to Medical Staff members to provide Patient/Resident care and to render specific diagnostic, therapeutic, medical, psychiatric/behavioral health, dental, podiatric or surgical services.

Day:

Unless otherwise stated herein, all references to days ~~shall~~will mean a calendar day.

Department of Public Health (DPH):

Refers to the San Francisco Department of Public Health.

Director of Health:

The individual who is the Director of the San Francisco Department of Public Health.

Director of SF Health Network:

The individual who is the director of San Francisco Health Network.

~~Executive Administrator of Laguna Honda ("Executive AdministratorNursing Home Administrator / Chief Executive Officer"):~~

The individual appointed by the Director of Health to manage the Hospital and to support its ~~issues~~ mission and goals. The ~~Chief Executive OfficerNursing Home Administrator~~ of Laguna Honda Hospital is also the Chief Executive AdministratorOfficer.

Governing Body:

Refers to the San Francisco Health Commission, subject to the responsibilities designated to the Director of Health by the Charter, including Section 4.126, and the San Francisco Municipal Code, including Section 2A.30.

Hospital/LHH:

Refers to Laguna Honda Hospital and Rehabilitation Center.

Investigation:

A formal process specifically initiated by the Medical Executive Committee to determine the validity, if any, of a concern or complaint raised against a member of the Medical Staff. The investigation does not include the usual activities of the Physician Well-being Committee.

Joint Conference Committee for Quality Assurance (JCC):

The Joint Conference Committee is the subcommittee of the San Francisco Health Commission where members of the governing body, hospital administration, and medical leadership review and discuss the hospital's credentialing, quality assurance, and performance improvement program.

Licensed:

Refers to a physician, dentist, clinical psychologist or podiatrist licensed to practice medicine, dentistry, clinical psychology or podiatry respectively in the State of California or qualified under California law to practice with an out-of-state license.

Limited License Practitioner:

A health care professional, other than a physician, who holds a license or other legal credential, as required by California law, to provide health care services.

Medical Executive Committee or "MEC":

The Executive Committee of the Medical Staff ~~which constitutes the governing body of the Medical Staff as described in these Bylaws.~~

Medical Staff:

~~All~~ The organizational component of the Hospital that includes all physicians (M.D. or D.O.), dentists (D.D.S. or D.M.D.), clinical psychologists (Ph.D. or Psy.D.), and podiatrists (D.P.M.) licensed to practice in the State of California who are privileged to attend Patients/Residents in the Hospital and have been granted status as members of the Medical Staff pursuant to the terms of these Bylaws.

Medical Staff Year:

The period from July 1 to June 30.

Member:

Any Practitioner whose application has been approved by the Medical Executive Committee and the Governing Body for membership on the Medical Staff~~An individual on the Medical Staff.~~

Patient/Resident:

A person who receives medical care at Laguna Honda.

Physician:

An individual with a M.D. or D.O. degree licensed by the Medical Board of California (MBC) or the Osteopathic Medical Board of California (OMBC).

Practitioner:

A physician (M.D. or D.O.), dentist (D.D.S. or D.M.D.), clinical psychologist (Ph.D. or Psy.D.), or podiatrist (D.P.M.) licensed to practice in the State of California.

San Francisco Health Network:

The integrated health care delivery system of the San Francisco Department of Public Health.

Special Notice:

Notice sent by personal delivery or certified mail, return receipt requested.

ARTICLE I: NAME AND PURPOSES

1.1 Name

The name of this organization ~~shall be~~ is the Medical Staff of Laguna Honda Hospital and Rehabilitation Center.

1.2 Purposes and Responsibilities of the Medical Staff

Purposes

- a. To promote the mission of the Hospital;
- b. To assure that all Residents admitted to the Hospital receive the same level of care consistent with community standards;
- c. To assure a high level of professional performance of all Practitioners authorized to practice in the Hospital through the appropriate delineation of the clinical privileges that each Practitioner may exercise in the Hospital and through review and evaluation of each Practitioner's performance in the Hospital;
- d. To organize and promote continuing medical education of the Medical Staff and education of undergraduate, graduate, and post graduate trainees in the health sciences, to ensure maintenance of scientific standards, and to encourage advancement in professional knowledge and skill;
- e. To develop and maintain Bylaws for self-governance of the Medical Staff;
- f. To provide a means whereby issues of mutual concern to the Medical Staff and to the administration of the Hospital may be discussed by the Medical Staff with the ~~Executive Administrator~~Nursing Home Administrator and the Governing Body; and
- g. To incorporate the principles of continuous quality improvement in the provision of clinical care.
- h. To provide for accountability of the Medical Staff to the Governing Body;
- i. To exercise the rights and responsibilities in a manner that does not jeopardize the hospital's license, Medicare and Medi-Cal provider status, or accreditation.

Responsibilities

- a. To provide patients with the quality of care meeting the professional standards of the Medical Staff of the Hospital.
- b. To provide medical care without regard to an individual's race, ethnicity, national origin, citizenship, religion, age, gender, sexual orientation, gender identity, preexisting medical condition, physical or mental disability, insurance or economic status, or ability to pay for medical services;
- c. To establish and enforce, subject to the Governing Body approval, professional standards related to the delivery of health care within the Hospital;
- d. To establish, amend as needed, and abide by Medical Staff Bylaws, rules and policies for the effective performance of Medical Staff responsibilities, as further described in these Bylaws;
- e. To discharge in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of Medical Staff membership, including committee assignments;
- f. To work cooperatively with other Medical Staff members, members of other disciplines, and Hospital administration to provide a uniform high standard of quality patient care;
- g. To complete medical records in compliance with regulatory standards;
- h. To be available for service in the event of a disaster;
- i. To select and remove Medical Staff officers;
- j. To keep confidential, as required by law, all information or records received in the patient-practitioner relationship;
- k. To initiate and pursue corrective action with respect to members when warranted;
- l. To provide information to and/or testifying on behalf of the Medical Staff or a practitioner under investigation regarding any matter under an investigation pursuant to Article VI Section 1 and those which are the subject of a hearing pursuant to Article VII.

- m. To account to the Governing Body for the quality of patient care provided by all members authorized to practice in the Hospital through the following measures:
 - 1. Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;
 - 2. An organizational structure that provides a mechanism of appointment, reappointment, and the matching of clinical privileges or specified services to be performed with the verified credentials and current demonstrated performance of the Medical Staff applicant or member;
 - 3. A continuing education program based on recommendations by the medical executive committee or quality improvement initiatives.
 - 4. A utilization review program to provide for the appropriate use of all medical services.
- n. To recommend to the Governing Body action with respect to appointments, reappointments, staff category, clinical privileges, and corrective action;
- o. To account to the Governing Body for the quality of patient care through regular reports and recommendations concerning the implementation, operation, and results of the quality review and evaluation activities;
- p. To provide a framework for cooperation with other community facilities and/or educational institutions or efforts.

ARTICLE II: MEDICAL STAFF

Section 1. Medical Staff Membership

Membership to the Medical Staff is a privilege that ~~shall~~will be extended only to Practitioners who continuously meet the qualifications, standards, and requirements set forth in these Bylaws.

Section 2. Nature of Membership

No Practitioner, including those in a medical administrative position, ~~shall~~will provide medical or health-related services to Patients/Residents in the Hospital unless the Practitioner is a member of the Medical Staff or has been granted temporary privileges in accordance with the procedures set forth in these Bylaws. Medical Staff membership ~~shall~~will confer only such clinical privileges and prerogatives as have been granted in accordance with these Bylaws.

Section 3. Basic Qualifications for Membership

- A. License.** Practitioners applying for membership must have a valid license to practice in the State of California or otherwise qualified under California State law to practice with an out of state license. Only physicians, dentists, podiatrists and clinical psychologists ~~shall~~will be deemed to possess basic qualifications for membership.
- 1. Physicians:** An applicant for physician membership on the Medical Staff must hold an M.D. or D.O. degree or the equivalent and a current and unrestricted license to practice medicine issued by the Medical Board of California or the Osteopathic Medical Board of California. For the purpose of this section, “or the equivalent” ~~shall~~will mean any degree (e.g., foreign) recognized by the Medical Board of California or the Osteopathic Medical Board of California.
 - 2. Dentists:** An applicant for dental membership on the Medical Staff must hold a DDS/DMD or equivalent degree and a current and unrestricted license to practice dentistry issued by the Dental Board of California.
 - 3. Podiatrists:** An applicant for podiatric membership on the Medical Staff must hold a D.P.M. degree and a current and unrestricted license to practice podiatry issued by the California Board of Podiatric Medicine.
 - 4. Clinical Psychologists:** An applicant for clinical psychologist membership on the Medical Staff must hold a doctorate degree in psychology from an American Psychological Association accredited

program and a current unrestricted license to practice clinical psychology issued by the California Board of Psychology.

- B. Board Certification.** Practitioners applying for membership must be certified by or currently eligible to take the board certification examination of a board recognized by the American Board of Medical Specialties, the American Board of Podiatric Surgery, the American Osteopathic Association, the American Board of Oral and Maxillofacial Surgery, the American Board of Professional Psychology, or a board or association with equivalent requirements approved by the Medical Board of California in the specialty that the Practitioner will practice at the Hospital. The Clinical Service Chief may recommend to the Medical Executive Committee and to the Governing Body that the requirements set forth in this section be waived for an individual who has demonstrated comparable qualifications.
- C. Professional Liability Insurance.** Individuals who are not employed by the City and County of San Francisco, ~~shall~~must maintain professional liability insurance in an amount not less than \$2 million each occurrence, \$6 million aggregate and if applicable, with an insurance carrier acceptable to the ~~Chief Executive Officer~~Nursing Home Administrator. Each such member ~~shall~~will upon acceptance to the Medical Staff and thereafter at any time requested by the Credentials Committee, provide the Credentials Committee with written evidence of conforming coverage. Each such member ~~shall~~will promptly report to the Credentials Committee any reduction, restriction, cancellation or termination of the required insurance coverage or, if applicable, change insurance carrier.
- D. Training, Character, Competence, and Judgment.** A Practitioner will qualify for Medical Staff membership only if the practitioner has demonstrated (1) adequate experience, education, and training, (2) current professional competence, (3) good judgment, (4) a determination to adhere to the ethics of his or her respective profession, and (5) an ability to work cooperatively with others so as not to adversely affect patient care.
- E. Drug Enforcement Agency (DEA)** If practicing clinical medicine, dentistry or podiatry in an area in which the practitioner provides medication or supervises others who prescribe or furnish medication, the practitioner must have a valid Federal DEA number.
- F. ACLS Certification.** All Internal Medicine and Family Medicine physicians of the active Medical Staff and as-needed night/weekend physicians must be ACLS certified. An online ACLS course satisfies the requirement.
- G. Employment or contract required.** A Practitioner will qualify for or maintain Medical Staff membership only if the practitioner is either employed by or under contract with the city to provide care at the Hospital. Employment or contract relationships are entirely at the discretion of the city, by and through

the Hospital, based upon its evaluation of its own needs and resources. Temporary and courtesy clinical privileges may be granted to qualified practitioners who are not employed or under contract when special circumstances exist.

- H. **No entitlement to membership.** No Practitioner ~~shall~~will be entitled to membership on the Medical Staff or to the exercise of clinical privileges in the Hospital merely by virtue of the fact that said practitioner is duly licensed to practice in California or in any other state, or that the practitioner is or has been a member of any professional organization, is certified by any clinical board, or that the practitioner has or has held such a position or privileges at another hospital.
- I. **Failure to meet basic qualifications.** A practitioner who does not meet these basic qualifications is ineligible to apply for Medical Staff membership, and the application ~~shall~~will not be accepted for review. If it is determined during processing that an applicant does not meet all of the above basic qualifications, the review of the application ~~shall~~will be discontinued. An applicant who does not meet the basic qualifications is not entitled to procedural rights set forth in these Bylaws but may submit comments and a request for reconsideration of the specific qualifications which adversely affected such practitioner.

Section 4. Conditions of Appointment

- A. **Governing Body action.** Initial appointments and re-appointments to the Medical Staff are made by the Governing Body upon recommendation of the Medical Executive Committee as provided in these Bylaws. The Governing Body acts on appointments, reappointments, and revocation of appointments only after there has been a recommendation from the Medical Staff through its Medical Executive Committee as provided in these Bylaws.
- B. **Clinical privileges.** Appointments to the Medical Staff ~~shall~~will confer on the appointee only those clinical privileges that have been granted by the Governing Body in accordance with these Bylaws.
- C. **Applicant agreement.** Every application for Medical Staff appointment ~~shall~~must be signed by the applicant and ~~shall~~must contain the applicant's specific acknowledgment to abide by the Medical Staff Bylaws, Rules and Regulations, all Policies and Procedures and to conduct himself or herself in the highest ethical tradition and in a manner consistent with the Code of Ethics of the American Medical Association, the American Osteopathic Association, the American Psychiatric Association, the American Dental Association, the American Psychological Association, or the American Podiatric Medical Association as applicable to the license of the applicant.

Section 5. Harassment

Harassment by a ~~Medical Staff m~~Member against any individual (i.e., against another Medical Staff member, Hospital employee, visitor, family member or Resident) on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender identity or sexual orientation, or any other prohibited basis shallwill not be tolerated. Refer to LH Hospital Policy and Procedure 80-10: Prohibition of Harassment and Bullying. All allegations of harassment will be investigated according to policies adopted by the City and County of San Francisco.

Section 6. Nondiscrimination

No aspect of Medical Staff membership or particular clinical privileges shallwill be denied on the basis of race, religion, color, national origin, ancestry, age, disability, marital status, sex, gender identity or sexual orientation, or other protected category. The credentialing and recredentialing processes will be conducted in a non-discriminatory manner and Members responsible for credentialing decisions will be required to sign an affirmative statement that they will make decisions in a non-discriminatory manner. Additionally, the Medical Staff must not discriminate with respect to staff privileges or the provision of professional services against a licensed physician and surgeon or podiatrist on the basis of whether the physician and surgeon or podiatrist holds an M.D., D.O., or D.P.M.

Section 7. Leave of Absence

A. Initiation and duration.

A member of the Medical Staff may request a leave of absence from the Medical Staff for up to 360 days. Such request must be in writing through the Clinical Service Chief and state the approximate period of leave desired. Both the Medical Executive Committee and the Chief Medical Officer must jointly act to approve, deny or take other affirmative action on the request. The clinical privileges, prerogatives, and responsibilities shallwill be suspended for members on leave of absence.

B. Extension; failure to return to work.

A leave of absence may be extended for an additional 360 days on receipt of a written request from the Medical Staff member thirty (30) days prior to expiration of the initial leave by the process set forth in section 7.A. above. If no request is received within thirty (30) days after the expiration of the initial leave, and the member does not return to work at the end of the scheduled leave, the Medical Staff member shallwill be deemed to have voluntarily resigned his or her membership and privileges. Such resignation shallwill not entitle the Medical Staff member to the procedural rights under the Corrective Action/Fair Hearing Rules.

C. Request for reinstatement; proctoring; hearing rights.

For any leave of absence, a request for reinstatement must be submitted through the Clinical Service Chief to the Medical Executive Committee before the member may return to active status. If the leave of absence is longer than 90 calendar days, the request for reinstatement must be submitted no less than thirty (30) days prior to expiration of the leave. Requests for reinstatement ~~shall~~must include information regarding the Practitioner's professional activities during the leave of absence and ~~shall~~must be processed in a manner parallel to reappointment. At the sole discretion of the Medical Executive Committee, the returning Practitioner may be required to undergo a specified period of proctoring under specified terms and conditions. If such proctoring requirement is based on a medical disciplinary cause or reason as defined under California Business and Professions Code section 805, or any other reason which triggers a reporting obligation on the part of the Medical Executive Committee to the National Practitioner Data Bank, the Medical Board of California, or the Osteopathic State Medical Board, the Practitioner ~~shall~~will be entitled to hearing rights set forth in Article VII of these Bylaws.

D. Civil service and personnel rules apply.

Leaves of absence for all employed Medical Staff members ~~shall~~will be subject to all applicable hospital, city, state and federal policies, rules, regulations and laws.

ARTICLE III: CATEGORIES OF THE MEDICAL STAFF

Section 1. The Medical Staff

A. **Medical Staff.** Any ~~individual Practitioner~~ granted clinical privileges at the Hospital who is licensed as a physician, dentist, clinical psychologist, or podiatrist. All medical staff members ~~shall~~will exercise only those ~~Celinal Pelinical~~ privileges granted by the Governing Body.

1. **Categories.** The categories of the Medical Staff ~~shall~~will include the following: Active, As-Needed, External Consultant, Temporary, Courtesy, and Telemedicine. At appointment and each time of reappointment the member's staff category ~~shall~~will be determined.

2. Only Active and As-Needed ~~shall~~will have the right to vote on any committee of the Medical Staff on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue ~~shall~~will be determined by the chair of the meeting, subject to final decision by the Medical Executive Committee.

B. Medical Staff Categories Defined

1. Active Medical Staff

Active Medical Staff ~~shall~~ consist of physicians, dentists, podiatrists and clinical psychologists who meet the general qualifications for membership set forth in Article 2, who are employees of the Hospital, and/or who are under contract with the Hospital; who regularly treat and care for Residents in the Hospital; and who assume all the functions and responsibilities of membership on the Active Medical Staff. Members of the Active Medical Staff ~~shall~~will be eligible to hold office on the Medical Staff, except as prohibited in these Bylaws. Active Medical Staff members may exercise only those clinical privileges that they have been granted by the Governing Body. All members of the Active Medical Staff ~~shall~~will be required to attend Medical Staff meetings, to accept Committee and consultation assignments and to participate in continuous quality improvement activities. A physician member of the Active Medical Staff ~~shall~~will be assigned to each resident of the Hospital and ~~shall~~will be responsible for that resident's medical care. Active Medical Staff members ~~shall~~will be eligible to vote.

2. As-Needed Medical Staff

The As-Needed Medical Staff ~~shall~~ consist of physicians employed at the Hospital by the City and County of San Francisco to provide medical care during periods when other staff may not be available. They will be under the supervision of the Chief of Service, Chief of Staff, and Chief

Medical Officer. They may, but ~~shall~~will not be required to, attend Medical Staff meetings and may serve ~~as members~~ on Medical Staff Committees. As-Needed staff members may admit Residents and exercise clinical privileges that they have been granted. As-Needed staff must satisfactorily complete credentialing and proctoring as determined by the MEC. ~~They are not eligible to hold office or vote, except as set forth in Article III, Section 1, A.2 above.~~

3. External Consultant Medical Staff

External Consultant Medical Staff ~~shall~~ consist of qualified physicians, dentists, podiatrists and clinical psychologists who are employees of the Hospital, or who are under contract with the Hospital but who do not spend sufficient time at the Hospital to participate fully in Medical Staff functions. For purposes of this section, the meaning of “sufficient time” ~~shall~~will be less than 20 hours/week of regularly scheduled duties. External Consultants must satisfactorily complete credentialing and proctoring as determined by the MEC based on the nature of the services for which the External Consultant has been retained and the number of hours per month the Consultant is expected to practice at the Hospital. External Consultants ~~may attend Medical Staff meetings and~~ but may not serve as members on Medical Staff Committees. ~~They are not eligible to vote or hold office.~~ They may request and be granted Active Medical Staff membership if they regularly treat and care for Residents at the Hospital and fulfill the Medical Staff participation requirements. Such a request should be made in writing to the Chief of Staff who will present the request to the Medical Executive Committee for consideration, and potential recommendation to the Governing Body, in accordance with these Bylaws.

4. Temporary Medical Staff

The Temporary Staff ~~shall~~ consist of licensed practitioners who have been granted temporary privileges according to Article IV, Section 2. Temporary Staff may attend Medical Staff meetings ~~and but may not~~ serve as members on Medical Staff Committees. ~~They are not eligible to hold office or vote.~~

5. Courtesy Medical Staff

The Courtesy Medical Staff ~~shall~~ consist of licensed practitioners qualified for Medical Staff membership who only occasionally admit and/or treat Residents in the Hospital. For purposes of this section, the meaning of “occasionally” ~~shall~~will be determined by the Medical Executive committee on a case-by-case basis. Courtesy Medical Staff may attend Medical Staff meetings ~~and but may not~~ serve as members on Medical Staff Committees. ~~They are not eligible to hold office or vote.~~

6. Telemedicine Medical Staff

The Telemedicine Staff ~~shall~~ consist of staff who are privileged and provide telemedicine services at LHH. Telemedicine staff members ~~shall will~~ not be eligible to vote ~~at committee meetings~~, hold office, serve on Medical Staff Committees, except at the discretion of the Chief of Staff, or vote in Medical Staff elections. may attend Medical Staff meetings but may not serve as members on Medical Staff Committees.

C. Affiliated Professionals

1. Affiliated Professionals are individuals who perform functions that would otherwise be considered the practice of medicine. They (1) are employees or contractors of the City and County of San Francisco; (2) provide health services requiring them to exercise independent judgment within the area of their professional competence and the limits established by the Governing Body, the Medical Staff, and the applicable practice laws; (3) do not qualify for Medical Staff membership because they are not licensed as physicians, dentists, clinical psychologists, or podiatrists, and (4) belong to a professional category that has been accepted for practice at the Hospital by the Governing Body after appropriate consultation. At present, Affiliated Professionals are practitioners from the following categories who meet the above requirements:

- Nurse Practitioners
- Clinical Nurse Specialists
- Physician Assistants
- Clinical Pharmacists
- Optometrists
- Certified Body Work Practitioners, i.e., certified massage therapists
- Acupuncturists

2. Although not eligible for Medical Staff membership, Affiliated Professionals ~~shall will~~ be credentialed through the Medical Staff and ~~shall will~~ be subject to general Medical Staff oversight and to the individual direction of a specific Medical Staff member. They are not Members of the Medical Staff and are not afforded the due process rights set forth in these Bylaws, and they may not vote on amendments to the Bylaws or Rules and Regulations .
3. The clinical responsibilities of each Affiliated Professionals ~~shall will~~ appear in a detailed job description prepared by the supervising physician and approved by the clinical service chief.

Section 2. Modification of Membership

The Medical Executive Committee may, on its own, pursuant to a request by a ~~m~~Member, or upon direction of the Governing Body, recommend a change in the Medical Staff category of a ~~m~~Member consistent with the requirements of these Bylaws.

ARTICLE IV: ~~CLINICAL PRIVILEGES~~ APPOINTMENTS AND REAPPOINTMENTS

Section 1. General

- A. Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) ~~shall~~will exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws.
- B. Appointments to the Medical Staff are dependent on available budgeted positions and the type of practitioner needed, as determined by the Chief Medical Officer, the Medical Executive Committee (“MEC”) and the Governing Body. An applicant for a Medical Staff position who is denied the position solely because there is no budgeted position is not entitled to exercise hearing rights.

Section 2. Application Process

- A. All applications for appointment and reappointment to the Medical Staff must be completed, signed by the applicant, and submitted to the Medical Staff Services Department (“MSSD”), ~~also known as the Credentials Office, which operates as the agent of the MEC~~on a form approved by the Governing Body.
- B. Every individual seeking appointment or reappointment must furnish a complete application and ~~shall have~~has the burden of producing accurate and adequate information for a proper evaluation of his or her current clinical competence, character and ethics.

Section 3. Application Content

An application is “completed” when the individual has supplied all the requested information on the application form approved by the Governing Body and all necessary verifications have been obtained, including current license, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank (NPDB) information, DEA, and CPR/ACLS certificate if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance and reference letters.

Section 4. ~~Misuse~~ Misrepresentation or Omission

Any significant misrepresentation or omission by an individual for appointment or reappointment ~~may be~~ grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff membership.

Section 5. Effect of Application

By applying for appointment or reappointment to the Medical Staff, each individual signifies his or her willingness to the following:

- a. To be bound by the Medical Staff ~~B~~bylaws and ~~policies~~Rules and Regulations.
- b. To appear for interviews with the Medical Staff ~~members~~;
- c. To provide references from members, administrators, or other personnel of other health care facilities with which the individual has been associated and who may have information bearing on the individual's competence, character, ethical qualifications, relevant mental and physical health and any claims history;
- d. To consent to the Medical Staff's consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and consent to such individuals and organizations candidly providing all such information;
- e. To consent to the Medical Staff's inspection of all records and documents that may be material to an evaluation of professional qualifications for Medical Staff membership and authorize all individuals and organizations in custody of such records and documents to permit such inspection and copying;
- f. To release from any liability the Hospital, the Medical Staff, the Governing Body, the City, and their directors, officers, agents, representatives and employees, for their acts performed in good faith and without malice in connection with evaluating the individual's credentials;

- g. To release from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;
- h. To consent to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the ~~hospital~~ Hospital or Medical Staff may have, and release the Medical Staff and ~~H~~ospital from liability for so doing to the fullest extent permitted by law; and
- i. To certify that ~~he or she shall~~ Applicant will promptly report to the MSSD any changes in the information submitted on the application form that may subsequently occur.

Section 6. Initial Appointment Process

- A. As soon as reasonably practicable, the Applicant ~~shall~~will be provided with a copy of, or access to, the Medical Staff Bylaws.
- B. The completed application for initial appointment ~~shall~~must include detailed information concerning the Applicant's professional qualifications, including, but not limited to education, professional training, experience, licensure, relevant physical and mental health, disciplinary history (including any pending or successful challenges to licensure or voluntary relinquishment of any license or registration, any voluntary or involuntary termination of organized Medical Staff membership, and any voluntary or involuntary limitation, reduction or loss of clinical privileges, and any past, pending, or current exclusion from a federal health care program), claims history, information regarding possible involvement in professional liability actions, biographical data, request for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws, specialty board status, and employment status; a signed agreement that the Applicant has read and ~~shall~~must abide by the Medical Staff Bylaws and Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; and a signed statement of respect for the confidentiality of all Medical Staff proceedings.
- C. An application ~~shall~~will not be finalized until the ~~e~~City approves an ~~A~~applicant's employment with the ~~e~~City or executes a valid agreement with the ~~C~~city to provide care at the ~~h~~Hospital.
- D. Incomplete Application and Applicant's Burden.**
 - 1. An incomplete application will not be processed, and if still incomplete four (4) months after the date of initial submission due

to the failure of the Applicant to provide required information, then it will be considered voluntarily withdrawn. Such withdrawal ~~shall~~will not entitle the Applicant to the procedural rights set forth in Article VI. The MEC may, for good cause, extend the time for completion of the application. Otherwise, the new Applicant's status is designated Applicant-withdrawn.

