Northern Inyo Hospital

# February 17 2021 Regular Meeting

## February 17 2021 Regular Meeting - February 17 2021 Regular

# *AGENDA*
## NORTHERN INYO HEALTHCARE DISTRICT
## BOARD OF DIRECTORS REGULAR MEETING
## February 17, 2021 at 5:30 p.m.

**Northern Inyo Healthcare District invites you to attend this Zoom meeting:**

TO CONNECT VIA **ZOOM**: (*A link is also available on the NIHD Website*)
https://zoom.us/j/213497015?pwd=TDlIWXRuWjE4T1Y2YVFWbnF2aGk5UT09
Meeting ID: 213 497 015
Password: 608092

**PHONE** CONNECTION:
888 475 4499 US Toll-free
877 853 5257 US Toll-free
Meeting ID: 213 497 015

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1. Call to Order (at 5:30 pm).
2. ***Public Comment***: The purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered.
3. New Business:
   A. NIHD and Inyo County Covid-19 update (*information item*).
   B. Moment of appreciation by Board members for District employees and providers (*information item*).
   C. Chief Executive Officer PEPRA Retirement Plan termination and approval of District Board Resolution 21-01 (*action item*).
   D. Human Resources Department update (*information item*).

E. Chief Executive Officer search update (*information item*).

F. February 20 2021 Special Board meeting, annual CEO evaluation (*information item*).

G. Bronco Clinic update (*information item*).

4. Chief of Staff Report, Charlotte Helvie, MD:

   A. Approval of proposed NIHD Medical Staff Bylaws (*action item*).

   B. Policy and Procedure approvals (*action items*):

      1. *Discharge Medications Policy*
      2. *Interfacility Transfer Guidelines*
      3. *Admission, Care, Discharge and Transfer of the Newborn*
      4. *Base Station Pre-Hospital Care Policy*
      5. *Base Station Quality Improvement Program Pre-Hospital*

   C. Notice of Automatic Action (*information item*):

      1. Ranier Manzanilla, MD (*cardiology*) – privileges have been suspended effective 1/1/21 for noncompliance with insurance requirements. This action is not for medical disciplinary cause or reason and is not a reportable action.

   D. Formation of Ad Hoc Joint Conference Committee (*action item*).

   E. Medical Executive Committee Meeting Report (*information item*).

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***Consent Agenda (action items)***

5. Approval of minutes of the January 20 2020 regular meeting
6. Pioneer Home Health quarterly report
7. Eastern Sierra Emergency Physicians quarterly report
8. Financial and Statistical reports as of December 31 2020
9. Cerner Implementation update

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10. NIHD Committee updates from Board members (*information items*):

    A. Review of NIHD Medical Staff/Board of Directors meeting minutes (*information item*).

11. Reports from Board members (*information items*).
12. Adjournment to Closed Session to/for:

    A. Conference with Labor Negotiators, Agency Designated Representative: Irma Moisa; Employee Organization: AFSCME Council 57 (*pursuant to Government Code Section 54957.6*).

13. Return to Open Session and report of any action taken (*information item*).
14. Adjournment.

*In compliance with the Americans with Disabilities Act, if you require special accommodations to participate in a District Board meeting, please contact administration at (760) 873-2838 at least 48 hours prior to the meeting.*

**STAFF REPORT**
**NORTHERN INYO HEALTHCARE DISTRICT**

**SUBJECT:**

***Freeze and Termination of the Northern Inyo Healthcare District PEPRA Retirement Plan***

**RECOMMENDATION:**

***That the Board of Directors of Northern Inyo Healthcare District adopt a resolution and an amendment to freeze and terminate the Northern Inyo Healthcare District PEPRA Retirement Plan***

**EXECUTIVE SUMMARY:** The District previously adopted the Northern Inyo Healthcare District PEPRA Retirement Plan, a defined benefit plan, to provide retirement benefits to its CEO. With the departure of the former CEO for whom the plan was established, the Board of Directors of the District wishes to freeze and terminate the Plan. The approval of the attached resolution (Attachment 1) will freeze participation and benefit accruals under the Plan and will terminate the Plan effective as of February 17, 2021. The resolution will approve the adoption of a Plan amendment (Attachment 2) to be executed by the Board President or other authorized officer of the District to freeze participation and benefit accruals and terminate the Plan effective as of February 17, 2021.

**FISCAL IMPACT:**

After all Plan benefits have been distributed, there is approximately $_____ remaining in the Plan which will be returned to the District. If the Board of Directors wishes to submit the Plan to the Internal Revenue Service to request a favorable determination letter upon the termination of the Plan, there will be a filing fee of $3,500 and a document preparation fee of approximately $3,000 to 5,000. However, a determination letter from the Internal Revenue Service is not required to terminate the plan .

**DISCUSSION:**

The District currently maintains the Northern Inyo Healthcare District PEPRA Retirement Plan ("Plan"). The Plan was submitted to the Internal Revenue Service requesting the issuance of a favorable determination letter on the Plan's qualification. The Internal Revenue Service issued the favorable determination letter on October 2, 2017.

The only participant eligible to participate in the Plan is the CEO of the District to the extent the CEO is not eligible to participate in the District's legacy defined benefit plan. The Plan provides a benefit based on a percentage of the CEOs Average Annual Compensation at the CEO's

retirement age multiplied by the CEO's years of credited service. The CEO is required to contribute 50% of the normal cost rate to the Plan.

The prior CEO had a severance from employment on or about May, 2020 and because he was not vested, he elected to receive a return of his employee contributions only.

It is the intention of the Board of Directors to discontinue the Plan.

Because there are no longer any participants in the Plan who have accrued benefits or will accrue benefits in the future, it is therefore recommended that the Board of Directors adopt a resolution and an amendment to freeze participation and benefits under the Plan, to terminate the Plan effective as of February 17, 2021, and in accordance with the provisions of the Plan, to return any remaining funds in the trust to the District. In addition, should the Board of Directors so recommend, the resolution further authorizes the submission of the Plan to the Internal Revenue Service requesting the issuance of a favorable determination letter upon the termination of the Plan. Submission to the Internal Revenue Service is optional, but provides the District the opportunity to obtain approval of the Plan's termination.

The attached resolution authorizes the execution of the attached amendment by the President of the Board of Directors or any other authorized officer of the District.

In summary, approval of the resolution in Attachment 1 and the adoption of the amendment in Attachment 2 will authorize the freeze of participation and benefits accruals, the termination of the Plan, and the return of any remaining funds in the trust to the District.

**RESOLUTION NO. _____**

**RESOLUTION OF THE BOARD OF DIRECTORS OF NORTHERN INYO HEALTHCARE DISTRICT APPROVING THE FREEZE OF PARTICIPATION AND BENEFIT ACCRUALS AND TERMINATION OF THE NORTHERN INYO HEALTHCARE DISTRICT PEPRA RETIREMENT PLAN**

**WHEREAS,** Northern Inyo Healthcare District ("District") previously established the Northern Inyo Healthcare District PEPRA Retirement Plan (the "Plan") for the benefit of eligible employees and their beneficiaries with an effective date of January 1, 2016; and

**WHEREAS**, eligibility in the Plan is limited to the District's CEO; and

**WHEREAS**, with the departure of the former CEO, the District wishes to discontinue the Plan; and

**WHEREAS**, the District's Board of Directors wishes to adopt the attached amendment ("Amendment") to freeze participation and accruals under the Plan and to terminate the Plan effective as of February 17, 2021; and

**WHEREAS**, after all participant benefits have been distributed, the District's Board of Directors wishes to have any remaining funds in the Plan returned to the District in accordance with Section 8.2 of the Plan.

**NOW, THEREFORE BE IT RESOLVED** by the Board of Directors of Northern Inyo Healthcare District that:

1. The Amendment to freeze and terminate the Plan is adopted.

2. The Board President or other authorized officer of the District is authorized to execute the Amendment.

3. The Board President and the appropriate officers of the District, without further action by the Board of Directors, are hereby specifically authorized and directed to take any and all actions that may be deemed necessary or appropriate with respect to the termination of the Plan, including the optional submission of the Plan to the Internal Revenue Service requesting the issuance of a favorable determination letter upon the Plan's termination and the adoption of such additional amendments as may be required by the Internal Revenue Service as result of the Plan's termination.

[District's Signature Block]

APPROVED AS TO FORM AND CONTENT:
BEST BEST & KRIEGER, LLP

By:_____
Attorneys for Employer

**AMENDMENT NO. 2**
**TO THE**
**NORTHERN INYO HEALTHCARE DISTRICT**

**PEPRA RETIREMENT PLAN**

RECITALS

A. The NORTHERN INYO HEALTHCARE DISTRICT ("Employer"), adopted the NORTHERN INYO HEALTHCARE DISTRICT PEPRA RETIREMENT PLAN (the "Plan") for the benefit of its Chief Executive Officer, effective January 1, 2016.

B. On June 17, 2020, the Employer amended the Plan to allow for the distribution of a Participant's contributions in the event of his or her termination of employment with no vested benefit under the Plan.

C. Article 8 of the Plan provides that the Employer reserves the right to amend and terminate the Plan in whole or in part at any time.

D. Effective as of February 17, 2021, the Employer wishes to amend and terminate the Plan as follows:

1.1 To freeze all participation under the Plan and prohibit entry of any additional participants;

1.2 To cease all contributions and benefit accruals under the Plan; and

1.3 To terminate the Plan and distribute the Plan assets in accordance with the terms of the Plan.

AMENDMENT

NOW, THEREFORE, effective as of February 17, 2021, the Employer hereby amends the NORTHERN INYO HEALTHCARE DISTRICT PEPRA RETIREMENT PLAN, as follows:

1. All participation under the Plan is frozen and no new Participants shall be allowed to enter the Plan.

2. All contributions and benefit accruals to the Plan shall cease.

3. The Plan is terminated as of the February 17, 2021 (the "Effective Date Of Plan Termination").

4. The Plan Administrator shall direct that distributions, if any, will be made to Participants and Beneficiaries in accordance with the forms and payments provided in the Plan within a reasonable period of time after the Effective Date Of Plan Termination.

5. Any remaining Plan assets shall be disposed of in accordance with the provisions of Section 8.2 of the Plan, which provides that any remaining funds shall be returned to the District.

6. This amendment supersedes the provisions of the Plan to the extent those provisions are inconsistent with the provisions of this Amendment. Except as amended above, the remaining provisions of the Plan shall remain in full force and effect.

IN WITNESS WHEREOF, the Employer has caused this amendment to be executed on February ____, 2021.

EMPLOYER:

NORTHERN INYO HEALTHCARE DISTRICT

By: _____

APPROVED AS TO FORM AND CONTENT:

BEST BEST & KRIEGER LLP

By: _____
Attorneys for Employer

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In summary, approval of the resolution in Attachment 1 and the adoption of the amendment in Attachment 2 will authorize the freeze of participation and benefits accruals, the termination of the Plan, and the return of any remaining funds in the trust to the District.

**RESOLUTION NO. 21-01**

**RESOLUTION OF THE BOARD OF DIRECTORS OF NORTHERN INYO HEALTHCARE DISTRICT APPROVING THE FREEZE OF PARTICIPATION AND BENEFIT ACCRUALS AND TERMINATION OF THE NORTHERN INYO HEALTHCARE DISTRICT PEPRA RETIREMENT PLAN**

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_____

Robert Sharp, District Board Chair

Northern Inyo Healthcare District

APPROVED AS TO FORM AND CONTENT:
BEST BEST & KRIEGER, LLP

By:_____
Attorneys for Employer

# HUMAN RESOURCES

Department Assessment Update – February 2021

# BACKGROUND

- January 2019: Reduction in force affecting HR department
- December 2019: Municipal Resource Group, LLC (MRG) assessment

# RECOMMENDED AREAS OF FOCUS


- Staffing
- Recruitment
- Leave Management
- Staff Professional Development
- HR Processes and Workflows

# STAFFING

- Recommendation: Increase staffing and review recommendations
- Action: Staff has increased from 4 to 7 FTEs

# RECRUITMENT

- Recommendation: Revisit recruitment process
- Action: Create a more proactive approach
  - Social media, specialty websites, and job boards
  - Partner with managers for recruitment plans
  - Screening and vetting candidates
  - Attend job fairs

# LEAVE MANAGEMENT

- Recommendation: Comprehensive assessment of Leave Management process
- Action: Move from manual process
  - Reviewing LOA tracking software options
  - Annual LOA-specific training
  - Highly specialized training for department

# STAFF PROFESSIONAL DEVELOPMENT

- Recommendation: HR staff should have additional training
- Actions: Staff to do the following training:
  - PHR certification
  - SHRM
  - CalPELRA
  - Hospital Association memberships
  - ADP learning
  - Study.com and LinkedIn Learning
  - HR.BLR

# HR PROCESSES AND WORKFLOWS


- Recommendation: Evaluate HR processes and workflows
- Actions:
  - Training Managers: In progress
  - Electronic personnel files: Complete
  - Review SOPs: In progress
  - Review Employee Handbook: Legal review to be completed Fall 2021
  - Department cross-training: In progress
  - Implement additional ADP modules: In progress
  - Compensation plan: In progress, to be completed August 2021

# CONCLUSION

- Structure
- Competence
- Customer Service
- Efficiency
- Workforce Management

**NORTHERN INYO HOSPITAL**
*Northern Inyo Healthcare District*
150 Pioneer Lane, Bishop, California 93514

Medical Staff Office
(760) 873-2136 voice
(760) 873-2130 fax

TO: NIHD Board of Directors
FROM: Charlotte Helvie, MD, Chief of Medical Staff
DATE: February 2, 2021
RE: Medical Executive Committee Report

The Medical Executive Committee met on this date. Following careful review and consideration, the Committee agreed to recommend the following to the NIHD Board of Directors:

A. Proposed New Medical Staff Bylaws (*action item*)

B. Policies and Procedures (*action item*)
   1. *Discharge Medications Policy*
   2. *Interfacility Transfer Guidelines*
   3. *Admission, Care, Discharge and Transfer of the Newborn*
   4. *Base Station Pre-Hospital Care Policy*
   5. *Base Station Quality Improvement Program Pre-Hospital*

C. Notice of Automatic Action (*information item*)
   1. Rainier Manzanilla, MD (*cardiology*) – privileges have been suspended effective 1/1/21 for noncompliance with insurance requirements. This action is not for medical disciplinary cause or reason and is not a reportable action.

D. Medical Executive Committee Meeting Report (*information item*)

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| Title: Discharge Medications | |
|---|---|
| Scope: District Wide | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 5/18/05 |

**PURPOSE:**

To incorporate a process which provides for the means to dispense prescription medication to specific patients that are being discharged from the District compliant to pharmacy regulations.

**POLICY:**

1. The pharmacy will not dispense any discharge medications for patients leaving the facility as the District does not maintain a retail license.
2. Should a 72 hour or less supply of medication be deemed necessary to expedite a discharge or during non-operation of retail pharmacy services the patient discharge packs housed in the ED Omnicell may be utilized for this purpose. The primary or attending physician will directly dispense the meds and inform the patient as to the use and rationale of the intended medication.
3. Multi-dose medications such as inhalers, insulin, topical items etc. may be directly dispensed by the physician to the patient or patient's family with instructions for use and storage even though they may exceed 72 hours so as not to needlessly waste these items.
4. Should a greater than 72 hour supply be necessary the physician responsible for the patient shall provide the patient with a prescription or transmit the required prescription information to an outside pharmacy of the patient's choice provided this is a feasible process.
5. If the patient requires a greater than 72 hour supply of medication for whatever reason the Director of Pharmacy or his immediate subordinate must authorize.
6. If the patient requires greater than a 72 hour supply of medication and is unable to financial secure prescriptions from an outside pharmacy social services and chief level approval will be required for this financial responsibility.
   If approval is granted the following procedure will be followed.
   a. The primary or attending physician will generate the prescription orders.
   b. These orders will be transmitted to Dwayne's Pharmacy (7 day supply) if additional day's supply are needed the primary or attending physician will be contacted for refill authorization.
   c. Dwayne's Pharmacy staff will, fill and dispense the prescription to the patient or patient's representative.
   d. Dwayne's Pharmacy will be responsible to perform the legally mandated medication counseling prior to dispensing.
   e. NIHD will be financially responsible for payment to Dwayne's for this service.

**References:**


1. Pediatrics February 2012 129(2) e562
2. Journal of Hospital Medicine Jan 2008 3(1) 12-19
3. Journal of American Geriatrics Society March 2020


**Cross References:**

1. To comply with B&PC 4074, CCR 1707.2

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| Title: Discharge Medications | |
|---|---|
| Scope: District Wide | Department: Pharmacy |
| Source: Pharmacy Director | Effective Date: 5/18/05 |

| **Committee Approval** | **Date** |
|---|---|
| CCOC | 10/29/2020 |
| Pharmacy and Therapeutics Committee | 12/17/2020 |
| Medical Executive Committee | 02/02/2021 |
| Board of Directors | |
| Board of Directors Last Review | |

Revised: 3/05, 9/2020fl
Reviewed: 3/08, 5/11, 6/13, 2/15/17, 2/21/18
Supersedes: 2/98

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| Title: Interfacility Transfer Guidelines | |
|---|---|
| Scope: Nursing | Department: Emergency Dept, ICU/CCU, Medical/Surgical, OB/Gyn |
| Source: Emergency Department Nurse Manager | Effective Date: |

**PURPOSE:**
To establish responsibilities of Registered Nurses (RNs) employed by Northern Inyo Healthcare District (NIHD)who accompany and provide care during interfacility transfer of patients as directed by Inland Counties Emergency Medical Agency(ICEMA) protocols.

**POLICY:**
In the event that the patients' needs are outside of the Emergency Medical Technician-Paramedic (EMT-P) scope of practice or critical care air transport is not possible, an ACLS certified RN may accompany a critical patient during an interfacility transfer via ambulance. The RN will follow established guidelines according to ICEMA protocols and any orders written by transferring physician.

**RN INTERFACILITY TRANSFER:**

**Prior to leaving the hospital:**

1. Receive a complete report on the patient.
2. Check completeness of all Interfacility transfer forms and accompanying documents.
3. Bring all necessary medications, IV solutions, etc. Confer with EMT-P on ACLS medications available in ambulance.

**During transport:**

1. The RN will be responsible for carrying out orders from the transferring physician.
2. In the event the patient condition deteriorates during transport, the EMT-P will contact the base hospital for orders or destination change if necessary.
    a. Advanced Cardiac Life Support (ACLS) protocols will be followed for any cardiopulmonary arrest during transport.
    b. The base hospital physician may consider discontinuing or continuing orders based on patient condition.
    c. The RN will document the base hospital physician's orders on the transferring facility's patient record. The EMT-P will document on their own electronic patient care record (ePCR).

**On arrival to receiving facility:**

1. Accompany the patient to the Emergency Department or designated room and give a full report to the receiving nurse.
2. Give copies of patient chart and the original transfer form (completed) to the receiving RN.

| Title: Interfacility Transfer Guidelines | |
|---|---|
| Scope: Nursing | Department: Emergency Dept, ICU/CCU, Medical/Surgical, OB/Gyn |
| Source: Emergency Department Nurse Manager | Effective Date: |

**Upon return to NIHD:**

1. Notify House Supervisor of return.
2. Complete an edit sheet with time of departure and time of return and mark as " ambulance transfer."

**REFERENCES:**

Inland Counties Emergency Medical Agency (ICEMA)( 2020). Policy, Procedure and Protocol Manual, Reference #8010.
California Code of Regulations. Title 22, Division 5- Article 6, s 70451 (2014). Retrieved from http://nursealliance ca.org/files/2012/06/Title-22-Chapter-5.pdf

**CROSS REFERENCE POLICY & PROCEDURES:**

EMTALA Policy

| **Approval** | **Date** |
|---|---|
| CCOC | 7/27/2020 |
| Emergency Services Committee | 9/11/2020 |
| Medical Executive Committee | 02/02/2021 |
| Board of Directors | |
| Last Board of Director Review | |

**Revised:** 3/95; 02/01; 7/11as; 2/15as, 6/2020gr

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| Title: Admission, Care, Discharge and Transfer of the Newborn | |
|---|---|
| Scope: Perinatal | Manual: Perinatal |
| Source: Chief Nursing Officer | Effective Date: 3/1/18 |

**PURPOSE:**
To ensure a safe transition after delivery, and to maintain optimal patient safety while admitting, caring for, and discharging a newborn. To provide guidelines during the transfer of a newborn to another facility.

**POLICY:**
A qualified Perinatal Unit RN shall oversee the initial and ongoing stabilization of the newborn. A qualified Perinatal Unit RN or LVN, cross trained, or float trained RN or LVN may take a neonatal patient assignment, including admission and discharge. A qualified Perinatal RN will care for any neonate needing transfer to a higher level of care.

Perinatal nurses will use the nursing process in the care of patients including: assessment, interpretation and diagnosis, interventions, and evaluation. Licensed, and unlicensed assistive personnel may assist in the nursing process by collecting assessment data, and orienting the patient and her family to the hospital/unit environment.

All discharge plans will be coordinated with the provider's plan of care and any concerns will be discussed with the provider in a timely manner. The Patient's needs and discharge planning shall be addressed throughout stay.

**PROCEDURE:**
1. Admission upon vaginal birth:
    a. Perform Hand Hygiene. Gloves should be worn when handling infant before the first bath, when changing diapers, or during procedures.
    b. Dry and stimulate infant, following NRP guidelines. If additional resuscitation required per NRP guidelines, infant will be placed on infant warmer. When/if infant is stable, infant should be returned to mother's chest for skin to skin contact, unless otherwise requested by the Pediatric Provider. If alternate caregiver unavailable, infant may remain on warmer on in bassinette.
        - The safety and stability of both mother and infant will be addressed prior to initiation of skin-to-skin~~, unless otherwise requested by the Pediatric Provider~~. If there is a medical contraindication, skin-to-skin will be delayed.
    c. Attach infant security band, and infant/mother bands. Follow *Infant Security* Policy and Procedure.
    d. A complete physical head to toe nursing assessment of the newborn will be performed upon 2 hours of birth, or when infant's stabilization is complete.
    e. The RN will assign APGAR scores at 1 and 5 minutes. If the five-minute APGAR score is less than 7, the RN will assign an APGAR score at 10 minutes of life.
    f. Notify Pediatric Provider for ongoing required intervention.
    g. Observe infant for signs of hypoglycemia or screen for indications for blood glucose monitoring. Follow *Blood Glucose Monitoring* Policy.
    h. After infant stabilization, vital signs shall be taken per MD orders. *Refer to Standardized Procedure for Admission of the Well Newborn.*

- Spot checking of infant condition may be performed more frequently at RN's discretion and is encouraged.
- Temperatures shall be taken via axillary method.
    - If the infant's temperature is less than 97.7 degrees F, assure infant is skin to skin (if available. If unavailable, place under radiant warmer), and reassess in 30 minutes. If infant's temperature remains less than 97.7 degrees F after interventions, confirm with a rectal temperature and notify Pediatric Provider and for further assessment and monitoring.

i. Erythromycin Ophthalmic Ointment 0.5% 1 application within 2 hours of delivery
j. Phytonadine IM (Vitamin K) 1 ml administered within 2 hours of delivery.
k. Infant measurements and weight shall be delayed until initial skin to skin bonding is complete after a minimum of one hour, unless such information is needed promptly for medical needs.
l. Upon completion of initial skin to skin contact, infant shall be weighed on an infant scale. All infant weights shall be taken naked, without a diaper, and recorded in grams in the electronic medical record.
m. Measure the infant's length from the crown of the head to the sole of the feet using a paper measuring tape. Record the length in inches in the electronic medical record.
n. Measure the head and the chest circumferences. Record in inches in the electronic medical record.
o. Fill out crib card with all information complete, and affix to infant bassinette.
p. Infant baths shall be delayed for at least 24 hours. Parents will be educated about the benefits of a delayed bath. Earlier or later baths may be done if medically indicated or per mother's request.
q. Mothers and caregivers will be encouraged to keep infant skin to skin as much as possible. If infant is not skin to skin, the infant shall be appropriately swaddled to maintain temperature WNL.
r. Leave umbilical area and clamped cord stump clean, dry and uncovered. Clamp may be removed once cord is dry. If umbilical cord is not dry upon hospital discharge, it may be removed at the Pediatric clinic.

2. Special consideration for cesarean birth:
    a. Newborn care upon birth via cesarean section shall follow the same process as for vaginal delivery with the following additions:
        i. Cesarean births shall be attended by a minimum of one Perinatal RN and one RT certified in NRP to care for infant.
        ii. Upon cesarean birth, place infant on warmer via sterile technique, and follow NRP guidelines until infant stable. The RN will assign APGAR scores at 1 and 5 minutes. If the five-minute APGAR score is less than 7, the RN will assign an APGAR score at 10 minutes of life.
        iii. Notify Pediatric Provider for ongoing required intervention.

iv. If Perinatal unit staffing allows, and if infant is stable, mother's condition is stable per anesthesia provider, and if mother will tolerate it, place the infant skin to skin on mother's chest in the OR. Perinatal RN or LVN shall remain present during skin to skin contact in the OR. Infant shall remain skin to skin until mother is ready to go to PACU or per mother's request and condition. When mother is ready to move to recovery, the RN shall accompany infant and support person (if available) to PACU to await mother. Infant may be placed skin to skin with support person in PACU until mother arrives and is stable and ready for infant to return to her chest. Infant may remain skin to skin as long as mother desires and condition remains stable until mother ready to return to Perinatal unit.

v. Continue to care for infant as per vaginal delivery (see 1, above).

3. Admission of infant after initial discharge:
    a. Infants up to and including 27 days shall be readmitted to the Perinatal unit. Infant older than 27 days shall be readmitted to the Pediatric unit. Exceptions may be made on individual bases per diagnosis.
    b. Upon admission a qualified Perinatal, float trained, or cross-trained RN shall perform a head to toe assessment of the infant, including naked weight, temperature, pulse and respirations. After initial assessment a qualified LVN may assume patient care.
    c. Attach infant security band, and infant/mother bands. Follow *Infant Security* Policy and complete the Code Amber Information Sheet, complete with a photo and demographic information of the infant.
    d. All reasonable efforts will be made to accommodate the infant's mother or caregiver to room-in with the infant. Include parents in the care of the child, being considerate in approach. Parents are to be encouraged to become involved in the child's care. Explain all treatments and procedures the parent and patient should anticipate.
    e. Refer to physician orders for frequency of vital signs and weights.
    f. Refer to *Breastfeeding and Supplementation* Policy and Procedure for infants readmitted due to weight loss, hyperbilirubinemia, and or as needed.
4. Transfer to a higher level of care:
    a. Complete all paperwork as specified on the *Neonatal Transfer Contents.*
    b. Care of the neonate shall be performed by a NIHD Perinatal RN until the transport team arrives and assumes care of the patient.
    c. Documentation should include a physician order and accepting provider and facility. The house supervisor should be involved to assist in coordination of the transfer.
    d. If the newborn Hearing Screen, Newborn Screen Testing, or hyperbilirubinemia assessments were not completed prior to transfer, documentation must be made in the EHR.

- If the Newborn Hearing Screening test was not performed prior to transfer, complete the Newborn Hearing Screening Infant Reporting Form (Inpatient Screen Not Done Section) and place with infant facesheet in the Hearing Screen Folder.
- If the Newborn Screening Test was not performed prior to transfer, complete California Newborn Screening Test Form with as much information as possible, referencing instructions for completion of the form #20.

**REFERENCES:**

1. http://pediatrics.aappublications.org/content/138/3/e20161889
2. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2994120/

**CROSS REFERENCE P&P:**

1. Breastfeeding and Supplementation
2. Infant Security Policy and Procedure
3. Blood Glucose Monitoring
4. Transfer to acute care facility (Lippincott procedure)

| **Approval** | **Date** |
|---|---|
| CCOC | 01/12/2021 |
| Peri-Peds | 12/22/2020 |
| MEC | 02/02/2020 |
| Board of Directors | |
| Last Board of Directors Review | |

**Developed:** 12/98
**Reviewed:**
**Revised**: 12/98; 2/2001; 12/2003jk; 01/08jk, 6/11jk, 9/12jk; 11/2015 jb; 12/2017af; 12/2020jmt

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| ~~Title: Pre-Hospital Care Policy~~Base Station Pre-Hospital Care Policy | |
|---|---|
| Scope: Emergency Department | Manual: Emergency Department – Communication (COM) |
| Source: Manager - Emergency Department | Effective Date: 11/1/17 |

**PURPOSE:**
To define Northern Inyo Healthcare District's (NIHD) role and requirements as a Base Station Hospital.

**POLICY:**
NIHD has agreed to be a base station for Inyo County and will follow the protocols and standards set forth by Emergency Medical Services Agency (EMSA) also known as Inland Counties Emergency Medical Agency (ICEMA) .

**PROCEDURE:**

A. **Radio Communication:**

1. Medical Direction to the Advanced Life Support (ALS) personnel may only be given via two-way radio or telephone communication by the Emergency Department Physician or by a certified Mobile Intensive Care Nurse (MICN). ALS and Basic Life Support (BLS) report may be received by non-MICN Registered Nurses when an MICN or Emergency Department (ED) Physician is unavailable. In the event that medical direction is requested or required, the non-MICN will locate an MICN or ED Physician. At no time will a non-MICN give medical direction or orders to BLS or ALS units.