D.2. The Applicant has the burden of submitting complete, accurate, and adequate information for a proper evaluation of the Applicant's qualifications, including all requirements specified in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the policies, Rules and Regulations of the department in relation to which that Applicant is seeking to work. This burden includes the burden of resolving any doubts about these matters and of providing any additional information requested by the Chief of Service, Chief of Staff, MSSD, or the Chair of the Credentials Committee. This burden also includes the Applicant paying any costs associated with verifications where the MSSD does not have access to the verification at issue. This burden may include submission to a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC and, for City employees, as consistent with City rules. The Applicant's failure to sustain this burden or the provision of information containing any misrepresentations or omissions is grounds for denial of the application or subsequent termination, suspension, or limitation of Membership or Privileges under these Bylaws.

E. When the Medical Staff Services Department has received all necessary verifications, the completed application and all supporting documentation and other relevant information (the "file") ~~shall~~will be submitted to the Service Chief for review and recommendations regarding membership and privileges. The Service Chief's recommendations ~~shall~~will be presented to the Credentials Subcommittee.

F. The Credentials Subcommittee ~~shall~~will then submit to the MEC its report and recommendations as to membership and privileges, for review at the next regularly scheduled meeting.

G. Medical Executive Committee Review and Action.

G.1. _____ The MEC ~~shall~~will review the Credentials Subcommittee's report and recommendations for approval. The ~~A~~applicant's file ~~shall~~will be reviewed when indicated.

H.2. _____ If the MEC's recommendation is that the application be deferred for a defined period of time for further consideration, the Applicant's status continues unchanged as "Applicant" for the defined period. A subsequent recommendation for approval or

denial must be made by the MEC within forty-five (45) days of the deferral.

~~I.3.~~ When the recommendation of the MEC is adverse to the Applicant with respect to appointment or Clinical Privileges, the MEC ~~shall~~will document the reasons for such recommendations and the Chief of Staff ~~shall~~will promptly notify the Applicant by ~~Special~~-Notice. The ~~Special~~-Notice ~~shall~~will inform the Applicant of the procedural rights available to the Applicant under Article VII of these Bylaws. The Governing Body ~~shall~~will be generally informed of the recommendation. If the Applicant waives the procedural rights, the MEC's recommendation is forwarded to the Governing Body for final action. During this time, the Applicant's status is "Applicant-denied".

~~J.4.~~ If the MEC's recommendation is favorable to the Applicant, it ~~shall~~will be forwarded to the Governing Body, which ~~shall~~will give great weight to the MEC's recommendation. The Governing Body ~~shall~~will act upon a favorable recommendation at its next regularly scheduled meeting and the Chief of Staff ~~shall~~will notify the Applicant of its decision.

H. Governing Body Review and Action.

~~K.1.~~ If the Governing Body approves this recommendation, the Applicant's status becomes "Active". All recommendations to approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges.

~~L.2.~~ If the Governing Body's decision is adverse to the Applicant with respect to appointment or Clinical Privileges, the Chief of Staff upon receiving notice of the Governing Body's decision, ~~shall~~will promptly notify the Applicant of such adverse decision by ~~Special written~~ ~~Notice~~notice. The ~~Special-Noticenotice~~ ~~shall~~will ~~shall~~ inform the Applicant of the procedural rights available to the Applicant under Article VII of these Bylaws.

~~M.3.~~ -The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review process ~~shall~~will not confer Privileges where none existed before.

~~N.4.~~ In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral back ~~shall~~will set a time limit (not to exceed sixty (60) days) within which the MEC is to provide additional information or recommendations or take further action.

~~O.5.~~ _____ The final decision of the Governing Body ~~shall~~will be made within forty-five (45) days of its initial consideration of a decision contrary to the recommendation of the MEC. This final decision ~~shall~~will be promptly forwarded to the MEC and the applicant.

~~P.1.~~ _____ The time periods set forth in this section are guidelines only and are not directives which create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties ~~shall~~will act as soon as reasonably practicable.

Section 7. Reappointment Process

- A. The Medical Staff ~~shall~~must reevaluate Active ~~Medical Staff Members~~ at least every two (2) years for the purpose of determining its recommendations for reappointment to the Medical Staff and the continuation of Clinical Privileges.
- B. ~~On or before four (4) months~~At least one hundred twenty (120) days before the expiration of an Active Medical Staff Member's appointment, the MSSD ~~shall~~must provide the ~~m~~Member a reappointment application. Within thirty (30) days of the date the application was provided, the Member must return the completed and signed application to the MSSD, along with all required information and materials.
- C. Each Service Chief in which the ~~Medical Staff~~ Member requests or has exercised Privileges ~~shall~~will review the ~~m~~Member's~~member's~~ completed application and file and ~~shall~~will forward his or her written recommendations to the Credentials Subcommittee. The recommendations ~~shall~~will include a statement that the recommendations are based on information that includes the Clinical Service's quality information about the Medical Staff Member, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information.
- D. If at the time of reappointment, the practitioner has had no clinical activity at Laguna Honda Hospital in the previous two years, there will be a 3 month grace period during which the practitioner will be required to complete the minimum required amount of cases, according to privileges requested, in order to be eligible for reappointment.
- E. In addition to the items listed in subsection C above, each recommendation concerning reappointment of a Medical Staff Member and the Clinical Privileges to be granted upon reappointment ~~shall~~will be based upon such Member's current competence, clinical or technical skills, clinical judgment in the treatment of patients, ongoing and "provider specific" continuous quality improvement evaluations, ethical conduct, attendance at Medical

Staff meetings and participation in Medical Staff affairs, compliance with the Medical Staff Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, a response from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of his or her Medical Staff category or Privileges with or without reasonable accommodation.

F. Credentials Committee Review and Action.

F. The Credentials Subcommittee **shallwill** review the reappointment application and file and the Clinical Service Chief's recommendations. The Credentials Subcommittee may personally interview the Member. The Credentials Subcommittee **shallwill** then submit to the MEC its written report and recommendations as to reappointment and Privileges.

G. Medical Executive Committee Review and Action.

G. At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Subcommittee, the MEC **shallwill** review the Credentials Subcommittee's report and recommendations. If indicated, the file and application **shallwill** be reviewed. After review, the medical executive committee **shallwill** make recommendations to the Governing Body that the application be deferred for further consideration, approved, or denied. When the recommendations include a denial of reappointment or a restriction of clinical privileges the MEC **shallwill** document the reasons for such recommendations

H. Term of Reappointment.

H. Reappointment to any Medical Staff category **shallwill** be for a maximum of two (2) years. If it appears that an application for reappointment will not be fully processed by the expiration of the Member's current term, for reasons other than the Member's failure to return documents or to otherwise timely cooperate in the reappointment process, the MEC and the Governing Body may approve a time- and Member-specific extension of the Member's membership and Clinical Privileges as Temporary Privileges, not to exceed thirty (30) days (status continues "Active" for that time period). Any extension of appointment pursuant to this section does not create a vested right in the member for continued appointment.

I. — Failure of the Member to return a complete application for reappointment at least ninety (90) days prior to the expiration of his or her current term **shallwill** result in automatic suspension of the Member's Privileges and prerogatives effective on the date the Member's current term expires, unless otherwise extended by the MEC and Governing Body. Prior to suspension, the Member **shallwill** be sent at least one (1) letter by Special Notice warning of the impending suspension. If an application for reappointment is not submitted and completed as required before the current term expires, the Member **shallwill** be

deemed to have resigned his or her Medical Staff membership, effective the date his or her current term expires (status becomes "Inactive"). Members who automatically resign under this section will be processed as a reinstatement should they wish to reapply.

Section 8. Reapplication after Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, or Privileges, or a Member who has resigned after notice of an adverse recommendation or a final adverse decision, ~~shall not be~~ is not eligible to reapply to the Medical Staff for a period of two (2) years from the date of the final adverse decision or resignation. ~~Any such reapplication shall be processed as an initial application, and~~ After 2 years, the Applicant may apply as a new Applicant and must submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

Section 9. Resignations

- A. Resignation of a Member from the Medical Staff ~~shall~~ must be submitted in writing to the MEC at least one month in advance.
- B. The MEC ~~shall~~ will act on the resignation at its next meeting.
- C. A resignation ~~shall~~ will be final on the effective date and ~~shall~~ will not thereafter be rescinded.
- D. A voluntary resignation from the Medical Staff ~~shall~~ will not result in hearing rights.
- E. Resignation from employment by an employed practitioner, elimination of Medical Staff positions for budgetary reasons or a change in a professional service contract ~~shall~~ will result in termination of ~~p~~Privileges and Medical Staff membership. Such termination ~~shall~~ will be based solely on Civil Service or contracting reasons and ~~shall~~ will not entitle the practitioner to hearing rights nor ~~shall~~ will such termination result in reports to regulatory bodies or data banks.
- F. Resignations from employment are subject to applicable Civil Service Rules and Regulations and ~~P~~personnel policies.

Section 10. Privileges and Immunities

The following ~~shall~~will constitute conditions of Medical Staff membership and/or the exercise of Clinical Privileges (or an application for either) at this Hospital.

- A. That any act, communication report, recommendation, or disclosure, with respect to any Member, performed or made in good faith and without malice, and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, ~~shall~~will be privileged to the fullest extent permitted by law.
- B. That such privilege ~~shall~~will extend to the Hospital, the Medical Staff, the Governing Body, and their directors, officers, representatives, agents or employees, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this section, the term “third parties” means both individuals and organizations from which a representative of the Medical Staff or the Hospital has requested information.
- C. That there ~~shall~~will be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report, recommendation, or disclosure, even when the information involved would otherwise be deemed to be privileged.
- D. That such immunity ~~shall~~will apply to all acts, communications, reports, or recommendations made in connection with this or any other health care institution’s activities related, but not limited, to:
 1. Application for appointment or Clinical Privileges;
 2. Periodic reappraisal for reappointment or Clinical Privileges;
 3. Summary suspension;
 4. Hearing and appellate review;
 5. Professional care evaluation;
 6. Utilization review; and
 7. Other Hospital, Medical Staff, Clinical Service or committee activities related to quality patient care and professional conduct.
- E. That the acts, communications, reports, recommendations and disclosures referred in this section may relate to a Practitioner’s professional qualification, clinical competency, character, physical or mental health,

ethics or any other matter that might directly or indirectly have an effect on patient care.

Section 11. Access to Own Credentials File

Medical Staff Members ~~shall be granted~~will be provided access to their own credentials file, subject to the following provisions:

- A. Timely notice of a request for access ~~shall~~will be made by the member to the Chief of Staff or designee;
- B. The Member may review and receive a copy of only those documents provided by or addressed personally to the ~~m~~Member.
- C. A summary of all other information, including but not limited to peer review findings, letters of reference, and proctoring reports and complaints, ~~shall~~will be provided to the Member, in writing, by the Chief of Staff, at the time the Member reviews the credentials file or within a reasonable period of time after receipt of a request for such summary, as determined by the MEC. Such summary ~~shall~~will disclose the substance, but not the source, of the information summarized; and
- D. The review by the Member ~~shall~~will take place in the Medical Staff Office, during regular working hours, with the Chief of Staff or designee present.

Section 12. Rights to Request Corrections/Additions

Medical Staff Members may exercise the right to request the corrections or appropriate additions to credentials file information following the below listed protocol.

- A. After reviewing the file, a Member may address a written request to the Chief of Staff asking for correction or deletion of information in the credentials file. Such request ~~shall~~will include a statement of the basis for the action requested.
- B. The Chief of Staff ~~shall~~will review such a request within a reasonable time and ~~shall~~will recommend to the MEC, after such review, whether or not to make the correction or deletion requested.
- C. The MEC, when so informed, ~~shall~~will either ratify or initiate action contrary to this recommendation.
- D. The Member ~~shall~~will be notified promptly, in writing, of the decision of the MEC.

- E. In any case, ~~Members~~ ~~members shall~~ will have the right to add to their own credentials file, upon written request to the MEC, a statement responding to any information contained in the file.

Section 1. Granting of Clinical Privileges

~~A. Scope of Privileges. Every practitioner practicing at the Hospital by virtue of Medical Staff membership shall~~ will, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, upon recommendation of the Medical Executive Committee as provided in these Bylaws. Except as provided in Article IV Section 2 (Temporary Privileges) or Article IV Section 3 (Emergency situations), the granting and scope of privileges depends upon (1) current licensure, (2) an individual's documented experience in categories of diagnostic and treatment areas, (3) peer or faculty recommendations.

~~A. Clinical Privileges are required for the provision of telehealth services. Specific privileges may cover the provision of both in-person and telehealth services. Privileges for Members or Affiliated Professionals who provide only telehealth services are subject to the same requirements that apply to all privileges.~~

~~B. Specific clinical privileges; qualifications; applicant's burden of proof. Every application for Medical Staff or Affiliated Professional appointment and reappointment must contain a request for the specific clinical privileges required by the appointment and desired by the applicant. The Medical Executive Committee shall~~ will evaluate the applicant's credentials and his/her request for privileges to perform special procedures, taking into consideration the applicant's education; training; experience; current demonstrated professional competence; clinical judgment; references; whether the applicant's health status, with reasonable accommodation, allows the performance of all procedures for which privileges have been requested according to accepted standards of professional performance and without posing a direct threat to Residents; and other relevant information, including quality review and monitoring which the Medical Executive Committee determines is appropriate. The Medical Executive Committee shall will recommend to the Governing Body the clinical privileges to be granted. The applicant shall will have the burden of establishing his/her qualifications and competence for the clinical privileges requested.

~~C. Changes in Privileges; hearing rights. Initial clinical privileges and additional privileges may be determined by the Medical Executive Committee based upon documentation of training and/or experience. Curtailment of clinical privileges may be determined by the Medical~~

~~Executive committee based upon the direct observation of care provided and review of records of Residents treated in the Hospital. Medical Staff privileges may be granted, continued or modified following the procedures and provisions of these Medical Staff Bylaws. Any decrease, limitation or restriction of a ~~staff mMember's~~member's clinical privileges that is imposed by the Medical Executive Committee ~~shall will~~ entitle the affected ~~staff mMember~~member to the due process rights provided for in Article VII of these Bylaws.~~

~~D. Availability within Hospital. No specific privilege may be granted to a Practitioner if the task, procedure, or activity constituting the privilege is not available within the Hospital despite the Practitioner's qualifications or ability to perform the requested privilege.~~

~~E. Criteria for "Cross-Specialty" Privileges Within the Hospital. Any request for clinical privileges that are new to the Hospital or that overlap more than one Clinical Service ~~shall will~~ initially be reviewed by the appropriate Clinical Service Chief, in order to establish the need for, and appropriateness of, the new procedure or services. The Medical Executive Committee ~~shall will~~ facilitate the establishment of hospital-wide credentialing criteria for new or cross-specialty procedures, with the input of all appropriate Clinical Service Chiefs, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad-hoc committee with representation from all appropriate Clinical Services.~~

Section 2. Temporary Privileges

A. Who May Obtain.

~~Temporary clinical privileges may be granted in the following circumstances:~~

- ~~1. An Applicant for membership or reappointment pending final approval by the Medical Executive Committee and Governing Body;~~
- ~~2. Consultants required for an individual Patient/Resident when the current Consultant Staff cannot fulfill this function; or~~
- ~~3. Practitioners who need to work at LHH for a limited duration of time (e.g., rotations in clinics or conducting approved special research projects).~~

B. Granting; Credentialing; Supervision.

~~Temporary clinical privileges may be granted by the Chief of Staff with the written concurrence of the appropriate Chiefs of the Clinical Service to a~~

~~practitioner following licensure verification and provision of evidence of malpractice coverage. Prior to the granting of any temporary privileges, the credentialing office shallwill query the appropriate professional board and the National Practitioner Data Bank for information regarding the practitioner. The Chief of Staff shallwill review the information obtained. In exercising temporary privileges, the practitioner shallwill act under the supervision of the Chief of Staff and the appropriate Chief of Clinical Service.~~

~~C. No Right to Temporary Privileges.~~

~~There is no right to temporary privileges. Accordingly, temporary privileges shallwill not be granted unless the available information supports with reasonable certainty a favorable determination regarding the requesting Practitioner's qualifications, ability, and judgment to exercise the Privileges requested. Temporary privileges may be deferred until doubts regarding the applicant's qualifications have been resolved. A determination to grant temporary privileges shallwill not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.~~

~~D. Duration.~~

~~The Chief of Staff, with the written concurrence of the appropriate Chiefs of the Clinical Service, will determine the duration of temporary privileges required for treatment and may at any time terminate a practitioner's temporary privileges. In general, temporary privileges will be granted for a period of four months to be renewed for additional periods of two months at the discretion of the Chief of Staff in with written concurrence of the appropriate Chiefs of the Clinical Service.~~

~~E. Bylaws / Rules and Regulations.~~

~~The Practitioner seeking temporary privileges must sign an acknowledgment that he or she has received and read the Medical Staff Bylaws and Rules and Regulations agrees to be bound by the terms thereof in all matters relating to Privileges.~~

~~F. Proctoring/Monitoring.~~

~~Requirements for proctoring and monitoring shallwill be imposed at the discretion of the Chiefs of the Clinical Service.~~

~~G. Failure to Complete Membership Application.~~

If an applicant for Medical Staff membership fails to submit all information necessary to complete the Medical Staff application within four (4) months from the granting of temporary privileges, the application will be deemed to have been withdrawn. In that circumstance, temporary privileges ~~shall~~will automatically terminate unless extended as provided in Section 2.D. of this Article. Such withdrawal ~~shall~~will not entitle the applicant to the procedural rights under Article VIII of these Bylaws but does not preclude reapplication for privileges and membership on the Medical Staff.

~~H. Action against Privileges.~~

The Chief Medical Officer or the Chief of Staff may, at their discretion and after consultation with the Chief of the relevant Clinical Service responsible for supervision of the Practitioner exercising temporary privileges, restrict, suspend or terminate any or all of the temporary privileges granted. The granting, refusal, denial, restriction, suspension or termination of temporary privileges is solely discretionary on the part of the individuals authorized to exercise such power. If any such action is taken, such action ~~shall~~will not confer upon the affected Practitioner any vested right to the continuation of such privileges, nor ~~shall~~will the Practitioner be entitled to the procedural rights provided for in Articles VI and VII herein, or to any other procedural rights. Should temporary privileges be restricted, suspended or terminated, however, for medical disciplinary cause or reason as defined in California Business and Professions Code service 805 or any applicable reason listed in Article VII, Section 2 (Grounds for Hearing) of these Bylaws, the practitioner ~~shall~~will have the right to due process as outlined under Article VII of these Bylaws.

~~I. Residents of Disciplined Practitioner with Temporary Privileges.~~

The Residents of a Practitioner with temporary privileges against whom an action against privileges has been taken in accordance with paragraph H ~~shall~~will be assigned, or in the case of a restricted practitioner, may be assigned, to a Medical Staff member by the appropriate Service Chief.

~~Section 3. Emergency Situations~~

~~A. In the event of an emergency, any practitioner, to the degree permitted by the license held and regardless of service or staff status, shall~~will be permitted and assisted to do everything possible to save the life of a Resident or to save a Resident from serious harm, The Practitioner ~~shall~~will promptly yield such care to a more qualified member of the Active Staff when one becomes available.

- ~~B. In extraordinary circumstances, when time does not permit completion of an application for Temporary Privileges, the Chief Medical Officer, Chief of Staff or appropriate Chief of a Clinical Service may invite outside consultation from a duly licensed practitioner; the appropriate application must be completed within 72 hours from the time the emergency circumstances are under control.~~

Section 4. Medical Staff Privileges

~~Privileges shallwill be granted to practitioners by the Governing Body upon recommendation of the Medical Executive Committee and shallwill be based on (1) current licensure, (2) an individual's documented experience in categories of diagnostic and treatment areas, (3) peer or faculty recommendation. At a minimum, eligibility for certification by the Practitioners' corresponding specialty board is required for the granting of privileges. Practitioners' clinical activity shallwill be under the overall supervision of the Clinical Service Chief. Practitioners shallwill exercise clinical privileges as granted by the Governing Body.~~

Section 5. Proctoring

~~A. General~~

~~All new appointees to the Medical Staff and existing members requesting additional privileges, regardless of specialty or category of membership so long as direct patient care is involved, shallwill be assigned a proctor by the Clinical Service Chief or designee and complete a period of proctoring.~~

~~The proctor must have unrestricted privileges to perform the evaluation(s) that s/he will proctor. The Clinical Service Chief will submit documentation to the Credentials Subcommittee attesting to the satisfactory completion of proctoring, including the types and number of cases observed. Documentation of the proctoring will reside in the Medical Staff Office.~~

~~B. Function and Responsibility of the Proctor~~

- ~~1. The proctor shallwill be responsible for evaluating the Practitioner's clinical competence for the requested privileges that may include evaluating the conditions for admission, discharge, diagnostic work-up and therapy management.~~

2. The proctor's primary responsibility is to evaluate the Practitioner's performance. The evaluation ~~shall~~will be performed using criteria developed by the Medical Executive committee including concurrent or retrospective chart review, consultation, and/or direct observation. If during the course of the proctoring period, the proctor has concerns, s/he ~~shall~~will promptly report them to the Clinical Service Chief. However, if the proctor believes intervention is warranted in order to avert harm to a Resident s/he ~~shall~~will take any action reasonably necessary to protect the Resident.

~~C. Proctoring Duration~~

1. Proctoring ~~shall~~will be deemed successfully completed when the Practitioner completes the proctoring as determined by the Medical Executive Committee. Proctoring ~~shall~~will commence upon granting of medical privileges and must be completed within the first six (6) months of initial granting of new privileges. This period may be extended by the MEC upon the recommendation of the Clinical Service Chief based on good cause.
2. For privileges that are infrequently performed by the Medical Staff member, the clinical service chief may submit a written request to the Credentials Subcommittee to extend the proctoring period, or to have the proctoring occur at another accredited hospital so long as the Proctor is a member of the LHH Medical Staff in good standing. These privileges ~~shall~~will be voluntarily relinquished or withdrawn if proctoring is not completed within twenty four (24) months of the initial granting of the infrequently required privileges.

~~D. Reciprocal Proctoring~~

Reciprocal proctoring is proctoring that is performed by non-LHH Medical Staff Members at sites other than the Hospital. This situation becomes necessary when no LHH Medical Staff Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Practitioner's practice ~~shall~~will be proctored by a Medical Staff member of Laguna Honda. Requirements for reciprocal proctoring are as follows:

1. The reciprocal proctor is an active member of the Medical Staff at an accredited hospital;
2. The reciprocal proctor possesses unrestricted privileges to perform the procedure for which the proctoring is being performed; and

- ~~3. The reciprocal proctoring arrangements and the reciprocal proctor have been approved by the relevant Chief of the Clinical Service.~~
- ~~4. For each case that is reciprocally proctored, the reciprocal proctor shallwill complete a LHH proctoring form and submit it to the Clinical Service Chief. The Clinical Service Chief shallwill submit an evaluation summary to the Credential Subcommittee.~~

~~E. Entitlement to Hearing Right for Proctored Practitioner.~~

~~If a medical disciplinary cause or other reason as defined in California Business and Professions Code Section 805 triggers a reporting obligation to the National Practitioner Data Bank, and or the relevant professional licensing agency, the pMemberractitioner shallwillPractitioner shall be entitled to hearing rights as set forth in Article VII of these Bylaws.~~

~~Section 6. Routine Peer Review~~

~~The Medical Quality Improvement (MQI) Committee Chair is responsible for assigning /delegating annual peer reviews for all Medical Staff mMembers. The Clinical Services Chiefs and MQI chair shallwill develop and routinely update peer review criteria based on current practices and standards of care. Criteria as updated are made known and accessible to all Medical Staff members. Medical Staff members are kept apprised of reviews of their performance. Any peer reviews of the Medical Staff shall must be treated with the utmost confidentiality and shall must not be discussed and disseminated outside of the protection of the peer review body or organization.~~

ARTICLE V: ~~APPOINTMENTS AND REAPPOINTMENTS~~ CLINICAL PRIVILEGES

Section 1. Granting of Clinical Privileges

A. Scope of Privileges. Every practitioner practicing at the Hospital by virtue of Medical Staff membership ~~shall~~will, in connection with such practice, be entitled to exercise only those clinical privileges specifically granted by the Governing Body, upon recommendation of the Medical Executive Committee as provided in these Bylaws. Except as provided in Article IV Section 2 (Temporary Privileges) or Article IV Section 3 (Emergency situations), the granting and scope of privileges depends upon (1) current licensure, (2) an individual's documented experience in categories of diagnostic and treatment areas, (3) peer or faculty recommendations.

F. Clinical Privileges are required for the provision of telehealth services. Specific privileges may cover the provision of both in-person and telehealth services. Privileges for Members or Affiliated Professionals who provide only telehealth services are subject to the same requirements that apply to all privileges.

B. Specific clinical privileges; qualifications; applicant's burden of proof.

Every application for Medical Staff ~~or Affiliated Professionals~~ appointment and reappointment must contain a request for the specific clinical privileges required by the appointment and desired by the applicant. The Medical Executive Committee ~~shall~~will evaluate the applicant's credentials and his/her request for privileges to perform special procedures, taking into consideration the applicant's education; training; experience; current demonstrated professional competence; clinical judgment; references; whether the applicant's health status, with reasonable accommodation, allows the performance of all procedures for which privileges have been requested according to accepted standards of professional performance and without posing a direct threat to Residents; and other relevant information, including quality review and monitoring which the Medical Executive Committee determines is appropriate. The Medical Executive Committee ~~shall~~will recommend to the Governing Body the clinical privileges to be granted. The applicant ~~shall~~will have the burden of establishing his/her qualifications and competence for the clinical privileges requested.

C. Changes in Privileges; hearing rights. Initial clinical privileges and additional privileges may be determined by the Medical Executive Committee based upon documentation of training and/or experience. Curtailment of clinical privileges may be determined by the Medical Executive committee based upon the direct observation of care provided and review of records of Residents treated in the Hospital. Medical Staff

privileges may be granted, continued or modified following the procedures and provisions of these Medical Staff Bylaws. Any decrease, limitation or restriction of a ~~staff m~~Member's~~member's~~ clinical privileges that is imposed by the Medical Executive Committee ~~shall~~will entitle the affected ~~staff~~m~~Member~~member to the due process rights provided for in Article VII of these Bylaws.

- D. Availability within Hospital.** No specific privilege may be granted to a Practitioner if the task, procedure, or activity constituting the privilege is not available within the Hospital despite the Practitioner's qualifications or ability to perform the requested privilege.
- E. Criteria for "Cross-Specialty" Privileges Within the Hospital.** Any request for clinical privileges that are new to the Hospital or that overlap more than one Clinical Service ~~shall~~will initially be reviewed by the appropriate Clinical Service Chief, in order to establish the need for, and appropriateness of, the new procedure or services. The Medical Executive Committee ~~shall~~will facilitate the establishment of hospital-wide credentialing criteria for new or cross-specialty procedures, with the input of all appropriate Clinical Service Chiefs, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the Medical Executive Committee may establish an ad-hoc committee with representation from all appropriate Clinical Services.

Section 2. Temporary Privileges

A. Who May Obtain.

Temporary clinical privileges may be granted in the following circumstances:

1. An Applicant for membership or reappointment pending final approval by the Medical Executive Committee and Governing Body;
2. Consultants required for an individual Patient/Resident when the current Consultant Staff cannot fulfill this function; or
3. Practitioners who need to work at LHH for a limited duration of time (e.g., rotations in clinics or conducting approved special research projects).

B. Granting; Credentialing; Supervision.

Temporary clinical privileges may be granted by the Chief of Staff with the written concurrence of the appropriate Chiefs of the Clinical Service to a practitioner following licensure verification and provision of evidence of malpractice coverage. Prior to the granting of any temporary privileges,

the credentialing office ~~shall~~will query the appropriate professional board and the National Practitioner Data Bank for information regarding the practitioner. The Chief of Staff ~~shall~~will review the information obtained. In exercising temporary privileges, the practitioner ~~shall~~will act under the supervision of the Chief of Staff and the appropriate Chief of Clinical Service.

C. No Right to Temporary Privileges.

There is no right to temporary privileges. Accordingly, temporary privileges ~~shall~~will not be granted unless the available information supports with reasonable certainty a favorable determination regarding the requesting Practitioner's qualifications, ability, and judgment to exercise the Privileges requested. Temporary privileges may be deferred until doubts regarding the applicant's qualifications have been resolved. A determination to grant temporary privileges ~~shall~~will not be binding or conclusive with respect to an applicant's pending request for appointment to the Medical Staff.

D. Duration.

The Chief of Staff, with the written concurrence of the appropriate Chiefs of the Clinical Service, will determine the duration of temporary privileges required for treatment and may at any time terminate a practitioner's temporary privileges. In general, temporary privileges will be granted for a period of four months to be renewed for additional periods of two months at the discretion of the Chief of Staff ~~in~~with written concurrence of the appropriate Chiefs of the Clinical Service.

E. Bylaws / Rules and Regulations.

The Practitioner seeking temporary privileges must sign an acknowledgment that he or she has received and read the Medical Staff Bylaws and Rules and Regulations agrees to be bound by the terms thereof in all matters relating to Privileges.

F. Proctoring/Monitoring.

Requirements for proctoring and monitoring ~~shall~~will be imposed at the discretion of the Chiefs of the Clinical Service.

G. Failure to Complete Membership Application.

If an applicant for Medical Staff membership fails to submit all information necessary to complete the Medical Staff application within four (4) months from the granting of temporary privileges, the application will be deemed to

have been withdrawn. In that circumstance, temporary privileges **shallwill** automatically terminate unless extended as provided in Section 2.D. of this Article. Such withdrawal **shallwill** not entitle the applicant to the procedural rights under Article VIII of these Bylaws but does not preclude reapplication for privileges and membership on the Medical Staff.

H. Action against Privileges.

The Chief Medical Officer or the Chief of Staff may, at their discretion and after consultation with the Chief of the relevant Clinical Service responsible for supervision of the Practitioner exercising temporary privileges, restrict, suspend or terminate any or all of the temporary privileges granted. The granting, refusal, denial, restriction, suspension or termination of temporary privileges is solely discretionary on the part of the individuals authorized to exercise such power. If any such action is taken, such action **shallwill** not confer upon the affected Practitioner any vested right to the continuation of such privileges, nor **shallwill** the Practitioner be entitled to the procedural rights provided for in Articles VI and VII herein, or to any other procedural rights. Should temporary privileges be restricted, suspended or terminated, however, for medical disciplinary cause or reason as defined in California Business and Professions Code service 805 or any applicable reason listed in Article VII, Section 2 (Grounds for Hearing) of these Bylaws, the practitioner **shallwill** have the right to due process as outlined under Article VII of these Bylaws.

I. Residents of Disciplined Practitioner with Temporary Privileges.

The Residents of a Practitioner with temporary privileges against whom an action against privileges has been taken in accordance with paragraph H **shallwill** be assigned, or in the case of a restricted practitioner, may be assigned, to a Medical Staff member by the appropriate Service Chief.

Section 3. Emergency Situations

- A. In the event of an emergency, any practitioner, to the degree permitted by the license held and regardless of service or staff status, **shallwill** be permitted and assisted to do everything possible to save the life of a Resident or to save a Resident from serious harm, The Practitioner **shallwill** promptly yield such care to a more qualified member of the Active Staff when one becomes available.
- B. In extraordinary circumstances, when time does not permit completion of an application for Temporary Privileges, the Chief Medical Officer, Chief of Staff or appropriate Chief of a Clinical Service may invite outside consultation from a duly licensed practitioner; the appropriate application

must be completed within 72 hours from the time the emergency circumstances are under control.

Section 4. Medical Staff Privileges

Privileges ~~shall~~will be granted to practitioners by the Governing Body upon recommendation of the Medical Executive Committee and ~~shall~~will be based on (1) current licensure, (2) an individual's documented experience in categories of diagnostic and treatment areas. (3) peer or faculty recommendation. At a minimum, eligibility for certification by the Practitioners' corresponding specialty board is required for the granting of privileges. Practitioners' clinical activity ~~shall~~will be under the overall supervision of the Clinical Service Chief. Practitioners ~~shall~~will exercise clinical privileges as granted by the Governing Body.

Section 5. Proctoring

A. General

All new appointees to the Medical Staff and existing members requesting additional privileges, regardless of specialty or category of membership so long as direct patient care is involved, ~~shall~~will be assigned a proctor by the Clinical Service Chief or designee and complete a period of proctoring.

The proctor must have unrestricted privileges to perform the evaluation(s) that s/he will proctor. The Clinical Service Chief will submit documentation to the Credentials Subcommittee attesting to the satisfactory completion of proctoring, including the types and number of cases observed. Documentation of the proctoring will reside in the Medical Staff Office.

B. Function and Responsibility of the Proctor

1. The proctor ~~shall~~will be responsible for evaluating the Practitioner's clinical competence for the requested privileges that may include evaluating the conditions for admission, discharge, diagnostic work-up and therapy management.
2. The proctor's primary responsibility is to evaluate the Practitioner's performance. The evaluation ~~shall~~will be performed using criteria developed by the Medical Executive committee including concurrent or retrospective chart review, consultation, and/or direct observation. If during the course of the proctoring period, the proctor has concerns, s/he

shallwill promptly report them to the Clinical Service Chief. However, if the proctor believes intervention is warranted in order to avert harm to a Resident s/he **shallwill** take any action reasonably necessary to protect the Resident.

C. Proctoring Duration

1. Proctoring **shallwill** be deemed successfully completed when the Practitioner completes the proctoring as determined by the Medical Executive Committee. Proctoring **shallwill** commence upon granting of medical privileges and must be completed within the first six (6) months of initial granting of new privileges. This period may be extended by the MEC upon the recommendation of the Clinical Service Chief based on good cause.
2. For privileges that are infrequently performed by the Medical Staff member, the clinical service chief may submit a written request to the Credentials Subcommittee to extend the proctoring period, or to have the proctoring occur at another accredited hospital so long as the Proctor is a member of the LHH Medical Staff in good standing. These privileges **shallwill** be voluntarily relinquished or withdrawn if proctoring is not completed within twenty-four (24) months of the initial granting of the infrequently required privileges.

D. Reciprocal Proctoring

Reciprocal proctoring is proctoring that is performed by non-LHH Medical Staff Members at sites other than the Hospital. This situation becomes necessary when no LHH Medical Staff Members who possess the necessary expertise are available to proctor a specific skill or procedure. Only such specific skills or procedures may be reciprocally proctored; all other elements of the Practitioner's practice **shallwill** be proctored by a Medical Staff member of Laguna Honda. Requirements for reciprocal proctoring are as follows:

1. The reciprocal proctor is an active member of the Medical Staff at an accredited hospital;
2. The reciprocal proctor possesses unrestricted privileges to perform the procedure for which the proctoring is being performed; and
3. The reciprocal proctoring arrangements and the reciprocal proctor have been approved by the relevant Chief of the Clinical Service.

4. For each case that is reciprocally proctored, the reciprocal proctor ~~shall~~will complete a LHH proctoring form and submit it to the Clinical Service Chief. The Clinical Service Chief ~~shall~~will submit an evaluation summary to the Credential Subcommittee.

F. Entitlement to Hearing Right for Proctored Practitioner.

If a medical disciplinary cause or other reason as defined in California Business and Professions Code Section 805 triggers a reporting obligation to the National Practitioner Data Bank, ~~and or~~ the relevant professional licensing agency, the ~~pMemberractitioner shallwillPractitioner shall~~ be entitled to hearing rights as set forth in Article VII of these Bylaws.

Section 6. Routine Peer Review

The Medical Quality Improvement (MQI) Committee Chair is responsible for assigning /delegating annual peer reviews for all Medical Staff ~~m~~MMembers. The Clinical Services Chiefs and MQI chair ~~shall~~will develop and routinely update peer review criteria based on current practices and standards of care. Criteria as updated are made known and accessible to all Medical Staff members. Medical Staff members are kept apprised of reviews of their performance. Any peer reviews of the Medical Staff ~~shall~~must be treated with the utmost confidentiality and ~~shall~~must not be discussed and disseminated outside of the protection of the peer review body or organization.

~~Section 1. General~~

- ~~C. Except as otherwise specified herein, no person (including persons engaged by the Hospital in administratively responsible positions) shallwill exercise clinical privileges in the Hospital unless and until that person applies for and receives appointment to the Medical Staff or is granted temporary privileges as set forth in these Bylaws.~~
- ~~D. Appointments to the Medical Staff are dependent on available budgeted positions and the type of practitioner needed, as determined by the Chief Medical Officer, the Medical Executive Committee ("MEC") and the Governing Body. An applicant for a Medical Staff position who is denied the position solely because there is no budgeted position is not entitled to exercise hearing rights.~~

Section 2. Application Process

- ~~C. All applications for appointment and reappointment to the Medical Staff must be completed, signed by the applicant, and submitted to the Medical Staff Services Department (“MSSD”), also known as the Credentials Office, which operates as the agent of the MEC on a form approved by the Governing Body.~~
- ~~D. Every individual seeking appointment or reappointment must furnish a complete application and shall have the burden of producing accurate and adequate information for a proper evaluation of his or her current clinical competence, character and ethics.~~

Section 3. Application Content

~~An application is “completed” when the individual has supplied all the requested information on the application form approved by the Governing Body and all necessary verifications have been obtained, including current license, licensing board disciplinary records, specialty board certification status, National Practitioner Data Bank (NPDB) information, DEA, and CPR/ACLS certificate if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance and reference letters.~~

Section 4. Misuse Misrepresentation or Omission

~~Any significant misrepresentation or omission by an individual for appointment or reappointment may be grounds for denial of the application or other appropriate corrective action, including revocation of Clinical Privileges and Medical Staff membership.~~

Section 5. Effect of Application

~~By applying for appointment or reappointment to the Medical Staff, each individual signifies his or her willingness to the following:~~

- ~~j. To be bound by the Medical Staff Bylaws and policies Rules and Regulations.~~
- ~~k. To appear for interviews with the Medical Staff members;~~

- ~~l. To provide references from members, administrators, or other personnel of other health care facilities with which the individual has been associated and who may have information bearing on the individual's competence, character, ethical qualifications, relevant mental and physical health and any claims history;~~
- ~~m. To consent to the Medical Staff's consultation with others who have been associated with the applicant and who may have information bearing on the applicant's competence, qualifications and performance, and consent to such individuals and organizations candidly providing all such information;~~
- ~~n. To consent to the Medical Staff's inspection of all records and documents that may be material to an evaluation of professional qualifications for Medical Staff membership and authorize all individuals and organizations in custody of such records and documents to permit such inspection and copying;~~
- ~~o. To release from any liability the Hospital, the Medical Staff, the Governing Body, the City, and their directors, officers, agents, representatives and employees, for their acts performed in good faith and without malice in connection with evaluating the individual's credentials;~~
- ~~p. To release from any liability, to the fullest extent provided by law, all individuals and organizations who provide information regarding the applicant, including otherwise confidential information;~~
- ~~q. To consent to the disclosure to other hospitals, medical associations, licensing boards, and to other similar organizations as required by law, any information regarding the applicant's professional or ethical standing that the hospital Hospital or Medical Staff may have, and release the Medical Staff and Hospital from liability for so doing to the fullest extent permitted by law; and~~
- ~~r. To certify that he or she shall Applicant will promptly report to the MSSD any changes in the information submitted on the application form that may subsequently occur.~~

Section 6. Initial Appointment Process

~~Q.J. As soon as reasonably practicable, the Applicant shall will be provided with a copy of, or access to, the Medical Staff Bylaws.~~

~~R.K. The completed application for initial appointment shall must include detailed information concerning the Applicant's professional qualifications,~~

including, but not limited to education, professional training, experience, licensure, relevant physical and mental health, disciplinary history (including any pending or successful challenges to licensure or voluntary relinquishment of any license or registration, any voluntary or involuntary termination of organized Medical Staff membership, and any voluntary or involuntary limitation, reduction or loss of clinical privileges, and any past, pending, or current exclusion from a federal health care program), claims history, information regarding possible involvement in professional liability actions, biographical data, request for Clinical Privileges, peer references, health care facility affiliations, current professional insurance coverage, documentation of additional appropriate licenses, certificates, or registrations required by law and/or the Medical Staff Bylaws, specialty board status, and employment status; a signed agreement that the Applicant has read and ~~shall must~~ abide by the Medical Staff Bylaws and Rules and Regulations; a release from liability for all parties engaging in good faith peer review, commencing with the credentialing process; and a signed statement of respect for the confidentiality of all Medical Staff proceedings.

~~S.L.~~ An application ~~shall will~~ not be finalized until the ~~c~~City approves an Applicant's employment with the ~~c~~City or executes a valid agreement with the ~~C~~city to provide care at the ~~h~~Hospital.

M. Incomplete Application and Applicant's Burden:

~~3.~~ An incomplete application will not be processed, and if still incomplete four (4) months after the date of initial submission due to the failure of the Applicant to provide required information, then it will be considered voluntarily withdrawn. Such withdrawal ~~shall will~~ not entitle the Applicant to the procedural rights set forth in Article VI. The MEC may, for good cause, extend the time for completion of the application. Otherwise, the new Applicant's status is designated Applicant withdrawn.

~~T.4.~~ The Applicant has the burden of submitting complete, accurate, and adequate information for a proper evaluation of the Applicant's qualifications, including all requirements specified in the Medical Staff Bylaws, Medical Staff Rules and Regulations, and the policies, Rules and Regulations of the department in relation to which that Applicant is seeking to work. This burden includes the burden of resolving any doubts about these matters and of providing any additional information requested by the Chief of Service, Chief of Staff, MSSD, or the Chair of the Credentials Committee. This burden also includes the Applicant paying any costs associated with verifications where the MSSD does not have access to the verification at issue. This burden may include submission to a medical, psychiatric, or psychological examination, at the Applicant's expense, if deemed appropriate by the MEC and, for City employees, as consistent with City rules. The Applicant's failure to sustain this burden or the provision of information containing any misrepresentations or omissions is

~~grounds for denial of the application or subsequent termination, suspension, or limitation of Membership or Privileges under these Bylaws.~~

~~U.N. When the Medical Staff Services Department has received all necessary verifications, the completed application and all supporting documentation and other relevant information (the “file”) shallwill be submitted to the Service Chief for review and recommendations regarding membership and privileges. The Service Chief’s recommendations shallwill be presented to the Credentials Subcommittee.~~

~~V.O. The Credentials Subcommittee shallwill then submit to the MEC its report and recommendations as to membership and privileges, for review at the next regularly scheduled meeting.~~

~~P. Medical Executive Committee Review and Action:~~

~~W.5. The MEC shallwill review the Credentials Subcommittee’s report and recommendations for approval. The Applicant’s file shallwill be reviewed when indicated.~~

~~X.6. If the MEC’s recommendation is that the application be deferred for a defined period of time for further consideration, the Applicant’s status continues unchanged as “Applicant” for the defined period. A subsequent recommendation for approval or denial must be made by the MEC within forty-five (45) days of the deferral.~~

~~Y.7. When the recommendation of the MEC is adverse to the Applicant with respect to appointment or Clinical Privileges, the MEC shallwill document the reasons for such recommendations and the Chief of Staff shallwill promptly notify the Applicant by Special Notice. The Special Notice shallwill inform the Applicant of the procedural rights available to the Applicant under Article VII of these Bylaws. The Governing Body shallwill be generally informed of the recommendation. If the Applicant waives the procedural rights, the MEC’s recommendation is forwarded to the Governing Body for final action. During this time, the Applicant’s status is “Applicant-denied”.~~

~~Z.8. If the MEC’s recommendation is favorable to the Applicant, it shallwill be forwarded to the Governing Body, which shallwill give great weight to the MEC’s recommendation. The Governing Body shallwill act upon a favorable recommendation at its next regularly scheduled meeting and the Chief of Staff shallwill notify the Applicant of its decision.~~

~~Q. Governing Body Review and Action:~~

~~AA.6. If the Governing Body approves this recommendation, the Applicant’s status becomes “Active”. All recommendations to~~

approve an application must also specifically recommend the Clinical Privileges to be granted and any special conditions or limitations relating to such Privileges.

~~BB.7.~~ If the Governing Body's decision is adverse to the Applicant with respect to appointment or Clinical Privileges, the Chief of Staff upon receiving notice of the Governing Body's decision, ~~shall will~~ promptly notify the Applicant of such adverse decision by ~~Special written Notice.~~ ~~Notice.~~ The ~~Special Notice~~ ~~notice shall will shall~~ inform the Applicant of the procedural rights available to the Applicant under Article VII of these Bylaws.

~~CC.8.~~ The fact that the adverse recommendation or decision is held in abeyance during the hearing and appellate review process ~~shall will~~ not confer Privileges where none existed before.

~~DD.9.~~ In the event the Governing Body wishes to defer action, it may do so by referring the matter back to the MEC with a statement of its reasons for doing so. Any such referral back ~~shall will~~ set a time limit (not to exceed sixty (60) days) within which the MEC is to provide additional information or recommendations or take further action.

~~EE.10.~~ The final decision of the Governing Body ~~shall will~~ be made within forty five (45) days of its initial consideration of a decision contrary to the recommendation of the MEC. This final decision ~~shall will~~ be promptly forwarded to the MEC and the applicant.

~~FF.R.~~ The time periods set forth in this section are guidelines only and are not directives which create any right for an Applicant to have an application processed within these precise periods. When no time periods are specified, all parties ~~shall will~~ act as soon as reasonably practicable.

Section 7. Reappointment Process

~~I.~~ The Medical Staff ~~shall must~~ reevaluate Active ~~Medical Staff Members~~ at least every two (2) years for the purpose of determining its recommendations for ~~re~~appointment to the Medical Staff and the continuation of Clinical Privileges.

~~J.~~ ~~On or before four (4) months~~ ~~At least one hundred twenty (120) days~~ before the expiration of an Active Medical Staff Member's appointment, the MSSD ~~shall must~~ provide the ~~m~~Member a reappointment application. Within thirty (30) days of the date the application was provided, the Member must return

~~the completed and signed application to the MSSD, along with all required information and materials.~~

- ~~K. Each Service Chief in which the **Medical Staff** Member requests or has exercised Privileges **shallwill** review the **mMember'smember's** completed application and file and **shallwill** forward his or her written recommendations to the Credentials Subcommittee. The recommendations **shallwill** include a statement that the recommendations are based on information that includes the Clinical Service's quality information about the Medical Staff Member, any professional liability claims, the Member's clinical activity, education, and training, and any other pertinent information.~~
- ~~L. If at the time of reappointment, the practitioner has had no clinical activity at Laguna Honda Hospital in the previous two years, there will be a 3-month grace period during which the practitioner will be required to complete the minimum required amount of cases, according to privileges requested, in order to be eligible for reappointment.~~
- ~~M. In addition to the items listed in subsection C above, each recommendation concerning reappointment of a Medical Staff Member and the Clinical Privileges to be granted upon reappointment **shallwill** be based upon such Member's current competence, clinical or technical skills, clinical judgment in the treatment of patients, ongoing and "provider specific" continuous quality improvement evaluations, ethical conduct, attendance at Medical Staff meetings and participation in Medical Staff affairs, compliance with the Medical Staff Bylaws and Rules and Regulations, voluntary or involuntary loss and/or relinquishment of Privileges or licensure, a response from the National Practitioner Data Bank inquiry, and mental or physical health that permits the Member to carry out the essential functions of his or her Medical Staff category or Privileges with or without reasonable accommodation.~~

~~N. Credentials Committee Review and Action:~~

~~N. The Credentials Subcommittee **shallwill** review the reappointment application and file and the Clinical Service Chief's recommendations. The Credentials Subcommittee may personally interview the Member. The Credentials Subcommittee **shallwill** then submit to the MEC its written report and recommendations as to reappointment and Privileges.~~

~~O. Medical Executive Committee Review and Action:~~

~~O. At its next regularly scheduled meeting after receipt of the written report and recommendations of the Credentials Subcommittee, the MEC **shallwill** review the Credentials Subcommittee's report and recommendations. If indicated, the file and application **shallwill** be reviewed. After review, the medical executive committee **shallwill** make recommendations to the Governing Body that the application be deferred for further consideration, approved, or denied. When the recommendations~~

include a denial of reappointment or a restriction of clinical privileges the MEC ~~shall~~will document the reasons for such recommendations

P. Term of Reappointment.

~~P. Reappointment to any Medical Staff category shall~~will be for a maximum of two (2) years. If it appears that an application for reappointment will not be fully processed by the expiration of the Member's current term, for reasons other than the Member's failure to return documents or to otherwise timely cooperate in the reappointment process, the MEC and the Governing Body may approve a time and Member-specific extension of the Member's membership and Clinical Privileges as Temporary Privileges, not to exceed thirty (30) days (status continues "Active" for that time period). Any extension of appointment pursuant to this section does not create a vested right in the member for continued appointment.

~~J. Failure of the Member to return a complete application for reappointment at least ninety (90) days prior to the expiration of his or her current term shall~~will result in automatic suspension of the Member's Privileges and prerogatives effective on the date the Member's current term expires, unless otherwise extended by the MEC and Governing Body. Prior to suspension, the Member ~~shall~~will be sent at least one (1) letter by Special Notice warning of the impending suspension. If an application for reappointment is not submitted and completed as required before the current term expires, the Member ~~shall~~will be deemed to have resigned his or her Medical Staff membership, effective the date his or her current term expires (status becomes "Inactive"). Members who automatically resign under this section will be processed as a reinstatement should they wish to reapply.

Section 8. Reapplication after Adverse Decision

An Applicant or Member who has received a final adverse decision regarding appointment, reappointment, membership, or Privileges, or a Member who has resigned after notice of an adverse recommendation or a final adverse decision, ~~shall not be~~is not eligible to reapply to the Medical Staff for a period of two (2) years from the date of the final adverse decision or resignation. ~~Any such reapplication shall be processed as an initial application, and~~After 2 years, the Applicant may apply as a new Applicant and must submit such additional information as may be required to demonstrate that the basis for the earlier adverse decision or recommendation no longer exists.

Section 9. Resignations

~~G. Resignation of a Member from the Medical Staff shall~~must be submitted in writing to the MEC at least one month in advance.