B. **Record Keeping:**

1. The Base Station Hospital Mobile Intensive Care Record will be completed by the Emergency Department personnel during all ALS and BLS calls.
    a. The Incident number will be the next sequential number from the previous run on the Base Station Facility Log.
    b. All vital signs, assessments, medications, and procedures completed prior to Base Station contact will be designated as "PTC" (prior to contact).
    c. All calls will be saved for a minimum of 19 years.
    d. All record keeping and submission of monthly reports to ICEMA is the responsibility of the Pre-Hospital Liaison Nurse (PLN) or Nurse Manager/Assistant Manager.
2. Northern Inyo Hospital will follow all Quality Improvement and audit requirements as established by ICEMA.

C. **EMS Radio**

1. There are two EMS radios, Telex-IP2002 in the ED.
    a. The first one is located in the Nurse's station of the ED and has two channels for EMS radio traffic and one channel for EMS phone traffic.
    b. The second radio is located in the ED Physician room and has one channel for EMS radio traffic and one channel for the TAC channel utilized by the Unified Command.
    c. There are six BK narrow-band radios in the ED with EMS Silver Peak, EMS

| | |
|---|---|
| ~~Title: Pre-Hospital Care Policy~~Base Station Pre-Hospital Care Policy | |
| Scope: Emergency Department | Manual: Emergency Department – Communication (COM) |
| Source: Manager - Emergency Department | Effective Date: 11/1/17 |

Local and Fire Tac.

**REFERENCES:**

1. ICEMA Policy Procedure and Protocol Manual.

**CROSS REFERENCE P&P:**

1. MICN Guidelines

| **Approval** | **Date** |
|---|---|
| CCOC | 7/27/2020 |
| Emergency Services Committee | 9/11/2020 |
| MEC | 02/02/2021 |
| Board of Directors | |
| Last Board of Directors Review | 6/19/19 |

Developed: 2/95
Reviewed: 6/11as; 2/15as;
Revised: 7/17gr, 11/19 gr, 7/2020gr

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| | |
|---|---|
| Title: Base Station **Quality Improvement Program Pre-Hospital** | |
| Scope: Emergency | Department: **Emergency Department** |
| Source: Emergency Department Nurse Manager | Effective Date: March 1995 |

**PURPOSE:**
To provide a standardized guideline for the continuous evaluation and improvement of the pre-hospital care system.

**POLICY:**
To maintain on-going records ensuring compliance with the requirements set forth by the Emergency Medical Services (EMS) agencies and Inland Counties Emergency Medical Agency (ICEMA)Continuous Quality Improvement Plan (CQIP).

**PROCEDURE:**
**I. Structure**

**A.** Minimum requirements for Base Station CQIP.

1. A base station team under the direction of the Base Station Medical Director
2. A CQIP Advisory group with members which may include but are not limited to:
    a. Base Station Medical Director
    b. Prehospital Liaison Nurse (PLN) or equivalent
    c. Base Station Mobile Intensive Care Nurse (MICN)
    (Availability of resources can vary greatly)

B. Responsibilities

1. Cooperate with ICEMA in carrying out the responsibilities of the CQIP and participate in the ICEMA CQIP process.
2. Cooperate with ICEMA in monitoring, collecting data, evaluation and implementation of state required EMS indicators.
3. Participate in meetings for review of Base station criteria and develop PI plans.
4. Provide reasonable training and in-service education to base station personnel.

C. Annual Reports

1. NIHD base station will maintain on going records ensuring compliance to the requirements set forth in the CQIP. The monitoring system will provide a standardized guideline for the assessment, identification, evaluation, feedback and implementation of changes to meet the needs of the CQIP.

**II. REVIEW OF PATIENT CARE DATA**

A. Mobile Intensive Care Nurse report (MICN). Monthly review of 10% randomly selected reports by the PLN or Base Station Medical Director for:

1. Complete documentation
2. Pre-hospital care treatment orders
3. Compliance with ICEMA protocol

| Title: Base Station **Quality Improvement Program Pre-Hospital** | |
|---|---|
| Scope: Emergency | Department: **Emergency Department** |
| Source: Emergency Department Nurse Manager | Effective Date: March 1995 |

B. Base station tape review

1. All audio files that fall in the following categories must be reviewed for determination of cause and must be logged and included in the quarterly report submitted to ICEMA:

a. Case review request is submitted

b. Any call where a physician has ordered an EMT-P to administer a medication or perform a skill out of his scope of practice, or deviation from protocol.

c. Runs involving internal disaster or trauma diversion.

d. High profile cases

C. Concurrent Retrospective Clinical Review Reports

1. The EMS Agency Quality Improvement Committee may select a clinical topic on a quarterly basis to be audited by the Base Hospital and ALS providers
2. The audits may be on cardiac arrests, head trauma and respiratory distress patients.
3. Reports may include timely administration of ACLS mediations, documentation of responses to the medication or procedures.

D. Base Station Statistics.

. 1. These will be kept as on-going logs for periodic reviews by the EMS agency staff. Requirements for documentation in this log are included on the Base Hospital Log form. Monthly reports shall be submitted as required by ICEMA.

E. Case Review Report

1. A confidential file of case review reports are maintained by the PLN and/or Base Hospital Director. They will be kept in a confidential file.

H. Radio Communication Failure Reports

1. The Base Hospital Medical Director or PLN will be required to investigate all radio communication failures as is set forth in the EMS Quality Improvement Plan. (See QI Form 001 in ICEMA Protocol Manual)

I. Quarterly Reports

1. Quarterly reports must include all relevant information and be forwarded to ICEMA at the first of every quarter.

**REFERENCE:**

1. ICEMA Policy and Procedure Protocol Manual. 4010 Continuous Quality Improvement Plan, 2011.

**NORTHERN INYO HEALTHCARE DISTRICT**
**POLICY AND PROCEDURE**

| | |
|---|---|
| Title: Base Station **Quality Improvement Program Pre-Hospital** | |
| Scope: Emergency | Department: **Emergency Department** |
| Source: Emergency Department Nurse Manager | Effective Date: March 1995 |

**CROSS –REFERENCES:**

1. Pre- Hospital Care Policy
2. MICN Guidelines

| **Approval** | **Date** |
|---|---|
| CCOC | 7/27/2020 |
| Emergency Services Committee | 9/11/2020 |
| MEC | 02/02/2021 |
| Board of Directors | |
| Last Board of Director review | 6/19/19 |

**Initiated:** 3/95, 02/01
Reviewed: 2/15as
Revised: 11/2019 gr; 7/2020gr

# Northern Inyo Healthcare District
# Medical Staff Bylaws

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**NORTHERN INYO HEALTHCARE DISTRICT**

**MEDICAL STAFF BYLAWS**

## PREAMBLE

These bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the medical staff and the Northern Inyo Healthcare District board of directors in protecting the quality of medical care provided in Northern Inyo Healthcare District and assuring the competency of the district's medical staff. The bylaws provide a framework for the independent self-governance of the medical staff, which is a collegial and democratic body with extensive knowledge in medical care. The bylaws assure an organization of the medical staff that permits the medical staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of medical staff functions supportive of those purposes, and to account to the board of directors for the effective performance of medical staff responsibilities. These bylaws provide the professional and legal structure for medical staff operations, organized medical staff relations with the board of directors, and relations with applicants to and members of the medical staff.

Accordingly, the bylaws address the medical staff's responsibility to establish criteria and standards for medical staff membership and privileges, and to enforce those criteria and standards; they establish clinical criteria and standards for quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the medical staff, its committees and departments, and review and analysis of patient medical records; they describe the standards and procedures for selecting and removing medical staff officers; and they address the respective rights and responsibilities of the medical staff.

Finally, notwithstanding the provisions of these bylaws, the medical staff acknowledges that the board of directors must act to protect the quality of medical care provided and the competency of the medical staff, and to ensure the responsible governance of Northern Inyo Healthcare District. In adopting these bylaws, the medical staff commits to exercise its responsibilities with diligence and good faith; and in approving these bylaws, the board of directors commits to fulfilling its functions and responsibilities with respect to an organized self-governing medical staff.

## ARTICLE I: PURPOSE AND TERMS

### 1.1 PURPOSE OF THE BYLAWS

~~These bylaws are adopted in order to provide for the organization of the medical staff of Northern Inyo Healthcare District and to provide a framework for self-government in order to permit the medical staff to discharge its responsibilities in matters involving the quality of medical care, and to govern the orderly resolution of those purposes.~~

(a) These bylaws are adopted in recognition of the mutual accountability, interdependence and responsibility of the Medical Staff and the Northern Inyo Healthcare District Board of Directors in protecting the quality of medical care provided at Northern Inyo Healthcare District and assuring the competency of the District's Medical Staff. These bylaws provide a framework for the self-governance of the Medical Staff, which is a collegial and democratic body with extensive knowledge in medical care. These bylaws assure an organization of the Medical Staff that permits the Medical Staff to discharge its responsibilities in matters involving the quality of medical care, to govern the orderly resolution of issues and the conduct of medical staff functions supportive of those purposes, and to account to the Board of Directors for the effective performance of Medical Staff responsibilities. These bylaws provide the professional and legal structure for Medical Staff operations, organized Medical Staff relations with the Board of Directors, and relations with applicants to and members of the Medical Staff.

(b) These bylaws address the Medical Staff's responsibility to establish criteria and standards for Medical Staff membership and privileges, and to enforce those criteria and standards. They establish clinical criteria and standards for quality assurance, utilization review, and other medical staff activities including, but not limited to, periodic meetings of the Medical Staff, its committees and departments, and review and analysis of patient medical records. They describe the standards and procedures for selecting and removing Medical Staff officers, and they address the respective rights and responsibilities of the Medical Staff.

(c) The Medical Staff acknowledges that the Board of Directors, in exercising its responsibility to protect the quality of medical care provided by and the competency of the Medical Staff and to ensure the responsible governance of the hospital, possesses administrative oversight authority of the Medical Staff. In exercising its administrative authority, the Board of Directors acknowledges and commits to respecting the rights and functions of a self-governing Medical Staff, as established by statute and through the Medical Staff bylaws. The Medical Staff commits to exercising its rights and responsibilities with diligence and good faith, and acknowledges that if it does not do so, the Board of Directors may act, as delineated in these bylaws, to fulfill the specific responsibility that the Medical Staff has failed to perform.

### 1.2 NAME

The name of this organization is the Medical Staff of Northern Inyo Hospital, a 501(c)(6) recognized organization.

### 1.3 PURPOSES AND RESPONSIBILITIES OF THE MEDICAL STAFF

The medical staff's purposes are:

(a) To assure that all patients admitted or treated in any of the Northern Inyo Healthcare District services receive a uniform standard of quality patient care, treatment and efficiency consistent with generally accepted standards attainable within the district's means and circumstances.

(b) To support professional education and community health education.

(c) To initiate and maintain rules for the medical staff to carry out its responsibilities for the professional work performed in Northern Inyo Healthcare District.

(d) To provide an avenue for the medical staff, board of directors, and administration to discuss issues of mutual concern.

(e) To exercise its rights and responsibilities in a manner that does not jeopardize the district's license, Medicare and Medi-Cal provider status, accreditation, and other credentialed statuses.

The medical staff's responsibilities are:

(a) To provide quality patient care.

(b) To assure for the benefit of the public, and also to account to the board of directors for, the quality of patient care provided by all members authorized to practice in Northern Inyo Healthcare District through the following measures:

(1) Review and evaluation of the quality of patient care provided through valid and reliable patient care evaluation procedures;

(2) A credentials program, including mechanisms of appointment, reappointment and the matching of clinical privileges to be exercised or specified services to be performed with the verified credentials and current demonstrated performance of the applicant;

(3) Participating in a utilization review program to provide for the appropriate use of all medical services.

(c) To establish and enforce professional standards related to the delivery of healthcare within Northern Inyo Healthcare District.

(d) To initiate and pursue corrective action with respect to members where warranted.

(e) To cooperate with other community health facilities and/or educational institutions or efforts that strive to improve the quality of scope of patient care within Northern Inyo Healthcare District.

(f) To establish and amend as needed medical staff bylaws and policies.

(g) To select and remove medical staff officers.

(h) To assess and utilize medical staff dues as appropriate for the purposes of the medical staff.

**1.4 DEFINITIONS**

**ACTIVE STAFF** means the category of medical staff members who regularly provide care at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these bylaws.

**AD HOC COMMITTEE** means a committee created for a particular purpose for a finite amount of time, as necessary.

**ADVERSE ACTION** means an action which is reportable under Business and Professions Code 805.

**ADMINISTRATOR or CHIEF EXECUTIVE OFFICER** means the person appointed by the board of directors to serve in an administrative capacity in the overall management of the district.

**ADVANCED PRACTICE PROVIDER or APP** means an individual, other than a licensed physician, dentist, or podiatrist, who exercises independent judgement within the areas of his or her professional competence and the limits established by the board of directors, the medical staff, and the applicable State Practice Act, who is qualified to render direct or indirect medical care under the supervision or direction of a medical staff member (with the exception of certified registered nurse anesthetists, who are APPs that practice under an independent license as per current California regulations).

**AUTHORIZED REPRESENTATIVE** means the individual(s) designated by the district and approved by the medical executive committee to provide information to and request information from the National Practitioner Data Bank according to the terms of these bylaws.

**BOARD OF DIRECTORS** means the governing body of Northern Inyo Healthcare District.

**CHAIR** means the individual practitioner elected to preside over a committee or meeting.

**CHIEF EXECUTIVE OFFICER** see ADMINISTRATOR.

**CHIEF MEDICAL OFFICER** means an active member of the medical staff appointed by the administrator to provide administrative support for the medical staff, communicate the views of the hospital administration to the medical staff, and serve as a liaison between the medical staff and the administration.

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

**CONTRACT PRACTITIONER** means a practitioner who is party to a clinical services agreement with the district.

**CONSULTING STAFF** means the category of medical staff members who treat and otherwise care for patients at Northern Inyo Healthcare District and meet the qualifications and prerogatives as listed in these bylaws.

**CORE COMMITTEE MEMBER** means a practitioner designated to regularly attend the departmental committee meetings to which they are assigned in order to represent their specialty.

**COURTESY STAFF** means the category of medical staff members who do not utilize Northern Inyo Healthcare District as the principle location of their practice but are given privileges and meet the qualifications and prerogatives as listed in these bylaws.

**CURRENT COMPETENCE** means a combination of observable and measurable knowledge, skills, abilities and personal attributes that constitute a practitioner's performance within the last twenty-four (24) months.

**DATE OF RECEIPT** means the date any notice, special notice, or other communication was delivered personally; or if such notice was sent by mail, it shall mean seventy-two (72) hours after the notice, special notice, or communication was deposited postage prepaid, in the United States mail.

**DAYS** means calendar days, unless otherwise specified.

**DEPARTMENT or CLINICAL DEPARTMENT** is a group of practitioners holding privileges in a designated clinical practice area.

**DEPARTMENT CHIEF** is the individual practitioner who is the elected leader of the designated clinical department.

**DISTRICT** means Northern Inyo Healthcare District (NIHD) and includes all inpatient and outpatient services operated by Northern Inyo Healthcare District.

**EX-OFFICIO** means service by virtue of office or position held. An ex-officio appointment is without vote unless otherwise specified.

**HONORARY STAFF** means those former medical staff members or other physicians, dentists or podiatrists who do not actively practice at Northern Inyo Healthcare District but are deemed deserving of membership as described in these bylaws.

**IN GOOD STANDING** means a member has unrestricted clinical privileges, is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws or policy of the medical staff.

**INVESTIGATION** means a process specifically instigated to determine the validity, if any, to a concern or complaint raised against a practitioner, and does not include activity of the physician wellness committee.

**LEAD APP** means the elected representative of the Advanced Practice Providers (APPs).

**LIMITED LICENSE PRACTITIONER** means a practitioner who is not a physician or an APP, but who practices under a license such as a dentist or podiatrist.

**MEDICAL EXECUTIVE COMMITTEE** means the executive committee of the medical staff.

**MEDICAL DIRECTOR** means the administratively-appointed physician leader of the medical or district department(s) or group(s).

**MEDICAL STAFF** means those Northern Inyo Healthcare District physicians (MD or DO), dentists, and podiatrists who have been granted recognition as members pursuant to the terms of these bylaws.

**MEDICAL STAFF YEAR** means the twelve-month period beginning July 1 through the subsequent June 30.

**MEMBER** means any physician, dentist, or podiatrist who has been appointed to the medical staff.

**NOTICE** means a written communication delivered personally to the addressee or sent by United States mail, first-class postage prepaid, addressed to the addressee at the last address as it appears in the official records of the medical staff or the district.

**PHYSICIAN** means an individual with an MD or DO degree who is currently licensed to practice medicine.

**PRACTITIONER** means, unless otherwise expressly limited, any currently licensed physician (MD or DO), limited license practitioner, or Advanced Practice Provider.

**PREROGATIVES** means the specific governance rights to which a member or APP may be entitled, depending upon the practitioner's category, including without limitation, rights to vote on medical staff and medical staff committee matters, hold medical staff office, or serve on medical staff committees.

**PRIVILEGES or CLINICAL PRIVILEGES** means the permission granted to a medical staff member or APP to render specific patient services.

**PROCEDURAL RIGHTS** means rights to a hearing and appeal in accordance with Article VII to which a practitioner becomes entitled to as the result of adverse actions taken or recommended which constitute grounds for a hearing.

**TELEMEDICINE** means the remote diagnosis and treatment of patients by means of telecommunications technology.

**UNFAVORABLE ACTION** means an action which adversely affects the practitioner but, unlike an adverse action, is not reportable as defined under Business and Professions Code 805.

## ARTICLE II: MEMBERSHIP

### 2.1 NATURE OF MEMBERSHIP

No practitioner, including those in a medical-administrative position by virtue of a contract with the district, shall admit or provide medical or health-related services to patients of Northern Inyo Healthcare District unless the practitioner is a member of the medical staff or advanced practice provider with corresponding privileges or has been granted temporary, telemedicine or disaster privileges in accordance with the procedures set forth in these bylaws. Appointment to the medical staff shall confer only such clinical privileges and rights as have been granted by the board of directors in accordance with these bylaws. Privileges shall be granted and maintained only if the requested privileges are within Northern Inyo Healthcare District's patient care needs.

### 2.2 QUALIFICATIONS FOR MEMBERSHIP

#### 2.2-1 GENERAL QUALIFICATIONS

Membership and privileges shall be extended only to practitioners who are professionally competent and continuously meet the qualifications, standards, and requirements as described in this article.

#### 2.2-2 BASIC QUALIFICATIONS

A practitioner must demonstrate compliance with all basic standards set forth in this Section in order to have an application for medical staff membership or privileges accepted for review, except in the instance of appointment to honorary staff. The practitioner must:

(a) Qualify to practice in California as follows:

(1) Physicians must hold an MD or DO degree or their equivalent and a valid and unrestricted license to practice medicine issued by the Medical Board of California or the California Board of Osteopathic Examiners. For purposes of this Section, "or their equivalent" shall mean any degree (i.e., foreign) recognized by the Medical Board of California or the California Board of Osteopathic Examiner;

(2) Podiatrists must hold a DPM degree and a valid and unrestricted certificate to practice podiatry issued by the Medical Board of California;

(3) Dentists must hold a DDS or equivalent degree and a valid and unrestricted license to practice dentistry issued by the California Board of Dental Examiners;

(b) Where applicable to their practice, have a valid and unrestricted federal Drug Enforcement Administration (DEA) certificate.

(c) Have professional liability insurance in not less than the minimum amounts as from time to time may be jointly determined by the board of directors and medical executive committee.

(d) Be board certified or board eligible as determined by the individual service and in the criteria for privileging.

(e) Be eligible to receive payments from the federal Medicare and state Medicaid (Medi-Cal) programs.

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

(g) Not have been convicted of, or plead guilty or no contest to, a felony related directly to his/her professional practice, or patient relationships, or involving moral turpitude, within the past seven (7) years.

A practitioner who does not meet these basic standards is ineligible to apply for medical staff membership or privileges, and the application shall not be accepted for review, except that the honorary medical staff do not need to comply with any of the basic standards. If it is determined during processing that an applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in these bylaws.

### 2.2-3 ADDITIONAL QUALIFICATIONS FOR MEMBERSHIP

In addition to meeting the basic standards, the practitioner must, through the credentialing and privileging processes:

(a) Demonstrate his or her:

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

(2) Current professional competence;

(3) Good judgment; and

(4) Adequate physical and mental health status to demonstrate to the satisfaction of the medical staff that he or she is professionally and ethically competent so that patients can reasonably expect to receive the generally recognized professional level of quality of care.

(b) Be determined to:

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

(2) Work cooperatively with others in the district setting so as to not adversely affect patient care or district operations, as well as abide by the policy on professional conduct and prohibition of disruptive or discriminatory behavior;

(3) Keep as confidential, as required by law, all information or records received in the physician-patient relationship; and

(4) Participate in and properly discharge medical staff responsibilities.

## 2.3 EFFECT OF OTHER AFFILIATIONS

No person shall be entitled to membership or privileges in the medical staff merely because that person holds a certain degree, is licensed to practice in this or in any other state, is a member of any professional organization,

is certified by any clinical board, or because such person had, or presently has, staff membership or privileges at another health care facility. Medical staff membership or clinical privileges shall not be conditioned or determined on the basis of an individual's participation or non-participation in a particular medical group, IPA, PPO, PHO, hospital-sponsored foundation, or other organization or in contracts with a third party which contracts with this district.

### 2.4 NONDISCRIMINATION

No aspect of medical staff membership or particular clinical privileges shall be denied on the basis of sex, race, age, creed, color, national origin, physical or mental impairment, or sexual orientation if it does not pose a threat to the quality and safety of patient care.

### 2.5 BASIC RESPONSIBILITIES OF MEDICAL STAFF MEMBERSHIP

Except for honorary staff, the ongoing responsibilities of each practitioner shall include:

(a) providing patients with the quality of care meeting the professional standards of the medical staff of this district;

(b) abiding by the medical staff bylaws, applicable Joint Commission (or other applicable accrediting body) standards, and applicable medical staff and district policies and procedures, including those related to the security of electronic health records;

(c) discharging in a responsible and cooperative manner such reasonable responsibilities and assignments imposed upon the member by virtue of medical staff membership or privileges, including committee assignments, serving as a proctor, or performing peer review;

(d) preparing and completing in timely fashion medical records for all the patients to whom the practitioner provides care in the district;

(e) abiding by the ethical principles of the appropriate state medical or other professional association(s);

(f) working cooperatively with members, nurses, district administration and others so as not to adversely affect patient care, as well as complying with medical staff policy on professional conduct;

(g) making appropriate arrangements for coverage of that member's patients;

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

(i) participating in and documenting continuing education programs as determined by the medical staff for maintenance of privileges;

(j) discharging such other reasonable staff obligations as may be lawfully established from time to time by the medical staff or medical executive committee;

(k) performing and documenting, if granted the requisite privileges, or arranging for the performance of, a history and physical on every patient he/she admits. As further detailed in medical staff policy, a medical history and physical examination shall be completed no more than thirty (30) days before, or twenty-four (24) hours after, admission or registration, but prior to surgery or a procedure requiring anesthesia services. When the medical history and physical examination is completed

within thirty (30) days before admission or registration, the physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The history and physical must be completed and documented by a practitioner in accordance with state law and medical staff policy.

(l) paying applicable dues and/or fees, if required; and

(m) promptly notifying the medical staff office in writing as soon as reasonably possible, but within 30 days:

(1) the initiation of formal proceedings by a medical licensing authority or the DEA to suspend, revoke, restrict or place on probation a license or DEA certificate;

(2) an action by the medical staff executive committee or the governing body of another hospital or health care entity to suspend, revoke, restrict, or deny clinical privileges for reasons related to professional competence or conduct;

(3) the practitioner's exclusion from participation in Medicare, Medi-Cal or any federal health care program or conviction of a criminal offense related to the provision of health care items or services;

(4) any formal allegations of fraud or abuse or illegal activity relating to the practitioner's professional practice or conduct made by any State or Federal government agency;

(5) any report filed with the National Practitioner Data Bank or Healthcare Integrity and Protection Data Bank,

(6) any injury, disability, or illness that would significantly interfere with his/her medical practice;

(7) the filing of any malpractice claim or action in which the Practitioner is a named defendant; or

(8) any other action that could affect his/her medical staff standing and/or clinical privileges at the healthcare district.

Failure to abide by the above-listed duties may result in adverse action.

## 2.6 CONTRACT PRACTITIONERS

### 2.6-1 MEMBERSHIP AND PRIVILEGES REQUIRED

A contract practitioner may provide services authorized pursuant to the applicable specified clinical services contract only if the specified clinical services are within the scope of privileges which the contract practitioner has been granted in accordance with these bylaws. Also, a practitioner who is an employee or subcontractor of a contract practitioner or a medical group or other professional entity which is a party to a contract at the district may be granted temporary privileges to serve as locum tenens for a contract practitioner, provided the practitioner otherwise meets applicable bylaws requirements for the granting and exercise of such temporary privileges.

### 2.6-2 EFFECT OF SPECIFIED CLINICAL SERVICES CONTRACT TERMINATION

The termination or expiration of the applicable specified clinical services contract shall automatically terminate only the practitioner's rights to provide services on such basis as specified in the contract, and

(a) Expressly shall not, of itself, affect the medical staff membership or privileges granted to the practitioner, and

(b) Accordingly, shall not entitle the contract practitioner to procedural rights unless otherwise required by law or expressly provided in the applicable specified clinical services contract.

The affected individual who wishes to maintain medical staff membership or privileges after termination of a contract must continue to comply with and adhere to the requirements set forth in these bylaws. Failure to comply will be deemed a voluntary resignation from medical staff membership and privileges. Such deemed resignation shall not entitle the practitioner to procedural rights.

### 2.6-3 MEDICAL STAFF ROLE IN SPECIFIED CLINICAL SERVICES CONTRACTING

Prior to approving, renewing, or modifying and, to the extent reasonably practical, prior to terminating, a specified clinical services contract, the board of directors, ~~or~~ administrator, or chief medical officer shall give notice of the planned action to the medical staff by transmitting the notice to the medical executive committee. The medical staff and/or the medical executive committee may review and make recommendations to the board of directors regarding quality of care issues related to specified clinical services contractual arrangements for physician and/or professional services, prior to the district board taking final action in the matter.

## 2.7 ADMINISTRATIVE PRACTITIONERS

Members may be assigned duties by the district board which are solely administrative in nature, provided that such duties are reasonably related to the member's official medical staff responsibilities. The district board, in its sole discretion, may terminate such assignment at any time. Unless otherwise required by law, such purely administrative service assignment and termination is independent of, and shall have no effect on, the member's membership or privileges, shall not entitle the member to procedural rights, and records of such assignment or termination shall not be deemed part of the member's credentials files or any other medical staff records.

The medical executive committee may make recommendations to administration in the selection of and assignment of responsibilities to department medical directors or other practitioners contracted by the district to provide administrative services.

## ARTICLE III: CATEGORIES OF MEMBERSHIP

### 3.1 CATEGORIES

The categories of the medical staff shall include the following: active, courtesy, consulting, and honorary. At appointment and each time of reappointment, the member's staff category shall be determined.

There are several groups of practitioners who, due to the nature of their practice, do not require assignment to a medical staff category. The scope and extent of these practitioners' relationships with the healthcare district can be found in Article IV of these bylaws.

### 3.2 MODIFICATION OF MEMBERSHIP

On its own, upon recommendation of the credentials committee, or pursuant to a request by a member under Section 5.6-1(b), or upon direction of the board of directors as set forth in Section 6.2-6, the medical executive committee may recommend a change in the medical staff category of a member consistent with the requirements of these bylaws.

### 3.3 ACTIVE STAFF

#### 3.3-1 QUALIFICATIONS

The active staff shall consist of members who:

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

(b) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department; and

(c) are regularly involved in patient care in this healthcare district and regularly involved in medical staff functions, as determined by the medical staff.

#### 3.3-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of an active member shall be to:

(a) exercise such clinical privileges as are granted pursuant to these bylaws;

(b) attend and vote on matters presented at general and special meetings of the medical staff and of the department and committees to which the member is duly appointed;

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

(d) pay medical staff membership dues in the amount as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

### 3.3-3 TRANSFER OF ACTIVE STAFF MEMBER

After two consecutive ongoing professional practice evaluation (OPPE) cycles as per policy in which a member of the active staff fails to regularly care for patients in this healthcare district or be regularly involved in medical staff functions as determined by the medical staff, that member shall be referred to the credentials committee to determine the appropriate category, if any, for which the member is qualified.

## 3.4 COURTESY STAFF

### 3.4-1 QUALIFICATIONS

The courtesy staff shall consist of members who:

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

(d) when on duty, are located close enough to the healthcare district to provide appropriate quality care, as per the policies of the specific department;

(b) do not utilize this healthcare district as the principle location in their practice and are not regularly involved in medical staff functions; and

(c) are members in good standing of the active medical staff of another licensed hospital, and at the time of appointment and reappointment, are able to provide proof of continued membership and privileges at the primary hospital. Exceptions to this requirement may be made by the medical executive committee for good cause.

### 3.4-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Except as otherwise provided, the rights and responsibilities of the courtesy staff shall be to:

(a) care for patients of the healthcare district and exercise such clinical privileges as are granted pursuant to these bylaws;

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

(c) provide patient activity and quality review information from his or her primary facility as may be requested at the time of appointment and reappointment;

(d) pay application fees, as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

Courtesy staff members shall not be eligible to hold office in the medical staff.