- H. The MEC ~~shall~~will act on the resignation at its next meeting.
- I. A resignation ~~shall~~will be final on the effective date and ~~shall~~will not thereafter be rescinded.
- J. A voluntary resignation from the Medical Staff ~~shall~~will not result in hearing rights.
- K. Resignation from employment by an employed practitioner, elimination of Medical Staff positions for budgetary reasons or a change in a professional service contract ~~shall~~will result in termination of ~~p~~Privileges and Medical Staff membership. Such termination ~~shall~~will be based solely on Civil Service or contracting reasons and ~~shall~~will not entitle the practitioner to hearing rights nor ~~shall~~will such termination result in reports to regulatory bodies or data banks.
- L. Resignations from employment are subject to applicable Civil Service Rules and Regulations and ~~P~~personnel policies.

Section 10. Privileges and Immunities

The following ~~shall~~will constitute conditions of Medical Staff membership and/or the exercise of Clinical Privileges (or an application for either) at this Hospital.

- F. That any act, communication report, recommendation, or disclosure, with respect to any Member, performed or made in good faith and without malice, and at the request of an authorized representative of this or any other health care facility, for the purpose of achieving and maintaining quality patient care in this or any other health care facility, ~~shall~~will be privileged to the fullest extent permitted by law.
- G. That such privilege ~~shall~~will extend to the Hospital, the Medical Staff, the Governing Body, and their directors, officers, representatives, agents or employees, and to third parties who supply information to any of the foregoing authorized to receive, release or act upon the same. For the purpose of this section, the term "third parties" means both individuals and organizations from which a representative of the Medical Staff or the Hospital has requested information.
- H. That there ~~shall~~will be, to the fullest extent permitted by law, absolute immunity from civil liability arising from any such act, communication, report,

~~recommendation, or disclosure, even when the information involved would otherwise be deemed to be privileged.~~

~~I. That such immunity ~~shall~~will apply to all acts, communications, reports, or recommendations made in connection with this or any other health care institution's activities related, but not limited, to:~~

~~8. Application for appointment or Clinical Privileges;~~

~~9. Periodic reappraisal for reappointment or Clinical Privileges;~~

~~10. Summary suspension;~~

~~11. Hearing and appellate review;~~

~~12. Professional care evaluation;~~

~~13. Utilization review; and~~

~~14. Other Hospital, Medical Staff, Clinical Service or committee activities related to quality patient care and professional conduct.~~

~~J. That the acts, communications, reports, recommendations and disclosures referred in this section may relate to a Practitioner's professional qualification, clinical competency, character, physical or mental health, ethics or any other matter that might directly or indirectly have an effect on patient care.~~

~~Section 11. Access to Own Credentials File~~

~~Medical Staff Members ~~shall be granted~~will be provided access to their own credentials file, subject to the following provisions:~~

~~E. Timely notice of a request for access ~~shall~~will be made by the member to the Chief of Staff or designee;~~

~~F. The Member may review and receive a copy of only those documents provided by or addressed personally to the ~~m~~Member.~~

~~G. A summary of all other information, including but not limited to peer review findings, letters of reference, and proctoring reports and complaints, ~~shall~~will be provided to the Member, in writing, by the Chief of Staff, at the time the Member reviews the credentials file or within a reasonable period of time after receipt of a request for such summary, as determined by the MEC. Such summary ~~shall~~will disclose the substance, but not the source, of the information summarized; and~~

~~H. The review by the Member shall will take place in the Medical Staff Office, during regular working hours, with the Chief of Staff or designee present.~~

Section 12. Rights to Request Corrections/Additions

~~Medical Staff Members may exercise the right to request the corrections or appropriate additions to credentials file information following the below listed protocol.~~

~~F. After reviewing the file, a Member may address a written request to the Chief of Staff asking for correction or deletion of information in the credentials file. Such request shall will include a statement of the basis for the action requested.~~

~~G. The Chief of Staff shall will review such a request within a reasonable time and shall will recommend to the MEC, after such review, whether or not to make the correction or deletion requested.~~

~~H. The MEC, when so informed, shall will either ratify or initiate action contrary to this recommendation.~~

~~I. The Member shall will be notified promptly, in writing, of the decision of the MEC.~~

~~E. In any case, Members shall will have the right to add to their own credentials file, upon written request to the MEC, a statement responding to any information contained in the file.~~

ARTICLE VI: MONITORING AND CORRECTIVE ACTION

Section 1. Focused Routine and Issue-Related Monitoring and Peer Review

The Chiefs of the Clinical Services are responsible for carrying out ~~delineated quality~~ peer review and other quality improvement functions for their services. In the event of a concern or complaint regarding a ~~Medical Staff member~~ Member, the Chiefs of the Clinical Services are responsible for delegating a focused peer review as set forth in these ~~Bylaws~~ bylaws. Based on the results of the routine or focused peer review, the Chief of the Clinical Services may counsel, educate, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out his or her duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. The Practitioner ~~shall~~ will be given an opportunity to respond in writing and to discuss the matter with the Chief of the Clinical Service. Any informal actions, monitoring, or counseling ~~shall~~ will be maintained in the Chief of the Clinical Service file. The Medical Executive Committee (“MEC”) approval is not required for such actions, although the actions ~~shall~~ will be reported to the MEC. ~~The Such~~ actions ~~shall~~ will not constitute a restriction of privileges or grounds for the procedural rights under Article VII.

Section 2. Professional Standards of Behavior

The Chiefs of the Clinical Service are responsible for monitoring the professional behavior of Members of their service and addressing ~~disruptive and~~ inappropriate behaviors.

- A. Expected Behaviors of Members ~~and Affiliated Professionals of the Medical Staff~~. All Members ~~of the Medical Staff and Affiliated Professionals~~ are expected to treat patients and their families and other visitors, as well as other providers, nurses, ancillary staff, and trainees in a courteous, dignified, and culturally respectful manner.
- B. Examples of ~~Disruptive and Inappropriate Behaviors~~ ~~Behaviors~~ include, but are not limited to the following:
 - 1. Shouting or using vituperative language.
 - 2. Use of profanity directed at an individual.
 - 3. Slamming or throwing objects
 - 4. Physical or verbal intimidation ~~and~~, harassment, or violence.

5. Hostile, condemning, or demeaning communications.
6. Derisive, insulting, or demeaning criticism of performance.
7. Deliberate failure to abide by ~~hHospital~~hospital or departmental Policies and Procedures, Medical Staff bylaws and Rules and Regulations, including refusal to comply with required duties.
8. Behavior disruptive to the delivery of quality patient care and an environment free of harassment and violence.
9. Retaliation against any person who addresses or reports incidents of ~~unacceptable~~ inappropriate behavior. Expressing contrary opinions is not disruptive conduct, nor is expressing concern regarding constructive criticism of existing policies or procedures or questioning potentially unacceptable performance or conditions, if it is done in good faith, in an appropriate time, place and manner, and with the aim of improving the environment of care rather than personally attacking any individual.

~~C. The Director of Health, or her/his designee, may restrict a Member's access to LHH infrastructure facilities or systems in instances involving violations of federal, state, or local laws or regulations, or LHH rules, policies or procedures that are not primarily related to quality of patient care, including, but not limited to, any violation of patient confidentiality laws, regulations, policies or procedures. The Director of Health or her/his designee may restrict, suspend, or permanently revoke access to patient health records kept or maintained by the City and/or to physical locations (LHH, or other building owned or operated by the City). The approval of the MEC is not required for such actions.~~

Section 3. Review of Investigation in Response to Alleged Disruptive and Inappropriate Behavior

- A. Alleged violations ~~of these Bylaws, other relevant policies, or the Code of Professional Conduct~~ may be reported by any hospital personnel using the confidential and 1157-protected Unusual Occurrence (UO) reporting form designed for this purpose, ~~or reported in writing to a direct supervisor, the Chief of Service, or the Chief of Staff.~~ Confidentiality will be maintained throughout the investigation of the alleged behavior and for any counseling, warning, or disciplinary action resulting from the investigation, except that the identity of the persons involved in the incident and reporting the incident may be provided to the person allegedly demonstrating the Disruptive or Inappropriate Behavior and others involved in the process in order to ensure a productive resolution. The person allegedly demonstrating Disruptive or

Inappropriate Behavior will be informed of the UO in writing by the Chiefs of the Clinical Service or designee and have the opportunity to respond in writing to the allegations or refute the allegations. If the review finds that the allegation does not meet the level of Disruptive and Inappropriate Behavior, the report will be closed and dismissed. Dismissed reports will not be considered in determination of recurrent Disruptive and Inappropriate Behaviors.

- B. The Chiefs of the Clinical Service or designee ~~shall~~will conduct an initial ~~review~~investigation within five business days of being notified by Risk Management of a UO Report or otherwise becoming aware of the issue. When ~~the a~~ Chiefs of the Clinical Service is the subject of the alleged behavior, the Chief of Staff or designee will conduct the investigation. The Chiefs of the Clinical Service or designee must discuss each UO report with the affected Member. The Chiefs of the Clinical Service, Chief of Staff, or designee will take appropriate action based on the following guidelines:
1. **Dismissed/No Action:** The alleged behavior does not meet the level of ~~Disruptive and inappropriate Behavior~~Inappropriate Behavior as defined in violation of these Bylaws, applicable policies, or the Code of Professional Conduct. The Chiefs of the Clinical Service or designee will report this outcome to Risk Management within five business days of completion of the ~~critical review~~initial investigation, including a brief explanation of why the alleged behavior did not meet the level of ~~disruptive and~~ inappropriate behavior as ~~defined by~~described in these Bylaws. The UO report will be recorded as “dismissed”. No further action ~~shall~~will be taken.
 2. **Meeting for Resolution:** The behavior is relatively minor, had low potential to adversely affect patient care, and likely can be resolved by a meeting of the involved parties. The Chiefs of the Clinical Service or designee may convene and facilitate a face-to-face ~~M~~meeting Meeting for Resolution between the Member and the affected party within ten business days of completion of the initial review. The Chief of Staff may help identify an alternative facilitator/mediator upon request. The Chiefs of the Clinical Service or designee will document for inclusion in the Member’s credentials file, at minimum, the time, place, persons involved and substance of the alleged behavior, as well as the time, place, persons involved, and substance of the face-to-face meeting, and if a UO was generated will notify Risk Management of the satisfactory outcome of the Meeting for Resolution.
 3. **Verbal Counseling:** The behavior had the potential to adversely affect patient care and is a first confirmed ~~Disruptive or inappropriate~~Inappropriate Behavior event for the Member. The Chiefs of the Clinical Service or designee ~~shall~~will verbally counsel the Member when an instance of ~~Disruptive and inappropriate~~Inappropriate Behavior.

~~Behavior~~ warrants such counseling within five business days of completion of the initial ~~review~~investigation. The ~~vVerbal Counseling shall~~Verbal Counseling shall emphasize the particular conduct that is inappropriate and stress that future similar conduct may result in more formal action under the Corrective Action procedures or as allowed by these Bylaws. ~~A-The Chief of the Clinical Services or designee will create a~~ record of the ~~vVerbal Counseling~~Verbal Counseling will be kept by the Chiefs of the Clinical Service or designee will document for inclusion in the ~~mMember's~~member's credentials file which will include: (1) the time, place, persons involved and substance of the alleged behavior, (2) the time, place, persons involved, and substance of the ~~vVerbal Counseling~~Verbal Counseling, and (3) expectations, the action plan, and the consequences of repeat behavior of a similar nature (which will include ~~wWritten cWritten Counseling~~). The Member ~~also~~ may also be directed by the Chiefs of the Clinical Service or designee to issue an apology to the involved party or parties. The Chiefs of the Clinical Service or designee ~~shall~~will maintain documentation of the counseling and if a UO was generated, notify Risk Management of this outcome.

4. **Written Counseling:** The behavior had the potential to adversely affect patient care and is sufficiently serious to make ~~vVerbal Counseling~~Verbal Counseling insufficient, inappropriate, or it represents recurrent ~~Disruptive and inappropriate Behavior~~Inappropriate Behavior that previously was addressed with ~~vVerbal Counseling~~Verbal Counseling. The Chiefs of the Clinical Service or designee will meet with the Member and write a formal letter within ten business days of completion of the initial ~~review~~investigation that sets forth, at minimum, (1) the serious nature of the ~~Disruptive and inappropriate Behavior~~Inappropriate Behavior (including the time, place, persons involved and substance of the alleged behavior), (2) reiterates any previous ~~fFace-to-fFace~~ meeting and ~~vVerbal cVerbal Counseling~~ in relation to similar ~~Disruptive and inappropriate Behavior~~Inappropriate Behavior exhibited by the Member, (3) emphasizes the responsibility of Medical Staff Members to treat all persons at the Hospital courteously, respectfully, and with dignity, and (4) informs the Member that future similar conduct may result in referral of the matter to the Medical Executive Committee for possible Corrective Action. The letter will include expectations, the action plan, and the consequences of repeat behavior of a similar nature. The Member ~~also~~ may also be directed by the Chiefs of the Clinical Service to issue an apology to the involved party or parties. A copy of the ~~wWritten Counseling~~Written Counseling shall be sent to the Chief of Staff, Chief Medical Officer, and the Medical Staff Services Office for inclusion in the Member's peer review (credentials) file. The Member may submit a letter of rebuttal within ten business days of the meeting between the Chiefs of the Clinical Service and the ~~mMember~~member; that will be placed in the Member's peer review file. The Chiefs of the Clinical

Service will report this outcome to Risk Management, within ten business days of the meeting between the Chiefs of the Clinical Service and the member.

5. **Action plans** may include remedial education, referral for psychological evaluation and treatment, referral for anger management counseling, or other professional assistance programs. The Chiefs of the Clinical Service ~~are is~~ encouraged to consult freely with the Chief of Staff, Chief Medical Officer, and/or ~~Executive Administrator~~Nursing Home Administrator in determining the appropriate plan of action. The ~~level of action may be revised by the~~ Chiefs of the Clinical Service, in consultation with the Chief of Staff, Chief Medical Officer, and/or Nursing Home Administrator as appropriate, may revise the level of action after further information is obtained in the course of investigation and counseling.

6. **Risk Management** will log UO reports and all outcomes, track trends, and report aggregate data to the Medical Quality Improvement Committee and to the ~~Executive Administrator~~Nursing Home Administrator twice annually. The identity of individual Members will not be disclosed in these reports.

Section 4. Medical Executive Committee Approval is Not Required and Procedural Rights are not Triggered

The approval of the MEC is not required for actions taken by the Chiefs of the Clinical Service as set forth in Section 3 herein nor do such actions give rise to procedural rights for the Member, ~~unless such actions would otherwise be reportable under Business and Professions Code Section 805.~~

Section 5. Formal Investigation

A. Criteria for Initiation of Corrective Action

1. A corrective action Investigation may be initiated whenever reliable information indicates that a member may have exhibited acts, demeanor, or conduct, either within or outside of the Hospital, that is reasonable likely to be:
 - a. detrimental to patient safety or to the delivery of quality patient care within the Hospital;
 - b. unethical;
 - c. contrary to the ~~Medical Staff se~~ Bylaws or Rules and Regulations;
 - d. below applicable professional standards;

- e. ~~disruptive detrimental of to~~ Medical ~~Medical~~ Staff or Hospital operations;
 - f. an improper use of Hospital resources; or
 - g. in violation of the fraud and abuse statutes or other regulations governing billing and reimbursement matters.
2. Any person who believes that corrective action may be warranted may provide information to the Chief of Staff, any other Medical Staff member, any other Medical Staff officer, any Clinical Service Chief, the Chief Medical Officer, the Governing Body, or the Executive Administrator Nursing Home Administrator. ~~Medical Staff~~ ~~mMembers~~ ~~members~~ who are not a Medical Staff officer, a Clinical Service Chief, or the Chief Medical Officer will convey this information to a Medical Staff officer, a Clinical Service Chief, or the Chief Medical Officer.

B. Initiation of a Formal Investigation

1. If the Chief of Staff, any other Medical Staff officer, any Clinical Service Chief, the Chief Medical Officer, the Governing Body, or the Executive Administrator Nursing Home Administrator determines that corrective action may be warranted, that person or entity may request the initiation of a ~~fFormal~~ ~~iFormal~~ Investigation. Such requests must be conveyed to the MEC in writing.
2. If the MEC concludes that an investigation is warranted, it ~~shall~~ will direct an investigation to be undertaken. The Chief of Staff ~~shall~~ will notify the Executive Administrator Nursing Home Administrator, or ~~his or her~~ their designee ~~in his or her absence~~, and the MEC, and ~~shall~~ will continue to keep them fully informed of all action taken. The Chief of Staff ~~shall~~ may initially investigate the matter ~~and, in conjunction with the MEC, may resolve the problem by discussing it with the practitioner and others;~~ or assign an Officer of the Medical Staff, a ~~Professional Activities Committee~~ standing committee, or ~~an Ad Hoc Committee~~ Ad Hoc Committee to formally investigate the matter.

C. Formal Investigation Process

1. The affected Practitioner ~~shall~~ will be given an opportunity for an interview with MEC to discuss or refute the charges. Such an interview ~~shall~~ does not constitute a “hearing” ~~as described in these Bylaws~~ and none of the procedural rights with respect to hearings or appeals ~~shall~~ will apply. The investigating entity must maintain a written record of the proceedings, including AaA record of the matters discussed and the findings resulting from the interview ~~shall be made.~~

2. If the formal investigation is delegated to an officer or committee other than the MEC, such officer or committee ~~shall~~must proceed with the ~~i~~investigation in a prompt manner and ~~shall~~will forward a written report of the ~~i~~investigation to the MEC as soon as practicable, but no later than sixty days from the initiation of the investigation, unless the circumstances of the matter warrant an extension of the investigation by the Chief of Staff. The report ~~shall~~will~~will~~ include findings of fact and recommendations for appropriate corrective action.
3. Regardless of the status of an investigation, the MEC ~~shall~~will~~will~~ retain the authority and discretion at all times to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

D. Medical Executive Committee Action

As soon as practicable after the conclusion of a formal investigation, but no later than thirty days after the conclusion of the investigation, the MEC ~~shall~~will take action, which may include, without limitation:

1. Determining that additional information is needed, in which case MEC will direct how that information will be obtained for consideration by the Investigator or MEC.
- ~~1.2.~~ Determining no corrective action be taken, and if the MEC determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the ~~M~~member's file;
- ~~2.3.~~ Deferring action for a reasonable time when circumstances warrant;
- ~~3.4.~~ Issuing letters of admonition, censure, reprimand, or warning, although nothing herein ~~shall be deemed to preclude~~preclude Clinical Service Chiefs or committee chairs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected ~~m~~Member~~member~~ may make a written response which ~~shall~~will be placed in the ~~m~~Member's~~member's~~ file;
- ~~4.5.~~ Recommending the imposition of terms of probation or special limitation upon continued Medical Staff membership or exercise of Clinical Privileges, including, without limitation, requirements for co-admission, mandatory consultation, or monitoring.
- ~~5.6.~~ Recommending reduction, modification, suspension or revocation of Clinical Privileges and, if suspension is recommended, the terms and duration of the suspension and the conditions that must be met before the suspension is ended; ~~shall~~must be stated;

~~6.7.~~ 6.7. Determining whether the action is taken or the recommendation is issued for any of the reasons required to be reported pursuant to Business & Professions Code Section 805.01; and

~~7.8.~~ 7.8. Taking other actions deemed appropriate under the circumstances.

E. Procedural Rights

1. **When no corrective action is recommended.** If the MEC determines that no corrective action is required ~~or~~, that only a letter of warning, admonition, reprimand, or censure should be issued, or that other action is to be taken that is not reportable to the Member's professional licensing organization, the decision ~~shall~~ will be transmitted to the Governing Body. The Governing Body ~~shall~~ will give great weight to the MEC's decision and may affirm, reject, or modify the action only if the failure to act is contrary to the weight of the evidence that is before it, and then only after it has consulted with the MEC and the MEC still has not acted. The decision ~~shall~~ will become final if the Governing Body affirms it or takes no action on it within seventy (70) days after receiving the Notice of Decision.
2. **When corrective action is recommended.** If the MEC recommends an action that gives rise to grounds for a hearing, the Chief of Staff ~~shall~~ will give the Practitioner ~~Special~~ Notice within seven days of the decision of the adverse recommendation and of the right to request a hearing in accordance with these Bylaws. The Governing Body may be informed of the recommendation, but ~~shall~~ will take no action until the ~~Member~~ has either waived his or her right to a hearing or completed the hearing.

F. Initiation by Governing Body

If the MEC fails to investigate or take corrective action, contrary to the weight of the evidence, the Governing Body may direct the MEC to initiate an investigation, but only after written notice to the MEC. If the MEC fails to take action in response to the Governing Body's direction, the Governing Body may initiate an investigation, but any corrective action must comply with these ~~Medical Staff~~ Bylaws. The Governing Body ~~shall~~ must inform the MEC in writing of such action.

Section 6. City and County of San Francisco Employees

Nothing in these Bylaws is intended to limit the City and County of San Francisco's ability to take appropriate disciplinary action with respect to City and County employees. The City has its own processes for employee discipline or other issues that are separate and distinct from processes under these Bylaws. To the extent that the City takes action against employees through its respective processes, such processes include appropriate due process protections.

Section 7. Summary Restriction or Suspension

- A. Whenever a Practitioner's conduct is such that a failure to take action may result in imminent danger to the health or safety of any individual, the Chief of Staff or the Chief Medical Officer may summarily restrict or suspend the Medical Staff membership or Clinical Privileges of such ~~mMember~~member.
- B. Unless otherwise stated, such summary restriction or suspension ("Summary Action") ~~shall becomes~~become effective immediately upon imposition, and the person or body responsible ~~shall will~~ promptly give written ~~Special Notice~~Notice to the member, and ~~Notice~~Notice to the MEC, the ~~Executive Administrator~~Nursing Home Administrator and the Governing Body generally describing the reasons for the action.
- C. The Summary Action may be limited in duration and ~~shall will~~ remain in effect for a stated period or until resolved as set forth ~~herein in these Bylaws.~~ Unless otherwise indicated by the terms of the summary action, the Chief of the involved Clinical Service ~~shall will~~ make the necessary arrangements to provide alternate coverage for proper and necessary patient care during the period of restriction or suspension.
- D. The notice of the Summary Action given to the MEC ~~shall will~~ constitute a request to initiate corrective action and the procedures set forth ~~herein in these Bylaws shall must~~ be followed.
- E. The affected Practitioner may request an interview with the MEC. The interview ~~shall must~~ be convened as soon as reasonably practicable under the circumstances but in no event less than seven (7) days after the Summary Action was taken, ~~and shall be informal and the interview does and~~ not constitute a hearing, as that term is used in these Bylaws, and none of the procedural rights ~~herein under these Bylaws shall~~ apply. The MEC may thereafter continue, modify, or terminate the terms of the Summary Action. It ~~shall will~~ give the Practitioner written ~~Special Notice~~ of its decision, ~~which must include the information specified under these Bylaws, if the action constitutes grounds for a hearing.~~
- F. **Procedural Rights.** Unless the MEC terminates the Summary Action, it ~~shall remains~~remain in effect during the completion of the corrective action and hearing and appellate review process. When a Summary Action is

continued, the affected Practitioner ~~shall be~~ entitled to the procedural rights set forth ~~hereinunder these Bylaws~~, but the hearing may be consolidated with the hearing on any other corrective action that is recommended so long as the hearing commences within sixty (60) days after the hearing on the Summary Action was requested.

- G. If no one authorized to take a Summary Action is available to summarily restrict or suspend a ~~M~~member's membership or Privileges, the Governing Body (or its designee) may immediately suspend or restrict a ~~m~~Member's ~~member's~~ Privileges if failure to do so may result in imminent danger to the health of any individual, provided that the Governing Body (or its designee) has made reasonable attempts to contact the Chief of Staff, the MEC, and the Chief of the Service to which the member is assigned before acting.
- H. Such Summary Action ~~imposed under subsection VI(7)G~~, is subject to ratification by the MEC. If the MEC does not ratify such ~~S~~summary ~~A~~summary action within two (2) working days of its imposition, excluding weekends and holidays, the summary action ~~shall will~~ terminate automatically.

Section 8. Administrative Suspension of Privileges

Basis for Administrative Suspensions: The Chief of Staff may administratively suspend a Member's privileges for failing to complete training mandated by the ~~H~~Hospital/hospital for regulatory purposes, failing to complete medical record documentation on a timely basis, failing to complete administrative responsibilities as required by the Chief of the Clinical Service or ~~Chief Executive Officer~~Nursing Home Administrator, and failure to obtain required health screening. Such administrative suspensions ~~shall do~~ not give rise to the due process rights of these Bylaws unless the suspension is in place for more than fourteen (14) days and therefore becomes reportable to the ~~Member's professional licensing organization (such as the~~ Medical Board).

Section 9. Automatic Suspension or Termination

In the following instances, the ~~M~~member's Privileges or membership may be suspended or limited as described:

- A. Whenever a ~~m~~Member's ~~member's~~ license or other legal credential authorizing practice in this state is revoked, limited, suspended, or expires without an application pending for renewal, Medical Staff membership and Privileges ~~shall be~~ automatically revoked as of the date such action becomes effective.
- B. Whenever a ~~m~~Member's ~~member's~~ license or other legal credential authorizing practice in this state is limited or restricted by the applicable

licensing or certifying authority, any Privileges ~~which~~ that are within the scope of such limitation or restriction ~~shall beare~~ automatically limited or restricted in a similar manner, as of the date such action becomes effective and throughout its term.