### 3.4-3 LIMITATIONS

Courtesy staff members who regularly admit patients or regularly care for patients at the district shall, upon review of the credentials committee and medical executive committee, be obligated to seek appointment to the appropriate staff category.

Courtesy staff members who do not maintain active staff membership at another licensed hospital shall be referred to the credentials committee to determine the appropriate category, if any, for which the member is qualified.

## 3.5 CONSULTING STAFF

### 3.5-1 QUALIFICATIONS

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

(a) meet the qualifications set forth in Section 2.2 and are not otherwise members of the medical staff;

(b) possess adequate clinical and professional expertise;

(c) are called upon periodically by a practitioner at Northern Inyo Healthcare District to render care to patients treated at or admitted to this facility.

### 3.5-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The rights and responsibilities of the consulting staff shall be to:

(a) treat and otherwise care for patients at this facility on request of the patient's practitioner;

(b) exercise such additional clinical privileges as are granted pursuant to these bylaws;

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

(d) pay application fees, as determined by the medical executive committee; and

(e) exercise other such rights and responsibilities at outlined in Table 3.8.

Consulting staff members shall not be eligible to hold office in the medical staff.

## 3.6 HONORARY STAFF

### 3.6-1 QUALIFICATIONS

The honorary staff shall consist of physicians, dentists, or podiatrists who do not actively practice at the district but are deemed deserving of membership by virtue of their outstanding reputation, noteworthy contributions to the health and medical sciences, or their previous long-standing service to the district, and who continue to exemplify high standards of professional and ethical conduct. Members who have retired from active practice and, at the time of their retirement, were members in good standing of the

medical staff, and who continue to adhere to appropriate professional and ethical standards, shall also be eligible for appointment to honorary staff upon recommendation of the medical executive committee.

### 3.6-2 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

Honorary members are not eligible to admit patients to the hospital or to exercise clinical privileges in the district, or to vote or hold office in this medical staff organization, but they may serve upon committees without vote at the discretion of the medical executive committee. They may attend staff and department meetings, including open committee meetings and educational programs. Appointment to honorary staff shall be indefinite, unless otherwise requested by the member.

## 3.7 GENERAL EXCEPTIONS TO PREROGATIVES

Regardless of the category of membership in the medical staff, limited license members (i.e., podiatrists and dentists):

(a) shall only have the right to vote on matters within the scope of their licensure. In the event of a dispute over voting rights, that issue shall be determined by the chair of the meeting, subject to final decision by the medical executive committee; and

(b) shall exercise clinical privileges only within the scope of their licensure and as set forth in Section 4.7.

## 3.8 TABLE OF PREROGATIVES BY MEDICAL STAFF CATEGORY

| | Active | Courtesy | Consulting | Honorary |
|---|---|---|---|---|
| **Exercise privileges** | Yes | Yes | Yes | No |
| **General voting rights** | Yes | No | No | No |
| **Attendance at general medical staff meeting required** | Yes | No | No | No |
| **May be committee member** | Yes | Yes | Yes | Yes |
| **Vote in committee** | Yes | No, unless specified at time of appointment to committee | No, unless specified at time of appointment to committee | No |
| **May hold medical staff office** | Yes | No | No | No |
| **May be committee chair** | Yes | No | No | No |
| **May be department chief** | Yes | No | No | No |
| **Pay dues** | Yes | No | No | No |
| **Pay application fee** | No | Yes | Yes | No |
| **Must have malpractice insurance** | Yes | Yes | Yes | No |
| **Must file for reappointment** | Yes | Yes | Yes | No |

## ARTICLE IV: CLINICAL PRIVILEGES

### 4.1 EXERCISE OF PRIVILEGES

Except as otherwise provided in these bylaws, a practitioner providing clinical services at this healthcare district shall be entitled to exercise only those clinical privileges specifically granted. Said privileges and services must be within the scope of any license, certificate or other legal credential authorizing practice in this state and consistent with any restrictions thereon, and shall be subject to applicable policies and the authority of the department chief. Medical staff privileges may be granted or continued by the board of directors only upon recommendation of the medical staff and following the procedures outlined in these bylaws. Medical staff privileges may be modified or terminated by the mechanisms as outlined in these medical staff bylaws.

### 4.2 PRIVILEGE REQUESTS

Each application for privileges must contain a request for the specific clinical privileges desired by the applicant. A request for a modification of clinical privileges may be made at any time, but such requests must be supported by documentation of training and/or experience supportive of the request.

### 4.3 LAPSE OF APPLICATION

If a practitioner requesting initial or additional clinical privileges fails to furnish the information necessary to evaluate the request within thirty (30) days (or as otherwise agreed upon), the application shall be regarded as incomplete and lapse as detailed in Section 5.5-4, and the applicant shall not be entitled to a hearing.

### 4.4 BASIS FOR PRIVILEGE DETERMINATION

Requests for clinical privileges shall be evaluated on the basis of the practitioner's education, training, experience, current demonstrated professional competence and judgment, clinical performance, physical and mental health affecting the ability to perform duties, and the documented results of patient care and other quality review and monitoring as per ongoing and focused professional practice evaluations (OPPE and FPPE). If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy. Privilege determinations may also be based on pertinent information concerning clinical performance obtained from other sources, especially other institutions and health care settings where a member exercises clinical privileges. The decision to grant or deny a privilege and/or to renew an existing privilege shall include peer recommendations which address the applicant's:

1. Patient care
2. Medical/clinical knowledge
3. Practice-based learning and improvement
4. Interpersonal and communication skills
5. Professionalism
6. Systems-based practice

Privileges shall be granted and maintained only if the requested privileges are within the district's patient care needs. Furthermore, no specific privilege may be granted to a practitioner if the task, procedure or activity constituting the privilege is not available within the district despite the practitioner's qualifications or ability to perform the requested privilege, except as provided for under emergency privileges Section 4.11.

## 4.5 CRITERIA FOR "CROSS-SPECIALTY" OR NEW PRIVILEGES WITHIN THE DISTRICT

Any request for clinical privileges that are new to the district shall initially be reviewed by the appropriate departments and administration in order to establish the need for, and appropriateness of, the new procedure or services. Any request for new clinical privileges that overlap more than one department shall initially be reviewed by the appropriate departments in order to address criteria for the procedure. The medical executive committee shall facilitate the establishment of district-wide credentialing criteria for new or trans-specialty procedures, with the input of all appropriate departments, with a mechanism designed to ensure that quality patient care is provided for by all individuals with such clinical privileges. In establishing the criteria for such clinical privileges, the medical executive committee may establish an ad hoc committee with representation from all appropriate departments.

Further details regarding the development and approval process for new privileges or new services can be found in applicable policy.

## 4.6 FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

### 4.6-1 FPPE FOR INITIAL PRIVILEGES

(a) General Provisions:

(1) All initial appointees to the medical staff and all practitioners granted new clinical privileges shall be subject to a period of initial review and evaluation as further described in the medical staff's Focused and Ongoing Professional Practice Evaluation (FPPE and OPPE) policy.

(2) Until an initial appointee has been evaluated for core privileges and released from FPPE for these core privileges, he or she cannot be considered for a medical staff leadership position and cannot vote on any medical staff issues.

(b) Failure to Complete FPPE:

(1) If FPPE for core privileges is not completed due to an insufficient amount of clinical activity as per the FPPE and OPPE policy, the practitioner's membership and privileges will automatically expire, unless otherwise recommended by the credentials committee and medical executive committee. Such expiration shall not entitle the practitioner to procedural rights.

(2) If FPPE for special privileges is not completed due to an insufficient amount of clinical activity, FPPE can be extended as recommended by the proctor(s), the credentials committee, and the medical executive committee. In this instance, the practitioner's core privileges and eligibility for reappointment shall not be affected. Additionally, such extension of FPPE shall not be considered a limitation or restriction of privileges entitling the practitioner to procedural rights.

(3) If FPPE for any privilege (core or special) is not completed satisfactorily due to competency or quality of care concerns, the relevant privilege, and the membership if the privileges under question are core privileges, may be terminated and/or revoked. In this instance, the practitioner shall be entitled to the procedural rights outlined in these bylaws.

### 4.6-2 FPPE ARISING FROM CONCERNS

FPPE may also be initiated when the performance or outcomes of a practitioner are questionable, which may become evident with the occurrence of a single or sentinel event and/or patterns or trends indicating potentially unsafe patient care. The initiation of FPPE arising from concerns differs from FPPE for new privileges described under Section 4.6-1. Practitioners subject to FPPE arising from concerns may be entitled to procedural rights if such action is a reportable action.

## 4.7 CONDITIONS FOR PRIVILEGES OF PRACTITIONERS

### 4.7-1 ADMISSIONS

(a) The following categories of practitioners are eligible to independently admit patients to the hospital:

(1) Physicians (MDs or DOs)

(b) The following categories of practitioners are eligible to co-admit patients to the hospital:

(1) Dentists (non-MD)

(2) Podiatrists

(3) Certified Nurse Midwives

(c) Additionally, the following categories of APPs with admitting privileges (as per relevant standardized procedures/protocols) may admit patients upon order of a member of the medical staff who has admitting privileges and who maintains responsibility for the overall care of the patient:

(1) Physician Assistants

(2) Nurse Practitioners

### 4.7-2 RESPONSIBILITY FOR CARE OF PATIENTS

(a) The admitting practitioner shall establish at the time of admission, the patient's condition and provisional diagnosis.

(b) For patients admitted by or upon order of a limited license practitioner, a physician with appropriate privileges must assume responsibility for the care of the patient's medical or psychiatric problems that are present at the time of admission or which may arise during hospitalization which are outside of the limited license practitioner's lawful scope of practice.

(c) Where a dispute exists regarding proposed treatment between a physician member and a practitioner with co-admitting privileges, the physician member's treatment plan shall be the recognized treatment plan.

### 4.7-3 SURGERY

Surgical procedures performed by limited license practitioners shall be under the overall supervision of the chief of the department of surgery or his or her designee.

## 4.8 TEMPORARY CLINICAL PRIVILEGES

Temporary privileges shall not exceed one hundred twenty (120) consecutive days, unless the medical executive committee recommends and the board of directors approves a longer period for good cause, and are allowed under two circumstances only: (1) to address a patient care need and (2) to permit patient care to be provided while an application is pending.

### 4.8-1 PATIENT CARE NEEDS

(a) Care of Specific Patient

Temporary clinical privileges may be granted to a practitioner where good cause exists to provide care to a specific patient or group of patients.

(b) Locum Tenens

Temporary clinical privileges may be granted to a practitioner serving as a locum tenens for a current member of the medical staff to meet the care needs of that member's patients or duties in his/her absence.

(c) Other Important Patient Care Needs

Temporary clinical privileges may be granted to allow a practitioner to fulfill an important patient care, treatment, or service need.

### 4.8-2 PENDING APPLICATION FOR MEDICAL STAFF MEMBERSHIP OR PRIVILEGES

Temporary clinical privileges may be granted to an applicant while his or her application for medical staff membership and/or privileges is completed and awaiting review and approval of the credentials committee, the medical executive committee or the board of directors.

### 4.8-3 PROCESS FOR GRANTING TEMPORARY CLINICAL PRIVILEGES

Applicants who appear to have qualifications, ability, and judgment consistent with Section 2.2 can qualify to be granted temporary clinical privileges for patient care needs or to permit patient care while an application is pending, provided that:

(a) The medical executive committee has not made a final recommendation that is adverse or with limitation.

(b) The applicant has no current or previously successful challenge to professional licensure or registration.

(c) The application has no involuntary termination of medical staff membership at any other organization, and no involuntary limitation, reduction, denial or loss of clinical privileges.

(d) The applicant has no unusual pattern of, or an excessive number of, professional liability actions resulting in a final judgment adverse to the applicant.

(e) The following has been completed:

(1) Verification of current California licensure;

(2) Verification of the National Practitioner Data Bank report;

(3) Verification of relevant training and experience;

(4) Verification of current competence and ability to perform the privileges requested.

A decision to grant temporary privileges to an applicant under this Section shall not be binding or conclusive with respect to an applicant's pending request for appointment to the medical staff. No practitioner has any right to be granted temporary privileges.

The administrator is given authority to grant temporary privileges to an applicant. Such action, however, shall be on the recommendation of the following medical staff members:

(1) The applicable clinical department chief;

(2) The credentials committee chairperson; and

(3) The chief of staff.

**4.8-4 GENERAL CONDITIONS OF TEMPORARY PRIVILEGES**

(a) If granted temporary privileges, the applicant shall act under the supervision of the department chief (or designee) to which the applicant has been assigned.

(b) Temporary privileges shall automatically terminate at the end of the designated period, unless earlier terminated or suspended under Articles VI and/or VII of these bylaws or unless affirmatively renewed. A medical staff applicant's temporary privileges shall automatically terminate if the applicant's initial application is withdrawn.

(c) Notwithstanding any other provision of these bylaws to the contrary, an applicant shall not be entitled to procedural rights if the applicant's request for temporary privileges is refused, or if all or any portion of the applicant's temporary privileges are suspended, unless such action is a reportable action.

(d) All persons receiving temporary privileges shall be bound by the medical staff bylaws and policies, and all applicable district policies.

**4.9 TELEMEDICINE PRIVILEGES**

Practitioners who wish to provide approved types of telehealth services will be credentialed and privileged according with this Section but, unless they separately qualify, apply, and are approved for

membership in a staff category described in Article III of these bylaws, will not be appointed to the medical staff in any membership category.

### 4.9-1 TELEMEDICINE CREDENTIALING

(a) In processing a request for telemedicine privileges, the medical staff may follow the normal credentialing process described in Article V of these bylaws, including but not limited to the collection of information from primary sources. Alternatively, the medical staff may elect to rely upon the credentialing and privileging decisions made by distant-site hospitals and telemedicine entities when making recommendations on privileges for individual distant-site practitioners, subject to meeting the conditions required by law and those specified in these bylaws.

(b) Telemedicine privileges shall be for a period not to exceed two (2) years, and shall be subject to re-evaluation and renewal pursuant to the same principles and process described in these bylaws for the renewal of clinical privileges held by medical staff members.

(c) The direct care or interpretive services provided by the distant-site practitioner must meet the professional standards of the district and its medical staff at all times. Distant-site practitioners holding telemedicine privileges shall be obligated to meet all of the basic responsibilities that must be met by members of the medical staff, as described in these bylaws, modified only to take into account their distance from the hospital and the need to pay dues.

(d) Telemedicine privileges may be denied, restricted, suspended or revoked at the discretion of the medical executive committee or the chief of staff acting on its behalf, without hearing rights as described in Article VII of these bylaws, except as required by law.

(e) Recognizing that telemedicine physicians may be privileged at many healthcare facilities and entities, the district shall conduct the primary verification procedures for an adequate number of hospitals, health care organizations and/or practice settings with whom the telemedicine physician is or has previously been affiliated in order to ensure current competency. In order to assist in this credentialing and privileging process, the district may request information from the telemedicine physician's primary practice site to assist in evaluation of current competency. The district may also accept primary source verification of credentialing information from the physician's primary practice site or the telemedicine entity to supplement its own primary source verification.

### 4.9-2 RELIANCE ON DISTANT-SITE ENTITIES

The medical staff may rely upon the credentialing and privileging decisions made by a distant-site hospital or distant-site telemedicine entity if the district board ensures through a written agreement with the distant-site hospital or entity that all of the following provisions are met:

(a) The distant-site entity acknowledges that it is a contractor of services to this district and, in accordance with 42 CFR §485.635(c)(4)(ii), furnishes services in a manner that permits Northern Inyo Healthcare District to be in compliance with the Medicare Conditions of Participation and appropriate accreditation agencies.

(b) The distant-site entity is either a Medicare-participating hospital or a lawful provider of the telemedicine services in question, and it confirms that its credentialing and privileging processes and standards for practitioners meet the standards described in the Medicare Conditions of Participation 42 CFR §485.616(c).

(c) The distant-site entity acknowledges, or the district confirms, that the distant-site entity has a process that is consistent with the credentialing and privileging requirements of the Healthcare Facilities Accreditation Program standards for critical access hospitals (05.00.14 and 05.00.15).

(d) The individual distant-site practitioner holds privileges at the distant-site entity to provide the services involved, and the distant-site entity provides the district with a current list of the distant-site practitioner's privileges at the distant-site entity.

(e) The individual distant-site practitioner is licensed in California, or is otherwise authorized by California law, to provide the services at issue, and is covered by professional liability insurance meeting the standards that apply to medical staff members at this district as described in these bylaws.

(f) The medical staff of Northern Inyo Healthcare District performs, and maintains evidence of, peer review of the distant-site practitioners' performance as it relates to district patients and sends the distant-site telemedicine entity such performance information for use in the periodic appraisal of the individual distant-site practitioners. At a minimum, the information this district will provide must include all adverse events that result from the telemedicine services provided by the distant-site practitioners to this district's patients and all complaints this district has received about the distant-site practitioners.

When the district is not a party to a written agreement with a distant-site Medicare participating hospital or distant-site entity containing all of the requirements of the CMS Hospital Conditions of related to distant-site telemedicine credentialing, the telemedicine physician must be credentialed and privileged pursuant to the general credentialing and privileging procedures described in Article V of these bylaws.

### 4.10 ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are not eligible for medical staff membership, as per California law. They may be granted practice privileges if they hold a license, certificate, or other legal credential in a category of APPs that the board of directors (after securing medical executive committee recommendations) has identified as eligible to apply for practice privileges as set forth in Article VIII.

### 4.11 EMERGENCY PRIVILEGES

In the case of an emergency involving a particular patient, any practitioner with clinical privileges, to the degree permitted by the scope of the applicant's license and regardless of department, staff status, or clinical privileges, shall be permitted to do everything reasonably possible to save the life of the patient or to save the patient from serious harm provided that the care provided is within the scope of the individual's license or training. Once the emergency has passed or assistance has been made available, further care of the patient shall be assumed by a practitioner of the appropriate department.

## 4.12 DISASTER PRIVILEGES

In the case of a disaster in which the disaster plan has been activated and the district is unable to handle the immediate patient needs, the following may grant disaster privileges to volunteer practitioners in accordance with the process outlined in the applicable medical staff policy:

(a) the chief of staff;

(b) any physician member of the medical executive committee;

(c) any department chief;

(d) any active medical staff member; or

(e) designee of any of the above.

The volunteer practitioner shall be required to submit identification and other such required documentation for verification as further detailed in policy. The medical staff shall oversee the performance of all volunteer practitioners. Once the care of disaster victims can be adequately assumed by the members of the regular medical staff, then disaster privileges of the volunteer will be terminated as further detailed in policy.

## ARTICLE V: APPLICATION PROCEDURES FOR PRIVILEGES

### 5.1 GENERAL

Except as otherwise specified herein, no person (including persons engaged by Northern Inyo Healthcare District in administratively responsible positions) shall exercise clinical privileges in the district or via telemedicine link unless and until that person applies for and receives approval to exercise clinical privileges as set forth in these bylaws, or, with respect to advanced practice providers, has been granted a service authorization or privileges under applicable medical staff policies.

A request for an initial application will be reviewed by the chief of staff for appropriateness. By applying to the medical staff for privileges (or, in the case of members of the honorary staff, by accepting an appointment to that category), the applicant acknowledges responsibility to first review these bylaws and policies, and agrees to comply with the responsibilities of medical staff membership and with the bylaws and policies of the medical staff as they exist and as they may be modified from time to time.

### 5.2 BURDEN OF PRODUCING INFORMATION

In connection with all applications for appointment, reappointment, privileges, or transfer of staff category, the applicant shall have the burden of producing information for an adequate evaluation of the applicant's current competence, character, ethics, and other qualifications and suitability for the clinical privileges and staff category requested, of resolving any reasonable doubts about these matters, and of satisfying requests for information. The applicant's failure to sustain this burden shall be grounds for the medical staff's refusal to take action on the application, which shall not be subject to appeal or review under Article VII of these bylaws. To the extent consistent with law, this burden may include submission to a medical or psychological examination as per relevant credentialing policy, at the applicant's expense, if deemed appropriate by the medical executive committee, which may select the examining physician. If current competency cannot be demonstrated, an applicant may be eligible for re-entry per the current policy.

### 5.3 APPOINTMENT AND AUTHORITY

The medical staff shall make recommendations to the board of directors for appointments, denials and revocations of appointments to the medical staff as set forth in these bylaws.

### 5.4 DURATION OF APPOINTMENT AND REAPPOINTMENT

Initial appointments and reappointments to the medical staff shall be for a period of up to two (2) years. Any recommendation for appointment or reappointment of less than two(2) years is at the sole discretion of the medical executive committee and is not subject to rights of appeal as set forth in Article VII.

### 5.5 APPLICATION FOR INITIAL APPOINTMENT, REAPPOINTMENT, AND PRIVILEGES

#### 5.5-1 APPLICATION FORM

An application form shall be developed by the district and the medical staff. The form shall require detailed information which shall include, but not be limited to, information concerning:

(a) the applicant's qualification, including, but not limited to, professional education, training and experience, current licensure, current DEA registration (if applicable), and continuing

medical education information related to the clinical privileges to be exercised by the applicant;

(b) peer references familiar with the applicant's current professional competence and ethical character;

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

(d) past or pending professional disciplinary action, voluntary or involuntary denial, revocation, suspension, reduction or relinquishment of medical staff membership or privileges or any licensure or registration, and related matters;

(e) any past or pending arrests, indictments, criminal charges, or convictions brought against the applicant;

(f) current physical and mental health status, to the extent necessary to determine the applicant's ability to perform obligations or requested privileges, or as otherwise permitted by law;

(g) final judgments, settlements, or arbitration awards made against the applicant in professional liability cases, and any filed and served cases pending;

(h) professional liability insurance coverage, in not less than the minimum amounts as from time to time may be jointly determined by the medical executive committee and board of directors; and

(i) any past, pending or current exclusion of suspension from a state or federal health care program, or any investigation or disciplinary action by any governmental agency relating to the applicant's professional license or practice.

Each application shall be in writing, or electronically submitted on the prescribed form with all provisions completed (or accompanied by an explanation of why answers are unavailable), and signed by the applicant. When an applicant requests an application form, that person shall be given a copy of these bylaws and, as deemed appropriate by the medical executive committee, copies or summaries of any other applicable medical staff and district policies relating to clinical practice in the district. Failure to disclose the information requested in the application, or knowingly providing false or misleading information may result in disciplinary action, including suspension or termination of membership and/or privileges, or in a decision that the application does not qualify for credentialing consideration.

**5.5-2 EFFECT OF APPLICATION**

In addition to the matters set forth in Section 5.1, by submitting an application for privileges, each applicant:

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

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

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

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

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

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

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

(h) agrees to provide quality care for patients;

(i) pledges to maintain an ethical practice, including refraining from illegal inducements for patient referral, providing for the care of the applicant's patients, seeking consultation whenever indicated, refraining from providing illusory or unnecessary surgical or medical services, and refraining from delegating patient care responsibility to non-qualified or inadequately supervised practitioners;

(j) pledges to be bound by the medical staff bylaws and policies, as well as applicable district policies; and

(k) agrees that if membership and/or privileges are granted, and for the duration of medical staff membership and/or privileges, the applicant has an ongoing and continuous duty to report to the medical staff office as soon as reasonably possible, but within thirty (30) days, any and all information that would otherwise correct, change, modify or add to any information provided in the application or most recent reapplication.

### 5.5-3 VERIFICATION OF INFORMATION

The applicant shall deliver a completely filled-in, signed, and dated application and supporting documents to the medical staff office and an advance payment of non-refundable medical staff dues or fees, if any is required. The administrator or chief medical officer and chief of staff shall be notified of the application. The medical staff office shall expeditiously seek to collect or verify the references, licensure status, and other evidence submitted in support of the application. The district's authorized representative shall query the National Practitioner Data Bank regarding the applicant or member and submit any resulting information to the credentials committee for inclusion in the applicant's or member's credentials file. The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain any reasonably requested information. Failure to provide any requested information within thirty (30) days of a request, or an otherwise agreed

to timeframe, shall be deemed a voluntary withdrawal of the application and no further action will be taken with respect to the application. When collection and verification of information is accomplished, all such information shall be transmitted to the credentials committee and the appropriate department(s). No final action on an application may be taken until receipt of the Data Bank report.

### 5.5-4 DETERMINE IF APPLICATION IS COMPLETE

The application will be deemed complete when all required information has been submitted by the applicant and all necessary verifications have been obtained. An application will become incomplete if the need arises for new, additional, or clarifying information at any time prior to final determination by the board. Notwithstanding any other provision of these bylaws, an application that is determined to be incomplete shall not qualify for privileging recommendations, regardless of any assessment or determination that may have been made as to its completeness at an earlier stage in the process. Should the applicant fail to make the application complete after thirty (30) days of a request, or an otherwise agreed-to timeframe, the credentialing and privileging process will be terminated. An incomplete application will not be processed. Termination of the credentialing and privileging process under this provision shall not entitle the applicant to any hearing or appeal under Article VII.

### 5.5-5 DEPARTMENT ACTION

After receipt of the application, the chief of each department to which the application is submitted shall review the application and supporting documentation, may seek additional information, and may conduct a personal interview with the applicant at the chief's discretion. The chief shall evaluate all matters deemed relevant to a recommendation, including information concerning the applicant's provision of services within the scope of privileges requested, his/her clinical and technical skills, any relevant data available from district performance improvement activities, and the applicant's participation in relevant continuing education. The chief shall transmit to the credentials committee his or her recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The chief may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

### 5.5-6 CREDENTIALS COMMITTEE ACTION

The credentials committee shall review the application, evaluate and verify the supporting documentation, the department chief's recommendations, and other relevant information. The credentials committee may elect to interview the applicant and seek additional information. As soon as practicable, the credentials committee shall transmit to the medical executive committee a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The credentials committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

### 5.5-7 MEDICAL EXECUTIVE COMMITTEE ACTION

At its next regular meeting after receipt of the credentials committee report and recommendation, or as soon thereafter as is practicable, the medical executive committee shall consider the report and any other relevant information. The medical executive committee may request additional information, return the matter to the credentials committee for further investigation, and/or elect to interview the applicant. The medical executive committee shall immediately forward to the administrator, for prompt transmittal to the board of directors, a written report with its recommendations and, if appointment is recommended, recommendations as to membership category, department affiliation, clinical privileges to be granted, and any special conditions to be attached to the appointment. The medical executive committee may also defer action on the application in the event that additional information is needed. In this case, the applicant will be notified and the application will be considered incomplete as described in Section 5.5-4.

### 5.5-8 EFFECT OF MEDICAL EXECUTIVE COMMITTEE ACTION

(a) Favorable recommendation: When the recommendation of the medical executive committee is favorable to the applicant, it shall be immediately forwarded to the board of directors and the supporting documentation shall be made available upon request.

(b) Unfavorable recommendation: When the recommendation of the medical executive committee is an unfavorable action, in whole or in part, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall not be entitled to procedural rights as provided in Article VII.

(c) Adverse recommendation: When a final recommendation of the medical executive committee is an adverse action, in whole or in part, the board of directors and the applicant shall be promptly informed by written notice. The applicant shall be entitled to procedural rights as provided in Article VII. The board of directors shall not take action on the pending adverse recommendation until the applicant has exhausted or waived his/her procedural rights.

### 5.5-9 BOARD OF DIRECTORS ACTION

On favorable recommendation of the medical executive committee:

(a) A decision of the board to adopt a favorable recommendation of the medical executive committee shall be deemed as final action.

(b) If the board is inclined to reject or modify a favorable recommendation, the board shall refer the matter to the joint conference committee.

(c) If the board's resolution constitutes grounds for a hearing under Article VII of the bylaws, the administrator shall promptly inform the applicant and the chief of staff, and the applicant shall be entitled to the procedural rights as provided in that Article. Once the applicant has exhausted or waived his/her procedural rights, the board may then take final action.

On adverse recommendation of the medical executive committee:

(a) Once the applicant has exhausted or waived his or her procedural rights, the board may take final action in the matter or refer the matter to the joint conference committee.

### 5.5-10 NOTICE OF FINAL DECISION

(a) Notice of the final decision shall be given to the applicant, the chief of staff, the chief of each department concerned, and the administrator if not previously informed.

(b) A decision and notice to appoint or reappoint shall include, if applicable: (1) the staff category to which the applicant is appointed; (2) the department to which that person is assigned; (3) the clinical privileges granted; and (4) any special conditions attached to the appointment.

### 5.5-11 REAPPLICATION AFTER ADVERSE OR UNFAVORABLE ACTION

An applicant who has received a final adverse action, as defined in these bylaws, regarding an application for appointment, reappointment, or privileges shall not be eligible to reapply to the medical staff for a period of three (3) years. Any such reapplication shall be processed as an initial application, and the applicant shall submit such additional information as may be required to demonstrate that the basis for the earlier adverse action no longer exists.

An applicant who has received an unfavorable action, as defined in these bylaws, is eligible to reapply once the deficiency has been corrected. The waiting period shall not apply.

### 5.5-12 TIMELY PROCESSING OF APPLICATIONS

Once an application is deemed complete, it is expected to be processed within one hundred twenty (120) days, unless it becomes incomplete at any point during processing as described in these bylaws. This time period is provided to assist in the processing of the application and not to create rights for applicants to have their applications processed within this specific time period.