- C. Whenever a ~~mMember~~ member is placed on probation by the applicable licensing or certifying authority, ~~his or her~~ their membership status and Privileges ~~shall~~ automatically become subject to the same terms and conditions of the probation as of the date such action becomes effective and throughout its term.
- D. Whenever a ~~mMember's~~ member's DEA certificate is revoked, limited, or suspended or expires, the member ~~shall~~ will automatically and correspondingly be divested of the right to prescribe medications covered by the certificate as of the date such action becomes effective and throughout its term.
- E. Whenever a ~~mMember's~~ member's DEA certificate is subject to probation, the ~~M~~ member's right to prescribe such medications ~~shall~~ will automatically become subject to the same terms of the probation as of the date such action becomes effective and throughout its term.
- F. Whenever a ~~M~~ member who is not employed by the City and County of San Francisco fails to maintain professional liability insurance in the manner described ~~in Article II, Section 3 (C) "Professional Liability Insurance"~~ of under these Bylaws, then the Member ~~shall~~ will automatically be suspended from the Medical Staff and ~~shall~~ will remain suspended until adequate evidence of insurance is provided. If the ~~M~~ member fails to provide adequate evidence of insurance within six (6) months, it ~~shall beis~~ deemed as a voluntary resignation from the Medical Staff.
- G. Whenever a ~~mMember~~ member fails to complete medical records in the time prescribed by the MEC and reasonable notice has been given, such failure to timely complete medical records ~~shall~~ will result in an automatic suspension until such time as the medical records are completed. Such suspension ~~shall~~ will apply to the Medical Staff member's right to admit, treat, or provide services to new Residents in the Hospital, but ~~shall~~ will not affect the right to continue to care for a Resident the ~~Medical Staff~~ mMember member has already admitted or is treating. The suspension ~~shall~~ will continue until the medical records are completed.
- H. A Member's privileges automatically revoked, suspended, restricted or limited under this subsection ~~139~~, may be reinstated only upon written notice from the Chief of Staff or his/her designee ~~and with the consent of the Executive Administrator~~ Nursing Home Administrator. Such reinstatement may include restrictions if imposed in accordance with subsection 7. If the Member provided patient care at LHH, or any City-

affiliated institution while the Member's license or credential was revoked, suspended, expired, limited, restricted or while the Member was on probation, reinstatement may not be granted until all instances of the Member's patient care during that time are reviewed to ensure that appropriate care was rendered, and to prevent improper billing.

Section 10. Procedural Rights for Automatic Suspensions and Terminations

Practitioner whose Privileges are automatically suspended and/or who have been deemed to have automatically resigned their Medical Staff membership ~~shall will~~ not be entitled to the procedural rights set forth in Article VII unless the suspension or resignation is reportable pursuant to California Business and Professions Code Section 805.

Section 11. Notice of Automatic Suspension and Transfer of Patients

~~Special~~—Notice of an automatic suspension ~~shall must~~ be given to the suspended individual and notice of the suspension ~~shall will~~ be given to the Chief of Service, MEC, ~~Executive Administrator~~Nursing Home Administrator, and Governing Body, but such notices ~~shall are~~ not ~~be~~ required for the suspension to become effective. Residents affected by an automatic suspension ~~shall will~~ be assigned to another Member by the Clinical Service Chief or Chief of Staff.

Section 12. Automatic Termination

If a Practitioner is suspended for more than six (6) months, ~~his or her~~their membership (or the affected Privileges, if the suspension is a partial suspension) ~~shall be is~~ automatically terminated. Thereafter, reinstatement to the Medical Staff ~~shall requires~~require an application and compliance with the appointment procedures applicable to ~~initial new a~~Applicants~~applicants~~.

ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

Section 1. General Provisions

A. Definitions

Except as otherwise provided in these Bylaws, the following definitions ~~shall~~ apply under this Article:

1. "Body Whose Decision Prompted the Hearing" or "Respondent" refers to the MEC in all cases when the MEC or authorized Medical Staff officers, members or committees took the action or rendered the decision, which resulted in a hearing being requested. It refers to the Governing Body in all cases when the Governing Body or its authorized officers, directors or committees took the action or rendered the decision that resulted in a hearing being requested.

2. "Party" and "Parties" refer to the Petitioner and Respondent, individually (Party) or collectively (Parties).

2.3. "Petitioner" as used in this Article refers to the Practitioner who has requested a hearing pursuant to this Article.

B. Substantial Compliance

Technical, insignificant or non-prejudicial deviations from the procedures set forth in these Bylaws ~~shall~~ are not ~~be~~ grounds for invalidating the action taken.

1. Exhaustion of Remedies

If an adverse action as described in this Article is taken or recommended, the Petitioner must exhaust the remedies afforded by these Bylaws before resorting to legal action.

Section 2. Grounds for Hearing

A. Except as otherwise specified in these Bylaws, any one or more of the following actions or recommended actions regarding a Member of the Medical Staff shall be ~~is~~ deemed an actual or potential adverse action and constitutes ~~constitute~~ grounds for a hearing.

1. Denial of Medical Staff appointment, reappointment and/or Privileges;

2. Revocation, suspension, restriction, or involuntary reduction of Medical Staff membership and/or ~~pPrivileges;privileges~~
3. Involuntary imposition of significant consultation or proctoring (excluding proctoring incidental to Initial or Temporary Medical Staff Membership or Privileges);~~;-~~
4. Summary suspension or restriction of Medical Staff membership and/or Privileges during corrective action and hearing and appeals procedures;~~;-~~ or;
5. Any other corrective action or recommendation that must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to Business and Professions Code Section 805.

B. Actions Taken by Director of Health.

1. The Medical Staff has authority, as outlined by these Bylaws, to consider whether to revoke, suspend, or restrict Privileges conferred by these Bylaws based on the conduct of a Member or Affiliated Professional. Actions taken by the Director of Health, or his/her designee, pursuant to the Director's administrative authority, Department of Public Health policies, or Hospital policies are not subject to a hearing under these Bylaws. Article VI Section 2 (C) are subject to hearing under these Bylaws only for the purpose of determining whether to revoke, suspend, or restrict privileges conferred by these Bylaws.

- 1.2. The Director of Health, or their designee, may restrict a Member's or Affiliated Professional's access to Hospital infrastructure, facilities, or systems in instances involving violations of federal, state, or local laws, or Hospital rules, regulations, or policies that are not primarily related to quality of patient care, including but not limited to any violation of patient confidentiality laws, regulations, or policies. The Director of Health or their designee may restrict, suspend, or permanently revoke access to patient health records kept or maintained by the City and/or to physical locations (the Hospital, clinics, or other buildings owned or operated by the City) in this manner. The approval of the MEC is not required for such actions.

- C. Removal from a position as Chief of a Clinical Service or as an Officer of the Medical Staff, or termination from the Medical Staff following two (2) years of inactive status, ~~shall~~ does not constitute grounds for a hearing.

Section 3. Request for Hearing

A. Notice of Action or Proposed Action

The Petitioner ~~shall~~must be notified in writing by ~~Special~~“Notice” of any recommendation or action which would constitute grounds for a hearing. The ~~n~~Notice ~~shall~~must inform the Petitioner of the following:

1. What action has been proposed against the Petitioner;
2. Whether the recommendation will be reported under Business and Professions Code Section 805.01, or if finally adopted by the Governing Body, reported to the Member’s professional licensing organization (such as the Medical Board) under Business and Professions Code Section 805 and to the National Practitioner Data Bank;
3. A concise statement of the reasons for the action or recommendation, including the acts or omissions with which the member is charged;
4. That the Petitioner may request a hearing;
5. That a hearing must be requested within thirty (30) days of the Special Notice; and
6. That the Petitioner has the hearing rights described in the Medical Staff Bylaws.

B. Request for Hearing

The Petitioner ~~shall have~~has thirty (30) days from the date of the ~~Special~~ Notice of such action or proposed action to request a hearing. The request for hearing ~~shall~~must be in writing addressed to the Chief of Staff with a copy to the ~~Executive Administrator~~Nursing Home Administrator. If the Petitioner does not request a hearing within the time and manner described, the Petitioner ~~shall~~will be deemed to have waived any right to a hearing and accepted the recommendation—~~or action involved~~. Such final recommendation ~~shall~~will be considered by the Governing Body within seventy (70) days ~~and shall~~. The Governing Body must consider such final recommendation, but the recommendation is not binding on the Governing Body, which will exercise its independent authority to render a final decision on the matter. ~~be given great weight by the Governing Body, although it is not binding on the Governing Body.~~

Section 4. Hearing Procedure

A. Hearings Prompted by Governing Body Action

If the hearing is based upon an adverse action by the Governing Body, the ~~Chair~~ President of the Governing Body or their designee shall will fulfill the functions assigned in this Section to the Chief of Staff.

B. Time and Place for Hearing

Upon receipt of a timely request for a hearing made by the Petitioner, the Chief of Staff ~~shall will~~ notify the ~~Executive Administrator~~ Nursing Home Administrator and the MEC, appoint a Judicial Review Committee, and ~~shall~~ schedule and arrange for a hearing before the Judicial Review Committee. The Chief of Staff ~~shall will~~ give ~~Special~~ Notice of the hearing within thirty (30) days after receipt of a request for it. The ~~n~~Notice ~~shall will~~ state the time, place, and date of the hearing. The date of the commencement of the hearing ~~shall will~~ be not less than thirty (30) days and not more than sixty (60) days from the date the Chief of Staff received the hearing request.

C. Notice of Charges

As part of, or together with, the notice of place, time and date of the hearing, the Chief of Staff ~~shall must~~ state in writing the reasons for the action taken or recommended, the acts or omissions with which the Petitioner is charged, and a list of the charts in question, when applicable. The Petitioner ~~shall must~~ be provided with a summary of the rights to which s(he) is entitled at the hearing. A supplemental notice of charges may be issued at any time provided the Petitioner is given sufficient time (at least seven (7) days) to prepare.

D. Judicial Review Committee

The Chief of Staff ~~shall will~~ appoint a Judicial Review Committee composed of not less than three (3) unbiased ~~mMembers~~ members of the Active Medical Staff who ~~shall will~~ gain no direct financial benefit from the outcome and who have not acted as accuser, investigator, fact finder, initial decision maker, or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. The Chief of Staff will appoint one of these members to serve as Chair. Knowledge of the matter involved ~~shall does~~ not preclude a member of the Medical Staff from serving as a member of the Judicial Review Committee. In the event it is not possible to appoint all Judicial Review Committee members from the Active Medical Staff, the Chief of Staff may appoint a ~~M~~member or members from other Medical Staff categories or Practitioners affiliated with DPH who are not members of the Medical Staff. When feasible, the Judicial Review Committee ~~shall will~~ include at least one (1) member who has the same healing arts licensure as the Petitioner and who practices in the same

specialty as the Petitioner. The Chief of Staff may appoint alternates who meet the standards described above and who can serve if a Judicial Review Committee member becomes unavailable.

E. The Hearing Officer

The Chief of Staff ~~shall~~will appoint a Hearing Officer to preside at the hearing. The Hearing Officer ~~shall~~must be an attorney at law qualified to preside over a quasi-judicial hearing, but not from a law firm regularly utilized by the Hospital, Medical Staff, involved Practitioner or Applicant for legal advice. The Hearing Officer ~~shall~~must not be biased for or against any party, ~~shall~~must not gain ~~no~~any direct financial benefit from the outcome, and must not act as a prosecuting officer or as an advocate.

The Hearing Officer ~~shall~~must 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 maintain~~ proper decorum ~~is maintained~~. The Hearing Officer ~~shall~~will ~~entitled to~~ determine the order of or procedure for presenting evidence and argument during the hearing and ~~shall have the~~has authority and discretion to make all rulings on questions which pertain to matters of law, procedure, or the admissibility of evidence that are raised prior to, during or after the hearing, including deciding when evidence may not be introduced, granting continuances, ruling on disputed discovery requests, and ruling on challenges to Judicial Review Committee members or himself or herself serving as the Hearing Officer.

At the commencement of the hearing, the ~~hHearing eOfficer~~hearing officer may also apprise the ~~jJudicial rReview eCommittee~~judicial review committee of its right to terminate the hearing due to the ~~member's~~ Petitioner's failure to cooperate with the hearing process but ~~shall~~will not independently make that determination. Except as provided above in this subsection E, if the Hearing Officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the Hearing Officer may take such discretionary action as ~~seems~~may be warranted by the circumstances, including, but not limited to, limiting the scope of examination and cross-examination and setting reasonable time limits on either side's presentation of its case. If requested, the Hearing Officer should participate in the deliberations of the Judicial Review Committee and be a legal advisor to it, but the Hearing Officer ~~shall~~does not ~~be entitled to have a~~ vote on the Judicial Review Committee.

F. Representation

The Petitioner ~~shall~~is, be entitled, at his or her own expense and choosing, to be represented by an attorney in any phase of the hearing. In the absence of legal counsel, the Petitioner ~~shall~~will be entitled to be

accompanied by and represented at the hearing by an individual of the Practitioner's choosing. If the Petitioner is represented by legal counsel, the MEC may also be represented by legal counsel. The MEC ~~shall~~ may not be represented by legal counsel if the Petitioner is not so represented. The Judicial Review Committee ~~shall~~ will determine the role of legal counsel and may reject any such counsel whose activities at the hearing are, in the judgment of the Hearing Officer, disruptive to the proper conduct of the hearing proceedings. The Body Whose Decision Prompted the Hearing ~~shall~~ will appoint a representative from the Medical Staff to present the recommendation and supporting evidence ~~in support thereof~~ and to examine witnesses.

1. The Petitioner ~~shall~~ must state, in writing, his or her intentions with respect to attorney representation at the time ~~he or she~~ they files the request for a hearing. Notwithstanding the foregoing and regardless of whether the Petitioner elects to have attorney representation at the hearing, the parties ~~shall~~ will have the right to consult with legal counsel to prepare for a hearing or an appellate review.
2. ~~Any time attorneys will be allowed to represent the parties at a hearing;~~ ¶ The Hearing Officer ~~shall have~~ has the discretion to limit the ~~attorney's~~ attorney's role of attorneys to advising their clients rather than presenting the case.

G. Postponements and Extensions

Postponements and extensions of the time limits beyond those ~~expressly permitted~~ stated in these Bylaws may be requested by anyone, may be granted by the Hearing Officer on a showing of good cause, and will but shall be granted upon mutual agreement of the parties Parties or by the Hearing Officer on a showing of good cause and the Judicial Review Committee.

H. Failure to Appear or Proceed

Failure without good cause of the Petitioner to personally attend and proceed at a hearing in an efficient and orderly manner ~~shall be deemed to constitute~~ constitute voluntary acceptance of the recommendations ~~or actions~~ involved and such ~~actions recommendations shall take effect~~ will be forwarded to the Governing Body immediately, without further action required by the MEC or the Governing Body for adoption.

I. Discovery

1. Rights of Inspection and Copying

The Petitioner may inspect and copy (at his or her own expense) any documentary information relevant to the charges that the Body Whose

Decision Prompted the Hearing has in its possession or under its control. The Body Whose Decision Prompted the Hearing may inspect and copy (at its expense) any documentary information relevant to the charges that the Petitioner has in his or her possession or under his or her control. The requests for discovery ~~shall~~must be fulfilled as soon as practicable. Failure to comply with reasonable discovery requests at least thirty (30) days prior to the hearing ~~shall~~will be good cause for a continuance of the hearing. Petitioner must consult with the City Attorney's Office before accessing any patient medical record for purposes of preparing for the Hearing in order to ensure compliance with state and federal privacy rules.

2. Limited Limits on Discovery

The Hearing Officer ~~shall~~will rule on discovery disputes the parties cannot resolve. Discovery may be denied when justified to protect peer review or in the interest of fairness and equity. Further, the right to inspect and copy by either ~~pParty~~party does not extend to confidential information referring solely to individually identifiable Practitioners other than the Petitioner nor does it create or imply any obligation to modify or create documents in order to satisfy a request for information.

Protected health information of any patient is generally not to be disclosed during discovery and may only be produced in redacted form. If the volume of materials makes redaction unfeasible, then the Judicial Review Committee must impose reasonable restrictions, in consultation with the City Attorney's Office, to ensure that protected health information is not removed from the Hospital or disclosed.

3. Ruling on Discovery Disputes

In ruling on discovery disputes, the factors that the Hearing Officer may ~~be considered~~ include, but are not limited to the following:

- a. Whether the information sought may be introduced to support or defend the charges;
- b. Whether the information is "exculpatory" or "inculpatory" in nature;
- c. The burden on the ~~pParty~~party in possession of producing the requested information; and
- d. What other discovery requests the ~~pParty~~party has previously submitted/resisted.

4. Objections to Introduction of Evidence Previously Not Produced for the Medical Staff:

The Body Whose Decision Prompted the Hearing may object to the introduction of evidence that was not provided during an appointment or ~~initial privilege application review~~reappointment process or investigation of other matters at issue despite the requests of the Medical Staff for such information. The information will be barred from the hearing by the Hearing Officer unless the Petitioner can prove he or she previously acted diligently and could not have submitted the ~~information~~evidence at issue.

J. Pre-Hearing Document Exchange

At the request of either ~~pParty~~party, the ~~pParties~~parties shall must exchange copies of all documents that will be introduced at the hearing. The ~~documentation~~documents must be exchanged at least ten (10) days before commencement of the hearing. A failure to do so is good cause for a continuance.

K. Witness Lists

At the request of either ~~pParty~~party, each ~~pParty~~party shall must furnish to the other a written list of the names and addresses of the individuals, who are reasonably expected to give testimony or evidence in support of that ~~pParty~~party at the hearing. Nothing in the foregoing ~~shall will~~ preclude the testimony of additional witnesses whose possible participation was not reasonably anticipated. The ~~pParties~~parties shall must notify each other as soon as they become aware of the possible participation of such additional witnesses. The failure to have provided the name of any witness at least 10 days prior to the hearing date at which the witness is to appear ~~shall constitutes~~constitute good cause for a continuance.

L. Procedural Disputes

1. ~~It shall be the duty of t~~The pParties have a duty to the parties to exercise reasonable diligence in notifying the Hearing Officer of any pending or anticipated procedural disputes as far in advance of the scheduled hearing as possible in order that decisions concerning such matters may be made in advance of the hearing. Objections to any pre-hearing decisions may be succinctly made at the hearing.
2. The ~~pParties shall will~~parties shall be entitled to file motions as deemed necessary to give full effect to rights established by the Bylaws and to resolve such procedural matters as the Hearing Officer determines may properly be resolved outside the presence of the Judicial Review Committee. Such motions ~~shall must~~ be in writing and ~~shall must~~

specifically state the motion, all relevant factual information, and any supporting authority for the motion. The moving party ~~smust~~shall deliver a copy of the motion to the opposing party, who ~~shall~~will have five (5) working days to submit a written response to the Hearing Officer, with a copy to the moving party. The Hearing Officer ~~shall~~will determine whether to allow oral argument on any such motions. The Hearing Officer's ruling ~~on the motion shall~~ be in writing and ~~shall~~will be provided to the ~~pParties~~parties promptly ~~upon its rendering~~. All motions, responses and rulings ~~thereon shall~~must be entered into the hearing record by the Hearing Officer.

M. Record of Hearing

At the choosing of the Hospital, either a recording device or a shorthand reporter ~~shall~~will be present to make a record of the hearing proceedings. The cost of the recording device or shorthand reporter ~~shall~~will be borne by the Hospital, but the cost of the transcript, if any, ~~shall~~will be borne by the ~~P~~party requesting it. The Hearing Officer may, but ~~shall~~will not be required to, order that oral evidence be taken on oath or affirmation.

N. Rights of the Parties

Within reasonable limitations, the Petitioner may ask the Judicial Review Committee members and Hearing Officer questions ~~which that~~ are directly related to evaluating ~~their qualifications to serve and for challenging such the impartiality of the Judicial Review Committee mMembers~~members or the Hearing Officer. ~~Challenges to the impartiality of any Judicial Review Committee Member will be ruled on by the Hearing Officer, and challenges to the impartiality of the Hearing Officer will be ruled on by the Chief of Staff in consultation with the City Attorney's Office. Both sides Parties~~Both sides may call and examine witnesses for relevant testimony, introduce relevant exhibits or other documents, cross-examine or impeach witnesses who have testified orally on any matter relevant to the issues, and otherwise rebut evidence, receive all information made available to the Judicial Review Committee, and ~~to~~ submit a written statement at the close of the hearing, as long as these rights are exercised in an efficient and expeditious manner. The Petitioner may be called by the Body Whose Decision Prompted the Hearing or the Judicial Review Committee and examined as if under cross-examination. The Judicial Review Committee may interrogate the witnesses or call additional witnesses if it deems such action appropriate.

O. Rules of Evidence

Judicial rules of evidence and procedure relating to the conduct of the hearing, examination of witnesses, and presentation of evidence ~~shall do~~ not apply to a hearing conducted under this Article. The Hearing Officer will

~~admit, AnyAny relevant evidence, including hearsay, shall be admitted the Hearing Officer determines is relevant to the determination of the issues presented during the hearing. if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of such evidence in a court of law.~~

P. Burdens of Presenting Evidence and Proof

1. At the hearing, the Body Whose Decision Prompted the Hearing ~~has~~shall ~~have~~ the initial duty to present evidence for each case or issue in support of its ~~action or~~ recommendation. The Petitioner ~~shall be obligated to~~may present evidence in response.
2. ~~If the Petitioner is challenging denial of AnAn initial application applicant for membership and/or Privileges shall the Petitioner bears~~ the burden of persuading the Judicial Review Committee, by a preponderance of the evidence ~~(meaning that something is more likely than not to be true, based on a review of all relevant information),~~ that ~~he or she~~the Petitioner is qualified for membership and/or the ~~denied or restricted~~ Privileges. ~~The Petitioner must produce information which allows for adequate evaluation and resolution of reasonable doubts concerning his or her current qualifications for membership and Privileges.~~ Initial applicants ~~shall will~~ not be permitted to introduce information not produced upon request of the peer review body during the application process, unless the initial applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.
3. ~~In relation to other recommendations, Except as provided above for initial applicants for membership and/or Privileges, throughout the hearing the~~ Body Whose Decision Prompted the Hearing ~~shall~~ bears the burden of persuading the Judicial Review Committee, by a preponderance of the evidence, that its ~~action or~~ recommendation is reasonable and warranted.

Q. Adjournment and Conclusion

~~After consult, tThe hHearing eOfficerthe hearing officer~~ may adjourn the hearing and reconvene ~~the same at~~it the convenience of the participants without ~~Special Notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing providing any specific form of notice.~~ Upon conclusion of the presentation of oral and written evidence, the hearing ~~shall be~~is deemed closed. The Judicial Review Committee ~~shall thereupon~~must then, outside of the presence of any person ~~other than the Hearing Officer,~~ conduct its deliberations and ~~render thereafter~~issue a written a decision and

accompanying report listing the basis for the decision (the “Decision”) as set forth in these Bylaws.

R. Basis for Decision

The decision of the Judicial Review Committee ~~shall~~must be based on the evidence and written statements introduced at the hearing, including all logical and reasonable inferences from the evidence and testimony.

S. Decision of the Judicial Review Committee

Except as described below, ~~Within~~Within thirty (30) days after final adjournment of the hearing, the Judicial Review Committee ~~shall render~~must issue the a written dDecisiondecision. If the Petitioner is currently under suspension, ~~however,~~ the time for the ~~dDecisiondecision and report shall~~will be fifteen (15) days after final adjournment. Final adjournment ~~shall be~~is when the Judicial Review Committee has concluded its deliberations. A copy of the ~~dDecisiondecision shall~~must be ~~forwarded sent~~ to the ~~Executive Administrator~~Nursing Home Administrator, the MEC, the Governing Body, ~~and to the Petitioner, and if applicable, the Petitioner’s representative.~~ The ~~report shall~~Decision must contain the Judicial Review Committee’s findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the decision reached. Both the Petitioner and the Body Whose Decision Prompted the Hearing ~~shall~~must be provided a written explanation of the procedure for appealing the ~~dDecisiondecision.~~ The ~~dDecisiondecision~~ of the Judicial Review Committee ~~shall be~~is considered final, subject only to such rights of appeal or Governing Body review as described in these Bylaws.

Section 5. Appeal

A. Time for Appeal

Within thirty (30) days after receipt of the ~~dDecisiondecision~~ of the Judicial Review Committee, either the Petitioner or the Body Whose Decision Prompted the Hearing may request an appellate review by the Governing Body. Said request ~~shall~~ must be delivered to the Chief of Staff in writing, in person or by certified mail and ~~must~~shall include a brief statement as to the reasons for appeal. If such appellate review is not request within such period, both ~~sides shall be~~Parties are deemed to have accepted the ~~action recommendation~~ involved and ~~it that recommendation shall thereupon~~then becomes ~~become~~, pending ratification by the Governing Body, final and ~~shall be~~ effective immediately.

B. Grounds for Appeal

On Appeal, the Governing Body may exercise its independent judgment in determining: (1) whether there was substantial failure of the Judicial Review Committee to comply with the procedures required by these Bylaws so as to deny a fair hearing; (2) whether the decision is reasonable and warranted; and (3) whether any bylaw, rule, or policy relied on by the Judicial Review Committee is unreasonable ~~or unwarrantedly applied or interpreted~~.

C. Time, Place and Notice

In the event of an appeal to the Governing Body, the Governing Body ~~will~~shall, within thirty (30) days after receipt of such notice of appeal, schedule and arrange for an appellate review. The Governing Body ~~shall~~will cause the ~~a~~Applicant~~applicant~~ or ~~m~~Member~~member~~ to be given notice of the time, place and date of the appellate review. The date of appellate review ~~shall not be less than thirty (30) days, nor more than~~must be within sixty (60) days from the date of receipt of the request for appellate review; however, when a request for appellate review comes from a ~~m~~Member~~member~~ who is under suspension, the review ~~shall~~must be held as soon as ~~arrangements may reasonably be made~~practical, but not to exceed ~~ten-twenty (120)~~(10) days from the date of receipt of the request. The time for appellate review may be extended by the ~~Chair~~President of the Governing Body for good cause.