## 5.6 REAPPOINTMENT AND REQUESTS FOR MODIFICATIONS OF STAFF STATUS OR PRIVILEGES

Applicants for reappointment, renewal of privileges, and requests for modifications of staff status or privileges shall be subject to all of the general application provisions of these bylaws, subject only the following additional provisions:

### 5.6-1 REAPPLICATION DEADLINE AND CONTENT

(a) At least one hundred fifty (150) days prior to the expiration date of the current staff appointment or expiration of privileges for privileges-only practitioners (for example, telemedicine), a reapplication form shall be submitted to the member or privileged practitioner. At least one hundred twenty (120) days prior to the expiration date, each applicant shall submit to the medical staff office the completed application form for renewal of appointment to the staff and for renewal or modification of clinical privileges. The reapplication form shall include all information necessary to update and evaluate the qualifications of the applicant. However, an applicant for reappointment shall not be required to repeat information which has been provided and verified in a prior application and in which there has been no change during the period since the application submitted

the prior application. For such information, in response to each relevant portion of the application form, the applicant shall indicate that the information is unchanged.

(b) A medical staff member or privileged practitioner who seeks a change in medical staff status or modification of clinical privileges may submit such a request at any time.

(c) The timely processing of reapplications from receipt of the application to final action shall be one hundred twenty (120) days.

### 5.6-2 FAILURE TO FILE REAPPOINTMENT APPLICATION

If an application for reappointment is not received at least one hundred twenty (120) days prior to the expiration date, written notice shall be promptly sent to the applicant advising that the application has not been received. The applicant may submit a request for extension to the medical executive committee for consideration.

If an applicant fails, without good cause, to submit the required application by the deadline, but submits it prior to the expiration date of the applicant's privileges, and no final decision has been rendered by the expiration date due to the delays caused by the applicant's failure to timely submit the complete application, the applicant's privileges and prerogatives shall be deemed to be automatically suspended upon the expiration date unless otherwise extended by the medical executive committee with the approval of the board of directors. The automatic suspension shall remain in effect until the district board makes a final decision on the application.

If an applicant fails, without good cause, to submit the required reappointment application by the expiration date of the applicant's privileges, or to provide information requested to complete the application after receiving a notice of incomplete application, the applicant shall be deemed to have voluntarily resigned from membership and relinquished all privileges, effective as of the expiration date of the applicant's term of appointment and/or privileges.

In the event membership terminates and/or privileges lapse for the reasons set forth herein, the procedures set forth in Article VII shall not apply.

## 5.7 LEAVE OF ABSENCE

A practitioner taking any of the following leaves of absence for a duration exceeding one hundred eighty (180) days must notify the medical staff office prior to the start of leave, stating the approximate period of leave desired, which may not exceed one (1) year. Absence for longer than one (1) year shall result in automatic expiration of medical staff appointment and clinical privileges, unless an extension is requested in writing at least forty-five (45) days prior to the one-year date and granted by the medical executive committee. Reinstatement from any leave shall be subject to the provisions listed in Section 5.7-5.

### 5.7-1 ROUTINE LEAVE OF ABSENCE

A practitioner may take a routine leave of absence, giving consideration to his/her contractual obligations. The medical executive committee shall be notified of the leave.

### 5.7-2 MEDICAL LEAVE OF ABSENCE

A practitioner may take a medical leave of absence to accommodate treatment for, or recovery from, a behavioral health or physical health condition affecting his or her fitness to practice safely. The approximate period of leave needed shall be specified, and as reasonable during the leave, the medical executive committee shall be kept informed of changes to the projected date of return. The practitioner may be required to submit a letter of release from the treating physician as part of the reinstatement process confirming that his or her health is free from any impairment prior to exercising any patient care. The medical executive committee may, at its discretion, require a fit for duty evaluation be performed by a provider of its choosing and at the practitioner's cost.

### 5.7-3 MILITARY LEAVE OF ABSENCE

A practitioner may request a leave of absence to fulfill military service obligations. Such request shall be granted upon notice and review by the medical executive committee.

### 5.7-4 OBLIGATION UNDER LEAVE OF ABSENCE

During the period of the leave, the practitioner shall not exercise clinical privileges at Northern Inyo Healthcare District, and membership rights and responsibilities shall be inactive, but the obligation to pay dues, if any, shall continue, unless waived by the medical executive committee.

Before any routine leave of absence may begin, all medical records must be completed and dues must be current, unless such dues are excused by the medical executive committee. Meeting attendance requirements will be waived during the period of leave.

### 5.7-5 REQUEST FOR REINSTATEMENT

At least forty-five (45) days prior to the termination of the leave of absence or as soon as reasonably known, the practitioner may request reinstatement of privileges by submitting a written notice to the medical executive committee (and in the case of an advanced practice provider, written notice to the interdisciplinary practice committee in addition to the medical executive committee). The medical executive committee shall make a recommendation concerning the reinstatement of the practitioner's privileges and prerogatives, which may take into consideration a summary of the practitioner's activities during the leave. Reinstatement may be granted subject to focused professional practice monitoring and/or evaluation as determined by the medical executive committee. A recommendation that a practitioner be denied reinstatement shall be considered a denial of privileges and may be appealed as such pursuant to these bylaws.

### 5.7-6 FAILURE TO REQUEST REINSTATEMENT

Failure, without good cause, to request reinstatement shall be deemed a voluntary resignation from the medical staff or advanced practice provider staff and shall result in automatic expiration of membership, privileges, and prerogatives. A practitioner whose membership and/or privileges automatically expires under this provision may contest this action to the medical executive committee by submitting a written statement or request a meeting before the committee. The medical executive committee's decision on the matter shall be final. A request for membership and/or privileges subsequently received from a member terminated under this provision shall be submitted and processed in the manner specified in these bylaws for initial appointments.

### 5.7-7 EXPIRATION OF APPOINTMENT WHILE ON LEAVE

If a practitioner's term of appointment is scheduled to expire during the period for which a leave is requested, the practitioner may:

(a) Seek and obtain reappointment prior to going on leave, which would result in an adjustment of the practitioner's subsequent term of appointment to reflect the new date of reappointment. The medical staff may require that supplemental information be produced to confirm current competence upon reinstatement; or

(b) Apply for reappointment at the scheduled time while on leave. The medical staff may require that supplemental information be produced to confirm current competence upon reinstatement; or

(c) Permit the current term of appointment to expire and reapply for membership and/or privileges as an initial applicant once the leave of absence has ended.

## ARTICLE VI: PEER REVIEW AND CORRECTIVE ACTION

### 6.1 MONITORING AND PEER REVIEW

Medical staff departments and committees are responsible for carrying out delegated peer review and quality assessment functions as per applicable peer review and quality policies. They may counsel, educate, issue letters of warning or censure, or initiate focused review or retrospective or concurrent monitoring (so long as the practitioner is only required to provide reasonable notice of admission and procedures) without initiating an investigation or formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing. Informal actions, focused review, monitoring or counseling shall be documented in the practitioner's file and reviewed as part of their ongoing professional practice evaluation. Medical executive committee approval is not required for such actions, but the medical executive committee shall be notified if trends or concerns are noted. Such routine peer review and quality assessment functions shall not constitute an investigation and shall not constitute a restriction of privileges or grounds for any formal hearing or appeal rights as described in Article VII of these bylaws.

### 6.2 CORRECTIVE ACTION

Corrective action is separate from routine monitoring and peer review and can be initiated at any time as outlined in this Section. A practitioner is not required to have exhausted all monitoring and peer review activities prior to initiation of a corrective action.

#### 6.2-1 CRITERIA FOR INITIATION

Any person may provide information to the medical staff office or officer of the medical staff about the conduct, performance, or competence of its members and practitioners, who will then take this information to the department chief, the chief of staff or medical executive committee. When reliable information indicates a practitioner may have exhibited acts, demeanor, or conduct reasonably likely to be (1) detrimental to patient safety or to the delivery of quality patient care within the district; (2) unethical; (3) contrary to the medical staff bylaws; or (4) below applicable professional standards, an investigation or request for action may be initiated.

#### 6.2-2 INITIATION

A request for an investigation or action against such practitioner may be initiated by the chief of staff or the medical executive committee. The request must be submitted to the medical executive committee, and supported by reference to specific activities or conduct alleged. If the medical executive committee initiates the request, it shall make an appropriate recording of the reasons in the minutes.

#### 6.2-3 INVESTIGATION

If the medical executive committee concludes an investigation is warranted, it shall direct an investigation to be undertaken. The medical executive committee may conduct the investigation itself, or may assign the task to an ad hoc committee of the medical staff. If an ad hoc committee is formed, the chief of staff shall appoint the members of the ad hoc committee with the recommendation of the medical executive committee. If the investigation is delegated to an officer or committee other than the medical executive committee, such officer or committee shall proceed with the investigation in a

prompt manner and shall forward a written report of the investigation to the medical executive committee as soon as practicable. The report may include recommendations for appropriate corrective action. The affected practitioner shall be promptly notified by the chief of staff that an investigation is being conducted and shall be given an opportunity to provide information in a manner and upon such terms as the investigating body deems appropriate. The body investigating the matter may, but is not obligated to:

(a) conduct interviews with persons involved; however, such investigation shall not constitute a "hearing" as that term is used in Article VII, nor shall the procedural rules with respect to hearings or appeals apply; and

(b) review the practitioner's file.

Despite the status of any investigation, at all times the medical executive committee shall retain authority and discretion to take whatever action may be warranted by the circumstances, including summary suspension, termination of the investigative process, or other action.

**6.2-4 EXECUTIVE COMMITTEE ACTION**

As soon as practicable after the conclusion of the investigation, the medical executive committee shall take action which may include, without limitation:

(a) determining no corrective action be taken and, if the medical executive committee determines there was no credible evidence for the complaint in the first instance, removing any adverse information from the practitioner's file;

(b) referring the practitioner to the Physician Wellness Committee for evaluation and follow-up as appropriate;

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

(d) issuing letters of admonition, censure, reprimand, or warning, although nothing herein shall be deemed to preclude committees or departments or their chiefs from issuing informal written or oral warnings outside of the mechanism for corrective action. In the event such letters are issued, the affected practitioner may make a written response which shall be placed in his or her file;

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

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

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

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

(i) taking other actions deemed appropriate under the circumstances.

### 6.2-5 SUBSEQUENT ACTION

The medical executive committee's action or recommendation following an investigation as described herein shall be presented to the board of directors at its next regularly scheduled meeting.

(a) If the medical executive committee has imposed or recommended corrective action as to which the affected practitioner may request a hearing, the board of directors may be advised of the action and hearing request at their next regularly scheduled meeting.

(b) If the medical executive committee decides not to take or recommend corrective action, or to take or recommend corrective action as to which the practitioner either has no rights of hearing or appeal or has waived such rights, and the board of directors questions or disagrees with the action of the medical executive committee, the matter may be remanded back to the medical executive committee for further consideration. If the decision of the board of directors is to take corrective action more severe than the action of the medical executive committee, and a hearing is required pursuant to Article VII, the procedure shall be as described in that Article for hearings that are prompted by action of the board of directors.

### 6.2-6 INITIATION BY BOARD OF DIRECTORS

If the medical executive committee fails to investigate or take disciplinary action in response to information about a practitioner's competence, performance, or conduct that is provided in accordance with the provisions of this Article, and if the board of directors determines that the medical executive committee's failure to proceed is contrary to the weight of the evidence, the board of directors may direct the medical executive committee to initiate investigation or disciplinary action. The board's request for medical staff action shall be in writing and shall set forth the basis for the request.

If the medical executive committee fails to take action in response to such direction from the board of directors, then the board may initiate the dispute resolution process as described in the Joint Conference Committee of these bylaws (unless immediate action is required to protect the health or safety or any individual, in which event the procedures for summary suspension shall apply). If the dispute resolution process does not result in action by the medical executive committee, and the board of directors still believes action is necessary, then the board of directors may initiate an investigation or corrective action after written notice to the medical executive committee, and shall fully comply with Articles VI and VII of these medical staff bylaws.

## 6.3 SUMMARY RESTRICTION OR SUSPENSION

### 6.3-1 CRITERIA FOR INITIATION

Whenever a practitioner's conduct is such that failure to take action may result in an imminent danger to the health of any individual, including but not limited to current or future patients, the chief of staff, the medical executive committee, or the chief of the department in which the practitioner holds privileges may summarily restrict or suspend the medical staff membership or clinical privileges of such practitioner. Unless otherwise stated, such summary restriction or suspension shall become effective immediately upon imposition, and the person or body responsible shall promptly give written notice to the board of directors, the medical executive committee, the medical staff office, the chief medical

officer and the administrator. In addition, the affected practitioner shall be provided with a written notice of the action that fully complies with the requirements of Section 6.3-2 below. The summary restriction or suspension may be limited in duration and shall remain in effect for the period stated or, if none, until resolved as set forth herein. Unless otherwise indicated by the terms of the summary restriction or suspension, the practitioner's patients shall be promptly assigned to another practitioner by the department chief or by the chief of staff, considering where feasible, the wishes of the patient in the choice of a substitute practitioner. Summary suspension or restriction shall automatically constitute a request for investigation pursuant to this Article.

**6.3-2 NOTICE OF SUMMARY SUSPENSION**

The affected practitioner shall be promptly provided with written notice of such suspension within two (2) business days. This initial written notice shall generally describe the reasons for the action, the extent of the action, and the effective date and time of the action. Oral notice of summary suspension may be provided immediately to the affected practitioner and prior to the written notice if needed in order to assure patient safety.

This initial notice shall not substitute for, but is in addition to, the notice required under Section 7.3-1 (which applies in all cases where the medical executive committee does not immediately terminate the summary suspension). The notice under Section 7.3-1 may supplement the initial notice provided under this Section, by including any additional relevant facts supporting the need for summary suspension or other corrective action.

**6.3-3 MEDICAL EXECUTIVE COMMITTEE ACTION**

As soon as reasonably possible under all circumstances after such summary restriction or suspension has been imposed, a meeting of the medical executive committee shall be convened to review and consider the action. Upon request, the affected practitioner may attend and make a statement concerning the issues under investigation, on such terms and conditions as the medical executive committee may impose, although in no event shall any meeting of the medical executive committee, with or without the practitioner, constitute a "hearing" within the meaning of Article VII, nor shall any procedural rules apply. The medical executive committee may modify, continue, or terminate the summary restriction or suspension, but in any event it shall furnish the practitioner with notice of its decision within two (2) working days of the meeting. A copy of the notice shall be given to the administrator and the chief medical officer, the district board, and the relevant department chief.

**6.3-4 PROCEDURAL RIGHTS**

Unless the medical executive committee promptly terminates the summary restriction or suspension, it shall remain in effect during the pendency of the corrective action, hearing and appeal process, and the practitioner shall be entitled to the procedural rights afforded by Article VII.

**6.3-5 INITIATION BY BOARD OF DIRECTORS**

If the chief of staff, members of the medical executive committee and the chief of the department in which the practitioner holds privileges are not available to summarily restrict or suspend the practitioner's membership or clinical privileges, the board of directors (or the administrator on-call, as designee) may immediately suspend a practitioner's privileges if a failure to suspend those privileges is

likely to result in an imminent danger to the health of any person, provided that the board of directors (or administrator on-call) made reasonable attempts to contact the chief of staff, members of the medical executive committee and the chief of the department before the suspension.

A suspension under this Section is subject to ratification by the medical executive committee. If the medical executive committee does not ratify such a summary suspension within two (2) business days, the summary suspension shall terminate automatically. If the medical executive committee does ratify the summary suspension, all other provisions under Section 6.3 of these bylaws will apply. In this event, the date of imposition of the summary suspension shall be considered to be the date of ratification by the medical executive committee for purposes of compliance with notice and hearing requirements.

## 6.4 AUTOMATIC SUSPENSION OR LIMITATION

In the following instances, the practitioner's privileges or membership may be suspended or limited as described, with no right to hearing unless reportable by law to the Medical Board of California. However, the practitioner may appear before the medical executive committee or submit a written statement addressing the question of whether grounds exist for the special action as set forth below. A practitioner may be eligible to reapply for reinstatement of privileges if the cause for such automatic action has been resolved.

### 6.4-1 LICENSURE

(a) Revocation and Suspension: Whenever a practitioner's license or other legal credential authorizing practice in this state is revoked or suspended, medical staff membership and clinical privileges shall be automatically revoked as of the date such action becomes effective.

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

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

(d) Expiration: Whenever a practitioner's license is expired or evidence of renewal has not been received, the practitioner shall be automatically suspended until such time as evidence of current licensure has been received. Failure to reinstate such license or other legal credential within thirty (30) days of such lapse or expiration shall result in automatic termination of medical staff membership and/or clinical privileges.

### 6.4-2 DRUG ENFORCEMENT ADMINISTRATION (DEA) CERTIFICATE

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

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

### 6.4-3 MEDICAL RECORDS

Members of the medical staff and other clinically privileged practitioners are required to complete medical records within such reasonable time as may be prescribed by the district and the medical staff. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed may be imposed by the chief of staff after notice of delinquency for failure to complete medical records within such period has been given to the practitioner. For the purpose of this Section, "related privileges" means voluntary on-call service for the emergency room, scheduling surgery, assisting in surgery, consulting on hospital cases, and providing professional services within Northern Inyo Healthcare District. Bona fide leave may constitute an excuse subject to approval by the medical executive committee. Practitioners whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations. The suspension shall continue until lifted by the chief of staff or his or her designee. If within ninety (90) days after implementation of suspension the practitioner has not completed the delinquent records, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

### 6.4-4 PROFESSIONAL LIABILITY INSURANCE

Failure to maintain professional liability insurance in the amounts indicated shall result in an automatic suspension of a practitioner's clinical privileges, and if within ninety (90) days after written warning of the delinquency the practitioner does not provide evidence of required professional liability insurance and evidence of coverage for the interim, the practitioner's membership and privileges shall be automatically terminated without right to a hearing unless reportable by law.

### 6.4-5 FAILURE TO PROVIDE INFORMATION OR SATISFY SPECIAL ATTENDANCE REQUIREMENT

Failure without good cause to provide information or appear when requested by a medical staff committee or department as described in these bylaws shall result in the referral to the medical executive committee for action, which may include automatic suspension of all privileges. The automatic suspension shall remain in effect until the practitioner has provided the requested information and/or satisfied the special attendance requirement.

### 6.4-6 FELONY CONVICTION OR PLEA

A practitioner who has been convicted of, or who has pleaded guilty or no contest to, a felony within the past seven (7) years shall not be eligible for privileges or initial appointment to the medical staff unless the medical executive committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships,.

If a practitioner of the medical staff is convicted of, or pleads guilty or no contest to a felony, the practitioner's medical staff membership and privileges shall be automatically suspended pending review by the medical executive committee. If the medical executive committee, in its sole discretion, confirms that the felony was directly related to the practitioner's professional practice or patient relationships or

involving moral turpitude, the practitioner's staff membership and privileges shall terminate without right to a hearing. If the medical executive committee determines, in its sole discretion, the felony was not directly related to the practitioner's professional practice or patient relationships, the practitioner shall be permitted to request reinstatement as an initial applicant.

### 6.4-7 EXCLUSION FROM GOVERNMENTAL PROGRAM

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

### 6.4-8 NOTICE OF AUTOMATIC ACTION

No notice shall be required for an automatic action to become effective. However, as soon as reasonably practical after the automatic action becomes effective, written notice shall be provided to the affected practitioner, the administrator, the chief medical officer, the department chief, and the chief of staff.

### 6.4-9 MEDICAL EXECUTIVE COMMITTEE DELIBERATION

As soon as practicable after automatic action is taken or warranted, the medical executive committee shall convene to review and consider the facts, and may recommend any further corrective action as it may deem appropriate in accordance with these bylaws.

## ARTICLE VII: HEARINGS AND APPELLATE REVIEWS

### 7.1 GENERAL PROVISIONS

#### 7.1-1 PROCESS TO CHALLENGE ADVERSE ACTIONS REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

The notice, hearing and appeal provisions available to a practitioner to contest an action or final recommended action which must be reported to the Medical Board of California under Business and Professions Code Section 805 shall be governed by the provisions of this Article commencing with Section 7.2 below.

#### 7.1-2 PROCESS TO CHALLENGE UNFAVORABLE ACTIONS NOT REPORTABLE UNDER BUSINESS AND PROFESSIONS CODE SECTION 805

A practitioner who is adversely and significantly affected by an unfavorable action or recommended action for which a review process is not otherwise provided in these bylaws or in or policies, and which is not reportable under Business and Professions Code Section 805, may contest such actions or recommended actions by delivering a written request for review to the medical executive committee. In no event shall any meeting of the medical executive committee, with or without the practitioner, constitute a hearing within the meaning of Article VII, nor shall any procedural hearing rights apply. If the action or recommended action was made by the board of directors, the practitioner may contest the matter by providing written request for review to the board of directors. Any such request for review must be delivered within thirty (30) days from the practitioner's receipt of notice of the action or recommendation.

Examples of matters reviewable under this Section include, without limitation, restriction of clinical privileges for less than thirty (30) days in a twelve (12) month period; summary suspension of clinical privileges for fourteen (14) days or less; and termination, denial or restriction of privileges or membership rights for reasons other than medical disciplinary cause as defined in Business and Professions Code Section 805.

#### 7.1-3 DUTY TO EXHAUST INTERNAL REMEDIES

All practitioners and applicants are obligated to exhaust all remedies provided in this Article or elsewhere in medical staff bylaws before initiating legal action. Any practitioner who fails to exhaust the remedies (including all hearing and appeal remedies) provided in these bylaws before initiating legal action, shall be liable to pay the full costs, including legal fees, required to respond to such legal action.

#### 7.1-4 TIMELY COMPLETION OF PROCESS

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

#### 7.1-5 FINAL ACTION

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

## 7.2 GROUNDS FOR HEARING

Except as otherwise specified in these bylaws, any one or more of the following adverse actions shall constitute grounds to request a hearing:

(a) denial of initial medical staff appointment or requested reappointment to the medical staff, based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(b) denial of requested clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(c) summary suspension of staff membership or staff privileges for greater than fourteen (14) days;

(d) termination or revocation of medical staff membership or clinical privileges based on professional competence or conduct which is reasonably likely to be detrimental to patient safety or to the delivery of patient care;

(e) involuntary reduction or restriction of clinical privileges or membership for thirty (30) days or more in any twelve (12) month period; or

(f) any other disciplinary action or recommendation that must be reported, by law, to the practitioner's California licensing authority under Business and Professions Code Section 805.

## 7.3 REQUESTS FOR HEARING

### 7.3-1 NOTICE OF ACTION OR PROPOSED ACTION

In all cases in which action has been taken or a recommendation made as set forth in Section 7.2, the practitioner shall be given prompt written notice of:

(a) the recommendation or final proposed action and that such action, if adopted, shall be taken and reported to the Medical Board of California and/or to the National Practitioner Data Bank, if required;

(b) a brief description of the reasons for the proposed action;

(c) the right to request a hearing pursuant to Section 7.3-3, and that such hearing must be requested in writing within thirty (30) days; and

(d) a summary of the rights granted in the hearing pursuant to the medical staff bylaws.

### 7.3-2 HEARINGS PROMPTED BY BOARD OF DIRECTORS ACTION

If the hearing is based upon an adverse decision or recommendation of the board of directors, the board of directors or its designee shall fulfill the duties assigned to the medical executive committee or the chief of staff when the medical executive committee is the body whose decision prompted the hearing. This shall include, but not be limited to, preparing the notice of adverse action or recommended action and right to a hearing, scheduling the hearing, providing the notice of hearing and statement of charges, and designating the judicial review committee, presenter and witnesses.

### 7.3-3 REQUEST FOR HEARING

The practitioner shall have thirty (30) days following receipt of notice of such action to request a hearing. The request shall be in writing addressed to the medical executive committee with a copy to the board of directors. Any such request shall include the practitioner's intent with regard to representation. In the event the practitioner does not request a hearing within the time and in the manner described, the practitioner shall be deemed to have waived any right to a hearing and accepted the recommendation or action involved.

### 7.3-4 TIME AND PLACE FOR HEARING

Upon receipt of a request for hearing, the medical executive committee has thirty (30) days to schedule a hearing. The medical executive committee will give notice to the practitioner of the time, place and date of the hearing. The date of the commencement of the hearing shall be not be more than sixty (60) days from the date of receipt of the request by the medical executive committee for a hearing, so long as the practitioner has at least thirty (30) days from the date of notice to prepare for the hearing, or both parties mutually agree to an earlier date. When the request is received from a practitioner who is under summary suspension the hearing shall be held as soon as the arrangements may reasonably be made.

### 7.3-5 NOTICE OF HEARING AND NOTICE OF REASONS OR CHARGES

Together with the notice stating the place, time and date of the hearing, the chief of staff or designee on behalf of the medical executive committee shall provide the reasons for the recommended action, including the acts or omissions with which the practitioner is charged and a list of the charts in question, where applicable.

### 7.3-6 JUDICIAL REVIEW COMMITTEE

When a hearing is granted, the medical executive committee shall recommend a judicial review committee. The judicial review committee shall be composed of not less than three (3) members of the active medical staff. The judicial review committee members shall be unbiased, shall gain no direct financial benefit from the outcome, and shall not have acted as accusers, investigators, fact finders, initial decision-makers or otherwise have not actively participated in the consideration of the matter leading up to the recommendation or action. Knowledge of the matter involved shall not preclude a member of the medical staff from serving as a member of the judicial review committee. In the event that it is not feasible to appoint a judicial review committee from the active medical staff, the medical executive committee may appoint members from other staff categories or practitioners who are not members of the medical staff. Such appointment shall include designation of the chair. The judicial review committee shall consist of one member who shall have the same healing arts licensure as the accused, and where feasible, include an individual practicing the same specialty as the practitioner. All other judicial review committee members shall have MD or DO degrees or equivalent license.

### 7.3-7 FAILURE TO APPEAR OR PROCEED

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

### 7.3-8 POSTPONEMENTS AND EXTENSIONS

Once a request for hearing is initiated, postponements and extensions of time beyond the times permitted in these bylaws may be permitted by the officer presiding over the hearing on a showing of good cause, or upon agreement of the parties.

## 7.4 HEARING PROCEDURE

### 7.4-1 PREHEARING PROCEDURE

(a) If either side to the hearing requests in writing a list of witnesses, within fifteen (15) days of such request, and in no event less than ten (10) days before commencement of the hearing, each party shall furnish to the other a written list of the names of the individuals, so far as is reasonably known or anticipated, who are anticipated to give testimony or evidence in support of that party at the hearing. Failure to disclose the identity of a witness at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

(b) At least thirty (30) days prior to the hearing, the practitioner may receive copies of documents or other evidence relevant to the charges which the medical executive committee possess or controls. The medical executive committee may inspect and copy at least thirty (30) days prior to the hearing, any documents or other evidence relevant to the charges which the practitioner possesses or controls as soon as practicable after receiving the request. The failure by either party to provide access to this information at least thirty (30) days before the hearing shall constitute good cause for a continuance. The right to inspect and copy by either party does not extend to confidential information referring solely to individually identifiable practitioners, other than the practitioner under review.

(c) The practitioner and the medical executive committee shall have the right to receive all evidence which will be made available to the judicial review committee. Failure to produce copies of all documents expected to be produced at least ten (10) days before the commencement of the hearing shall constitute good cause for a continuance.

(d) The hearing officer (see Section 7.4-3) shall consider and rule upon any request for access to information and may impose any safeguards the protection of the peer review process and justice requires. In so doing, the hearing officer shall consider:

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

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

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

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

(e) The practitioner shall be entitled to a reasonable opportunity to question and challenge the impartiality of judicial review committee members and the hearing officer. Challenges to the

impartiality of any judicial review committee member shall be ruled on by the hearing officer. Challenges the impartiality of the hearing officer shall be ruled on by the hearing officer.

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

### 7.4-2 REPRESENTATION

The hearings provided for in these bylaws are for the purpose of intraprofessional resolution of matters bearing on professional conduct, professional competency, or character. The parties may be represented by legal counsel.

In all instances, the chief of staff or another physician designated by the medical executive committee shall have the authority to:

(a) be present during all phases of the hearing process;

(b) to make decisions regarding the detailed contents of the notice of reasons or charges;

(c) to make decisions regarding the presentation of testimony and exhibits;

(d) to direct the activities of the medical executive committee's attorney, if any;

(e) to consult with prospective and designated witnesses for the medical executive committee; and

(f) to amend the notice of reasons or charges as he or she seems warranted during the course of the proceedings, subject to the practitioner's procedural rights.

However, the medical executive committee's representative shall not have the authority to modify the nature of the medical executive committee's action or recommendation without the medical executive committee's approval.

### 7.4-3 THE HEARING OFFICER

The medical executive committee shall recommend a hearing officer to the board of directors to preside at the hearing. The board of directors shall be deemed to approve the selection unless it provides prompt written notice to the medical executive committee stating the reasons for its objections. The hearing officer shall be an attorney-at-law qualified to preside over a quasi-judicial hearing, but attorneys from a firm regularly utilized by the district, the medical staff or the involved practitioner or applicant for membership, for legal advice regarding their affairs and activities shall not be eligible to serve as hearing officer. The hearing officer shall gain no direct financial benefit from the outcome and must not act as a prosecuting officer or as an advocate. The hearing officer shall endeavor to assure that all participants in the hearing have a reasonable opportunity to be heard and to present relevant oral and documentary evidence in an efficient and expeditious manner, and that proper decorum is maintained. The hearing officer shall be entitled to determine the order of or procedure for presenting

evidence and argument during the hearing and shall have the authority and discretion to make all rulings on questions which pertain to matters of law, procedure or the admissibility of evidence. If the hearing officer determines that either side in a hearing is not proceeding in an efficient and expeditious manner, the hearing officer may take such discretionary action as seems warranted by the circumstances, in accordance with California law. If requested by the judicial review committee, the hearing officer may participate in the deliberations of such committee and be a legal advisor to it, but the hearing officer shall not be entitled to vote.