D. Appeal Board

The Governing Body may sit as the Appeal Board, or it may ~~appoint an appeal board which shall be composed of not less than three (3) members of the Governing Body. Knowledge of the matter involved shall not preclude any person from serving as a member of the Appeal Board, so long as that person did not take part in a prior hearing on the same matter.~~delegate the appeal process to the Governing Body Members appointed to the Joint Conference Committee. The Appeal Board may select an attorney to assist it in the proceeding, but that attorney ~~shall not be~~is not entitled to vote with respect to the appeal. The attorney selected by the ~~g~~Governing~~governing~~ Body ~~shall~~will not have represented either ~~P~~party at the hearing before the Judicial Review Committee and ~~will~~shall not have served as Hearing Officer for the Judicial Review Committee.

E. Nature of Appellate Review

The proceedings by the Appeal Board ~~shall be~~are in the nature of an appellate hearing based upon the record of the hearing before the Judicial Review Committee, provided that the Appeal Board may, at its discretion, accept additional oral or written evidence subject to the same rights of cross-examination or confrontation provided at the Judicial Review

Committee hearing. However, if the Appeal Board elects to exercise its discretion in such a manner, and then contemplates a final decision on the action contrary to the Judicial Review Committee, the Appeal Board ~~shall will~~ refer the matter back to the Judicial Review Committee for further consideration. Each ~~pParty~~party ~~shall will~~ have the right to present a written statement in support of their position on appeal, to personally appear and make oral arguments, and to be represented by an attorney. At the conclusion of oral argument, if allowed, the Governing Body may thereupon, at a time convenient to itself, conduct deliberations outside the presence of the ~~appellant and respondent~~Parties and their representatives. The Governing Body may affirm, modify or reverse the decision of the Judicial Review Committee or, at its discretion, refer the matter for further review and recommendation.

F. Final Decision

Within thirty (30) days after the conclusion of the proceedings before the Governing Body ~~(including , both the appellate hearing and subsequent deliberations),~~ the Governing Body ~~shall must~~ render a final decision in writing and ~~shall~~ deliver copies ~~thereof of that decision~~ to the ~~aApplicant~~applicant or ~~mMember~~member of the Medical Staff and to the Chief of Staff, in person or by certified mail.

G. Further Review

Except when the matter is referred for further review and recommendation in accordance with Article VII, Section 5 D, the final decision of the Governing Body following the appeal procedures set forth in this Article ~~shall will~~ be effective immediately and ~~shall is~~ not ~~be~~ subject to further review. If the matter is referred back to the Judicial Review Committee for further review and recommendations by the Governing Body, this further review process and the report back to the Governing Body ~~shall in no event must not~~ exceed thirty (30) days except as the ~~pParties~~parties may otherwise stipulate.

H. Right to One Hearing Only

Except as otherwise provided in these Bylaws, no ~~aApplicant~~applicant or ~~mMember~~member ~~shall is~~ be entitled ~~as a matter of right to more than to~~ one (1) evidentiary hearing and one (1) appellate review on any single matter which ~~may be is~~ the subject of an adverse recommendation ~~or action~~.

I. Exceptions to Hearing Rights

1. Hospital Contract Practitioners

The procedural rights of this Article VII do not apply to Practitioners who have contracted with the Hospital to provide clinical services. Removal

of these Practitioners from office and of any exclusive Privileges (but not their Medical Staff membership) ~~shall~~will instead be governed by the terms of their individual contracts and agreements with the Hospital. The procedural rights of this Article VII ~~shall~~will apply if an action is taken which must be reported pursuant to Business and Professions Code Section 805 and/or the Practitioner's Medical Staff membership status or Privileges which are independent of the Practitioner's contract are removed or suspended.

2. Affiliated Professionals, Medical Residents, and Students

Affiliated Professionals, medical residents, and students are not entitled to the procedural rights set forth in ~~this Article~~these Bylaws.

3. Denial of Applications for Failure to Meet the Minimum Qualifications

Practitioners ~~shall not be~~are not entitled to the procedural rights of this Article if their membership, Privileges, applications or requests are denied because of ~~their~~the Applicant's failure to: have a current California license to practice medicine, dentistry, clinical psychology or podiatry relevant to their position;~~;~~; ~~to~~maintain an unrestricted Drug Enforcement Administration certificate;~~;~~; ~~to~~maintain sufficient professional liability insurance;~~;~~; or ~~to~~meet any of the other basic qualifications for Medical Staff membership;~~;~~; or ~~to~~file a complete application.

4. Automatic Suspension or Limitation of Privileges

A ~~mMember~~member ~~shall is~~is not ~~be~~be entitled to any procedural rights when the ~~mMember's~~member's license or legal credential to practice has been substantially revoked or suspended as set forth in ~~Article VI, Section 10~~these Bylaws. In other cases, the issues which may be considered at a hearing, if requested, ~~shall~~may not include evidence designed to show that the determination by the licensing or credentialing authority or the DEA was unwarranted, but only whether the ~~mMember~~member may continue to practice in the Hospital with those limitations imposed.

Practitioners whose Privileges are automatically suspended and/or who have resigned their Medical Staff membership for failing to complete medical records or for failing to maintain malpractice insurance are not entitled to any procedural rights except when a suspension for failure to complete medical records will exceed thirty (30) days in any 12-month period and it must be reported to the Member's professional licensing organization (such as the Medical Board) pursuant to California Business and Professions Code Section 805.

5. Employees of the City and County of San Francisco

Disciplinary actions that do not relate to professional competence and involve practitioners employed by the City and County of San Francisco ~~shall are~~ not be subject to the hearing and appellate review process set forth ~~in these Bylaws~~ herein. Instead, such matters ~~shall will be~~ resolved through the City and County of San Francisco Civil Service Rules and Regulations.

ARTICLE VIII: OFFICERS

Section 1. Officers of the Medical Staff

The Officers of the Medical Staff ~~shall~~will be the Chief of Staff, the Vice-Chief of Staff, the Immediate Past Chief of Staff, and Secretary. The Chief Medical Officer (CMO) is the Medical Director of LHH; the CMO is not a Medical Staff Officer.

Section 2. Qualification of Officers

The Officers ~~shall~~must be ~~mMembers~~members of the Active Medical Staff at the time of nomination and election and must remain in good standing during their term of office. Failure to maintain such status ~~shall~~will immediately create a vacancy in that office. By regulation, the responsibility for organization and conduct of the Medical Staff must be assigned only to an individual Doctor of Medicine or osteopathy. Therefore only M.D. and D.O. members of the Medical Staff may serve as Chief of Staff and Vice Chief of Staff.

Section 3. Election of Officers

- A. **Chief of Staff.** The Chief of Staff ~~shall~~will be a Physician elected for a two-year term at the Annual Medical Staff Meeting by a majority of the Active Medical Staff by secret ballot voting. The Chief of Staff may be elected for multiple terms but not more than two terms in succession. Any eligible candidate must have been a member of the Active Medical Staff for three years and ~~shall~~will have served on a standing Medical Staff Committee or a qualified ad hoc Medical Staff Committee for at least one of those three years.
- B. **Vice Chief of Staff.** The Vice Chief of Staff ~~shall~~will be a Physician elected for a two year term at the Annual Medical Staff Meeting by a majority of the Active Medical Staff by secret ballot voting. The Vice Chief of Staff may be elected for multiple terms but not more than two terms in succession. Any eligible candidate must have been a member of the Active Medical Staff for three years and ~~shall~~will have served on a standing Medical Staff Committee or a qualified ad hoc Medical Staff Committee for at least one of those three years.
- C. **Election in alternating years.** The regular elections of the Chief of Staff and of the Vice Chief of Staff ~~shall~~will take place in alternate years.
- D. **Immediate Past Chief of Staff.** A Chief of Staff who completes a term and is not reelected, or who chooses not to run for reelection, ~~shall~~will, after

expiration of his or her term as Chief of Staff, serve a two-year term on the Medical Executive Committee as the Immediate Past Chief of Staff. If a Chief of Staff is reelected, there **shall will** be no Immediate Past Chief of Staff position on the Medical Executive Committee. Instead, a third at-large member of the Medical Staff **shall will** be elected to the Medical Executive Committee for a term not to exceed two years. That at-large member may run for reelection for that position only if the Chief of Staff does not succeed to the Immediate Past Chief of Staff position under this provision.

- E. **Secretary.** The Secretary **shall will** be elected for a two-year term at the Annual Medical Staff Meeting by a majority of the Active Medical Staff by secret ballot voting. The Secretary may be elected for multiple terms but not more than two terms in succession. Any eligible candidate must have been a member of the Active Medical Staff for three years and **shall will** have served on a standing Medical Staff Committee or a qualified ad hoc Medical Staff Committee for at least one of those three years. Any active member of the Medical Staff may serve as Secretary.
- F. **Nominations.** The voting members of the Medical Executive Committee **shall will** serve as the Nominating Committee. This Committee **shall will** offer one or more nominees for the offices of Chief of Staff, Vice-Chief of Staff and Secretary. Nominations for Chief of Staff, Vice-Chief of Staff or Secretary may also be made by petition of at least one third of the members of the Active Medical Staff if the petition has been filed with the Chief of Staff not less than fourteen days prior to the meeting at which elections will be held.

Section 4. Vacancies

- A. **Chief of Staff.** If the Chief of Staff position becomes vacant, the Vice Chief of Staff **shall will** serve for the remainder of the term for that position. A Chief of Staff who resigns before the term is completed **shall will** not serve the role of Immediate Past Chief of Staff.
- B. **Vice Chief of Staff or Secretary.** Should the office of Vice Chief of Staff or Secretary become vacant more than 30 days prior to the Annual Medical Staff Meeting, the Medical Executive Committee **shall will** appoint a member of the Active Medical Staff to the vacant office to serve until the next Annual Medical Staff Meeting. At the Annual Medical Staff Meeting, an election **shall will** be held to fill the position. The newly elected Vice Chief of Staff, or Secretary, **shall will** then serve until the next regularly scheduled election for that position.

Section 5. Duties of Officers

- A. **The Chief of Staff shall will:**

1. Serve as the Chief of the Medical Staff;
2. Serve as Chair of the Medical Executive Committee;
3. Refer suitable matters or problems to the Medical Staff, Medical Executive Committee and/or Chief Medical Officer for discussion and evaluation;
4. Schedule and prepare the agenda for and chair all Medical Executive Committee meetings and the monthly Medical Staff meetings;
5. Be responsible for reporting on Medical Staff Quality Improvement activities to the Governing Body, or appointing a designee to do so;
6. Be responsible for ensuring compliance with the Medical Staff Bylaws and Rules and Regulations;
7. Represent the views, policies, needs and grievances of the Medical Staff as a whole and the Credentials Subcommittee in dealings with the Governing Body, Hospital Administration and/or the Chief Medical Officer;
8. Advise the Chief Medical Officer and Clinical Services Chiefs of staff scheduling as necessary;
9. Appoint Medical Staff Committee members and chairs, subject to Article X of these Bylaws;
10. Serve as a member of the Joint Conference Committee, the Credential Sub Committee, the Medical Quality Improvement Committee, and the Hospital-wide Performance Improvement and Patient Safety Committee. Serve as ex-officio member of all other Medical Staff Committees;
11. Be responsible for implementation of suspensions, restrictions, modifications and terminations of clinical privileges as provided for in these Bylaws;
12. Along with the Chief Medical Officer, be the spokesperson for the Medical Staff in its external professional and public relations;
13. Receive and interpret for the Medical Staff the policies of the Governing Body;
14. Perform specific review of individual Medical Staff member practices if deemed necessary.

B. The Vice Chief of Staff ~~shall~~will:

1. Be a member of the Medical Executive Committee and Joint Conference Committee, and serve as chair of the Credentials Subcommittee;
2. Perform the duties as assigned by the Chief of Staff, and in the absence of the Chief of Staff, ~~shall~~will have the authority of the Chief of Staff.

C. The Secretary ~~shall~~will:

1. Be a member of the Medical Executive Committee;
2. Record minutes. In the absence of the Secretary, the Chief of Staff ~~shall~~will appoint a designee.
3. Ensure that accurate minutes of all Medical Executive, Medical Staff, and Medical Staff Committee minutes are maintained.

Section 6. Removal of Officers

A Medical Staff Officer may be removed from office for any valid cause, including but not limited to, failure to carry out the duties of the office, gross neglect, or misfeasance. Except as otherwise provided in these Bylaws, removal of an officer may be initiated by a majority vote of the Medical Executive Committee or upon the written request of thirty percent (30%) of the members eligible to vote for officers. Such removal may be effected by a majority vote of the Medical Executive Committee members or, if upon written request of at least thirty percent (30%) of the Medical Staff members eligible to vote for officers, by a two-thirds vote of the Medical Staff members eligible to vote for officers. Voting on removal of an elected officer ~~shall~~will be by secret written ballot.

ARTICLE IX: CLINICAL SERVICES

Section 1. Clinical Services Organization

The Medical Staff **shallwill** have four clinical services, each headed by a Service Chief. These services **shallwill** be Medicine, Physical Medicine and Rehabilitation, Psychiatry, and Outpatient Clinics. Each Service Chief **shallwill** be responsible for the overall supervision of the clinical work, teaching and research within that service. Each service may be organized into sub-services.

Section 2. Qualifications and Appointment of Service Chiefs

- A. The chiefs of the four clinical services **shallwill** be board certified or board eligible in their respective specialties.
- B. The Chief of each of the four services **shallwill** be a member of the Active Medical Staff **shallwill** be appointed by the Chief Medical Officer with the concurrence of the Medical Executive Committee, based on his/her professional training, experience and demonstrated ability for the position. The Chief of each Service **shallwill** be responsible for the day-to-day business of the Service.

Section 3. Functions of the Service Chiefs

All Service Chiefs function under the Chief of Staff.

A. Service Chiefs **shallwill**:

1. Be accountable for all professional and administrative activities of the service;
2. Provide consulting services to the Medical Staff;
3. Be responsible for implementation of actions taken by the Medical Executive Committee;
4. Make recommendations to the Chief of Staff concerning staff scheduling, privileges and reappointments;
5. Be responsible for Staff scheduling;
6. Act as presiding officer at service meetings;

7. Recommend sufficient staff to provide clinical services;
8. Report to the Credentials Subcommittee concerning the appointment, reappointment, and delineation of clinical privileges for all applicants seeking privileges in the clinical service;
9. Make recommendations to the Credentials Subcommittee regarding the qualifications and competence of clinical service personnel who are affiliated professional staff;
10. Be responsible for the evaluation of all temporary appointees and report thereon to the Credentials Subcommittee;
11. Be responsible for peer review with respect to the quality and appropriateness of Resident care provided within the clinical service;
12. Monitor the professional performance of all individuals who have delineated clinical privileges in the clinical service and report thereon to the Credentials Subcommittee as part of the reappointment process and at such other times as may be indicated;
13. Be responsible for proctoring protocols and quality improvement activities;
14. Be a member of the Medical Education Committee and work in conjunction with the Medical Education Coordinator to implement and evaluate education programs in the Clinical Services;
15. Be responsible and accountable to the Medical Executive Committee for the clinical and administrative activities within the service;
16. Be a member of the Medical Executive Committee;
17. Be responsible for the integration of the clinical service into the primary functions of the organization;
18. Be responsible for developing and ensuring compliance with the Medical Staff Bylaws and Rules and Regulations and hospital policies and procedures within the respective clinical service;
19. Be responsible for the orientation of new members;
20. Be responsible for implementation within the clinical service of actions taken by the Governing Body; hospital administration and the Medical Executive Committee;

21. Be responsible for the administration of the clinical service in collaboration with other departments and hospital administrator.
22. Make reports and recommendations to the Medical Executive Committee on matters affecting Resident care in the clinical service;
23. Be responsible for assessing and recommending off-site sources that provide Resident care services not available at the Hospital;
24. Be responsible for the preparation of annual reports, including budgetary planning pertaining to the clinical service as may be requested by the Chief of Staff, the Medical Executive Committee, the Chief Medical Officer, the ~~Executive Administrator~~Nursing Home Administrator, or the Governing Body;
25. Delegate to Active staff members of the clinical service such duties as appropriate;
26. Establish as-needed subservices within the clinical service and appoint a director subject to the approval of the Medical Executive Committee and the Governing Body;
27. Perform such other duties commensurate with the office as may be reasonably requested by the Chief of Staff or Medical Executive Committee.

B. Meetings of Clinical Services

Each clinical service ~~shall~~will conduct meetings as necessary; but no less than quarterly, with the exception of the Outpatient Clinics. Service Chiefs ~~shall~~will be responsible for scheduling meetings and providing the agenda for the meeting and all supporting materials. A formal record of Clinical Service meetings ~~shall~~will be maintained and forwarded to the Medical Staff Secretary. Any conclusions, recommendations or actions from the clinical services ~~shall~~will be forwarded to the Medical Executive Committee for review and further action as appropriate.

Section 4. Review of Service Chiefs

Service Chiefs ~~shall~~will be reviewed and recommended for reappointment not less than every four (4) years by the Chief Medical Officer. Input from members of the Medical Staff ~~shall~~will be solicited and considered during this process. Reappointment as Service Chief is contingent upon the results of this review and concurrence of the Medical Executive Committee.

Section 5. Removal of Service Chiefs

If a Service Chief is unable, unwilling, or fails to fulfill the duties of the office, or engages in any other conduct or activity which warrants removal, the Chief Medical Officer may remove the Service Chief with the concurrence of the Medical Executive Committee and the approval of the Governing Body.

Section 6. Inability of Service Chief to Perform Function

- A. If the Service Chief is unable to fulfill a function (e.g., the identified function exceeds the scope of their licensure), the Service Chief, with the approval of the Chief Medical Officer, ~~shall~~will delegate a qualified member of the Active Medical Staff to perform that function.
- B. If a Service Chief is unable to perform his/her functions because of temporary absence of the position for a substantial period of time, prompt notification ~~shall~~will be made to the Chief Medical Officer and the Medical Executive Committee. Upon receipt of such notice, appointment of a temporary Service Chief ~~shall~~will be made by the Chief Medical Officer in consultation with the Medical Executive Committee.

ARTICLE X: MEDICAL STAFF NIGHT AND WEEKEND SUPERVISOR

Section 1. Qualifications and Appointments

- A. Night and Weekend Supervisor **shall** be an Active Member of the Medical Staff or an As Needed Medical Staff Member and **will** be appointed by the Chief Medical Officer with the concurrence of the Medical Executive Committee

Section 2. Functions of Night and Weekend Supervisor

- A. Night and Weekend Supervisor **shall**:

1. Be accountable for all professional and administrative activities of the position;
2. Be responsible for night and weekend staff scheduling;
3. Be responsible for case review with respect to the quality and appropriateness of Resident care provided by the night and weekend staff;
4. Be responsible for the orientation of new night and weekend members;
5. Recruit and hire Night and Weekends Members in conjunction with the Chief Medical Officer;
6. Be responsible for completing Annual Performance Plan and Appraisal Report for night and weekend staff;

Section 3. Review and Removal of Night and Weekend Supervisor

Night and Weekend Supervisor **shall** be reviewed and reappointed no less than every four (4) years by the Chief Medical Officer, with input from the Medical Executive Committee. Continued appointment of this position is contingent upon the results of this review and concurrence of the Medical Executive Committee.

If Night and Weekend supervisor is unable, unwilling or fail to fulfill the duties, or engages in any other conduct or activity which warrants removal, the Chief Medical Officer may remove this appointed person with the concurrence of the Medical Executive Committee.

ARTICLE XI: MEDICAL STAFF COMMITTEES

Section 1. General Provisions

A. Designation

1. Standing committees, subcommittees and ad hoc committees of the Medical Staff are created for, and meet for, the purpose of evaluation and improvement of the quality of care rendered in the Hospital.
2. The committees described in this article, other than ad hoc committees, **shallwill** be the standing committees of the Medical Staff. Medical Staff committees **shallwill** include, but not be limited to, the Medical Staff when meeting as a committee of the whole, the Medical Executive Committee, committees established under this Article, and ad hoc committees created by the Chief of Staff pursuant to this Article.
3. Unless otherwise noted, the Medical Executive Committee **shallwill** review, modify as it deems appropriate, and approve all proposed policies and procedures of the Medical Staff. These will include policies and procedures drafted and/or recommended by committees of the Medical Staff. MEC approval is required before any policy or procedure may be disseminated and implemented.
4. The Committees **shallwill** request of the Chief of Service, and if appropriate, the Chief of Staff, the specific review of individual Medical Staff practices when necessary.
5. All provisions in this article **shallwill** apply to the standing and ad hoc committees described herein, including the Medical Executive Committee, unless otherwise stated in these Bylaws.

B. Professional Activity Committees

Professional Activity Committees of the Medical Staff **shallwill** be the Health Information Management, Utilization Management, Pharmacy and Therapeutics, Infection Prevention and Control, Medical Quality Improvement, Code Blue, Bioethics, Well-Being, Interdisciplinary Practices, Bylaws, and Medical Education Committees.

C. Ad Hoc Committees

As the need arises, the Chief of Staff, subject to consultation with the Medical Executive Committee, may appoint ad hoc committees to deal with specific problems, including the evaluation and improvement of the quality of care rendered in the Hospital. These ad hoc committees **shallwill** keep

written records of their proceedings and activities and **shallwill** render a report of their activities to the Medical Executive Committee.

D. Parliamentary Procedure

All meetings of all committees and subcommittees **shallwill** be conducted following Robert's Rules of Order. Technical or non-substantive departures from such rules **shallwill** not invalidate actions taken at such meetings.

E. Scheduling and Notice of Committee Meetings; Agenda Packets

Medical Staff committees **shallwill** hold regular meetings as specified in these Bylaws, the meeting schedule of which **shallwill** be reviewed and/or revised by the Chair of each committee at the beginning of each Medical Staff year. Chairs are responsible for scheduling meetings. Each committee will meet at least quarterly unless otherwise required by these Bylaws. Chairs **shallwill** provide the agenda for each meeting and all supporting materials to committee members, preferably no later than two working days prior to the meeting. The requirements for prior provision of agendas and supporting materials **shallwill** not apply to the Well Being Committee.

F. Changes in Committee Meeting Dates

If changes must be made to the established meeting schedule or to individual meeting dates, the members of the committee **shallwill** be advised of the new meeting date(s) in writing, preferably at least two working days in advance of scheduled meeting(s) which have been changed, or two working days in advance of the newly scheduled meeting date(s), whichever is earlier.

G. Appointment of Chairs, Vice Chairs and Members of Committees

Standing committee chairs, vice chairs and members of committees **shallwill** be appointed by the Chief of Staff except when chairs are specified in these Bylaws. Subcommittee chairs of standing committees **shallwill** be appointed by the Chairs of his/her respective standing committee. Standing committees of the Medical Staff **shallwill** be chaired only by members of the Active Medical Staff. The Chair of the Committee must be a member of the Medical Staff. The Vice Chair of the Committee must be a member of the hospital staff.

H. Terms of Committee Members

Unless otherwise specified, committee members **shallwill** serve until the member's successor is appointed or until the member resigns voluntarily or is removed from the committee.

I. Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed from committees of which that person is a member by the Chief of Staff.

J. Voting Privileges

1. For the Medical Executive Committee, only the Chief of Staff, the Vice Chief of Staff, the Immediate Past Chief of Staff, the Secretary, the four Clinical Service Chiefs, and at-large members elected by the Medical Staff ~~shall~~will have voting privileges.
2. For all other committees, all committee members ~~shall~~will have voting privileges unless otherwise specified in these Bylaws.

K. Quorum

1. For the Medical Executive Committee, a quorum is six members with voting privileges.
2. For all other committees, a quorum is 50 percent of the committee membership and must include one physician member.

L. Manner of Action

Having established a quorum, the action of a simple majority of the voting members present at a meeting of any committee ~~shall~~will represent the action of the committee.

M. Attendance Requirements

All Active and Provisional members of the Medical Staff are expected to show good faith participation in the governance and quality evaluation process of the Medical Staff by attending a minimum of 50 percent of all committee meetings to which they are assigned, and a minimum of 50 percent of all Medical Staff meetings (occurring during that member's regularly scheduled work hours).

Attendance will be recorded and will be available to the Credentials Subcommittee.

N. Minutes and Reports

1. Minutes of all Medical Staff Committee and Clinical Service meetings, unless otherwise stated, **shallwill** be written in the format prescribed by the Medical Executive Committee and **shallwill** be forwarded to the Secretary of the Medical Staff, who serves as the official repository for official business of the Medical Staff.
2. Minutes of meetings **shallwill** include, but not limited to, summaries of any and all recommended new policies or changes in policy. All policy or other recommendations **shallwill** be presented to the Medical Executive Committee for action relevant to the issue.
3. Minutes of all Professional Activities Committees and ad hoc committees **shallwill** be sent in final form to the Secretary of the Medical Staff for review prior to the next committee meeting.
4. All new policies and other recommendations **shallwill** be forwarded to the Chief of Staff for presentation to the MEC for action.
5. Subcommittees **shallwill** report to their respective standing committees which **shallwill**, in turn, review the recommendations of the subcommittee and identify those items that need to be forwarded in the standing committee's report to the Secretary of the Medical Staff.
6. Minutes of all meetings of committees of the Medical Staff, and all material caused to be prepared for the use of said committees, **shallwill** be considered confidential and privileged to the fullest extent permitted by law.
7. All committees **shallwill** report at least quarterly to the Medical Executive Committee through reports presented at the monthly Medical Staff meetings

O. Invitees to Committee Meetings

Any committee may invite any individuals as guests whose expertise may be needed for its work. Guests may participate in discussion but do not vote on any issue before the committee. By confirming their attendance at the meeting, the guest asserts their agreement to maintain confidentiality as to the matter(s) discussed.

P. Confidentiality of Medical Staff Matters

1. General

Discussions, deliberations, records and proceedings of all Medical Staff committees having responsibility of evaluation and improvement of quality of care rendered in this Hospital ~~shall~~will, to the fullest extent permitted by law, be confidential. This confidentiality of protection includes, but is not limited to, information regarding any member or applicant to this Medical Staff, meetings of the Medical Staff, meetings of Clinical Services, meetings of committees of the Medical Staff, and meetings of ad hoc committees.

2. When Disclosure is Permitted

- a. Dissemination or disclosure of discussions, deliberations, records and proceedings ~~shall~~will only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee.
- b. In all other cases, access to such information and records ~~shall~~will be limited to authorized members of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
- c. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities ~~shall~~will be maintained by that body as confidential.
- d. Information contained in the credentials file of any member may be disclosed with the member's consent to other Medical Staffs, hospitals, or professional licensing boards.

3. Breach of Confidentiality

Effective quality of care activities, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions within the quality improvement process. Any breach of confidentiality of the discussions, deliberations, records or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Medical Staff members, violates these Medical Staff bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in

any other proceeding as to matters protected by this confidentiality provision.

Q. Executive Session

An executive session of any Medical Staff committee may be called at the discretion of the chair or at the request of a member and subject to a duly adopted motion. Executive sessions ~~shall~~will be called as necessary to foster openness and candor in discussing issues involving peer review, personnel, discipline, quality assurance, quality improvement, and other sensitive matters. Only committee members who are members of the Active Medical Staff and have voting privileges and other individuals whose attendance is expressly requested by the chair may attend an executive session of a committee.

Section 2. Medical Executive Committee

The Medical Executive Committee ~~shall~~will be a standing committee of the Medical Staff of the Hospital. A majority of voting members of the Medical Executive Committee must be physicians.

A. **Composition.** The Medical Executive Committee ~~shall~~will consist of the following persons:

1. Chief of Staff
2. Vice Chief of Staff
3. Immediate Past Chief of Staff or a third at-large member of the Medical Staff, as provided in Article VIII, Section 3.D.
4. Secretary
5. Chief of Physical Medicine and Rehabilitation
6. Chief of Psychiatry
7. Chief of Medicine
8. Chief of Outpatient Clinics
9. ~~Executive Administrator~~Nursing Home Administrator or designee

10. Two members-at-large who are Active Medical Staff members and who are physicians (M.D. or D.O.) or clinical psychologists (Ph.D. or Psy.D.) and who are elected by the Medical Staff
11. Chief Medical Officer
12. Assistant Medical Director; and
13. Chief Medical Officer of San Francisco Health Network or designee;
14. Chief Nursing Officer or designee
15. Director of Pharmacy or designee
16. Chief Medical Informatics Officer or designee
17. Chief Quality Officer or designee

B. Chair of MEC. The Chief of Staff ~~shall~~will be the chair.

C.C. ~~_____~~ **No Alternates Permitted for voting members.** If a voting member is unable to attend a meeting of the Medical Executive Committee, no substitute or designee for that member may attend the meeting.

D.D. ~~_____~~ **Invitees Permitted.** The Chair of the MEC may invite anyone to attend a meeting of the Committee, whether employed by the Hospital or not, ~~whichever~~ he or she deems useful to the work of the Committee. No invitee ~~shall~~will have voting rights.

E. Election of Members-At-Large.

1. **Length of terms; qualifications.** Two members-at-large ~~shall~~will serve at all times on the MEC, with a third member at large serving when the Immediate Past Chief of Staff does not serve, as provided in Article VIII, Section 3.D. Terms ~~shall~~will be for two years each and, except for the third at-large position, staggered in such a way that one member-at-large is elected each year. The Member at Large may be elected to multiple terms but not more than two terms in succession. In the event that a member fills two positions in the MEC such as an officer and Chief of Service, this will not give rise to the election of another at-large member or give that member more than one vote.
2. **Eligibility.** To be eligible for election, each of the three members-at-large must have been a member on the Active Medical Staff for at least one year and have served on one of the following: (a) a Professional Activity Committee for one year, (b) an ad hoc committee created by the Medical

Staff or (c) a task force created by Hospital administration which the MEC has determined qualifies as providing experience commensurate with that provided by a Professional Activity Committee.

3. **Nominations of at-large members.** The MEC ~~shall~~will serve as the Nominating Committee for the at-large members. Nominations may also be made by petition of at least one third of the members of the Active Medical Staff, said number determined from the total number of Active Medical Staff Members that existed on the fourth Tuesday before the annual election meeting. The petition must be filed with the Chief of Staff not less than fourteen calendar days prior to the annual election meeting. Nominees ~~shall~~will be elected by a plurality of the Active Medical Staff at the annual election meeting by secret ballot. Absentee ballots ~~shall~~will be available for those Medical Staff members who will predictably be absent from the annual election meeting.
4. **Vacancies of at-large positions.** Should one of the members at-large be unable to fill out the term of his or her office on the Medical Executive Committee, the MEC ~~shall~~will appoint a member of the Active Medical Staff to the vacant office to serve for the remainder of the term for that position.

F. Functions of the MEC:

1. To represent and to act on behalf of the Medical Staff, subject to limitations imposed by these Bylaws;
2. To review the recommendations from the Credentials Committee of all applicants and make recommendations to the Governing Body for staff membership and delineation of clinical privileges for reappointment and renewal or changes in Clinical Privileges;
3. To ensure professional and ethical conduct and competent clinical performance on the part of all members, including the initiation of and participation in Medical Staff corrective action or review measures when warranted;
4. To undertake quality assessment and improvement activities and to continuously evaluate the medical care rendered to Residents in the Hospital;
5. To provide a forum with which the Medical Staff can cooperate and work with the Hospital Administration, Nursing, and other Hospital departments in identifying and resolving issues for purposes of improving Resident care and Hospital operations;
6. To receive and act upon reports submitted by Medical Staff committees;

7. To review and act on all proposed policies that may impact Resident care prior to dissemination and implementation;
8. To assess whether Medical Staff dues ~~shall~~will be collected and appropriate utilization of such dues, and to then present the assessment to the Medical Staff for decision by a two-thirds vote majority, and to if approved, to collect such dues and appropriately expend in accordance with the Medical Staff decision;
9. To assess whether to retain and be represented by independent legal counsel at the expense of the Medical Staff, unless otherwise agreed to by the Governing Body;
10. To fulfill the Medical Staff's accountability to the Governing Body for the quality of care rendered to Residents;
11. To report Medical Staff and MEC activities directly to the Governing Body at least quarterly;
12. To make recommendations directly to the Governing Body for its approval regarding the following:
 - a. The Medical Staff's structure;
 - b. The mechanism used to review credentials and to delineate individual clinical privileges;
 - c. Individuals for Medical Staff membership;
 - d. Delineated clinical staff privileges for each eligible individual;
 - e. The participation of the Medical Staff in performance improvement activities.

G. Meetings of the MEC

The MEC ~~shall~~will meet on a monthly basis, not less than ten times a year. Agenda items must be submitted to the Chief of Staff at least 5 working days prior to the meeting. Special meetings may be called preferably with 48 hours advance notice, excluding weekends and holidays, by the Chief of Staff or by any four voting Committee members, provided that the agenda is included in the notice and only matters included on the agenda may be considered at the special meeting.

H. Credentials Subcommittee

The Credentials Subcommittee shall will be a subcommittee of the MEC.

1. Purpose

The primary purpose of the Credentials Subcommittee is to review the credentials of applicants for membership to the Medical Staff and to make recommendations for membership and delineation of clinical privileges. The Subcommittee will review all information available regarding the competence of staff members and make recommendations to the MEC for the granting of privileges, reappointments, and the assignment of practitioners to the Clinical Services.

2. Composition

The Credentials Subcommittee shall will consist of four physician voting members of the MEC plus a psychologist member of the Active Medical Staff, who shall will participate in the review of psychologists. The chair of the Subcommittee shall will be the Vice-Chief of Staff or designee. The Chief of Staff shall will appoint the other members of the Subcommittee. If needed, the Chair of Credentials shall will request participation of appropriate specialists.

3. Meetings

The Credentials Subcommittee shall will meet on a monthly basis, no less than ten times a year, and as needed.

4. Functions

- a. To review applications for initial staff appointment and reappointment, evaluate and verify the supporting documentation and other relevant information, including the results of performance improvement and peer review activities;
- b. To make recommendations as to appointment and, if appointment is recommended, as to membership category, clinical privileges to be granted, and any special conditions to be attached to the appointment;
- c. Review all information available regarding the competence of Medical Staff members and as a result of such review make recommendations for the granting of Privileges, reappointments, and the assignment of Practitioners to the various Clinical Services as provided in these Bylaws.

- d. To assure conformity, where indicated, with licensure and certification requirements; and
- e. To take all reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and participation in corrective action or review measures, when warranted.
- f. To make a report to the MEC on each applicant for Medical Staff membership and privileges, which **shall/will** include recommendations from the appropriate Clinical Service Chief.

I. Performance Improvement & Patient Safety Committee

1. Purpose

The primary purpose of the Performance Improvement & Patient Safety Committee is to facilitate continuous coordinated review of the care provided by the Hospital and by those other than members of the Medical Staff. This committee is a Joint Hospital-wide and Medical Staff committee.

2. Committee Chair

The Co-Chairs of the Committee **shall/will** be the Chief Medical Officer and the Chief Quality Officer

3. Composition

The Performance Improvement & Patient Safety Committee **shall/will** include the following persons:

- a. Chief of Staff;
- b. Chair of the Medical Quality Improvement Committee, or designee;
- c. Director of Quality Management or designee;
- d. Quality Improvement Coordinator(s);
- e. Chief Operating Officer or designee;
- f. Director of Health Information Management or designee
- g. Chief Nursing Officer or designee;
- h. Chief Dietitian or designee;

- i. Director of Social Services or designee;
- j. Director of Pharmacy or designee;
- k. Director of Activity Therapy or designee;
- l. Chief of Psychiatry or designee;
- m. Chief of Medicine or designee;
- n. Chief of Physical Medicine and Rehabilitation Services or designee;
- o. Chief of Outpatient Clinics or designee;
- p. Deputy City Attorney;
- q. ~~Executive Administrator~~Nursing Home Administrator;
- r. Director of Rehabilitation Services or designee;
- s. Associate Chief Health Informatics Officer;
- t. Infection Control and Prevention Officer
- u. Any other consultant as deemed advisable.

4. Functions

- a. To identify, support, and monitor the quality improvement activities of all hospital departments;
- b. To identify and address quality issues impacting patient safety;
- c. To review the Unusual Occurrence Reports, including trend analysis; identification of potential liability concerns; and development and monitoring of corrective action plans;
- d. To report at least quarterly to the Medical Executive Committee.

5. Meetings

The Performance Improvement & Patient Safety Committee ~~shall~~will meet monthly, no less than ten times a year. Representatives from other departments and services may be invited to attend a given meeting, if

requested by the Committee; such a request ~~shall~~will be noted in the agenda of the meeting.

6. PIPS Subcommittee

The Joint Medicine Nursing Quality Improvement Committee

- a. **Purpose:** The primary purpose of the Joint Medicine Nursing Quality Improvement Committee is to collaborate in and coordinate the quality improvement activities of the Medicine and Nursing Services of the hospital, including unit-based quality assurance and performance improvement activities.
- b. **Composition:**
 - a. Medical Quality Improvement Committee Chair;
 - b. Performance Improvement and Patient Safety Committee Chair;
 - c. Chief Nursing Officer or designee;
 - d. Director of Quality Management or designee;
 - e. Director of Nursing Quality or designee
- c. **Meetings:** The Joint Medicine Nursing Quality Improvement Committee ~~shall~~will meet monthly, no less than ten times a year.

Section 3. Professional Activity Committees

A. Health Information Management Committee

1. Purpose

- a. Develop long term health care information systems goals that are consistent with the hospital and San Francisco Health Network strategic goals;
- b. Evaluate HIM needs and priorities, and determine best utilization of HIS resources, including approving and prioritizing projects;
- c. Perform QI activities to monitor and improve as needed:
 - Monitor documentation and ICD 10 and E/M coding
 - Monitor completion of records to meet regulatory standards
- d. Monitor new HIM technologies to ensure privacy standards are met
- e. Identify Information Systems (IS) solutions through a collaborative decision-making process
- f. Ensure that HIM compliance standards are met

2. Composition

- a. Chair - as designated by Chief of Staff
- b. Vice Chair - Director of HIM

- c. Chief Medical Officer
- d. Chief of Staff
- e. LHH IT Representative
- f. CNO or designee
- g. Privacy Officer
- h. Chief of Psychiatry or designee
- i. Chief of Medicine or designee
- j. Chief of Physical Medicine and Rehabilitation
- k. Chief of Outpatient Clinics or designee
- l. Compliance Officer
- m. Chief Quality Officer or designee
- n. Admission and Eligibility Director or designee
- o. Associate Chief Health Informatic Officer or designee
- p. Any other consultant as deemed advisable
- q. Two members of the Medical Staff

3. Medical records Forms Committee will be a subcommittee of HIM Committee
 - a. Meets as needed to review/approve/revise/delete forms
 - b. Members:
 - HIS staff
 - Nursing Staff
 - QM Staff
 - Active Medical Staff

4. HIM Committee will meet monthly, at least ten times per year

B. Utilization Management Committee

1. Purpose

The primary purpose of the Utilization Management Committee is to monitor appropriateness and clinical necessity of admissions, continued stays and supportive services, and to promote efficient and effective clinical practices while ensuring quality and continuity of care.

2. Composition

- a. At least three physician members of the Active Medical Staff, including one rehabilitation physician, one acute care unit physician, and one other unit physician appointed on an annual basis by the Chief of Staff, one of whom will be appointed Chair, and another Vice-Chair;

- b. Chief Medical Officer

- c. Chief Nursing Officer or designee;
- d. The Director of Health Information Services or designee;
- e. All Utilization Management Coordinators;
- f. The Director of the Admissions and Eligibility Department or designee;
- g. The Director of the Social Services Department or designee;
- h. The Chief Financial Officer or Director of Patient Financial Services or designee;
- i. The Director of Quality Management;
- j. Compliance Officer
- k. Patient Flow Coordinators
- l. Chief of Psychiatry or designee
- m. Any other consultant as deemed advisable.

3. Functions

- a. To ensure that the utilization management functions of the Medical Staff are carried out according to the requirements of the Hospital Utilization Management Plan and federal and state law and regulations;
- b. To ensure optimal outcomes through effective and efficient use of resources;
- c. To facilitate discharge planning;
- d. To develop and monitor policies and procedures related to utilization management;
- e. To ensure coordination of utilization management activities with quality improvement and risk management functions;
- f. To promote efficient use of Hospital and community resources through effective interdepartmental planning, coordination, and collaboration on Resident care issues;

- g. To review and make recommendations and/or take necessary action in response to denials and extended stays;
- h. To ensure that the utilization management program applies to all Residents (both inpatients and outpatients) at all levels of care regardless of payment source;
- i. To conduct quality improvement studies related to utilization management activities per the Hospital Utilization Management Plan and present a summary of findings from these activities at least quarterly to the Medical Quality Improvement Committee;
- j. To facilitate Utilization Management Committee Medical Staff Member review of individual practices if deemed necessary; and
- k. To report quarterly to the Medical Executive Committee.

4. Meetings

The Utilization Management Committee ~~shall~~will meet monthly, and no less than ten times a year.

C. Pharmacy and Therapeutics Committee

1. Purpose

The primary purpose of the Pharmacy and Therapeutics Committee is to ensure the safe and effective use of medications.

2. Composition

- a. At least three physician members of the Active Medical Staff, including one member of the Psychiatry Service, appointed on an annual basis by the Chief of Staff, one of whom will be appointed Chair and one Vice-Chair;
- b. Pharmacy Director;
- c. All clinical pharmacists;
- d. One Nursing Director, Nursing Manager, or Clinical Nurse Specialist appointed by the Chief Nursing Officer; and
- e. Any other consultant as deemed advisable.

3. Subcommittees of Pharmacy and Therapeutic Committee

Nutrition, Medical Error Reduction, Psychotropic Drug Use, Diabetes Task Force and Formulary Review are subcommittees of Pharmacy and Therapeutics Committee. Pharmacy and Therapeutics Committee ~~shall~~will conduct a portion of its business through these committees.

4. Functions

- a. To determine policy pertaining to evaluation, selection, procurement, storage, distribution, safe practice and use of medicines;
- b. To serve in an advisory capacity to the Medical Staff, Pharmacy Staff, and other groups in the selection, choice, and use of medications that meet the best standards of quality;
- c. To objectively evaluate clinical data regarding new medications or agents proposed for use in the Hospital;
- d. To develop a Formulary of approved medications for use in the Hospital and to revise the Formulary on an ongoing basis;
- e. To establish or plan programs or other methods of communication for the professional staff about pertinent matters related to medications and their use;
- f. To recommend policies regarding the safe use of medications in the Hospital, including such matters as investigational medications, hazardous medications, and others;
- g. To monitor and investigate adverse medication events;

5. Meetings

The Committee ~~shall~~will meet monthly, or at least 10 times a year.

D. Infection Control Committee

1. Purpose

The primary purpose of the Infection Control Committee is to develop and monitor policies and procedures for the prevention and control of infections.

2. Composition

The Infection Control Committee ~~shall~~will consist of the following members

- a. At least two physician members of the Active Medical Staff appointed on an annual basis by the Chief of Staff, one of whom will be appointed Chair and one Vice-Chair;
- b. The Chief Quality Officer or designee
- c. Infection Control Nurse;
- d. One representative from Materials Management;
- e. One administrative representative appointed by the ~~Executive Administrator~~Nursing Home Administrator;
- f. One representative from Nursing Services, appointed by Chief Nursing Officer;
- g. One Pharmacist appointed by the Director of Pharmacy;
- h. One Facilities representative appointed by the Chief Operating Officer;
- i. Director of Nutrition Services or designee;
- j. Respiratory Therapy Supervisor or designee; and
- k. Industrial Hygienist
- l. Any other department representative or consultant as deemed advisable by the Chief of Staff.

3. Functions

- a. To develop and recommend to the Medical Executive Committee written standards for Hospital sanitation and medical asepsis. These standards ~~shall~~will include a definition of infection for the purpose of surveillance, as well as specific indications of the need for, and the procedures to be used in, isolation.
- b. To develop, evaluate and revise on a continuing basis the procedures and techniques for meeting established sanitation and asepsis standards, including the routine evaluation of materials used in the Hospital's sanitation program.

- c. To evaluate and maintain records of infections in order to provide an indication of the endemic level of all nosocomial infections, and to trace the sources of infections and identify epidemic or potentially epidemic situations.
- d. To develop and monitor infection control policies for adoption by the MEC, which will serve as the hospital Infection Control program for the surveillance, prevention and control of infections.
- e. Coordinate Medical Staff education related to infection control issues;
- f. Develop policies for communicating infection control issues to hospital staff.
- g. To perform Quality Improvement activities related to the use of antibiotics and to present a summary of the findings of these activities to the Medical Quality Improvement Committee.
- h. To oversee use of the hospital isolation rooms.
- i. To collaborate with Infectious Disease specialist to ensure that the hospital has a robust antimicrobial stewardship program that meets regulatory requirements.

4. Meetings

The Infection Control Committee **shall/will** meet at least quarterly and as frequently as necessary to carry on the business of the Infection Control functions of the Hospital.

E. Medical Quality Improvement Committee

1. Purpose

The primary purpose of the Medical Quality Improvement Committee is to facilitate continuous, coordinated review of the clinical activities of the Hospital and the Medical Staff to ensure that the care Residents receive at the Hospital meets or exceeds the standards of the community and to take action as needed.

2. Composition

The Medical Quality Improvement Committee **shall/will** consist of the following members, one of whom **shall/will** be appointed Chair of the Committee and one as Vice-Chair in accordance with these Bylaws:

- a. Three physicians from the Medicine Service;
- b. One physician or psychologist from the Psychiatry Service;
- c. One physician from the Rehabilitation Service.
- d. Chief Medical Officer
- e. Chief of Staff
- f. Night and Weekend Supervising Physician
- g. The Chair ~~shall~~will not be the Chief Medical Officer, Chief of Staff, or Chief of Clinical Service
- h. Chief Quality Officer or designee will be invited as needed.

3. Functions

- a. To develop Medical Quality Improvement Plans.
- b. To assign specific Quality Improvement and peer review functions to members of the Committee, other members of the Medical Staff, and other Medical Staff committees and to review summary reports of these activities.
- c. To review summary reports at least quarterly on the results of monitoring and evaluation of all blood transfusions and to review and discuss individual cases where problems or opportunities for improvement of transfusion-related medical care have been identified by a peer reviewer.
- d. To review tissue report at least quarterly and ensure appropriate follow up.
- e. To review quarterly summary reports on Medical Quality Review activities carried out by Professional Activities Committees and Clinical Services and to review and discuss both individual cases and identified practice patterns which indicate problems or opportunities for improvement of medical care.
- f. To monitor, evaluate, and make recommendations regarding the quality of care provided at the Hospital in general and by the Medical Staff based on the results of medical quality review activities.

- g. To review monthly summary reports on the results of mortality review during the preceding month and to forward for discussion at Medical Staff meetings cases where problems or opportunities for improvement of medical care have been identified by a peer reviewer.
- h. To receive input and recommend changes in policies and procedures regarding medical practice to resolve problems and improve medical care.
- i. To identify medical education needs and make recommendations to the Medical Education Committee.
- j. To periodically evaluate the results of actions taken for the purpose of resolving problems and improving care to assure that the intended results were obtained.
- k. To arrange for presentation of Committee or other peer review analyses of quality issues at regular meetings of the Medical Staff in order to educate the Medical Staff and improve the quality of care in the Hospital.

4. Meetings

The Medical Quality Improvement Committee ~~shall~~will meet monthly, and no less than ten times a year. Representatives from other departments and services may be invited to attend a given meeting, if requested by the Committee; such a request ~~shall~~will be noted in the written announcement of the meeting.

F. Bioethics Committee

1. Purpose

The purpose of the Bioethics Committee is to enhance quality of life and preserve the autonomy and dignity of residents of LHH through consideration of issues concerning death and dying, ethics and cultural diversity.

2. Composition

Membership ~~shall~~will be interdisciplinary, including at least the following:

- a. At least three members of the Active Medical Staff, one of whom ~~shall~~will be a member of the Psychiatry Service;

- b. Three nursing representatives appointed by the Chief Nursing Officer, including one representative from the Acute Care staff.
- c. One representative of Hospital Administration, appointed by the ~~Executive Administrator~~Nursing Home Administrator;
- d. The Director of Social Services or designee;
- e. The Chief Quality Officer or designee; and
- f. Other members at the discretion of the Committee Chair, in consultation with the Chief of Staff, such as an individual from the community qualified to act as an advocate for Resident concerns , i.e. The State ombudsman, public guardian, public conservator, member of the clergy or other qualified members of the community.

3. Functions

- a. To educate Hospital staff about ethical issues related to care of Hospital residents and to assist Hospital departments in developing in-service education programs on related topics;
- b. To develop policies and guidelines, to assist care providers in dealing with autonomy of residents, including quality of life issues, subject to MEC approval;
- c. To provide consultation on ethical issues when requested by any member of the health care team;
- d. To assist in Resident and family education on Residents' rights and autonomy.
- e. To report at least quarterly to the Medical Executive Committee of activities and findings.

4. Meetings

The Bioethics Committee ~~shall~~will meet at least 8 times a year.

G. Code Blue Committee

1. Purpose

The primary purpose of the Code Blue Committee is to develop and monitor policies and procedures, subject to the approval of the Medical

Executive Committee, for Code Blues performed at the Hospital and to review the outcomes of Code Blues.

2. Composition

The Code Blue Committee **shallwill** be a standing committee of the Medical Staff and **shallwill** consist of the following members:

- a. At least two physician members of the Medical Staff appointed on an annual basis by the Chief of Staff, one of whom will be appointed Chair and one Vice-Chair;
- b. One respiratory therapist, appointed by the Director of Respiratory Therapy;
- c. One nurse, appointed by the Chief Nursing Officer;
- d. One Pharmacist, appointed by the Director of Pharmacy; and
- e. One Quality Improvement Coordinator, appointed by the Chief Quality Officer

3. Functions

- a. To develop written standards for Hospital Code Blues, subject to the approval of the Medical Executive Committee.
- b. To be responsible for developing, evaluating, and revising on a continuing basis, subject to the approval of the Medical Executive Committee, the procedures and techniques for meeting established guidelines in the performance of codes. The evaluation **shallwill** be based upon data supplied from reputable sources, current scientific literature and experience.
- c. To develop a practical system for reporting, evaluating, and keeping records of Code Blues in order to provide an indication of the frequency of Code Blues and their outcomes.
- l. To report at least quarterly to the Medical Executive Committee and the Medical Quality Improvement Committee on activities and findings.
- m. To review the composition and organization of the crash cart and to make recommendations to the Pharmacy and Therapeutics Committee regarding medications available on the crash carts and in the emergency medication boxes.

4. Meetings

The Code Blue Committee ~~shall~~will meet quarterly, no less than three times a year. Committee members who are unable to attend a regularly scheduled meeting must send a qualified substitute.

H. Interdisciplinary Practices Committee

1. Purpose

- a. To establish policy and provide jurisdiction over issues relating to standardized procedures performed by Affiliated Health Practitioners; and
- b. To review the practice of Affiliated Health Practitioners at the Hospital, and as requested by the Chief Medical Officer or the Chief of Staff.

2. Composition

- a. At least two physician members of the Active Medical Staff, one of whom serves as chair;
- b. the Chief Medical Officer;
- c. the Chief Nursing Officer or designee;
- d. a nurse active in clinical practice appointed by the Chief Nursing Officer;
- e. a member of the Affiliated Health Practitioner staff appointed by the Chief of Staff;
- f. a member of Hospital administration appointed by the ~~Executive Administrator~~Nursing Home Administrator; and
- g. any other consultant as deemed advisable.