### 7.4-4 RECORD OF THE HEARING

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

### 7.4-5 RIGHTS OF THE PARTIES

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

### 7.4-6 MISCELLANEOUS RULES

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

### 7.4-7 BURDENS OF PRESENTING EVIDENCE AND PROOF

(a) At the hearing the medical executive committee shall have the initial duty to present evidence for each case or issue in support of its action or recommendation. The practitioner may present evidence in response.

(b) An applicant shall bear the burden of persuading the judicial review committee, by a preponderance of the evidence, of the applicant's qualifications by producing information which allows for adequate evaluation and resolution of reasonable doubts concerning the applicant's current qualifications for membership and privileges. An applicant shall not be

permitted to introduce information requested by the medical staff but not produced during the application process or corrective action proceedings, unless the applicant establishes that the information could not have been produced previously in the exercise of reasonable diligence.

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

### 7.4-8 ADJOURNMENT AND CONCLUSION

After consultation with the chair of the judicial review committee, the hearing officer may adjourn the hearing and reconvene the same without special notice at such times and intervals as may be reasonable and warranted, with due consideration for reaching an expeditious conclusion to the hearing. Both the medical executive committee and the practitioner may submit a written statement at the close of the hearing. Upon conclusion of the presentation of oral and written evidence, or the receipt of closing written arguments, if submitted, the hearing shall be closed.

### 7.4-9 BASIS FOR DECISION

The decision of the judicial review committee shall be based on the evidence introduced at the hearing, including all logical and reasonable inferences from the evidence and the testimony. The decision of the judicial review committee shall be subject to such rights of appeal as described in these bylaws.

### 7.4-10 DECISION OF THE JUDICIAL REVIEW COMMITTEE

Within thirty (30) days after final adjournment of the hearing, the judicial review committee shall render a decision which shall be accompanied by a report in writing and shall be delivered to the medical executive committee. If the practitioner is currently under suspension, however, the time for the decision and report shall be fifteen (15) days. A copy of said decision also shall be forwarded to the administrator, the chief medical officer, the board of directors, and to the practitioner. The report shall contain a concise statement of the reasons in support of the decision including findings of fact and a conclusion articulating the connection between the evidence produced at the hearing and the conclusion reached. Both the practitioner and the medical executive committee shall be provided a written explanation of the procedure for appealing the decision. The decision of the judicial review committee shall be subject to such rights of appeal or review as described in these bylaws.

## 7.5 APPEAL

### 7.5-1 TIME FOR APPEAL

Within ten (10) days after receipt of the decision of the judicial review committee, either the practitioner or the medical executive committee may request an appellate review. A written request for such review shall be delivered to the chief of staff, the administrator, the chief medical officer, the other party in the hearing, and a copy provided to the board of directors. If a request for appellate review is not requested within such period, that action or recommendation shall thereupon become the final action of the medical staff.

### 7.5-2 GROUNDS FOR APPEAL

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

(a) substantial non-compliance with the procedures required by these bylaws or applicable law which has created demonstrable prejudice;

(b) the decision was not supported by substantial evidence based upon the hearing record or such additional information as may be permitted pursuant to Section 7.5-5; or

(c) the judicial review committee failed to sustain an action or recommendation from the medical executive committee, that, based on the evidence in the hearing record, was reasonable and warranted.

### 7.5-3 APPEAL BOARD

The board of directors may sit as the appeal board, or it may delegate that function to an appeal board which shall be composed of not less than three (3) individuals designated by the board of directors. Knowledge of the matter involved shall not preclude any person from serving as a member of the appeal board, so long as that person did not take part in a prior hearing on the same matter. The appeal board may select an attorney to assist it in the proceeding, but that attorney shall not be entitled to vote with respect to the appeal. The attorney firm selected by the board of directors shall be neither the attorney firm that represented either party at the hearing before the judicial review committee nor the attorney who assisted the hearing panel or served as hearing officer.

### 7.5-4 TIME, PLACE AND NOTICE

The appeal board shall, within thirty (30) days after receipt of request for appellate review, schedule a review date and cause each side to be given notice of the time, place and date of the appellate review. The appellate review shall commence within sixty (60) days from the date of such request for appellate review, provided however, that when a request for appellate review concerns a practitioner who is under suspension which is then in effect, the appellate review should commence within forty-five (45) days from the date of receipt of the request for appellate review. The time for appellate review may be extended by the appeal board for good cause.

### 7.5-5 APPEAL PROCEDURE

The proceeding by the appeal board shall be in the nature of an appellate hearing based upon the record of the hearing before the judicial review committee, provided that the appeal board may accept additional oral or written evidence, subject to a foundational showing that such evidence could not have been made available to the judicial review committee in the exercise of reasonable diligence and subject to the same rights of cross-examination or confrontation provided at the judicial review hearing; or the appeal board may remand the matter to the judicial review committee for the taking of further evidence and for decision. Each party shall have the right to be represented by legal counsel, or any other representative designated by that party in connection with the appeal, to present a written statement in

support of that party's position on appeal, and to personally appear and make oral argument. The appeal board may thereupon conduct, at a time convenient to itself, deliberations outside the presence of the appellant and respondent and their representatives. The appeal board shall present to the board of directors its written recommendations as to whether the board of directors should affirm, modify, or reverse the judicial review committee decision consistent with the standard set forth in Section 7.5-6, or remand the matter to the judicial review committee for further review and decision.

### 7.5-6 DECISION

(a) Except as provided in Section 7.5-6(b), within thirty (30) days after the conclusion of the appellate review proceedings, the board of directors shall render a final decision. The board of directors may affirm, modify, reverse the decision or remand the matter for further review by the judicial review committee or any other body designated by the board of directors for reconsideration stating the purpose for the referral. The board of directors shall give great weight to the judicial review committee findings and shall not act arbitrarily or capriciously. The board of directors may, however, exercise its independent judgment in determining whether a practitioner was afforded a fair hearing, whether the decision was reasonable and warranted, and whether any bylaw or policy relied upon by the judicial review committee is unreasonable and unwarranted. The decision shall be in writing, shall specify the reasons for the action taken, and shall provide findings of fact and conclusions articulating the connection between the evidence produced at the hearing and the appeal (if any), and the decision reached, if such findings and conclusions differ from those of the judicial review committee. If the board of directors determines that the practitioner was not afforded a fair hearing in compliance with the bylaws, the board of directors shall remand the matter.

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

(c) The appeal board's decision shall constitute the final decision of the district. Any recommendation affirmed by the appeal board shall become effective immediately. The decision reached shall be forwarded to the chief of staff, the medical executive and credentials committees, the subject of the hearing, the chief medical officer and the administrator.

### 7.5-7 RIGHT TO ONE HEARING

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

## 7.6 EXCEPTION TO HEARING RIGHTS

### 7.6-1 AUTOMATIC ACTION BASED UPON ACTIONS TAKEN BY ANOTHER PEER REVIEW BODY

(a) The medical executive committee shall be empowered to:

(1) use as a basis for disqualification from membership and/or privileges, or

(2) automatically impose

any adverse action that has been taken within the preceding thirty-six (36) months by another peer review body (as that term is used in the federal or California laws) after that action is considered final and the action was taken in conformance with California Business & Professions Code section 809 et seq. For purposes of this Section, an action shall be considered final when the practitioner has completed the hearing, appeal and judicial proceedings related to the action.

(b) The practitioner shall not be entitled to any hearing or appeal unless the medical executive committee takes an action that is more restrictive than the final action taken by the original peer review body. Any hearing and appeal that is requested by the practitioner shall not address the merits of the action taken by the original peer review body, which were already reviewed at the original peer review body's hearing, and shall be limited to only the question of whether the automatic action is more restrictive than the original peer review body's action.

(c) Nothing in this Section shall preclude the medical staff or board of directors from taking a more restrictive action than another peer review body based upon the same facts or circumstances.

## ARTICLE VIII: ADVANCED PRACTICE PROVIDERS

### 8.1 QUALIFICATIONS OF ADVANCED PRACTICE PROVIDERS

Advanced Practice Providers (APPs) are non-physician practitioners who are eligible to apply for privileges at Northern Inyo Healthcare District. APPs are not eligible for medical staff membership as described in California state law. They may be granted practice privileges if they hold a license, certificate or other credentials in a category of APPs that the board of directors (after securing medical executive committee recommendation) has identified as eligible to apply for practice privileges, and only if the APPs are professionally competent and continuously meet the qualifications, standards, and requirements set forth in the medical staff bylaws as demonstrated by the medical staff ongoing and focused professional practice evaluation process.

### 8.2 CATEGORIES

The board of directors may determine, based upon recommendation of the medical executive committee and such other information as it has before it, those categories of APPs that shall be eligible to exercise privileges at Northern Inyo Healthcare District. Such APPs shall be subject to the supervision requirements developed and approved by the interdisciplinary practice committee, the medical executive committee, and the board of directors.

### 8.3 PRIVILEGES

(a) APPs may exercise only those setting-specific privileges granted to them by the board of directors. The range of privileges for which each APP may apply, and any special limitations or conditions to the exercise of such privileges, shall be based on recommendations of the interdisciplinary practice committee, subject to approval by the credentials committee, the medical executive committee and the board of directors.

(b) An APP must apply and qualify for practice privileges. Applications for initial granting of practice privileges and biennial renewal thereof shall be submitted and processed in a similar manner to that provided for medical staff members, unless otherwise specified in medical staff policies.

(c) Each APP shall be subject to terms and conditions similar to those specified for medical staff members as they may logically be applied to APPs and appropriately tailored to the particular APP.

### 8.4 RIGHTS AND RESPONSIBILITIES (PREROGATIVES)

The prerogatives which may be extended to an APP shall be defined in medical staff and/or district policies. Such prerogatives may include:

(a) Provision of specified patient care services; which services may be provided independently or under the supervision or direction of a medical staff member and consistent with the practice privileges granted to the APP and within the scope of the APP's licensure or certification.

(b) Participation in the open session of general meetings of the medical staff in a non-voting role.

(c) Being a voting participant at departmental committees appropriate to their specialty, which vote shall be limited to the following:

(1) Departmental policies, procedures, or other matters specific to the APP's line of practice; and

(2) Election of department chief.

(d) Attendance at district and medical staff education programs.

Additionally, each APP shall:

(a) Meet those responsibilities required by applicable policies and as specified in the bylaws, Section 2.5, and as they may be logically applied to reflect the scope of practice of the APP.

(b) Retain appropriate responsibility within the APPs area of professional competence for the care and supervision of each patient in the district for whom the APP is providing services.

(c) Participate in peer review of other APPs as appropriate, participate in quality improvement and discharge such other functions as may be required from time to time.

## 8.5 PROCEDURAL RIGHTS OF ADVANCED PRACTICE PROVIDERS

### 8.5-1 GRIEVANCE RIGHTS AFTER ADVERSE ACTIONS

Except as otherwise provided in this Section with respect to automatic termination or other matters, an APP shall have the right to utilize the grievance hearing process set forth in this Section in order to challenge any action that, if taken against a medical staff member, would be an adverse action constituting grounds for a procedural rights hearing pursuant to these bylaws. However, nothing contained in these bylaws shall be interpreted to entitle an APP to procedural rights, including, but not limited to, a procedural rights hearing or appellate review to which a medical staff member may be entitled.

An APP may challenge such adverse action by filing a written grievance with the medical executive committee no later than fifteen (15) days after such action. Upon receipt of such a grievance, the medical executive committee or its designee shall conduct an investigation that shall afford the APP an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" pursuant to the bylaws and shall not be conducted according to the procedural rules applicable to such hearings as set forth in Article VII. Before the interview, the APP shall be informed of the general nature and circumstances giving rise to the action, and the APP may present information relevant thereto at the interview. A record of the interview shall be made. The medical executive committee or its designee shall make a decision and recommendation for final action based on the interview and all other information available to it, and shall submit a written report of its recommendation, decision, and statement of basis for it to the board of directors. After receipt of the medical executive committee report, the board of directors shall take final action on the matter.

### 8.5-2 EMPLOYMENT BY THE DISTRICT

If the APP is an employee of Northern Inyo Healthcare District, disciplinary actions related to the terms and conditions of employment of the APP shall be governed by applicable human resources policies.

### 8.5-3 AUTOMATIC TERMINATION

(a) Notwithstanding the provisions of Section 8.5-1, an APP's privileges shall automatically terminate without review if the APP's certification or license expires, is revoked, or is suspended.

(b) Notwithstanding the provisions of Section 8.5-1, an APP's privileges may be subject to termination following review by the interdisciplinary practice committee and medical executive committee if no appropriate supervising practitioner is available because:

(1) The medical staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary and no other member is able or willing to function as the supervising practitioner; or

(2) The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the APP and the supervising practitioner is otherwise terminated, regardless of the reason thereof and no other member is able or willing to function as the supervising practitioner.

(c) Additionally, APPs are subject to the automatic action provisions of Section 6.4 of these bylaws.

### 8.5-4 REVIEW OF CATEGORY DECISIONS

The grievance rights afforded by this Section shall not apply to any decision regarding whether a category of APP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the board of directors, which has the discretion to decline to review the request or to review it using any procedure the board of directors deems appropriate.

## ARTICLE IX: OFFICERS

### 9.1 OFFICERS OF THE MEDICAL STAFF

#### 9.1-1 IDENTIFICATION

The officers of the medical staff shall be the chief of staff, vice chief of staff, immediate past chief of staff, and member-at-large. In addition, the medical staff's department chiefs shall be deemed medical staff officers within the meaning of California law.

#### 9.1-2 QUALIFICATIONS

Officers must be members of the active medical staff at the time of their nomination and election, and must remain members in good standing during their term of office. Failure to maintain such status shall create a vacancy in the office involved.

The chief medical officer will not be eligible to hold medical staff office during employment by the District. Should a medical staff officer accept a position as chief medical officer they will resign from their medical staff position and a replacement shall be determined per the process outlined in these bylaws. The chief medical officer will retain voting privileges to which they are eligible to participate based on their rights as an active medical staff member.

Additionally, the chief of staff must have previously served on the medical executive committee in some capacity for at least one term.

#### 9.1-3 NOMINATIONS

(a) The medical staff election year shall be every two years.

(b) The medical executive committee shall nominate one or more nominees for the office of chief of staff and may nominate one or more nominees for member-at-large to be filled at the time of elections. The medical executive committee shall give notice of the nominations to members eligible to vote on the officers no later than thirty (30) days prior to the election.

(c) Nominations may also be made by any member entitled to vote by submitting a written nomination to the medical staff office. A member may also nominate him- or herself, provided that he or she qualifies for such office.

(d) All nominees for election shall disclose in writing to the medical staff those current or impending personal, professional, or financial affiliations or relationships of which they are reasonably aware, including contractual, employment or other relationships with the district, which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff.

#### 9.1-4 ELECTIONS

The chief of staff and member-at-large shall be elected by written ballot sent to eligible members prior to the end of the medical staff year during which an election is held. Whenever feasible, the election

shall be held three (3) to six (6) months prior to the end of the medical staff year so as to give the newly elected officer the opportunity to begin transitioning into the role. Voting shall be by written ballot submitted to the medical staff office or via electronic vote. A nominee shall be elected upon receiving a majority of the valid votes cast. If no candidate for the office receives a majority vote on the first ballot, a run-off election shall be held promptly between the two candidates receiving the highest number of votes. In the case of a tie on the second ballot, the majority vote of the medical executive committee shall decide the election by written ballot at its next meeting or a special meeting called for that purpose.

#### 9.1-5 TERM OF ELECTED OFFICE

The chief of staff shall serve a two (2) year term, commencing on the first day of the medical staff year following the election. The chief of staff shall be eligible to serve consecutive terms.

The vice chief of staff, immediate past chief of staff, and member-at-large shall serve a one (1) year term. The vice chief of staff and member-at-large shall be eligible to serve consecutive terms.

Each officer shall serve until the end of that officer's term, unless that officer resigns or is removed from office.

#### 9.1-6 RECALL OF OFFICERS

Any medical staff officer may be removed from office for valid cause, including, but not limited to, gross neglect or misfeasance in office, or serious acts of moral turpitude. Recall of a medical staff officer may be initiated by the medical executive committee or by a petition signed by at least one-third of the members of the active medical staff presented to the medical executive committee or chief of staff. Recall shall require a majority vote of the medical executive committee. A special meeting may be called for this purpose.

At least ten (10) days prior to the initiation of any removal action, the individual shall be given written notice of the date of the meeting at which action is to be considered. The individual shall be afforded an opportunity to speak to the medical executive committee prior to a vote on removal. This provision does not include actions such as summary suspension where such timeline may not be feasible.

#### 9.1-7 VACANCIES IN ELECTED OFFICE

Vacancies in office occur upon the death or disability, resignation, or removal of the officer, or such officer's loss of membership in the medical staff. Vacancies shall be filled by appointment by the chief of staff with consultation with the medical executive committee until the next regular election, except for the member-at-large, which may remain vacant.

### 9.2 DUTIES OF OFFICERS

#### 9.2-1 CHIEF OF STAFF

The chief of staff shall serve as the chief officer of the medical staff. With the assistance of the medical executive committee where appropriate, the duties required of the chief of staff (or designee, as allowed by the bylaws) shall include, but not be limited to:

(a) enforcing the medical staff bylaws and policies, implementing sanctions where indicated in consultation with the medical executive committee, and promoting compliance with procedural safeguards where corrective action has been requested or initiated;

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

(c) serving as chair of the medical executive committee and calling, presiding at, and being responsible for the agenda of all meetings thereof;

(d) in the interim between medical executive committee meetings, performing those responsibilities of the committee that, in the chief of staff's opinion, must be performed prior to the next regular or special meeting of the committee;

(e) serving as an ex-officio member of all other staff committees without vote, unless chief of staff membership in a particular committee is required by these bylaws;

(f) interacting with the administrator, chief medical officer and board of directors in all matters of mutual concern within the district;

(g) representing the views and policies of the medical staff to the board of directors, the administrator or designee, and chairing the joint conference committee as indicated in these bylaws;

(h) regularly reporting to the board of directors on the performance of medical staff functions and communicating to the medical staff any concerns expressed by the district board;

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

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

(k) performing such other functions as may be assigned to the chief of staff by the bylaws, the medical staff, or the medical executive committee.

### 9.2-2 VICE CHIEF OF STAFF

The vice chief of staff shall serve a one (1) year term and is selected from among the current department chiefs serving on the medical executive committee. The vice chief of staff shall assume all duties and authority of the chief of staff in the absence of the chief of staff and shall perform such other duties as may be assigned. The vice chief of staff will serve as chair of the medical staff quality improvement committee and participate in the district quality improvement committees, as described in the district quality plan.

### 9.2-3 IMMEDIATE PAST CHIEF OF STAFF

The immediate past chief of staff will remain a member of the medical executive committee for one (1) year, and shall attend at least the first three (3) consecutive months of their term to assure a smooth transition with the change in leadership and longer as deemed necessary. The immediate past chief of staff shall perform such other duties as may be assigned.

### 9.2-4 MEMBER-AT-LARGE

The member-at-large shall be a member of the medical executive committee and shall perform duties as may be assigned.

## ARTICLE X: CLINICAL DEPARTMENTS

### 10.1 ORGANIZATION OF CLINICAL DEPARTMENTS

The active medical staff shall be organized into clinical departments. Each department shall be organized as a separate component of the medical staff and shall have a chief selected and entrusted with the authority, duties, and responsibilities specified in this Article. When appropriate, or at the recommendation of the departmental committee, the medical executive committee may approve the creation, elimination, modification, or combination of departments.

Department committees, as described in Article XI, may represent a single clinical department or a combination of clinical departments as appropriate.

Additional medical or surgical specialties not currently listed as a department will be assigned to an existing department through the credentialing and privileging process.

### 10.2 DEPARTMENTS

The clinical departments under these bylaws are:

(a) Anesthesia

(b) Emergency Medicine

(c) Surgery (including Pathology)

(d) Inpatient Medicine

(e) Obstetrics & Gynecology

(f) Orthopedic Surgery (including Podiatry)

(g) Outpatient Medicine

(h) Pediatrics

(i) Radiology

### 10.3 ASSIGNMENT TO DEPARTMENTS

Each privileged practitioner shall be assigned membership based on specialty or board certification in at least one department, but may also be granted membership and/or clinical privileges in other departments consistent with practice privileges granted.

### 10.4 FUNCTIONS OF DEPARTMENTS

The general functions of each department shall include:

(a) Conducting patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment provided to patients within the department, as per the medical staff's policy on ongoing and focused professional practice evaluation.

(b) Recommending to the medical executive committee guidelines for the granting of clinical privileges and the performance of specified services within the department.

(c) Evaluating and making appropriate recommendations to the credentials committee and the medical executive committee regarding the qualifications of applicants seeking appointment or reappointment and clinical privileges within that department.

(d) Reviewing and evaluating departmental adherence to: (1) medical staff and district policies and procedures, (2) sound principles of clinical practice, and (3) quality improvement.

(e) Coordinating with nursing and ancillary staff in regards to patient care provided by the department's members with nursing and ancillary patient care services.

(f) Reporting to the departmental committee concerning: (1) the activities of the department, and (2) recommendations for maintaining and improving the quality of care provided in the department and the district.

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

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

(i) Formulating departmental policies/procedures as reasonably necessary for the proper discharge of its responsibilities subject to the approval by the medical executive committee.

## 10.5 DEPARTMENT CHIEFS

### 10.5-1 QUALIFICATIONS

Each department shall have a chief who shall be a member of the active staff and shall be qualified by licensure, training, experience and demonstrated ability in at least one of the clinical areas covered by the department. If required by applicable California regulations or other law, the department chief must be certified by an appropriate specialty board or eligible for certification by an appropriate specialty board. Otherwise, the department chief shall possess comparable competence as affirmatively established through the peer review process.

### 10.5-2 SELECTION

The department chief shall be elected by the voting members of their department. In the event of a tie vote, the chief will be appointed by vote of the medical executive committee. Departments with a single member will automatically have the single member designated as chief. Vacancies due to any reason shall be filled for the unexpired term through special election by the respective department with such mechanisms as that department may adopt.

The medical director of the department may be eligible to serve as the department chief, if so elected. If after election, the department chief becomes the administratively-appointed medical director of his or her department, a re-election will be held at the next departmental meeting.

### 10.5-3 TERM OF OFFICE

Each department chief shall serve a one (1) year term which coincides with the medical staff year or until his or her successor is chosen, unless he or she shall sooner resign, be removed from office, or lose his or her medical staff membership or clinical privileges in that department. Department chiefs shall be eligible to serve consecutive terms.

**10.5-4 REMOVAL**

Removal of department chiefs from office may occur for cause by a two-thirds vote of the department members. The medical executive committee may remove department chiefs in the course of a corrective action proceeding as indicated.

**10.5-5 DUTIES**

Each chief shall have the following authority, duties and responsibilities, and shall otherwise perform such duties as may be assigned:

(a) oversee the quality of patient care, professional performance and behaviors rendered by practitioners with clinical privileges in the department and designate proctors as necessary;

(b) assign a member of the medical staff to assume responsibility for duties and/or the care of another member's patients in the event the member is unable to fulfill their obligations due to termination of privileges, illness, or similar extenuating circumstances;

(c) enforce the medical staff bylaws and medical staff and district policies within the department;

(d) implement within the department appropriate actions taken by the medical executive committee;

(e) coordinate with district administration, department medical director (if any), and nursing services in matters relevant to the department;

(f) perform such other duties commensurate with the office as may from time to time be reasonably requested by the chief of staff or the medical executive committee.

## ARTICLE XI: COMMITTEES

### 11.1 DESIGNATION

The medical executive committee and the other committees described in these bylaws shall be the standing committees of the medical staff. Special or ad hoc committees may be created by the medical executive committee or the chief of staff to perform specified tasks. Any committee that is carrying out all or any portion of a function or activity required by these bylaws is deemed a duly-appointed and authorized committee of the medical staff.

### 11.2 GENERAL PROVISIONS

#### 11.2-1 APPOINTMENT OF COMMITTEE MEMBERS AND CHAIRS

The chair and members of committees shall be designated as per the bylaws. If not specified in the bylaws, the chair and members of committees shall be appointed by and may be removed by the chief of staff, subject to consultation with the medical executive committee. Medical staff committees shall be responsible to the medical executive committee. Each committee chair or other authorized person chairing a meeting has the right to discuss and to vote on issues presented to the committee.

The administrator, or his or her designee, shall appoint any non-medical staff committee members who are not otherwise designated by title in the provision or resolution creating the committee.

The removal of any committee member who is automatically assigned to a committee because he or she is a general officer or other official shall be governed by the provisions pertaining to removal of such officer or official.

#### 11.2-2 COMMITTEE COMPOSITION

Except as otherwise provided in the bylaws, committees established to perform medical staff functions required by these bylaws may include any category of: medical staff members; advanced practice providers; representatives from district services such as administration, nursing services, or medical records; representatives of the community; and persons with special expertise, depending upon the functions to be discharged. Each active medical staff member and advanced practice provider who serves on a committee participates with vote unless the statement of committee composition provides for designation of the position as non-voting.

#### 11.2-3 REPRESENTATION ON DISTRICT COMMITTEES AND PARTICIPATION IN DELIBERATIONS

The medical staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility and services planning, financial management, and physical plant safety by providing medical staff representation on district committees established to perform such functions. The medical executive committee will be responsible for providing a medical staff or APP representative on district committees when requested by the board or administration.

### 11.2-4 EX-OFFICIO MEMBERS

The chief of staff and the administrator or designee are ex-officio members of all standing and special committees of the medical staff. They and all other persons designated to serve as ex-officio committee members shall serve without vote unless provided otherwise in the provision or resolution creating the committee.

### 11.2-5 ACTION THROUGH SUBCOMMITTEES

Any medical staff standing committee may establish subcommittees to assist in carrying out its duties, in addition to any such subcommittees established by the medical executive committee or expressly designated in the bylaws. A subcommittee shall be composed of one or more voting members of the standing committee. The medical executive committee shall be informed when a subcommittee is established. The committee chair may also appoint individuals to serve as non-voting subcommittee members, after consulting with, and subject to the approval of, the chief of staff regarding medical staff members, and the administrator or designee regarding district personnel. An ad hoc committee is not considered a subcommittee.

### 11.2-6 TERM OF COMMITTEE MEMBERS

The term of committee members shall be as designated in the bylaws. If not specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee.

### 11.2-7 COMMITTEE VACANCIES

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

### 11.2-8 LIMITATION OF ATTENDANCE AT COMMITTEE MEETINGS

Unless otherwise specified in the bylaws, any privileged practitioner who is in good standing may be permitted to attend any portion of a medical staff committee's meeting dealing with a matter of importance to that practitioner even though the practitioner is not a member of the committee. However, the committee chair or the chief of staff shall have the discretion to deny entry to the meeting to such practitioner, or to request any nonmember to leave the meeting. Any such nonmember who attends shall abide by all bylaws applicable to that committee.

In addition, during any portion of a committee meeting when the committee is in closed session or conducting peer review and chart review functions with respect to specific medical staff members, applicants, or other practitioners or advanced practice providers, attendance at the committee's meeting shall be restricted to (a) privileged practitioners who are members of the committee through assignment or election by the medical staff, and (b) any medical staff member or other person whom the committee has invited or requested to attend to assist in the functions (but only for the portion of the meeting designated by the committee or the committee chair).

The committee chair, after consulting with the chief of staff and administrator, may call on outside consultants or other special advisors to assist the committee in fulfilling its duties and allow such special

advisors to attend committee meetings related to the assistance they are providing, but such advisors shall not be deemed members of the committee.

Any nonmember who attends a committee meeting shall be deemed to have agreed, by his or her presence at the meeting, to maintain the confidentiality of and to refrain from any unauthorized disclosure to other persons of the committee's records, deliberations, and proceedings.

#### 11.2-9 ACCOUNTABILITY

All medical staff committees shall be accountable to the medical executive committee.

## 11.3 MEDICAL EXECUTIVE COMMITTEE

#### 11.3-1 COMPOSITION

The medical executive committee shall be composed of the chief of staff, vice chief of staff, immediate past chief of staff, department committee chairs, and a member-at-large, if elected. The chief of staff shall chair and preside over the medical executive committee. The administrator or designee and the chief nursing officer shall be a non-voting ex-officio members.

#### 11.3-2 DUTIES

With the assistance of the chief of staff and/or the use of ad hoc committees as appropriate, the medical executive committee shall:

(a) represent and act on behalf of the medical staff, subject to such limitations as may be imposed by these bylaws;

(b) ensure the medical staff fulfills its responsibilities to the district board as per the district bylaws;

(c) monitor, evaluate, and supervise the performance of all medical staff functions, including conducting an annual review of medical staff policies;

(d) review, evaluate, or take other appropriate action for matters related to the competence and other qualifications of privileged practitioners or practitioners applying for privileges;

(e) taking reasonable steps to promote ethical conduct and competent clinical performance on the part of all privileged practitioners and when indicated, initiate and/or pursue disciplinary or corrective actions affecting privileged practitioners, as provided in the bylaws;

(f) ensure medical staff's knowledge of and compliance with the medical staff bylaws and policies; the district's bylaws, rules, and policies; state and federal laws and regulations; and other accreditation requirements;

(g) oversee the development of medical staff policies, approve (or disapprove) all such policies, and oversee the dissemination and implementation of all such policies following their approval by the medical staff;

(h) implement, as they relate to the medical staff, the approved policies, procedures, standards, and rules of the district, including, without limitation, the Compliance program (which

program relates to Medicare and Medi-Cal fraud and abuse matters); the district confidentiality policies and procedures related to compliance with applicable law, including but not limited to the federal Health Insurance Portability and Accountability Act ("HIPAA") and the California Medical Information Act; and the district medical error reporting program, including without limitation, applicable disclosure and reporting protocols.

(i) provide liaison between the medical staff, the administrator and the district board by regularly reporting to the district board and to the medical staff;

(j) make recommendations to the district board regarding medical staff structure, membership and privileges requirements, application, disciplinary, and hearing procedures, peer review and quality assessment and improvement activities, and other aspects of medical staff affairs addressed in the medical staff bylaws;

(k) make recommendations to administration in the selection of and assignment of responsibilities to department medical directors, the chief medical officer, or other practitioners contracted by the district to provide administrative services;

(l) review and make recommendations to the ~~administrator~~chief medical officer regarding quality of care issues related to specified clinical services contract arrangements for professional medical services;

(m) participate and provide information when requested in district proceedings involved with making specified clinical services contracting decisions;

(n) establish, as needed, such ad hoc committees that will fulfill particular functions for a limited time and will report directly to the medical executive committee;

(o) appoint committee members for all standing committees, all special medical staff, liaison, or multi-disciplinary committees, and designating the chairs of these committees, except where otherwise provided by these bylaws; and

(p) recommend the amount of annual dues for each medical staff membership category, subject to medical staff approval, and recommend the manner of expenditure of dues funds, subject to the committee's acknowledgment that such expenditures must be consistent with applicable law regarding such expenditures.

### 11.3-3 MEETINGS

The medical executive committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

## 11.4 QUALITY IMPROVEMENT COMMITTEE

### 11.4-1 COMPOSITION

The quality improvement committee shall consist of the members of the medical executive committee. The administrator or designee and the chief nursing officer shall be ex-officio non-voting members. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity. The chair shall be the vice chief of staff.

### 11.4-2 DUTIES

The quality improvement committee shall be responsible for overall supervision of patient care services quality monitoring, assessment, and improvement activities and accordingly shall:

(a) in collaboration with the district, oversee the development and implementation of a district-wide quality improvement plan and perform an annual review and recommend revisions as needed;

(b) carry out the duties as described in the district quality improvement plan;

(c) review quality improvement reports from department chiefs, committees, and other medical staff patient care review activities; and

(d) refer problems for assessment and corrective action to appropriate departments or committees.

### 11.4-3 MEETINGS AND REPORTS

The medical staff quality improvement committee should be scheduled to meet on a monthly basis and shall meet at least ten (10) times during the medical staff year.

## 11.5 BYLAWS COMMITTEE

### 11.5-1 COMPOSITION

The bylaws committee shall be composed of at least three (3) active staff members.

### 11.5-2 DUTIES

The bylaws committee shall make reasonable efforts to assure that the medical staff bylaws and policies adequately and accurately reflect the current structure and practices of the medical staff and comply with applicable legal requirements by:

(a) conducting an annual review of the bylaws;

(b) developing and submitting proposals for bylaws changes to the medical executive committee and to the medical staff in accordance with bylaws procedures;

(c) receiving, evaluating, and making recommendations with respect to bylaws or policies proposals made by the executive committee, department chiefs, member petition or other sources; and

(d) engaging in such other activities as reasonably appropriate for fulfilling these and other functions as specified in the bylaws or policies.

### 11.5-3 MEETINGS AND REPORTS

The bylaws committee will meet at least annually and otherwise as requested by the bylaws committee chair or chief of staff. The committee shall report its activities and recommendations at least annually to the medical executive committee.

## 11.6 CREDENTIALS COMMITTEE

### 11.6-1 COMPOSITION

The credentials committee shall be composed of at least five (5) active staff members, selected on a basis that will ensure insofar as feasible, representation of the clinical departments and the major clinical specialties which are routinely practiced by privileged practitioners at Northern Inyo Healthcare District.

### 11.6-2 DUTIES

The credentials committee shall evaluate and make recommendations with respect to the qualifications of all applicants for medical staff appointment, reappointment, privileges, and changes in staff categories, and fulfill other functions as specified in the bylaws or policies.

### 11.6-3 MEETINGS AND REPORTS

The credentials committee shall meet at least quarterly, or as often as necessary as determined and called by the committee chair, the chief of staff, or the medical staff office. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws and shall otherwise report the status of pending applications and its activities to the medical executive committee.

## 11.7 INFECTION CONTROL COMMITTEE

### 11.7-1 COMPOSITION

The infection control committee shall be composed of at least three (3) privileged practitioners, at least two (2) of which shall be active staff members. Ex-officio members serving without vote shall include the infection prevention nurse, the administrator (or the administrator's designee), and a representative from the clinical laboratory (bacteriology). In addition, representatives from areas such as, but not limited to, the employee health, dietary, respiratory therapy, and environmental service departments may be invited to attend and participate in discussion without vote. The chair of the infection control committee shall be required to complete the necessary infection control training as mandated per state regulations.

### 11.7-2 DUTIES

The duties of the infection control committee shall include assisting the district in:

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

(b) developing a system for reporting, identifying and analyzing the incidence and cause of healthcare-associated infections, including assignment of responsibility for the ongoing collection and analytic review of such data;

(c) monitoring implementation of corrective actions for healthcare-associated infections, and making recommendations to eliminate future such infections;

(d) developing and implementing a preventative and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

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

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

(g) taking such actions as reasonably necessary to assure infection control compliance with regulatory agencies and with established guidelines such as those of the Center for Disease Control and APIC (Association for Professionals in Infection Control and Epidemiology); and

(h) reviewing sensitivities of organisms specific to the facility.

### 11.7-3 MEETINGS

The infection control committee shall meet at least quarterly. The committee, or a representative of the committee, shall provide to the medical executive committee and the quality improvement regular reports of the committee's activities.

## 11.8 INTERDISCIPLINARY PRACTICE COMMITTEE

### 11.8-1 COMPOSITION

The interdisciplinary practice committee (IDPC) shall be composed of:

(a) an equal number of medical staff members who are physicians and nursing staff who are registered nurses;

(b) the lead advanced practice provider;

(c) the chief nursing officer; and

(d) the administrator (or the administrator's designee, who may not be a registered nurse or a physician medical staff member).

The medical executive committee shall appoint the physician members and designate one of them as the chairperson. The chief nursing officer shall appoint the nursing staff members. In addition, representatives in the categories of advanced practice providers granted privileges in the district may serve as consultants on an as-needed basis, and shall participate, when requested and feasible, in the committee proceedings when a member of the same APP category is applying for privileges.

### 11.8-2 DUTIES

The IDPC functions to establish, implement, monitor, and evaluate policies and procedures for interdisciplinary medical practice pursuant to Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws. IDPC duties shall include, but not necessarily be limited to, the standardized procedures and credentialing duties as set forth below in this Section.

(a) **STANDARDIZED PROCEDURE DUTIES:**

(1) The IDPC shall develop and review standardized procedures that apply to nurses or APPs, identify functions that are appropriate for standardized procedures, initiate such procedures, and review and approve standardized procedures in accordance

with applicable licensure regulations, such as Title 22, California Code of Regulations, Sections 70706 and 70706.2, other applicable law, and the bylaws.

(2) Request for development of standardized procedures may be initiated by the administrator, the chief medical officer, the chief nursing officer, the medical executive committee, the chief of staff, the appropriate department chiefs, the affected registered nurses or APPs, or supervising practitioners.

(3) Prior to approval of new or amended standardized procedures, the IDPC shall obtain consultation and recommendations from the department chief(s), other appropriate medical staff members, and nonmedical staff members who practice in the clinical field or medical or nursing specialties under review as subject of the proposed standardized procedures.

(4) Standardized procedures shall be reviewed and approved by the IDPC, the medical executive committee, the administrator, and the board of directors in order to become effective.

(5) The IDPC may approve standardized procedures only by affirmative vote of the following IDPC members: the administrator (or the administrator's designee), a majority of the physician members, and a majority of the registered nurse members (including the chief nursing officer).

(6) The IDPC is responsible for assuring that standardized procedures are a collaborative effort among administrators and health professionals, including physicians and nurses. Each standardized procedure shall:

i. Be in writing and show the date or dates of each required approval, including approval by the IDPC;

ii. Specify which standardized procedure functions which registered nurses are authorize to perform and under what circumstances;

iii. State any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;

iv. Specify any experience, training, and/or special education requirements for performance of the standardized procedure functions;

v. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedure functions;

vi. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedure functions;

vii. Specify the nature and scope of review and/or supervision required for performance of the standardized procedure functions. For example, if the function is to be performed only under the immediate supervision of a

physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;

viii. Set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;

ix. State the limitations on settings or departments within the facility where the standardized procedure functions may be performed;

x. Specify any special requirements for procedures relating to patient recordkeeping; and

xi. Provide for a method of periodic review of the standardized procedure.

(b) **CREDENTIALING ADVANCED PRACTICE PROVIDERS DUTIES:**

(1) Upon request by the medical executive committee or the board of directors, or at its own initiative, the IDPC shall make recommendations regarding APP category eligibility, delineation of APP practice privileges, supervision requirements, and other such matters related to APP practice at the district.

(2) The IDPC shall review and evaluate APP applications and requests for privileges and forward its written report and recommendations to the appropriate department chief or credentials committee.

(3) The IDPC shall serve as liaison between APPs and the medical staff.

### 11.8-3 MEETINGS

The IDPC shall meet as often as needed, but at least annually. The committee shall report its activities and recommendations with respect to applicants as specified in the bylaws to the credentials committee.

## 11.9 JOINT CONFERENCE COMMITTEE

### 11.9-1 COMPOSITION

The joint conference committee shall be composed of two (2) members of the board of directors and two (2) members of the medical executive committee, one (1) of which shall be the chief of staff, and the other which shall be appointed by the medical executive committee. The administrator, or designee, shall be a non-voting, ex-officio member. The chair of the committee should alternate yearly between the board of directors and the medical staff; odd-numbered years will be the board of directors, and even-numbered years will be the medical staff.

### 11.9-2 DUTIES

The function of the joint conference committee is to serve as an official means of liaison between members of the board of directors, the district administration, and the medical staff. The joint conference committee shall act in an advisory function and provide a forum for:

(a) maintenance of effective communications to keep the board, medical staff, and the administrator cognizant of any pertinent actions taken or contemplated;

(b) planning for growth and development of the district and the medical staff;

(c) discussion of matters of district and medical staff policy, practice, and planning not related to peer review; and

(d) interaction between the board of directors and the medical staff on such matters as may be referred by the medical executive committee or the board of directors.

The joint conference committee shall meet on an ad hoc basis to act as a deliberative body as described below for:

(a) the resolution of conflicts or disputes between the medical staff and the board of directors or administration; and

(b) the resolution of any dispute related to the medical staff's rights or self-governance or discharge of medical staff responsibilities.

**11.9-3 DISPUTE RESOLUTION PROCESS**

All disputes between administration or the board of directors and the medical staff that have not been resolved by prior informal meetings and discussions shall be addressed to and mediated by the joint conference committee.

(a) Following written notice of a dispute needing mediation, the committee shall convene within fourteen (14) days after the next regularly scheduled district board meeting.
(b) The committee shall meet and confer in good faith to formulate a recommendation for mediation of the dispute.
(c) If the committee cannot reach a consensus, the committee may appoint an outside professional mediator as a member of the committee, and the mediator shall serve as the chair of the committee but shall have no vote. The parties shall cooperate to select the mediator from a list of candidates provided by services such as the Judicial Arbitration and Mediation Service or the American Arbitration Association. The cost of the mediator shall be covered by the district.

**11.9-4 MEETINGS AND REPORTS**

The committee shall meet at least semi-annually, but may also meet as needed on an ad-hoc basis as described above. The chief of staff, or designee, shall report the committee's activities or discussions to the medical executive committee and to the medical staff via email or at the next regularly scheduled meetings, as appropriate for the subject matter. Minutes shall be kept during meetings and a copy maintained at the district office and the medical staff office.

**11.10 PHARMACY AND THERAPEUTICS COMMITTEE**

**11.10-1 COMPOSITION**

The pharmacy and therapeutics committee shall be composed of at least three (3) active staff members, the pharmacy director (with vote), and the chief nursing officer or other nurse designated by the chief nursing officer (with vote). Ex-officio members serving without vote shall include the administrator, or the administrator's designee, and a representative from clinical informatics. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

**11.10-2 DUTIES**

The duties of the pharmacy and therapeutics committee shall include:

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

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

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

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

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

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

(g) maintaining a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the medical executive committee concerning those activities; and

(h) reviewing untoward drug reactions.

**11.10-3 MEETINGS**

The pharmacy and therapeutics committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee and the quality improvement committee on a regular basis.

## 11.11 PHYSICIAN WELLNESS COMMITTEE

**11.11-1 COMPOSITION**

The physician wellness committee shall be composed of at least three (3) medical staff members, one (1) of whom should be a psychiatrist whenever feasible. Insofar as feasible, members of this committee shall not actively participate on other peer review, corrective action ad hoc committee, or quality improvement committees while serving on this committee.

Additionally, in order to facilitate open communication about provider wellness, meetings of the physician wellness committee will be limited to the medical staff members of that committee and other participants will be included by invitation of the chair of the committee only.

**11.11-2 DUTIES**

The committee shall:

(a) Consider general matters related to the health and well-being of medical staff members and, with the approval of the medical executive committee or chief of staff, develop educational programs or staff events for promoting well-being.

(b) Educate staff on illness and impairment recognition issues specific to physicians.

(c) Review, evaluate, and make recommendations as appropriate or otherwise required by the bylaws:

(1) Voluntary disclosures to the committee by members or other practitioners regarding their health status;

(2) Health status referrals or reports from the chief of staff or other medical staff officer or committee regarding a member; and

(3) Responses from applicants concerning physical or mental disabilities.

(d) Investigate any applicant, member, or other practitioner who has or may have physical or mental disability that may affect the practitioner's capability to exercise the privileges applied for and/or held by the practitioner in a manner that meets the patient care quality standards of the district and the medical staff. An investigation may include any or all of the following steps:

(1) Ascertain the health status of the practitioner through committee interview;

(2) Medical examination by an appropriate healthcare professional to evaluate whether the practitioner has a physical or mental disability or other health problem that may affect patient care;

(3) Evaluate the effects of the health status on the practitioner's capability to exercise privileges applied for or held by the practitioner, and when relevant with respect to a qualified physical or mental disability under applicable law, assess if and how reasonable accommodations can be made;

(4) Provide advice, counseling, or referrals as appropriate.

The activities of the physician wellness committee shall be confidential. However, if the committee receives information that demonstrates that the health or impairment of a practitioner may pose a risk of harm to patients, self or others, that information shall be referred to the chief of staff or the medical executive committee. This committee is not disciplinary in nature and does not preclude other review mechanisms as set forth in these bylaws.

### 11.11-3 MEETINGS, REPORTING AND MINUTES

The physician wellness committee shall meet as often as necessary, but at least quarterly. It shall maintain only such records of its proceedings as it deems advisable and consistent with confidentiality concerns, and shall routinely report on its activities to the medical executive committee.

## 11.12 UTILIZATION REVIEW AND MEDICAL RECORDS COMMITTEE

### 11.12-1 COMPOSITION

The utilization review and medical records committee shall consist of at least three (3) medical staff members. Representatives from quality, utilization review, nursing, billing, medical records, and social services shall be invited as non-voting members.

### 11.12-2 DUTIES

The utilization review and medical records committee shall perform the following functions:

(a) Delineate the scope of utilization review provided within the district;

(b) Develop critical indicators to be used as screening devices in reviewing the utilization of district services;

(c) After cases have been isolated using the critical indicators, evaluate utilization of services administered and identify areas for improvement, if necessary;

(d) Review patient care services to ascertain if utilization of services within the standards of the district and medical staff are being provided in the most cost-effective manner, address overutilization, underutilization, and inefficient scheduling of care and resources;

(e) Review diagnoses, problems, procedures and the practices of practitioners that appear to have utilization-related problems, and examine relevant quality assurance findings and interface with the practitioners as deemed necessary or appropriate;

(f) Determine appropriate action to be taken with respect to identified utilization and other patient care problems, and report such matters to the medical executive committee and the quality improvement committee;

(g) Refer problems which cannot reasonably be resolved at the committee level to the appropriate committee;

(h) Develop, implement, and maintain such Utilization Review Plan as approved by the medical executive committee and district board; and

(i) Comply with applicable federal and state regulations.

### 11.12-3 MEETINGS

The utilization review and medical records committee shall meet at least quarterly. The committee shall report a summary of its activities or findings to the medical executive committee on a regular basis. The committee shall also give notification to the medical executive committee promptly after the committee receives notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

## 11.13 DEPARTMENTAL COMMITTEES

### 11.13-1 COMPOSITION

The departmental committees can represent a single clinical department or a combination of clinical departments. The departmental committees shall be composed of at least three (3) practitioners from the represented departments that are designated as core committee members. The majority of core committee members must be physicians. The chair may also be a core committee member.

Core committee members will be designated by the chair of the departmental committee following consultation with the committee members. Core committee members have the duty to attend all meetings of the department, unless excused for good reason by the chair of the committee.

Additional committee members may be assigned as needed to represent all disciplines of the department at regularly scheduled meetings. All practitioners are encouraged to attend their departmental committees, even if not designated as a core member of the committee.

(a) Emergency Services Committee

The emergency services committee shall represent all medical services provided in the emergency department. In addition, the emergency room nurse manager and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(b) Inpatient Medicine Committee

The inpatient medicine committee represents the adult medical services provided in the medical/surgical and intensive care unit departments. At least one core member of the committee shall be a hospitalist. The medical/surgical nurse manager and the administrator (or designee), as well as representatives from the respiratory therapy, physical therapy, dietary, and pharmacy departments shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(c) Outpatient Medicine Committee

The outpatient medicine committee represents the outpatient services including family medicine, internal medicine, outpatient infusion department, and other outpatient medicine departments not represented by other committees. The clinical nurse manager, a

representative from the outpatient infusion department, and the administrator (or designee) shall be non-voting ex-officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(d) Perinatal/Pediatrics Committee

The perinatal/pediatrics committee shall represent the pediatric and obstetrical departments. The nurse managers of the perinatal and pediatrics units and the administrator (or designee) shall be ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(e) Radiology Services Committee

The radiology committee represents the radiology services. The director of diagnostic services and the administrator (or designee) shall be non-voting ex officio members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

(f) Surgery/Tissue/Transfusion/Anesthesia Committee

The surgery, tissue, transfusion and anesthesia (STTA) committee represents all surgical, anesthesia, and pathology services. The director of perioperative nursing and the administrator (or designee) shall serve as ex-officio non-voting members. Other departments may participate as needed by invitation. As available, the administrator shall designate a district quality representative to this committee in a non-voting capacity.

**11.13-2 DUTIES**

The medical staff departmental committees listed in Section 11.13-1 are responsible for overseeing the quality and appropriateness of patient care rendered in the department by, without limitation:

(a) Using critical indicators to conduct concurrent and retrospective peer review of medical records with referral for committee review as indicated;

(b) Monitoring and evaluating clinical performance of all privileged practitioners attending patients or administering care in the department;

(c) Periodically reviewing and evaluating the medical services provided;

(d) Making recommendations concerning matters for which the committee is responsible to the medical executive committee, the quality improvement committee and the administrator or chief medical officer as appropriate;

(e) Reviewing applicants for privileges when requested by the department chief;

(f) Electing annually the departmental committee chair, who presides over the meetings and attends the medical executive committee meetings. This departmental committee chair may or may not be the chief of the department; and

(g) Receiving reports from other committees as appropriate.

**11.13-3 MEETINGS AND REPORTS**

The medical staff departmental committees shall meet at least quarterly. The committees shall report a summary of their activities or findings to the medical executive committee and quality improvement committee on a regular basis. The committees shall also give notification to the medical executive committee promptly after the committees receive notice of any matter for which a practitioner is required to give notice to the medical staff pursuant to these bylaws, if not already reported.

## ARTICLE XII: MEETINGS

### 12.1 GENERAL MEDICAL STAFF MEETINGS

#### 12.1-1 REGULAR MEETINGS

Regular meetings of the medical staff members shall be held each quarter. The date, place and time of the regular meetings shall be determined by the medical executive committee, and adequate notice shall be given to the members.

#### 12.1-2 AGENDA

The order of business at a meeting of the medical staff shall be determined by the chief of staff and medical executive committee. The agenda shall include, as applicable:

(a) reading and acceptance of the minutes of the last regular and all special meetings held since the last regular meeting;

(b) administrative reports from the chief of staff, departments, and committees, chair of the quality improvement committee, and the administrator or designee;

(c) election of officers when required by these bylaws;

(d) old business; and

(e) new business.

#### 12.1-3 SPECIAL MEETINGS

Special meetings of the medical staff may be called at any time by the chief of staff or the medical executive committee, or shall be called upon the written request of ten percent (10%) of the members of the active medical staff. The person calling or requesting the special meeting shall state the purpose of such meeting in writing. The meeting shall be scheduled as soon as reasonably possible, but within thirty (30) days after receipt of such request. Notice shall be given to the members of the staff with as much advance notice as possible, which includes the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting.

### 12.2 COMMITTEE AND DEPARTMENT MEETINGS

#### 12.2-1 REGULAR MEETINGS

Except as otherwise specified in these bylaws, the chairs of medical staff and departmental committees may establish the times for the holding of regular meetings. The chairs shall make every reasonable effort to ensure the meeting dates are disseminated to the members with adequate notice.

#### 12.2-2 SPECIAL MEETINGS

A special meeting of any medical staff committee or department may be called by the chair thereof, the medical executive committee, or the chief of staff.

## 12.3 QUORUM

### 12.3-1 GENERAL MEDICAL STAFF MEETINGS

The presence of fifty percent (50%) of the total members of the active medical staff at any regular or special meeting in person or through written (electronic) ballot shall constitute a quorum for the purpose of the election or removal of medical staff officers, or other special votes as determined by the chief of staff. The presence of twenty-five percent (25%) of members shall constitute a quorum for all other actions.

### 12.3-2 DEPARTMENT AND COMMITTEE MEETINGS

A quorum of fifty percent (50%) of the voting members shall be required for medical executive and credentials committee meetings. For all other medical staff and department committees, a quorum shall consist of all three core members or substitutes as appointed by the departmental chair (in accordance with Section 11.13-1).

## 12.4 VOTING AND MANNER OF ACTION

### 12.4-1 VOTING

Unless otherwise specified in these bylaws, only members of the active medical staff may vote in medical staff general meetings and elections. All members of the medical staff and APP staff are entitled to vote at committee and department meetings appropriate to their specialty as described at time of appointment.

### 12.4-2 MANNER OF ACTION

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. A meeting at which a quorum is initially present may continue to transact business notwithstanding the withdrawal of members, if any action taken is approved by at least a majority of the required quorum for such meeting, or such greater number as may be specifically required by these bylaws. A meeting in which a quorum is not initially present may be started, though no action may be taken until a quorum is present. Committee and medical staff action may be conducted by telephone conference or other electronic communication. Votes collected by electronic means require a majority vote to be valid.

## 12.5 MINUTES

Except as otherwise specified herein, minutes of meetings shall be prepared and retained. They shall include, at a minimum, a record of the attendance of members and the vote taken on significant matters.

## 12.6 ATTENDANCE REQUIREMENTS

### 12.6-1 REGULAR ATTENDANCE

Members are expected to attend all meetings of the medical staff and of the department or committee to which assigned. Attendance via telephone conference or other electronic communication shall be accepted. Each member of the consulting or courtesy staff shall be required to attend such meetings as may be determined by the medical executive committee.

### 12.6-2 ABSENCE FROM MEETINGS

Any member who is compelled to be absent from any medical staff, department, or committee meeting shall promptly provide to the regular presiding officer thereof the reason for such absence. Unless excused for good cause by the presiding officer of the department or committee, or the medical staff office for medical staff meetings, failure to attend may be included in the practitioner's ongoing professional practice evaluation, reviewed by the medical executive committee, and may be grounds for removal from such committee or for corrective action.

### 12.6-3 SPECIAL ATTENDANCE

At the discretion of the chair or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular department or committee meeting, the member may be requested to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given at least seven (7) days prior to the meeting and shall include the time and place of the meeting and a general indication of the issue involved. Failure of a member to appear at any meeting to which notice was given, unless excused by the medical executive committee upon a showing of good cause, shall be a basis for corrective action.

## 12.7 CONDUCT OF MEETINGS

Unless otherwise specified, meetings shall be conducted according to Robert's Rules of Order; however, technical or non-substantive departures from such rules shall not invalidate action taken at such a meeting.

## 12.8 EXECUTIVE SESSION

The chairperson of any standing, special, or ad hoc committee of the medical staff, including departments, may call an executive session meeting. Only members of the active medical staff holding voting privileges on the committee shall attend the executive session meeting. The chairperson, at his or her discretion, may request other individuals to attend the meeting in an informational capacity. Executive session may be called to discuss peer review issues, personnel issues, or any other sensitive issues requiring confidentiality.

## ARTICLE XIII: CONFIDENTIALITY, IMMUNITY AND RELEASES

### 13.1 AUTHORIZATION AND CONDITIONS

By applying for or exercising clinical privileges within Northern Inyo Healthcare District, an applicant:

(a) authorizes representatives of the district and the medical staff to solicit, provide, and act upon information bearing upon, or reasonably believed to bear upon, the applicant's professional ability and qualifications;

(b) authorizes persons and organizations to provide information concerning such practitioner to the medical staff;

(c) agrees to be bound by the provisions of this Article and to waive all legal claims against any representative of the medical staff or the district who would be immune from liability under Section 13.3 of this Article; and

(d) acknowledges that the provisions of this Article are express conditions to an application for medical staff membership, the continuation of such membership, and to the exercise of clinical privileges at this district.

### 13.2 CONFIDENTIALITY OF INFORMATION

#### 13.2-1 GENERAL

The minutes, files, records and proceedings of the medical staff and all departments and standing or ad hoc committees, including information regarding any applicant, member or other individual exercising clinical privileges or practice privileges, shall be considered medical staff minutes or records and, to the fullest extent permitted by law, shall be confidential and protected from discovery pursuant to California Evidence Code Section 1157 and any other applicable peer review or other policy or privilege. This information shall become part of the medical staff committee files and shall not become part of any patient files, general district records, or any member's personal or office files.

Dissemination of such information and records shall only be made where expressly required by law, as authorized by these bylaws, or pursuant to officially adopted policies of the medical staff or, where no officially adopted policy exists, only with the express approval of the chief of staff and the administrator.

#### 13.2-2 BREACH OF CONFIDENTIALITY

As effective peer review and consideration of the qualifications of medical staff members and applicants to perform specific procedures must be based on free and candid discussions, any breach of confidentiality of the discussions or deliberations of medical staff departments or committees, except in conjunction with other hospital, professional society, or licensing authority, is outside appropriate standards of conduct for this medical staff, violates the medical staff bylaws, and will be deemed disruptive to the operations of the district. If it is determined that such a breach has occurred, the medical executive committee may undertake such corrective action as it deems appropriate.

### 13.2-3 ACCESS TO AND RELEASE OF CONFIDENTIAL INFORMATION

All requests for access to medical staff records, including confidential committee records and credential files, shall be presented to an authorized representative. Authorized representatives include the authorized medical staff office personnel and medical staff officers.

(a) Access for Official Purposes

(1) The following individuals may access medical staff records, including confidential committee records and credentials files, to the extent described:

i. Committee members and their authorized representatives, for the purpose of conducting authorized committee functions.

ii. Medical staff and department officials, and their authorized representatives, for the purpose of fulfilling any authorized function of such official.

iii. The administrator, the board of directors, and their authorized representatives, for the purpose of enabling them to discharge their lawful obligations and responsibilities. Information which is disclosed to the board of directors or its appointed representatives shall be maintained as confidential.

iv. Consultants or attorneys engaged by the district may be granted access to credential files that are necessary to enable them to perform their functions, if an authorized medical staff representative agrees.

v. Representatives of licensure agencies, accreditation agencies, or auditors from Medicare or Medicaid, if an authorized representative is with them.

(2) All subpoenas pertaining to medical staff records, including confidential committee records and credentials files, shall be referred to the medical staff office, who shall first consult with the administrator, the chief of staff, and legal counsel regarding appropriate response.