3. Functions

- a. To establish standards for Affiliated Health Practitioners;
- b. To participate in Affiliated Health Practitioners peer review and quality improvement and may initiate corrective action when needed.

- c. Standardized procedures can be approved only after consultation with the Medical Staff service involved and by affirmative vote of the administration representative, a majority of physician members, and a majority of the nursing members.
- d. To assure conformity as necessary with external certification requirements;
- e. To differentiate between nursing and medical functions and to define the areas of overlap for all proposed standardized procedures;
- f. To forward regular reports of its activities and make recommendations to the Medical Executive Committee.

4. Meetings

The Interdisciplinary Practices Committee shall will meet at least biannually and shall will submit minutes of each meeting to the Medical Executive Committee.

I. Well-Being Committee

1. Purpose

The purpose of this committee is to be a resource for Medical Staff members who have health, chemical dependency, or other factors that affect their well-being and performance. The committee shall will not engage in treatment or disciplinary functions.

2. Composition

- a. The Medical Staff Well-Being Committee shall will consist of no less than three Medical Staff members, one of whom shall will have expertise in chemical dependency. A majority of the members shall will be physicians.
- b. Members of the Committee shall will be appointed by the Chief of Staff.
- c. Insofar as possible, the Committee should have at least one member from the Psychiatry Service.
- d. Insofar as possible, members of the Well-being Committee shall will not serve as active participants on other peer review or quality assessment and improvement committees while serving on this committee.

- e. Any other consultant as deemed advisable.

3. Functions

- a. To serve as a confidential source of information to Medical Staff members;
- b. To facilitate self-referral by a Medical Staff member and referral by other organization staff;
- c. To facilitate referral of the affected Medical Staff member to the appropriate internal or external professional resources for diagnosis and treatment of the condition or concern;
- d. To provide for the maintenance of the confidentiality of the Medical Staff member seeking referral or referred for assistance, except as limited by law, ethical obligation, or when safety of a patient is threatened;
- e. To assure evaluation of the credibility of a complaint, allegation, or concern;
- f. To monitor the affected Medical Staff member for the safety of patients until the rehabilitation or any disciplinary process is completed;
- g. To provide assistance and referrals for disruptive Medical Staff members
- h. To advise the Chief of Staff if the committee receives information that clearly demonstrates that the health or known impairment of a Medical Staff member poses a risk of harm to Residents or others.

4. Meetings

The Committee ~~shall~~will meet as frequently as necessary.

5. Minutes

It ~~shall~~will maintain records of its meetings and proceedings as it deems advisable and ~~shall~~will report quarterly on its activities to the MEC. Any minutes of the Medical Staff Well-Being Committee ~~shall~~will be kept by the Chair under secure conditions and ~~shall~~will be available only to authorized Medical Staff members. All references to physicians ~~shall~~will be coded. Minutes will not be submitted to the Medical Executive

Committee, nor will they be made available to any person or agency, except as may be required by law.

J. Bylaws Committee

1. Purpose

The purpose of the Bylaws Committee is to review the Bylaws to assure that they reflect current practices.

2. Composition

- a. The Committee **shall will** consist of at least four members of the Active Medical Staff appointed by the Chief of Staff, one of whom **shall will** be the Chief of Staff or Immediate Past Chief of Staff
- b. Any other consultant as deemed advisable.
- c. The Chief of Staff **shall will** also appoint the committee chair.

3. Functions

The committee **shall will** conduct a biannual review of the Bylaws and **shall will** submit recommendations for amendments to the Medical Executive Committee; prior to any required notification to the Active Medical Staff.

4. Meetings

The committee **shall will** meet as frequently as necessary to carry out its duties.

K. Medical Education Committee

1. Purpose

The Medical Education Committee is to provide education for the Medical Staff through ongoing and special clinical and scientific programs to assure optimal patient care and contribute to the continuing education of each Practitioner.

2. Composition

The Medical Education Committee **shall will** consist of the following members, one of whom **shall will** be appointed chair by the Chief of Staff:

- a. The Medical Education Coordinator or designee;

- b. The Chief Medical Officer;
- c. Service Chiefs;
- d. Medical QI Committee chair, or designee;
- e. One or more members of the Active Medical Staff.

3. Functions

- a. Plan, implement, coordinate, and promote ongoing educational programs for the Medical Staff. This includes
 - i. identifying the educational needs of the Medical Staff;
 - ii. formulating clear statements of objectives for each program;
 - iii. assessing the effectiveness of each program;
 - iv. choosing appropriate teaching methods and knowledgeable faculty for each program; and
 - v. documenting staff attendance at each program;
- b. establish liaison with the quality assessment and improvement program of the Hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity;
- c. maintain close liaison with Medical Staff committees and other Hospital committees concerned with patient care;
- d. make recommendations to the Medical Executive Committee regarding educational resources needs;
- e. advise the Chief Medical Officer of the financial needs of the medical education program;

4. Meetings.

The Medical Education committee **shallwill** meet quarterly or as often as necessary at the call of its chair. It **shallwill** maintain a permanent record of its proceedings and activities and **shallwill** report to the Medical Executive Committee as necessary but at least quarterly.

L. Joint Conference Committee

The Medical Staff ~~shall~~will participate in the Joint Conference Committee as set forth in the Governing Body Bylaws

ARTICLE XII: MEDICAL STAFF MEETINGS

Section 1. Regular Meetings

- A. Medical Staff Meetings shall be held monthly, with no less than ten meetings per year. One third of the Active Membership shall constitute a quorum for the purposes of conducting business.
- B. The purpose of these meetings is:
 - 1. to serve as a means for self-government and to allow the Medical Staff to conduct its lawful business;
 - 2. to keep the Medical Staff members abreast of matters of administrative and professional importance; and
 - 3. to permit discussion of Hospital-wide issues pertaining to the Medical Staff.
- C. The June meeting shall be considered the Annual Medical Staff Meeting at which time elections of officers for the ensuing period shall be conducted.
- D. The Chief of Staff shall designate the date, time, place, and agendas for all regular Medical Staff Meetings.
- E. The Chief of Staff shall serve as chair of the Medical Staff meetings.

Section 2. Special Meetings

- A. Special Medical Staff Meetings may be called by the Chief of Staff, the Medical Executive Committee, or by not less than one-third of the members of the Active Medical Staff. In such cases, the Chief of Staff shall call the meeting within seven days. The purpose of the Special Meetings shall be stated in the meeting notice.
- B. Written notice stating the date, time, place, and agenda items of any Special Meeting of the Medical Staff shall be posted not less than two days before the date of the meeting. No business shall be transacted except that stated in the notice calling the meeting.

- C. Meetings with the express purpose of the timely dissemination of information may be called without the above stated notice. No business ~~shall~~will be transacted. Information provided at the meeting will be disseminated via other routes to members who are unable to attend.

Section 3. Attendance Requirements

Each member of the Active Medical Staff ~~shall~~will be required to attend at least fifty percent of regular Medical Staff Meetings each year that fall on regularly assigned workdays. Failure to meet the foregoing annual attendance requirements may be grounds for corrective action and meeting attendance may be considered by the Credentials Subcommittee at the time of re-credentialing.

Section 4. Records and Agenda

- A. The Medical Staff Secretary or designee ~~shall~~will keep minutes of all meetings of the Medical Staff. The agenda for regular Medical Staff meetings ~~shall~~will follow these guidelines:
1. Call to order;
 2. Attendance;
 3. Acceptance of the minutes of the last regular and of all Special Meetings;
 4. Announcements/Recognitions;
 5. Unfinished Business;
 6. Chief Medical Officer's Report;
 7. Reports of Committees and Clinical Services;
 8. New Business; and
 9. Adjournment.
- B. Actions requiring a vote ~~shall~~will be valid when approved by a simple majority of Members present.

C. Members are to submit agenda items to the Chief of Staff at least 48 hours prior to the meeting excluding weekends and holidays.

D. The agenda at Special Meetings ~~shall~~will be:

1. Reading of the Notice calling the meeting;
2. Transaction of business for which the meeting was called; and
3. Adjournment

Section 5. Absentee Voting

Medical Staff members may vote by absentee ballot for the election of officers, amendments to the Bylaws, and other items submitted to the Medical Staff for a vote if the member submits an absentee ballot at least three calendar days prior to the meeting. This time requirement may be waived due to exigent circumstances at the sole discretion of the Chief of Staff.

Section 6. Parliamentary Procedure

All meetings of the Medical Staff ~~shall~~will be conducted following Robert's Rules of Order. Technical or non-substantive departures from such rules ~~shall~~will not invalidate actions taken at such meetings.

ARTICLE XIII: CONFIDENTIALITY OF INFORMATION; IMMUNITY AND RELEASES

Section 1. Authorization and Conditions

By applying for or exercising clinical privileges with the Hospital, an applicant:

- A. authorizes representatives of the Hospital and the Medical Staff to solicit, provide and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;
- B. authorizes persons and organizations to provide information concerning such practitioner to the Medical Staff;
- C. acknowledges that the Medical Staff is required to respond to credentialing inquiries received from other peer review bodies and produce information about any peer review undertaken with respect to the applicant or Medical Staff member for a medical disciplinary cause or reason. In responding to the inquiry, the Medical Staff may elect to produce a written summary of relevant peer review information or produce records reflecting allegations and findings, explanatory or exculpatory information submitted by the Medical Staff member, any conclusion made, any actions taken, and the reasons for those actions. The Medical Staff's duty to produce this information exists whether or not the peer review process resulted in an action that was reportable to the Medical Board of California;
- D. agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the Medical Staff or the Hospital who would be immune from liability under Section 3 of this Article; and
- E. acknowledges that the provisions of this Article are express conditions to an application for Medical Staff membership, the continuation of such membership, and to the exercise of clinical privileges at this Hospital.

Section 2. Confidentiality of Information

- A. **General.** Discussions, deliberations, records and proceedings of all Medical Staff committees having the responsibility of evaluation and improvement of quality of care rendered in this Hospital ~~shall~~will, to the fullest extent permitted by law, be confidential. This confidentiality protection includes but is not limited to information regarding any member or applicant to this Medical Staff, and any meetings of the Medical Staff meetings of Clinical Services, meetings of committees established under Article X, and

meetings of ad hoc committees created by the Medical Executive Committee.

B. When Disclosure Is Permitted.

1. Dissemination or disclosure of such discussion, deliberations, records and proceedings ~~shall~~will only be made where expressly required by law, pursuant to officially adopted policies of the Medical Staff or, where no officially adopted policy exists, only with the express approval of the Medical Executive Committee.
2. In all other cases, access to such information and records ~~shall~~will be limited to authorized members of the Medical Staff for the sole purpose of discharging Medical Staff responsibilities and subject to the requirement that confidentiality be maintained.
3. Information which is disclosed to the Governing Body or its appointed representatives in order that the Governing Body may discharge its lawful obligations and responsibilities ~~shall~~will be maintained by that body as confidential.
4. Information contained in the credentials file or peer review file of any applicant or Medical Staff member may be disclosed to other Medical Staffs, hospitals, professional licensing boards, or medical schools.
5. Initiation of a corrective action investigation or report pursuant to Business and Correspondence Code section 805.01 or other adverse actions related to Medical Staff membership and/or privileges ~~shall~~will be reported to the peer review bodies of any other component of the San Francisco Health Network in which the Member provides care services.

C. Breach of Confidentiality. Effective quality of care activities, peer review, and consideration of the qualifications of Medical Staff members and applicants to perform specific procedures must be based on free and candid discussions within the quality improvement process. Any breach of confidentiality of the discussions, deliberations, records or proceedings of Medical Staff Clinical Services or committees is outside appropriate standards of conduct for Medical Staff members, violates these Medical Staff bylaws, and will be deemed disruptive to the operations of the Hospital. If it is determined that such a breach has occurred, the Medical Executive Committee may undertake such corrective action as it deems appropriate. In particular, and without limitation, a breach of confidentiality includes any unauthorized voluntary testimony or unauthorized offer to testify before a court of law or in any other proceeding as to matters protected by this confidentiality provision.

Section 3. Immunity from Liability

- A. **For Action Taken by the Medical Staff and Hospital.** Each representative of the Medical Staff and Hospital **shallwill** be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.
- B. **For Providing Information.** Each representative of the Medical Staff and Hospital and all third parties **shallwill** be immune, to the fullest extent provided by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning such person who is, or has been, an applicant to or member of the staff or who did, or does, exercise clinical privileges or provide services at this Hospital.

Section 4. Activities and Information Covered

The confidentiality and immunity provided by this Article **shallwill** apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facility's or organization's activities concerning, but not limited to:

- A. application for appointment, reappointment or clinical privileges;
- B. corrective action;
- C. hearings and appellate reviews;
- D. utilization and quality assurance reviews;
- E. activities related to monitoring and maintaining quality patient care and appropriate professional conduct; and
- F. queries and reports concerning the National Practitioner Data Bank, peer review body or organization, the Respective Professional Board, and similar queries and reports.

ARTICLE IV: CONFLICTS AND DISPUTE RESOLUTION

Section 1. Conflicts and Disputes between the Medical Staff and the MEC

- A. The Chief of Staff ~~shall~~will convene a meeting to resolve a conflict or dispute between the MEC and the Medical Staff upon receipt of a written petition, signed by at least forty percent (40%) of the Active Medical Staff members that sets forth the rule, policy, or other significant matter at issue.
- B. The meeting ~~shall~~will include up to five representatives of the Active Medical Staff selected by the petitioners and an equal number of MEC members selected by the Chief of Staff. The meeting ~~shall~~will be chaired by the Chief of Staff who will not be considered as one of the MEC representatives and who will not have voting privileges at this meeting.
- C. The representatives of the Medical Staff and of the MEC ~~shall~~will exchange information relevant to the conflict and ~~shall~~will work in good faith to resolve differences in a manner that respects the position of the Medical Staff, the leadership responsibilities of the MEC, and the safety and quality of patient care at the Hospital.
- D. Resolution at this level requires a majority vote of the representatives of the Medical Staff and a majority vote of the representatives of the MEC.
- E. Unresolved matters ~~shall~~will be submitted to the ~~Joint Conference~~Committee Governing Body for final resolution.

ARTICLE XV: APPROVAL AND AMENDMENT OF BYLAWS AND RULES AND REGULATIONS

Section 1. General

- A. The Medical Staff ~~shall~~will have the responsibility to formulate, adopt and recommend Medical Staff Bylaws, and Rules and Regulations and amendments thereto to the Governing Body.
- B. Such responsibility ~~shall~~will be exercised in good faith and in a reasonable, timely, and responsible manner, reflecting the interest of providing quality and efficient Resident care and of maintaining harmony of purpose and effort with the Governing Body.

Section 2. Approval by the Medical Executive Committee

- A. These Bylaws and Rules and Regulations, and subsequent amendments thereto, ~~shall~~will be approved by an affirmative vote of two-thirds of a quorum of the Medical Executive Committee.
- B. Upon approval by the Medical Executive Committee, the Bylaws and Rules and Regulations, and subsequent amendments thereto, ~~shall~~will be submitted for a vote by the Active Medical Staff.

Section 3. Approval by Active Medical Staff

- A. These Bylaws and Rules and Regulations, and subsequent amendments thereto, ~~shall~~will be approved at any regular or special meetings by an affirmative vote of two-thirds of the Active Medical Staff members who cast a vote
- B. If these Bylaws and Rules and Regulations are not approved, recommendations made by the Medical Staff members will be brought forth to the Medical Executive Committee for consideration and approval.
- C. Upon approval by the Active Medical Staff, these Bylaws and Rules and Regulations, and subsequent amendments thereto, ~~shall~~will be submitted for a vote by the Governing Body.

Section 4. Approval by Governing Body

- A. These Bylaws and Rules and Regulations, and subsequent amendments thereto, ~~shall~~will be approved by an affirmative vote of a majority of the Governing Body, which approval ~~shall~~will not be unreasonably withheld;
- B. Neither the Governing Body nor the Medical Staff may unilaterally amend the Medical Staff Bylaws and Rules and Regulations.

ARTICLE XVI: PROVISION FOR RULES AND REGULATIONS OF THE MEDICAL STAFF

The Medical Staff ~~shall~~will adopt Rules and Regulations necessary to implement the general principles found within these Bylaws, subject to the approval of the Governing Body. These ~~shall~~will relate to the proper conduct of Medical Staff organizational activities and ~~shall~~will embody the level of practice that is to be required of each practitioner in the Hospital. Such Rules and Regulations ~~shall~~will be a part of these Bylaws. Agreement to abide by the Bylaws includes agreement to abide by the Rules and Regulations.



San Francisco Health Network
Laguna Honda Hospital and Rehabilitation Center

LAGUNA HONDA HOSPITAL AND REHABILITATION CENTER

RULES AND REGULATIONS OF THE MEDICAL STAFF

REVISED JUNE 9, 2023

RULES AND REGULATIONS OF THE MEDICAL STAFF

I. ADMISSION AND DISCHARGE OF RESIDENTS

- A. The Hospital, depending on availability of beds, ~~shall~~will accept Residents for admission in accordance with Service 115.1 of the Health Code of the City and County of San Francisco.
- B. A Resident may be admitted to the Hospital only by a member of the Medical Staff. All practitioners ~~shall~~will be governed by the official admission policy of the Hospital.
- C. A member of the Active Medical Staff ~~shall~~will be the Primary Physician, responsible for the medical care and treatment of each Resident on his or her assignment in the Hospital. On Resident relocation, the responsibility is transferred to the newly assigned Primary Physician.
- D. In the absence of the Primary Physician, other Active Medical Staff physicians or as-needed night and weekend physicians are assigned by the Service Chief or Chief Medical Officer to have the responsibility for the care of the Resident.
- E. Exception can be made to the hospital admission policy in case of disaster.
- F. Residents ~~shall~~will be admitted, transferred or discharged only on the written order of a physician.
- G. In the event of a Resident's death, he/she ~~shall~~will be pronounced dead by a physician member of the Medical Staff within a reasonable period of time. Notification of the family ~~shall~~will be done by a physician except in unusual circumstances. The body ~~shall~~will not be released until an entry has been made in the medical record by a physician member of the Medical Staff certifying time of death. The release of bodies ~~shall~~must conform to hospital policy.
- H. Death certificates ~~shall~~must be completed by the Primary Physician or the covering physician as soon as possible but no later than one business day following expiration.

II. MEDICAL RECORDS

- A. All Medical Staff members **shallwill** be responsible for complete, accurate and legible documentation in the medical record.
- B. For residents admitted to skilled nursing units, the responsible physician **shallwill** complete an admission history and physical examination within 48 hours of admission or within 72 hours if the weekend intervenes. For residents admitted to the acute units, the responsible physician **shallwill** complete an admission history and physical examination within 24 hours of admission.
- C. Each of the Resident's clinical problems **shallwill** be clearly identified and addressed in the medical records. All patients in acute medical or rehabilitation require daily evaluation and progress notes. For all SNF Residents an evaluation and progress note is required every 30 days for the first 90 days after admission or readmission at a minimum after which an evaluation and progress note is required every 60 days, at a minimum, as meets Regulatory requirements. Residents who are critically ill or have complex medical problems, more frequent progress notes that reflect ongoing management are required.
- D. The transferring physician **shallwill** complete relocation notes upon relocation between care units. These **shallwill** include a summary of Resident problems, treatment suggestions for continued management, indication of need for follow-up on pending data, need for tests, and any other pertinent information.
- E. Residents discharged from the acute medical or acute rehabilitation unit **shallwill** have a discharge summary completed by the discharging physician or covering physician within 48 hours.
- F. The non-medication orders **shallwill** be reviewed and updated at least monthly for skilled level of care Residents and as needed for acute level of care Residents. For skilled nursing units, the problem list and medication list will be verified electronically at the time of the visit. For acute units, the orders will be reviewed and updated daily.
- G. Consultations **shallwill** be part of the Resident's medical record.
- H. All entries in the Resident's medical record **shallwill** be dated, timed, and signed
- I. Entries in the medical record **shallwill** not be erased, crossed out, or removed with eradicator or other similar techniques. Errors noted at the time they are made in the paper record **shallwill** be lined through and the correction made immediately following and initialed

- J. Errors in the content of the medical record, discovered after the time that they are made, may not be changed. An addendum in the electronic record will be completed and chart correction ticket completed if applicable. For a paper record, a currently dated statement by the physician in the progress notes should be made, stating the correction and the reason for the correction.
- K. A dictated or typed discharge summary **shall/will** be completed on all Residents hospitalized for more than 24 hours and **shall/will** be signed by the physician member of the Medical Staff who completed the summary. Such summaries must be completed upon transfer of Residents between acute level of care and skilled nursing level of care units at the Hospital and when a Resident is transferred out of the facility. The Laguna Honda physician will communicate required information about the resident to the receiving physician at the time of transfer. For Residents hospitalized for less than 24 hours, the discharge summary and the admission history and physical examination may be combined in one report.
- L. When the Primary Physician is absent, the physician assigned to cover **shall/will** be responsible for completing admission histories and physical examinations, and for maintaining the medical record as if he or she were the Primary Physician.
- M. The Primary Physician **shall/will** complete the Resident's chart within 14 days after discharge from acute level of care units and 30 days from skilled nursing level of care units. If records are not completed within 2 working days of a notice of delinquency, the name of the physician **shall/will** be referred to the Chief of Staff who may bring the matter to the Medical Executive Committee for appropriate action.
- N. For a Medical Staff member resigning or retiring, every effort must be made to complete medical records before leaving. If an incomplete record is found after a member is no longer on the staff, the record will remain incomplete and closed as such with the approval of the Health Information Management Committee.
- O. Written consent of the Resident or his/her authorized legal representative is required for the release of medical information, unless required by law.
- P. All medical records are legal documents and the property of LHH and may not be removed from the Hospital's jurisdiction and safekeeping without a court order or subpoena. In the case of readmission of a Resident, all previous records **shall/will** be available for the use of the Attending Physician. Unauthorized access or removal of medical records will result in appropriate legal or disciplinary action. The Health Information Management Department is the custodian of all medical records.

- Q. Medical records may be made available for study and research on projects approved by the Medical Executive Committee and the Hospital Executive Committee. Confidentiality of personal information **shall/will** be maintained.

III. ORDERS

All orders for treatment **shall/will** be:

1. Complete and clearly and legibly written or electronically entered;
2. Signed legibly by a practitioner if written.
3. Immediately reduced to entries in the electronic health record, when dictated or telephoned to a registered nurse. The nurse taking such orders must sign them and give the name of the prescriber. The nurse taking the telephone order must repeat the order back to the physician who will then confirm accuracy. Such orders must be countersigned by a physician. The expectation is all verbal orders are signed by the end of the shift. Per rules and regulations, all verbal orders on acute units must be signed with 48 hours, and on SNF units within 5 days. A name stamp alone without a signature **shall/will** not be used. Failure of a practitioner to properly sign his/her orders for treatment will be reported to the Chief Medical Officer for appropriate action.
4. Licensed Rehabilitation Therapists may take verbal orders for rehabilitation therapies. All orders for rehabilitation therapies **shall/will** be immediately reduced to entries in the electronic health record. The therapist taking the order must sign them and give the name of the prescriber. Such orders must be countersigned by a physician.
5. Respiratory Therapists, Dietitians and Pharmacists may take verbal orders within the scope of their practice.

IV. CONSULTATIONS

- A. Any qualified practitioner with clinical privileges in the Hospital may be called into consultation within his/her area of expertise. In acting as a consultant, the practitioner may make recommendations regarding diagnosis, treatment, and follow-up, and/or provide ongoing management. The primary responsibility for the general medical care of the Resident **shall/will** remain with the primary physician.
- B. The Attending Physician is primarily responsible for requesting consultation. Most consultations are done by electronic referral. A report **shall/will** be created on all consultations.

- C. All consultations must be documented and signed electronically or in writing by the consultant.
- D. Where circumstances justify such action, the Chief Medical Officer, Chief of Staff or Chief of Service may request a consultation.

V. GENERAL RULES REGARDING SURGICAL CARE

- A. Surgical services at the Hospital are limited to procedures that can be safely performed under local anesthesia with the personnel and equipment available at the Hospital.
- B. The surgeon is responsible for the proper identification of the Resident who is to have a procedure performed.
- C. Consent ~~shall~~must be obtained prior to any surgical procedure or any invasive diagnostic procedure unless the delay involved in obtaining consent would be imminently detrimental to the health or well-being of the Resident.
- D. A surgical note ~~shall~~will be documented in the Resident's medical record at the time of a surgical procedure. Surgical reports ~~shall~~will include a detailed account of findings as well as the details of the surgical technique used.
- E. All specimens removed surgically ~~shall~~will be properly labeled and sent to the Hospital's contractual pathology laboratory for identification and, when indicated, tissue diagnosis ~~shall~~will be performed by a qualified pathologist. The pathologist's authenticated report ~~shall~~will be made a part of the Resident's medical record.

VI. EMERGENCY SERVICES

- A. In the event of an emergency, any member of the Medical Staff or affiliated professionals, as well as any other licensed health care professional, ~~shall~~will be permitted to do everything reasonable to save the life of a resident or to save a resident from serious harm. The member, affiliated professional, or other licensed health care professional ~~shall~~will promptly yield care to a more qualified member of the Medical Staff when one becomes available.
- B. The Chief Medical Officer or his/her designated substitute ~~shall~~will work with the Administration in defining the role of the Medical Staff in Emergency Preparedness.

VII. RESIDENT CARE POLICIES

The Policies and Procedures adopted by the Medical Staff ~~shall~~will supplement these Rules and Regulations.