(b) Limits on Access to Practitioner's Credentials File

(1) A practitioner can view the contents of his or her credentials file, as described below, during normal business hours upon reasonable prior request to the chief of staff or medical staff officer. The individual only has the right to review and receive a copy of documents provided by or addressed personally to the individual practitioner. The medical staff has discretion to disclose other documents to a member, but in no case shall copies of confidential letters of reference, hospital verifications or other confidential correspondence be disclosed. An individual practitioner may review the above identified parts of his or her credentials file under the following circumstances:

i. Review of the credentials file is accomplished in the presence of one of the following: authorized medical staff office personnel, officer of the medical staff, a member of the credentials committee, or department chief.

ii. The practitioner understands that he or she may not remove any items from the credentials file.

iii. The practitioner understand that, subject to review by the chief of staff, he or she may add an explanatory note or other document to the file.

iv. The practitioner understands that he or she may not review confidential letters of reference, hospital verifications or other confidential correspondence received by the district or the medical staff.

v. Documents provided by the practitioner for inclusion in the credentials file (e.g., Curriculum Vitae, licenses, insurance policy, continuing medical education) may be photocopied. No other items may be photocopied without the express permission of the credentials chair.

(c) Medical Staff Committee Files and Minutes

(1) Any member shall be allowed access to minutes or other medical staff records which describe meetings or activities of the medical staff committees that they were entitled to attend (e.g. their department committees of which they are members). This does not include minutes or records of meeting or activities from which the practitioner was specifically excluded.

## 13.3 IMMUNITY FROM LIABILITY

### 13.3-1 FOR ACTION TAKEN

Each representative of the medical staff and district shall 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 district.

### 13.3-2 FOR PROVIDING INFORMATION

Each representative of the medical staff and district and all third parties shall 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 district 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 district.

## 13.4 ACTIVITIES AND INFORMATION COVERED

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

(a) application for appointment, reappointment, or clinical privileges;

(b) corrective action;

(c) hearings and appellate reviews;

(d) utilization reviews;

(e) other department, committee or medical staff 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 organization, the Medical Board of California, and similar queries and reports.

**13.5 RELEASES**

Each applicant or member shall, upon request of the medical staff or district, execute general and specific releases in accordance with the express provisions and general intent of this Article. Execution of such releases shall not be deemed a prerequisite to the effectiveness of this Article.

**13.6 INDEMNIFICATION**

Northern Inyo Healthcare District shall indemnify, defend and hold harmless the medical staff, its individual members, and its appointed representatives (e.g. expert witnesses, lay committee members, hearing officers) from and against losses and expenses (including attorneys' fees, judgments, settlements, and all other costs, direct or indirect) incurred or suffered by reason of or based upon any threatened, pending or completed action, suit, proceeding, investigation, or other dispute relating or pertaining to any alleged act or failure to act within the scope of peer review, quality assessment, or activities related to establishing standards, policies and/or procedures pursuant to the self-governing medical staff provisions, including, but not limited to:

(a) as a member of or witness for a medical staff department, service, committee or hearing panel;

(b) as a member of or witness for the district board or any district task force, group, or committee, and;

(c) as a person providing information to any medical staff or hospital group, officer, board member or employee for the purpose of aiding in the evaluation of the qualifications, fitness or character of a medical staff member or applicant.

The medical staff or member may seek indemnification for such losses and expenses under this bylaws provision, statutory and case law, any available liability insurance or otherwise as the medical staff or member sees fit, and concurrently or in such sequence as the medical staff or member may choose. Payment of any losses or expenses by the medical staff or member is not a condition precedent to the district's indemnification obligations hereunder. In no event will the district indemnify an indemnitee for acts or omissions taken in bad faith or in pursuit of the indemnitee's private economic interests.

## ARTICLE XIV: GENERAL PROVISIONS

### 14.1 DUES OR ASSESSMENTS

The medical executive committee shall have the power to recommend the amount of annual dues or assessments, if any, for each category of medical staff membership, subject to the approval of the medical staff, and to determine the manner of expenditure of such funds received.

Failure of a member to pay dues or assessments, without good cause as determined by the medical executive committee, will be included in the member's ongoing professional practice evaluation and may be grounds for corrective action.

### 14.2 AUTHORITY TO ACT

Any member or members who act in the name of this medical staff without proper authority shall be subject to such disciplinary action as the medical executive committee may deem appropriate.

### 14.3 DIVISION OF FEES

Any division of fees by members of the medical staff is forbidden and any such division of fees shall be cause for exclusion or expulsion from the medical staff.

### 14.4 NOTICES

Except where specific notice provisions are otherwise provided in these bylaws, any and all notices, demands, requests required or permitted to be mailed shall be in writing properly sealed, and shall be sent through United States Postal Service. An alternative delivery mechanism may be used if it is reliable, as expeditious, and if evidence of its use is obtained. Notice to the medical staff or officers or committees thereof, shall be addressed as follows:

Name and proper title of addressee
Name of department or committee
*[c/o medical staff office, chief of staff]*
Hospital name
Street address
City, State, Zip code

Mailed notices to a member, applicant or other party shall be to the addressee at the address as it last appears in the official records of the medical staff or district.

### 14.5 DISCLOSURE OF INTEREST

All nominees for election or appointment to medical staff offices, department chief, or the medical executive committee shall, at least twenty (20) days prior to the date of election or appointment, disclose in writing to the medical executive committee those personal, professional, or financial affiliations or relationships of which they are reasonably aware which could foreseeably result in a conflict of interest with their activities or responsibilities on behalf of the medical staff. Further information on conflict of interest may be found in Northern Inyo Healthcare District's compliance program.

### 14.6 RETALIATION PROHIBITED

Neither the medical staff, its members, committees or department heads, the board of directors, its chief executive officer, or any other employee or agent of the district or medical staff, may engage in any punitive or retaliatory action against any member of the medical staff because that member claims a right or privilege afforded by, or seeks implementation of any provision of, these medical staff bylaws.

## ARTICLE XV: ADOPTION AND AMENDMENT OF BYLAWS AND POLICIES

### 15.1 BYLAWS

#### 15.1-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the bylaws may be initiated by either of the following methods:

(a) The medical executive committee, with the recommendation of the bylaws committee, or on its own motion, may recommend adoption, amendment or repeal of the bylaws to the voting members of the medical staff as provided in this Article.

(b) The members of the active staff, by a written petition signed by at least twenty percent (20%) of the active staff members, may petition the medical executive committee to initiate a proposal to adopt, amend or repeal the bylaws. Such petition shall identify exact language to be added, changed or deleted. If the medical executive committee agrees with the proposed change, it may recommend the change as provided in subsection (a), above.

#### 15.1-2 APPROVAL BY THE ACTIVE STAFF

If a proposal is initiated as provided above, the chief of staff shall inform the members of the active staff, by mail or by electronic means, of the proposed change. Not less than thirty (30) days and not more than ninety (90) days from the date of such notice, the chief of staff shall either call a special meeting of the medical staff or add it to the agenda of a regular meeting to consider the proposed change.

To be adopted, a proposed change must be approved by a majority of the members of the active staff voting in person or by written ballot. If a written ballot is used, the ballots shall be opened and counted at the meeting and the results shall be announced.

#### 15.1-3 APPROVAL BY THE DISTRICT BOARD

Upon action by the active staff as provided above, the proposed change shall be submitted to the board of directors for approval. The board of board of directors may not unreasonably withhold its approval from the active staff's recommended change. If the board of directors votes to disapprove any part of the recommended change, the board of directors shall give the chief of staff written notice of the reasons for non-approval within ten (10) business days from the board of directors' action. At the request of the medical executive committee, the board of directors' disapproval shall be submitted to the Joint Conference Committee for resolution.

### 15.2 MEDICAL STAFF POLICIES

#### 15.2-1 PROCEDURE FOR PROPOSALS

Proposals to adopt, amend or repeal the medical staff policies may be initiated by any active medical staff member or medical staff committee.

### 15.2-2 APPROVAL

(a) Approval by the appropriate medical staff committee(s), as applicable;

(b) Approval by the medical executive committee;

(c) Approval by the active medical staff; and

(d) Submission to the board of directors for approval. If the board of directors disapproves the policy, it will be referred back to the appropriate committee(s).

## 15.3 TECHNICAL AND EDITORIAL AMENDMENTS

Notwithstanding any other provision of the bylaws to the contrary, the medical executive committee shall have authority on behalf of the medical staff to approve such amendments to the bylaws or policies as the medical executive committee deems to be necessary or appropriate to correct or clarify punctuation, spelling, grammatical or expression errors or ambiguities; cross references; numbering or organization; names or titles of committees, officers, practitioner categories, or other such identifiers. The medical executive committee shall give notice of such amendments to the medical staff members, the administrator, and the district board. Such amendments shall become effective upon approval by the district board.

## 15.4 DISTRIBUTION OF APPROVED PROPOSALS

Promptly after approval, and if reasonably practical, prior to the proposal's effective date, a copy of an approved proposal for bylaws or policies changes shall be distributed to all members, applicants, and other privileged practitioners and APPs who hold any type of privileges pursuant to the bylaws.

ADOPTED by the medical staff on

_____, 20_____
Date

_____
Chief of Staff

_____
Vice Chief of Staff

APPROVED by the board of directors on

_____, 20_____
Date

_____
President

_____
Secretary

| | |
|---|---|
| CALL TO ORDER | The meeting was called to order at 5:30 pm by Robert Sharp, District Board Chair. |
| PRESENT | Robert Sharp, Chair<br>Jody Veenker, Vice Chair<br>Mary Mae Kilpatrick, Secretary<br>Topah Spoonhunter, Treasurer<br>Jean Turner, Member-at-Large<br>Kelli Davis MBA, Interim Chief Executive Officer and Chief Operating Officer<br>William Timbers MD, Interim Chief Medical Officer<br>Allison Partridge RN, MSN, Chief Nursing Officer<br>Charlotte Helvie MD, Chief of Staff<br>Keith Collins, General Legal Counsel (Jones and Mayer) |
| OPPORTUNITY FOR PUBLIC COMMENT | Mr. Sharp announced that the purpose of public comment is to allow members of the public to address the Board of Directors. Public comments shall be received at the beginning of the meeting and are limited to three (3) minutes per speaker, with a total time limit of thirty (30) minutes being allowed for all public comment unless otherwise modified by the Chair. Speaking time may not be granted and/or loaned to another individual for purposes of extending available speaking time unless arrangements have been made in advance for a large group of speakers to have a spokesperson speak on their behalf. Comments must be kept brief and non-repetitive. The general Public Comment portion of the meeting allows the public to address any item within the jurisdiction of the Board of Directors on matters not appearing on the agenda. Public comments on agenda items should be made at the time each item is considered. No comments were heard. |
| NEW BUSINESS | Mr. Sharp opened the meeting by thanking all Northern Inyo Healthcare District (NIHD) staff and Medical Staff for their continued hard work, dedication, and unwavering commitment during the Covid-19 pandemic. |
| CHILLER PLANT UPGRADE | NIHD Facilities Director Scott Hooker and Louis Varga with Colombo Construction provided an update on the Northern Inyo Hospital chiller plant upgrade construction project. The existing chiller plant is being re-engineered to create a higher quality longer-lasting system, and the cost of the project is estimated to be $822,328, a significant increase over the $250,000 previously budgeted for the current fiscal year. Following review of the information provided and discussion of the importance of the cooling system to hospital operations, it was moved by Jody Veenker, seconded by Jean Turner, and unanimously passed to approve the chiller plant upgrade for an estimated cost of $822,328. Director Spoonhunter noted the importance of having legal counsel specializing in construction agreements review the District's capital construction |

contracts, and Interim Chief Executive Officer Kelli Davis, MBA stated that District leadership will help to ensure that the appropriate legal reviews take place. It was additionally noted that the chiller plant upgrade proposal is not a guaranteed maximum price agreement.

VMG HEALTH INTRODUCTION

Chief Medical Officer William Timbers, MD introduced Anthony Domanico with VMG Health, who provided an overview of services the company currently provides for NIHD. VMG provides financial valuation advisory services, and the company is currently assisting the District in reviewing physician and provider contracts in order to ensure that they are in compliance with Fair Market Value (FMV) laws and requirements. The Board thanked Doctor Timbers for assisting the District with this difficult task, expressing their full support of the work being done and acknowledging that it will help to ensure that all NIHD physician and provider agreements are fair and equitable going forward.

FORMATION OF SUBCOMMITTEE TO ADDRESS PHYSICIAN COMPENSATION

Doctor Timbers called attention to the possibility of developing a subcommittee to address physician compensation and to assist in developing a fair and equitable provider compensation model that is based on service provided as well as the quality of that service provided. The subcommittee would ideally be made up of multi-disciplinary members including NIHD Chiefs; Medical Staff; Compliance; Human Resources; Board members; and a brain trust of other appropriate departments. It was moved by Ms. Turner, seconded by Mary Mae Kilpatrick, and unanimously passed to approve the formation of a subcommittee to address physician compensation, and to appoint directors Veenker and Sharp to represent the NIHD Board of Directors on that subcommittee.

HUMAN RESOURCES DEPARTMENT UPDATE

Ms. Davis respectfully requested that the Human Resources (HR) update listed on the agenda for this meeting be tabled to the February regular meeting, in order to allow time for a more detailed HR model to be presented. The Board agreed to the request to table this agenda item.

APPROVAL OF COVID VACCINATION FINANCIAL POLICY

Chief Nursing Officer Allison Partridge RN, MSN, called attention to a proposed policy titled *Covid Vaccination Financial Policy*, the purpose of which is to help ensure the expedient, equitable, and efficient administration of the Covid-19 vaccine during the current public health crisis. The proposed policy includes specification regarding administering of the vaccine to all vaccine-eligible individuals regardless of their ability to pay, in accordance with federal guidelines. It was moved by Ms. Veenker, seconded by Topah Spoonhunter, and unanimously passed to approve the *Covid Vaccination Financial Policy* as presented.

NIHD CHIEF EXECUTIVE OFFICER SEARCH

Ms. Davis called attention to the need to begin discussion on the selection of the District's next permanent Chief Executive Officer (CEO), in light of the fact that her Interim CEO agreement will expire in the month of June. The Board indicated their preference for re-establishing a CEO

Search Ad Hoc Committee to begin the Request for Proposals (RFP) process for selection of a CEO search firm, and they acknowledged their appreciation of the outstanding job that Ms. Davis has done as Interim CEO. It was moved by Ms. Kilpatrick, seconded by Ms. Veenker, and unanimously passed to establish an Ad Hoc Committee of Board members Spoonhunter and Turner to address NIHD's permanent Chief Executive Officer search, and to begin the RFP process to select a CEO search firm.

CHIEF OF STAFF REPORT

Chief of Staff Charlotte Helvie MD reported following careful review, consideration, and approval by the appropriate Committees the Medical Executive Committee recommends approval of the following District-wide Policies and Procedures:

POLICY AND PROCEDURE APPROVALS

1. *Early Progressive Mobility Protocol*
2. *Echocardiography Use of Contrast*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve both Policies and Procedures as presented.

MEDICAL STAFF REAPPOINTMENT

Doctor Helvie additionally reported the Medical Executive Committee recommends approval of the following Medical Staff reappointment for calendar years 2021 and 2022:

1. *Mark Robinson, MD (orthopedics) – Active Staff*

It was moved by Ms. Kilpatrick, seconded by Ms. Turner, and unanimously passed to approve the reappointment of Mark Robinson MD for calendar years 2021 and 2022 as requested.

MEDICAL EXECUTIVE COMMITTEE MEETING REPORT

Doctor Helvie additionally reported that Medical Staff Committees continue to meet to help ensure the quality of patient care within the District, including the Infection Control Committee; the Pharmacy and Therapeutics Committee; and the Medical Staff Bylaws Committee. She noted that the Bylaws Committee intends to bring revised Medical Staff Bylaws to the February Board of Directors meeting for approval. She additionally reported that the Medical Executive Committee has voted to establish a monthly Covid Response Hero award, and that it will choose a recipient for the award on a monthly basis. This month, the following three staff members have been chosen to receive the award, due to difficulty encountered when trying to select only one person for the honor:

- *Tracy Aspel RN, BSN, former Chief Nursing Officer*
- *Robin Christensen RN, BSN, Director of Quality and Infection Prevention*
- *Ben (Dorman) McShan, ICU RN*

Doctor Helvie additionally reported that the Medical Executive Committee has appointed Lara Jeanine Arndal MD to serve as Interim Chief of Surgical Services.

CONSENT AGENDA

Mr. Sharp called attention to the Consent Agenda for this meeting, which contained the following items:

1. *Approval of minutes of the December 16 2020 regular meeting*

2. *Interim Chief Executive Officer report*
3. *Interim Chief Medical Officer report*
4. *Chief Nursing Officer report*
5. *Financial and Statistical reports as of November 30, 2020*
6. *Cerner Implementation update*
7. *Policy and Procedure annual approvals*

It was moved by Ms. Veenker, seconded by Mr. Spoonhunter, and unanimously passed to approve all seven (7) Consent Agenda items as presented.

BOARD MEMBER COMMITTEE UPDATES

Mr. Sharp reported that the Ad Hoc Committee established for the purpose of reviewing the NIHD Medical Staff Bylaws recently met and agreed upon a Bylaws version that will be presented for approval at the February regular meeting. He additionally thanked the Medical Staff, Dr. Timbers, and Dr. Helvie for their countless hours of work dedicated to the Bylaws revision effort. Director Kilpatrick reported that she recently attended a meeting of the NIHD Quality Committee, and also requested that the minutes of the meetings of the NIHD Ad Hoc Committee and Medical Staff members be reviewed in greater detail at the February Board of Directors meeting, requesting that minutes from those meetings which were attended by Dr. Helvie to be reviewed first. No other updates were heard.

BOARD MEMBER REPORTS

Director Turner reported that the Association of California Healthcare Districts (ACHD) will offer a virtual Harassment Prevention training that will be available to members of the Board, and she encouraged Board members to register for the class. Director Kilpatrick expressed her heartfelt appreciation of the outpouring of support and kindness extended to her following the passing of her husband, Chuck Kilpatrick.

ADJOURNMENT TO CLOSED SESSION

At 6:49 pm Mr. Sharp reported the meeting would adjourn to Closed Session to allow the District Board of Directors to:

A. Conduct a Public Employee Performance Evaluation (*pursuant to Government Code Section 54957(b*)), Title: Interim Chief Executive Officer.
B. Discuss significant exposure to litigation (*pursuant to paragraph (2) of subdivision (d) of Government Code Section 54956.9*), three cases.

RETURN TO OPEN SESSION AND REPORT OF ACTION TAKEN

At 9:02 pm the meeting returned to Open Session. Mr. Sharp reported that the Board took no reportable action.

ADJOURNMENT

The meeting adjourned at 9:02 pm.

_____
Robert Sharp, Chair

Attest: _____
Mary Mae Kilpatrick, Secretary

**Pioneer**
**Home Health Care, Inc.**
162 East Line Street Bishop, CA 93514 760/872-4663 Fax 760/872-4665

February 5, 2021

Dear NIHD Board Members,

Attached is a summary of our services provided, revenue received and costs during the year of 2020. Additionally, I've included some comparison information to prior years.

Thank you for your support.

Sincerely,

Ruby Allen, RN, Administrator

# Pioneer Home Health Care, Inc.
# 2020 Revenue and Expenses Report

## Revenue

**Home Health Care Program**

Medicare PDGM - based on 80% of admissions

Insurances, Worker's Comp, Private Pay - based on 20% of admissions

| | | |
|---|---|---|
| • Representing 310 total admissions and 2076 total visits | 1,138,847.90 | |
| • Travelled 37,888 miles | | |
| | **$ 1,138,847.90** | |

**Hospice Program**

| | | |
|---|---|---|
| • Representing 30 admissions and 1781 patient days of care | 274,438.56 | |
| • Travelled 8,504 miles | | |
| | **$ 274,438.56** | |

**Personal Care Program**

| | | |
|---|---|---|
| • Representing 19,702 hours of home aide care | $ 484,944.70 | |
| | **$ 484,944.70** | |

**Other One-Time Revenue**

| | | |
|---|---|---|
| • Cares Act | 43,966.30 | |
| • Paycheck Protection Program | 290,951.00 | |
| • NIHD February and March Support | 220,000.00 | |
| | **$ 554,917.30** | |
| **Total Revenue** | | **$ 2,453,148.46** |

## Expenses

**DIRECT EXPENSES**

| | | |
|---|---|---|
| Direct Salaries | 744,843.35 | |
| Direct Payroll Taxes | 63,155.56 | |
| Direct Benefits | 112,934.33 | |
| Direct Transportation @ .50 cents per mile | 22,440.00 | |
| Contracted Therapy Services from NIHD | 27,332.95 | |
| Billable Medical Supplies | 2,177.58 | |
| **TOTAL Direct Expenses** | **972,883.77** | |

**INDIRECT EXPENSES**

| | | |
|---|---|---|
| Indirect Salaries | 458,513.18 | |
| Indirect Payroll Taxes | 35,379.83 | |
| Indirect Benefits | 67,883.85 | |
| Indirect Transportation | 1,108.96 | |
| Operational Costs | 278,099.54 | |
| Mortgage Principle | 4,846.74 | |
| **TOTAL Indirect Expenses** | **840,985.36** | |
| **Total Expenses** | | **$ 1,813,869.13** |

**Total Net** **$ 634,432.59**

# Pioneer Home Health Care
## 2020 Home Health Visit Totals

### Home Health Visits
through December 2020

| | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SN | 59 | 62 | 81 | 116 | 75 | 106 | 107 | 121 | 81 | 98 | 82 | 99 | 1087 |
| PT | 50 | 52 | 43 | 61 | 56 | 74 | 82 | 114 | 108 | 79 | 58 | 61 | 838 |
| OT | 7 | 5 | 6 | 8 | 14 | 4 | 10 | 4 | 9 | 14 | 9 | 8 | 98 |
| ST | 0 | 0 | 0 | 0 | 0 | 3 | 3 | 3 | 5 | 4 | 4 | 3 | 25 |
| MSW | 5 | 5 | 4 | 4 | 3 | 4 | 0 | 0 | 0 | 0 | 0 | 3 | 28 |
| CHHA | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Totals | **121** | **124** | **134** | **189** | **148** | **191** | **202** | **242** | **203** | **195** | **153** | **174** | **2076** |

Average visits per month = **173**

| | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2019** | 91 | 118 | 116 | 134 | 131 | 129 | 131 | 142 | 94 | 165 | 147 | 160 | **1558** |
| **2018** | 61 | 75 | 71 | 107 | 73 | 49 | 73 | 120 | 93 | 160 | 138 | 93 | **1113** |
| **2017** | 104 | 86 | 72 | 88 | 63 | 65 | 70 | 84 | 53 | 75 | 61 | 49 | **870** |
| **2016** | 143 | 117 | 161 | 139 | 126 | 138 | 98 | 87 | 92 | 67 | 87 | 78 | **1333** |
| **2015** | 144 | 180 | 164 | 154 | 170 | 174 | 197 | 144 | 127 | 124 | 130 | 101 | **1809** |
| **2014** | 211 | 210 | 172 | 143 | 170 | 143 | 217 | 172 | 191 | 153 | 140 | 139 | **2061** |
| **2013** | 213 | 178 | 195 | 207 | 152 | 226 | 133 | 138 | 211 | 260 | 185 | 192 | **2290** |
| **2012** | 134 | 173 | 196 | 219 | 201 | 175 | 158 | 160 | 156 | 195 | 197 | 149 | **2113** |
| **2011** | 199 | 239 | 230 | 152 | 203 | 215 | 199 | 169 | 200 | 184 | 159 | 177 | **2326** |
| **2010** | 243 | 193 | 228 | 185 | 226 | 209 | 172 | 195 | 151 | 189 | 219 | 231 | **2441** |
| **2009** | 237 | 193 | 237 | 170 | 179 | 233 | 256 | 196 | 172 | 178 | 154 | 203 | **2408** |
| **2008** | 177 | 159 | 145 | 156 | 172 | 202 | 216 | 154 | 208 | 184 | 199 | 205 | **2177** |
| **2007** | 146 | 119 | 135 | 134 | 124 | 99 | 157 | 118 | 137 | 121 | 138 | 169 | **1597** |

# Hospice of the Owens Valley
## 2020 Hospice Visit Totals

## Hospice Visits

through December 2020

| | Jan-20 | Feb-20 | Mar-20 | Apr-20 | May-20 | Jun-20 | Jul-20 | Aug-20 | Sep-20 | Oct-20 | Nov-20 | Dec-20 | YTD |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| SN | 26 | 20 | 27 | 18 | 19 | 20 | 19 | 14 | 16 | 11 | 4 | 15 | 209 |
| PT | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| OT | 0 | 0 | 0 | 0 | 0 | 0 | 4 | 5 | 4 | 4 | 4 | 1 | 22 |
| MSW | 4 | 1 | 2 | 2 | 4 | 1 | 0 | 0 | 0 | 0 | 0 | 2 | 16 |
| Aide | 17 | 8 | 7 | 1 | 1 | 2 | 0 | 0 | 0 | 2 | 0 | 0 | 38 |
| Chaplain | 4 | 1 | 0 | 0 | 0 | 0 | 1 | 4 | 5 | 2 | 3 | 5 | 25 |
| Bereavement | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Totals | **51** | **30** | **36** | **21** | **24** | **23** | **24** | **23** | **25** | **19** | **11** | **23** | **310** |
| | | | | | | | | Average visits per month = | | | **26.0** | | |
| **2019** | 25 | 27 | 12 | 39 | 25 | 22 | 26 | 36 | 37 | 38 | 66.0 | 62 | **415** |
| **2018** | 27 | 25 | 50 | 39 | 53 | 51 | 23 | 56 | 32 | 32 | 37.0 | 16 | **441** |
| **2017** | 2 | 9 | 0 | 0 | 0 | 20 | 15 | 24 | 21 | 12 | 24 | 19 | **146** |
| **2016** | | | | 2 | 1 | 11 | 19 | 18 | 18 | 14 | 16 | 0 | **99** |

# Home Health Referral History

for period ending 12/31/20

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2020** | 14 | 21 | 24 | 18 | 25 | 32 | 29 | 37 | 25 | 20 | 22 | 24 | 291 |
| **2019** | 16 | 21 | 19 | 15 | 17 | 19 | 14 | 20 | 12 | 22 | 23 | 16 | 214 |
| **2018** | 11 | 13 | 12 | 23 | 8 | 12 | 13 | 12 | 14 | 33 | 19 | 13 | 183 |
| **2017** | 16 | 12 | 14 | 21 | 12 | 15 | 12 | 16 | 13 | 13 | 12 | 11 | 167 |
| **2016** | 29 | 15 | 30 | 20 | 19 | 27 | 12 | 17 | 14 | 15 | 15 | 16 | 229 |
| **2015** | 22 | 27 | 19 | 27 | 21 | 30 | 26 | 21 | 17 | 18 | 18 | 18 | 264 |
| **2014** | 34 | 28 | 25 | 23 | 25 | 17 | 38 | 22 | 25 | 22 | 23 | 24 | 306 |
| **2013** | 34 | 27 | 26 | 28 | 15 | 29 | 17 | 17 | 36 | 27 | 21 | 27 | 304 |
| **2012** | 25 | 26 | 24 | 26 | 27 | 18 | 22 | 21 | 24 | 26 | 24 | 23 | 286 |
| **2011** | 26 | 25 | 34 | 22 | 26 | 33 | 26 | 22 | 23 | 16 | 21 | 23 | 297 |
| **2010** | 28 | 22 | 29 | 20 | 29 | 25 | 20 | 26 | 22 | 31 | 26 | 28 | 306 |
| | 255 | 237 | 256 | 243 | 224 | 257 | 229 | 231 | 225 | 243 | 224 | 223 | 2847 |
| **Average q mo:** | 23 | 22 | 23 | 22 | 20 | 23 | 21 | 21 | 20 | 22 | 20 | 20 | |

# Hospice Referral History

for period ending 12/31/20

| | Jan | Feb | Mar | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Totals |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **2020** | 2 | 2 | 3 | 4 | 2 | 2 | 2 | 1 | 1 | 0 | 0 | 2 | 21 |
| **2019** | 5 | 2 | 3 | 2 | 2 | 2 | 3 | 3 | 2 | 0 | 5 | 1 | 30 |
| **2018** | 3 | 5 | 0 | 2 | 5 | 1 | 3 | 4 | 0 | 3 | 5 | 3 | 34 |
| **2017** | 1 | 1 | 0 | 0 | 0 | 6 | 0 | 2 | 3 | 0 | 2 | 3 | 18 |
| **2016** | 0 | 0 | 0 | 1 | 0 | 1 | 3 | 1 | 0 | 2 | 0 | 0 | 8 |
| | 11 | 10 | 6 | 9 | 9 | 12 | 11 | 11 | 6 | 5 | 12 | 9 | 111 |
| **Average q mo:** | 2 | 2 | 1 | 2 | 2 | 2 | 2 | 2 | 1 | 1 | 2 | 2 | |

NORTHERN INYO HEALTHCARE DISTRICT

*Improving our communities, one life at a time. One Team. One*

150 Pioneer Lane
Bishop, California 93514

(760) 873-5811 Ext. 3415

DATE: February 2021

TO: Board of Directors, Northern Inyo Healthcare District

FROM: Sierra Bourne, MD

RE: Eastern Sierra Emergency Physicians (ESEP) Quarterly Report

---

**Recruitment**

Emergency and Hospitalist programs are fully staffed at this time. We continue to collect physicians interested in working in the area to avoid future gaps in staffing.

**Hospitalist Program**

**Hospital Medicine Clinic**

**Goal:**
Screen surgical patients with co-morbidities to fully optimize medical issues prior to surgery
Minimize surgery cancellations
Minimize post operative complications
Provide quick ED and hospital follow-ups for patients who are either unable to see their PCP in a timely manner or patients without a local PCP

**Logistics:**
Staffed by local hospitalists (Schunk, Jesionek, Mehrens, Engblade)

Located at Rural Health Clinic
Starting in April 2021 with 2 half days per week. Plans to expand to full days if needed, pending patient census.
Post discharge referrals to come from discharging physician in ED or inpatient – to be used when patient does not have PCP, is traveling from out of the area, or is unable to see PCP in a timely manner.

Otherwise, our Emergency Physician and Hospitalist programs are running smoothly. Thank you.

**Overview:** Billed charges are ahead of budget in December, and this is continuing the trend for FY2021.
We have yet to see the decrease in gross revenue that was expected from the impacts of COVID-19.

| | Charges | Budget |
|---|---|---|
| December 2019 | 13,880,182 | 14,095,678 |
| January 2020 | 16,271,574 | 14,095,678 |
| February 2020 | 13,886,140 | 13,186,280 |
| March 2020 | 12,141,181 | 14,095,678 |
| April 2020 | 6,887,085 | 13,640,980 |
| May 2020 | 10,687,793 | 14,095,678 |
| June 2020 | 13,443,103 | 13,640,980 |
| July 2020 | 14,939,822 | 11,862,737 |
| August 2020 | 13,989,077 | 11,533,455 |
| September 2020 | 14,652,230 | 10,715,581 |
| October 2020 | 14,539,677 | 12,487,777 |
| November 2020 | 12,978,658 | 11,166,411 |
| December 2020 | 15,139,508 | 11,863,789 |

**Gross Accounts Receivables** in Athena total $41,570,823, up from $38.95M at the end of November.
Gross Legacy AR is at $1,996,371, with most of that being uncollectible due to the age of the AR.

**Salaries and Wages** for hospital operations were up 20% from November. Some of this increase was due to PTO payouts.

| | Salaries & Wages | Cost Per Day |
|---|---|---|
| December 2019 | 2,235,031 | 72,098 |
| January 2020 | 2,169,008 | 69,968 |
| February 2020 | 2,144,412 | 73,945 |
| March 2020 | 2,306,958 | 74,418 |
| April 2020 | 1,999,126 | 66,638 |
| May 2020 | 2,082,141 | 67,166 |
| June 2020 | 2,130,598 | 71,020 |
| July 2020 | 2,244,335 | 72,398 |
| August 2020 | 2,263,144 | 73,005 |
| September 2020 | 2,142,762 | 71,425 |
| October 2020 | 2,227,959 | 71,870 |
| November 2020 | 2,161,607 | 72,054 |
| December 2020 | 2,596,191 | 83,748 |

**December 2020 Financial Results:** Revenues continued to trend higher than budget, which continued from the first five months of FY2021. Direct costs were higher than budget in December by $3.2M, (includes $1.7M of FY2021 Bad Debt Expense) but G&A costs were lower than budget by $93k.

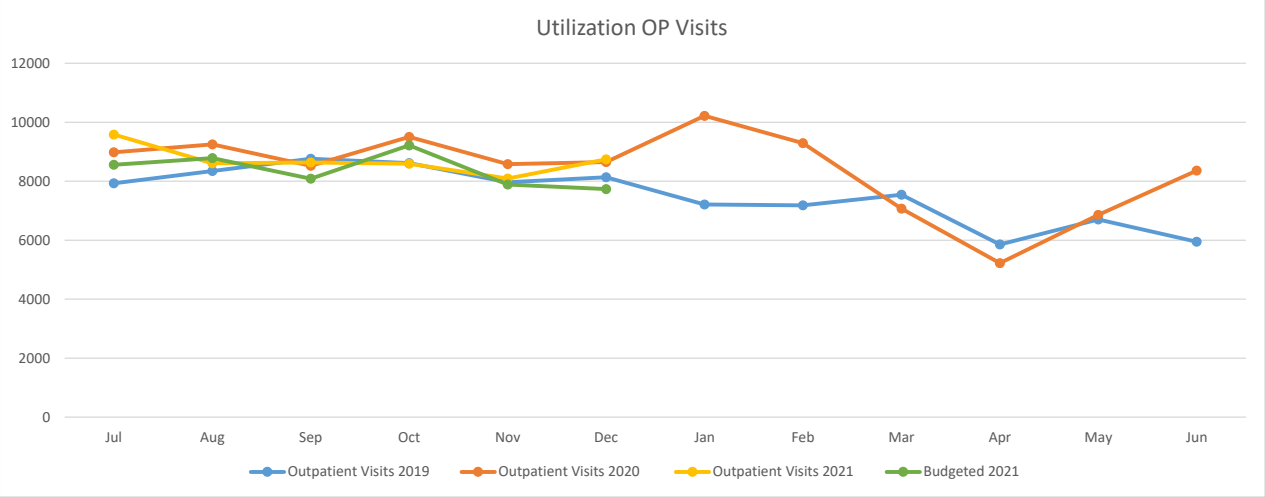
FY2021

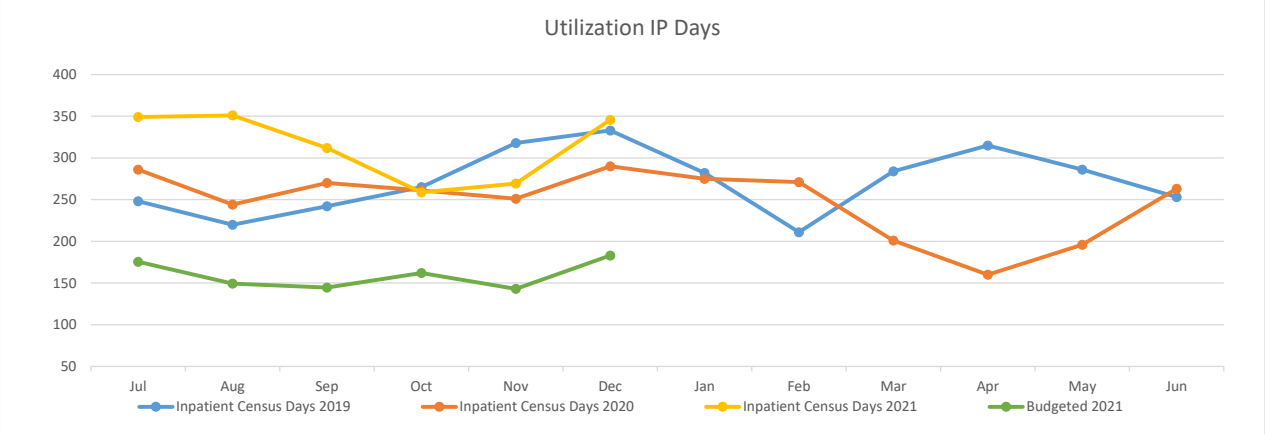
| *Unit of Measure* | July 2020 | August 2020 | September 2020 | October 2020 | November 2020 | December 2020 |
|---|---|---|---|---|---|---|
| Cash, CDs & LAIF Investments | 56,272,847 | 55,214,586 | 52,965,190 | 53,539,618 | 50,491,090 | 47,413,188 |
| Days Cash on Hand | 226 | 225 | 220 | 218 | 185 | 143 |
| | | | | | | |
| Gross Accounts Receivable | 46,949,619 | 48,287,230 | 45,195,462 | 39,988,328 | 38,951,324 | 41,570,823 |
| Average Daily Revenue | 481,930 | 466,595 | 473,708 | 472,527 | 464,702 | 468,886 |
| Gross Days in AR | 97.42 | 103.49 | 95.41 | 84.63 | 83.82 | 88.66 |
| | | | | | | |
| ***Key Statistics*** | | | | | | |
| Acute Census Days | 263 | 275 | 232 | 203 | 210 | 310 |
| Swing Bed Census Days | 42 | 44 | 34 | 8 | 20 | 8 |
| Observation Days | 44 | 32 | 46 | 48 | 39 | 28 |
| Total Inpatient Utilization | 349 | 351 | 312 | 259 | 269 | 346 |
| Avg. Daily Inpatient Census | 11.3 | 11.3 | 10.4 | 8.3 | 9.0 | 11.5 |
| | | | | | | |
| Emergency Room Visits | 691 | 639 | 581 | 624 | 516 | 504 |
| Emergency Room Visits Per Day | 22 | 21 | 19 | 20 | 17 | 16 |
| Operating Room Inpatients | 31 | 26 | 39 | 23 | 27 | 18 |
| Operating Room Outpatient Cases | 81 | 74 | 74 | 74 | 79 | 90 |
| RHC Clinic Visits | 2,670 | 2,614 | 2,535 | 2,730 | 2,490 | 2,758 |
| NIA Clinic Visits | 1,792 | 1,794 | 1,918 | 1,681 | 1,555 | 1,642 |
| Outpatient Hospital Visits | 4,431 | 3,558 | 4,139 | 3,560 | 3,531 | 3,837 |
| | | | | | | |
| ***Hospital Operations*** | | | | | | |
| Inpatient Revenue | 3,201,903 | 3,105,168 | 3,469,234 | 2,495,776 | 2,626,028 | 4,084,113 |
| Outpatient Revenue | 10,836,050 | 10,143,216 | 10,036,379 | 10,848,725 | 9,124,901 | 10,195,061 |
| Clinic (RHC) Revenue | 901,868 | 740,693 | 1,146,616 | 1,195,178 | 1,227,729 | 896,334 |
| Total Revenue | 14,939,822 | 13,989,076 | 14,652,230 | 14,539,679 | 12,978,658 | 15,175,508 |
| Revenue Per Day | 481,930 | 451,261 | 488,408 | 469,022 | 432,622 | 489,533 |
| % Change (Month over Month) | | -6.36% | 8.23% | -3.97% | -7.76% | 13.15% |
| | | | | | | |
| Salaries | 2,244,335 | 2,263,143 | 2,142,762 | 2,227,959 | 2,161,607 | 2,596,191 |
| PTO Expenses | 221,460 | 234,078 | 225,291 | 249,855 | 258,672 | 124,932 |
| Total Salaries Expense | 2,465,795 | 2,497,221 | 2,368,053 | 2,477,814 | 2,420,279 | 2,721,123 |
| Expense Per Day | 79,542 | 80,556 | 78,935 | 79,929 | 80,676 | 87,778 |
| % Change | | 1.27% | -2.01% | 1.26% | 0.93% | 8.80% |
| | | | | | | |
| Operating Expenses | 6,681,333 | 6,598,376 | 6,443,189 | 6,700,067 | 7,141,845 | 9,200,728 |
| Operating Expenses Per Day | 215,527 | 212,851 | 214,773 | 216,131 | 238,062 | 296,798 |
| | | | | | | |
| Capital Expenses | 118,728 | 243,872 | 146,626 | 47,518 | 24,398 | 47,743 |
| Capital Expenses Per Day | 3,830 | 7,867 | 4,888 | 1,533 | 813 | 1,540 |
| | | | | | | |
| Total Expenses | 8,056,147 | 7,962,211 | 7,811,638 | 7,971,619 | 8,554,701 | 10,596,071 |
| Total Expenses Per Day | 259,876 | 256,846 | 260,388 | 257,149 | 285,157 | 341,809 |
| | | | | | | |
| Gross Margin | 2,200,258 | 1,770,841 | 1,569,390 | 1,411,167 | 667,943 | (182,482) |
| | | | | | | |
| ***Debt Compliance*** | | | | | | |
| Current Ratio (ca/cl) > 1.50 | 1.51 | 1.49 | 1.47 | 1.47 | 1.53 | 1.52 |
| Quick Ratio (Cash * Net AR/cl) > 1.33 | 1.41 | 1.38 | 1.36 | 1.37 | 1.41 | 1.39 |
| Days Cash on Hand > 75 | 226 | 225 | 220 | 218 | 185 | 143 |

| | July 2020 | August 2020 | September 2020 | October 2020 | November 2020 | December 2020 |
|---|---|---|---|---|---|---|
| Total Net Patient Revenue | 8,881,591 | 8,369,217 | 8,239,709 | 8,111,234 | 7,809,788 | 9,018,246 |
| | | | | | | |
| Cost of Services | | | | | | |
| Salaries & Wages | 2,244,335 | 2,263,143 | 2,142,762 | 2,227,958 | 2,161,607 | 2,596,191 |
| Benefits | 1,285,813 | 1,444,212 | 1,418,815 | 1,486,044 | 1,593,889 | 1,473,236 |
| Professional Fees | 1,729,883 | 1,641,804 | 1,519,996 | 1,734,533 | 1,988,193 | 2,046,081 |
| Pharmacy | 176,452 | 304,490 | 373,754 | 268,114 | 229,276 | 403,646 |
| Medical Supplies | 373,322 | 237,452 | 307,119 | 362,431 | 571,269 | 284,134 |
| Hospice Operations | - | - | - | - | - | - |
| Athena EHR System | 85,401 | 86,356 | 129,219 | 145,890 | 103,674 | 89,294 |
| Other Direct Costs | 592,164 | 492,312 | 420,847 | 475,097 | 493,937 | 608,146 |
| Bad Debt | 193,962 | 128,607 | 161,285 | - | - | 1,700,000 |
| Total Direct Costs | 6,681,333 | 6,598,376 | 6,473,796 | 6,700,067 | 7,141,845 | 9,200,728 |
| | | | | | | |
| Gross Margin | 2,200,258 | 1,770,841 | 1,765,913 | 1,411,167 | 667,943 | (182,482) |
| Gross Margin % | 24.77% | 21.16% | 21.43% | 17.40% | 8.55% | -2.02% |
| | | | | | | |
| General and Administrative Overhead | | | | | | |
| Salaries & Wages | 341,944 | 326,215 | 323,043 | 340,706 | 348,981 | 335,953 |
| Benefits | 280,576 | 230,351 | 242,620 | 273,351 | 315,018 | 235,101 |
| Professional Fees | 182,344 | 187,479 | 170,202 | 172,012 | 230,120 | 263,864 |
| Depreciation and Amortization | 348,949 | 350,898 | 350,981 | 351,061 | 351,070 | 351,786 |
| Other Administrative Costs | 196,201 | 195,246 | 152,383 | 134,422 | 167,667 | 208,639 |
| Total General and Administrative Overhead | 1,350,014 | 1,290,188 | 1,239,230 | 1,271,552 | 1,412,856 | 1,395,343 |
| | | | | | | |
| Net Margin | 850,244 | 480,653 | 526,683 | 139,614 | (744,913) | (1,577,825) |
| Net Margin % | 9.57% | 5.74% | 6.39% | 1.72% | -9.54% | -17.50% |
| | | | | | | |
| Financing Expense | 121,150 | 119,676 | 114,676 | 134,694 | 146,215 | 115,920 |
| Financing Income | 56,337 | 56,337 | 56,337 | 56,337 | 1,076,210 | 56,337 |
| Investment Income | 49,812 | 29,010 | 34,393 | 52,775 | 23,405 | 31,044 |
| Miscellaneous Income | 91,226 | 52,266 | 51,822 | 35,727 | 284,821 | 88,180 |
| | | | | | | |
| Net Surplus | 926,469 | 498,589 | 554,560 | 149,759 | 493,308 | (1,518,184) |

| | December 2020 |
|---|---|
| Assets | |
| Current Assets | |
| Cash and Liquid Capital | 3,513,148 |
| Short Term Investments | 42,641,415 |
| PMA Partnership | 574,941 |
| Accounts Receivable, Net of Allowance | 25,239,323 |
| Other Receivables | 1,794,599 |
| Inventory | 2,882,776 |
| Prepaid Expenses | 1,596,012 |
| Total Current Assets | 78,242,213 |
| Assets Limited as to Use | |
| Internally Designated for Capital Acquisitions | 1,193,799 |
| Short Term - Restricted | 648,894 |
| Limited Use Assets | |
| LAIF - DC Pension Board Restricted | 836,702 |
| DB Pension | 18,895,468 |
| PEPRA - Deferred Outflows | 8,320 |
| PEPRA Pension | 79,568 |
| Total Limited Use Assets | 19,820,058 |
| Revenue Bonds Held by a Trustee | 2,434,447 |
| Total Assets Limited as to Use | 24,097,197 |
| Long Term Assets | |
| Long Term Investment | 1,763,634 |
| Fixed Assets, Net of Depreciation | 74,844,934 |
| Total Long Term Assets | 76,608,567 |
| Total Assets | 178,947,978 |
| Liabilities | |
| Current Liabilities | |
| Current Maturities of Long-Term Debt | 1,569,776 |
| Accounts Payable | 4,457,718 |
| Accrued Payroll and Related | 9,575,266 |
| Accrued Interest and Sales Tax | 156,647 |
| Notes Payable | 8,927,628 |
| Unearned Revenue | 21,314,925 |
| Due to 3rd Party Payors | 2,341,874 |
| Due to Specific Purpose Funds | (25,098) |
| Other Deferred Credits - Pension | 3,045,352 |
| Total Current Liabilities | 51,364,088 |
| Long Term Liabilities | |
| Long Term Debt | 37,634,947 |
| Bond Premium | 429,098 |
| Accreted Interest | 14,244,849 |
| Other Non-Current Liability - Pension | 39,799,580 |
| Total Long Term Liabilities | 92,108,474 |
| Suspense Liabilities | (1,260,164) |
| Uncategorized Liabilities | 291,435 |
| Total Liabilities | 142,503,833 |
| Fund Balance | |
| Fund Balance | 37,313,448 |
| Temporarily Restricted | 648,881 |
| Net Income | (1,518,184) |
| Total Fund Balance | 36,444,145 |
| Liabilities + Fund Balance | 178,947,978 |

| | Budget 12/31/2020 | Actual 12/31/2020 | Budget Expense as a % of Revenue 12/31/2020 | Actual Expense as a % of Revenue 12/31/2020 |
|---|---|---|---|---|
| Total Net Patient Revenue | 6,525,084 | 9,018,246 | | |
| Cost of Services | | | | |
| Salaries & Wages | 2,199,200 | 2,596,191 | 33.70% | 28.79% |
| Benefits | 1,388,355 | 1,473,236 | 21.28% | 16.34% |
| Professional Fees | 1,525,565 | 2,046,081 | 23.38% | 22.69% |
| Pharmacy | 185,025 | 403,646 | 2.84% | 4.48% |
| Medical Supplies | 338,769 | 284,134 | 5.19% | 3.15% |
| Hospice Operations | 42,367 | - | 0.65% | 0.00% |
| Athena EHR System | 116,146 | 89,294 | 1.78% | 0.99% |
| Other Direct Costs | 185,965 | 608,146 | 2.85% | 6.74% |
| Bad Debt | - | 1,700,000 | 100.00% | 100.00% |
| Total Direct Costs | 5,981,392 | 9,200,728 | 91.67% | 102.02% |
| Gross Margin | 543,692 | (182,482) | | |
| Gross Margin % | 8.33% | -2.02% | | |
| General and Administrative Overhead | | | | |
| Salaries & Wages | 455,637 | 335,953 | 6.98% | 3.73% |
| Benefits | 352,253 | 235,101 | 5.40% | 2.61% |
| Professional Fees | 239,999 | 263,864 | 3.68% | 2.93% |
| Depreciation and Amortization | 376,075 | 351,786 | 5.76% | 3.90% |
| Other Administrative Costs | 64,500 | 208,639 | 0.99% | 2.31% |
| Total General and Administrative Overhead | 1,488,464 | 1,395,343 | 22.81% | 15.47% |
| Net Margin | (944,772) | (1,577,825) | | |
| Net Margin % | -14.48% | -17.50% | | |
| Financing Expense | 222,000 | 115,920 | 3.40% | 1.29% |
| Financing Income | 190,500 | 56,337 | 2.92% | 0.62% |
| Investment Income | 41,250 | 31,044 | 0.63% | 0.34% |
| Miscellaneous Income | 26,250 | 88,180 | 0.40% | 0.98% |
| Net Surplus | (908,772) | (1,518,184) | | |


Utilization OP Visits
12000
10000
8000
6000
4000
2000
0
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Outpatient Visits 2019
Outpatient Visits 2020
Outpatient Visits 2021
Budgeted 2021


Utilization IP Days
400
350
300
250
200
150
100
50
Jul
Aug
Sep
Oct
Nov
Dec
Jan
Feb
Mar
Apr
May
Jun
Inpatient Census Days 2019
Inpatient Census Days 2020
Inpatient Census Days 2021
Budgeted 2021

**NORTHERN INYO HEALTHCARE DISTRICT**
**REPORT TO THE BOARD OF DIRECTORS**
**FOR INFORMATION**

Date: February 5, 2021
Title: **CERNER PROJECT UPDATE**


## Narrative

As we move into February, we conclude the data validation phase and move into the testing phase. We have a multi-phased plan to thoroughly test the system. The plan includes unit testing in the departments. During unit testing each department will test the functionality of the system that they are responsible for. We also have three rounds of integration testing. During integration testing we will test workflows and data flow. A team was assembled to create integration test scripts. These scripts test real-world patient scenarios from the time the patient enters the health system at registration continuing on all the way through simulating a claims submission. The team created thirty-four test scripts which reflect our most frequent patient visit types.

The integration testing events run over a period of two weeks each. The first week of testing includes all hospital and clinic departments, except for patient accounting/billing. The second week of testing is specific to patient accounting/testing. In addition to testing our workflows and data flows, we anticipate identifying some bugs in the system. We have a process designed to report these bugs to our Cerner consultants for resolution.

This event is a major undertaking. We have identified approximately one hundred staff and providers that will rotate in and out to participate in the event. Due to COVID-19 this event will be conducted virtually with our staff, the Cerner team and the Wipfli project manager all participating remotely or from their office on campus. We have created specific tools to communicate between team members and the project management team in order to maintain control over the event and to share information.

We are approximately one hundred days from our cutover/go-live date of May 17. Subject Matter Expert and Super User activity will continue to increase during the testing phase and into the end-user training phase.

## Top Accomplishments for this Reporting Period

1. **Integration Test Event Planning:** As previously mentioned, we have developed an extensive plan for testing the system. We will execute the test plan on February 2- 4 and February 9 – 11. The second round of testing will occur in March followed by a third round of testing in April.

2. **Project Communication:** The communication team launched another fun event – Word Game. The response was amazing, and we believe our staff enjoyed this activity. Within a short period of time from when we released the game, we received 10 winning responses. Awards were presented to the winners and a photo was included in the most current newsletter.

   The committee released an all-staff survey the week of January 25. The purpose of the survey is to gage the level of staff satisfaction with the content that is being provided, the frequency of distribution, and the media used to communicate. The committee will review the responses and make alterations if needed.

3. **Training Plans:** With the assistance of Cerner, Marjorie Routt is helping guide our SME/SU in the development of their training plans. We will schedule a Training Readiness event in February. This will provide us with insight on how ready our trainers are to deliver training.

4. **Order Sets:** An order set is a grouping of orders that physicians commonly place based on diagnosis code. Think of them like a check list. With an order set, physicians aren't completely reliant on their knowledge and memory to place the appropriate orders. Additionally, they don't need to search for and select each order individually. Rather, they are presented with a group of orders whereby, they simply select the ones they want to order. Order sets improve physician efficiency and satisfaction. We have developed 116 order sets which is approximately 95% of our total order sets. We will continue to review and refine the order sets over the next two months. Developing order sets is one of the largest single tasks of the project and we are slightly ahead of schedule.

## Changes in Scope of Work:

1. **7Medical Interface**: It was determined that an Orders and Results interface between Cerner and 7Medical PACS system is needed. The Cerner portion of the interface is included in Cerner's Schedule 1. We have received a quote from 7Medical for their portion of the interface. The cost for this interface is $6,240. The quote is currently with our compliance team for review.

### Issues or Concerns the Board of Directors Should Be Aware Of

1. **Staff Availability / Missed Deadlines:** Cerner has expressed concern about some departments falling behind and missing deadlines. These departments include Charge Services, Case/Care Management, Pharmacy, Supply Chain, and Experian. The likely cause for falling behind is related to staff availability to work on project tasks. Cerner's plan is to have the Cerner consultants responsible for these solutions work with our team during the Integration Testing event to see if they can get caught up. During Integration Testing, there will be some downtime where some teams are waiting for a test script to work on. During this downtime is when the consultants will work with our teams to try to get caught up.

   Shortly after the Integration Testing event is complete, Meredith Cook, Cerner Project Manager, will survey all the Cerner consultants, not just those responsible for areas that are behind. This survey will determine which departments are behind from the consultant's perspective, which tasks are behind, and if there is a mitigation plan in place to get caught up. Meredith will schedule a call with the project senior leadership team to discuss the survey findings.

2. **COVID-19:** The virus continues to be a factor impacting the project. The steering committee made the decision to conduct the first round of the Integration Testing event virtually. Cerner has conducted a few similar events virtually, but certainly this is out of the norm. Logistically it is more complicated to run the event virtually. We have created a plan and approach that will be communicated to the SME/SU the week of January 25. We anticipate a few glitches similar to what we experienced with the Workflow and Integration and Train the Trainer virtual events. However, if all goes according to plan, we expect to be successful with this event.

## Upcoming Events or Milestones

1. **Integration Testing Rounds 1, 1.5, and 2.** Cerner is a highly integrated system. We will perform end to end testing of our most common patient scenarios using integrated test scripts. We will begin our integration testing on February 2 and will complete testing on April 15.

2. **End User Training:** Along with comprehensive testing of the new system, effective end user training is vitally important to the success of the project. Our Education Coordinator and Cerner are working on the education plan and schedule. We will use a Train the Trainer approach and our trainers have received education and will continue to enhance their knowledge over the next couple of months to prepare them to be effective trainers.

**Upcoming Event Calendar**


Prepared by: _Daryl Duenkel, Project Manager, Wipfli__
Name and Title

Reviewed by: _____
Name
Title of Chief who reviewed

Approved by: _____
Name
Title of Chief who approved

**FOR EXECUTIVE TEAM USE ONLY:**

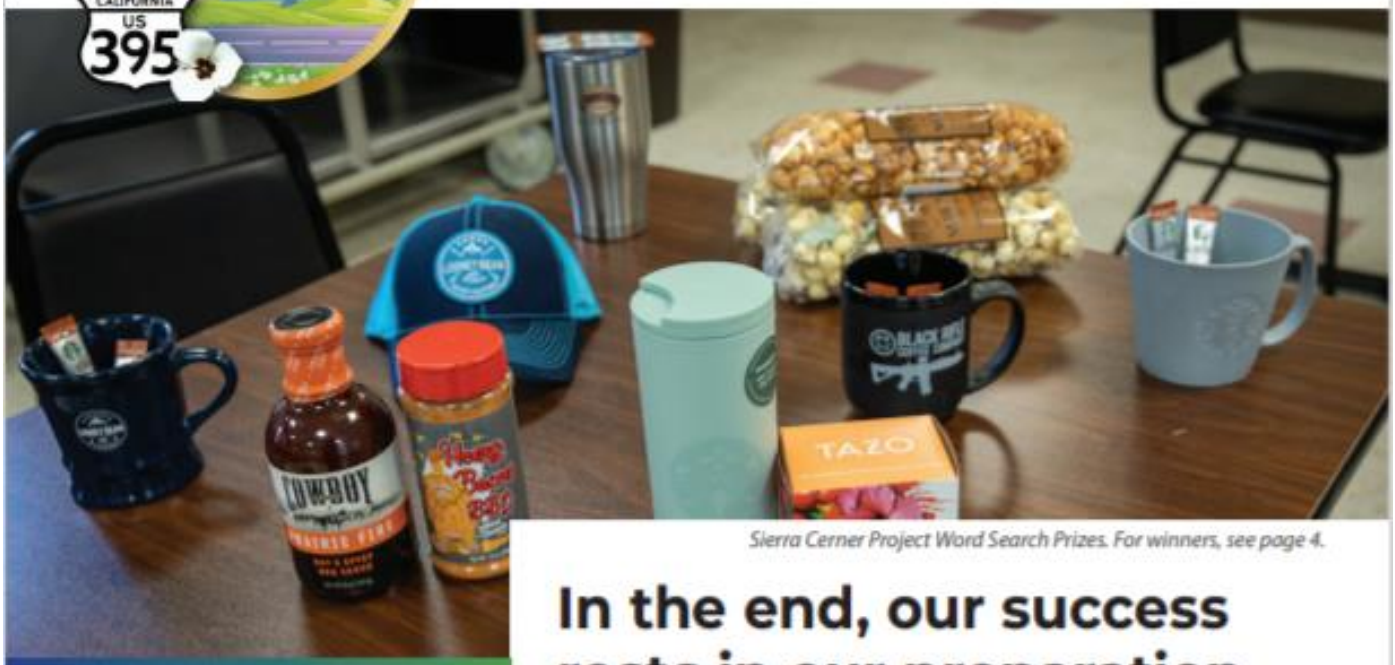
Date of Executive Team Acceptance: _____ Submitted by: _____
Chief Officer

An Internal NIHD Communication

January 26, 2020

# NEWSLETTER

Produce bi-weekly during The NIHD Cerner Implementation




*Sierra Cerner Project Word Search Prizes. For winners, see page 4.*



Change is the law of life and those who look only to the past or present are certain to miss the future.

*-- 35th U.S. President John F. Kennedy*

# In the end, our success rests in our preparation

## Integration testing will be a virtual effort

**Top Accomplishments from the Past Month**

**Train the Trainer:** We completed the Train the Trainer event the week of December 14 and the Physician Train the Trainer event the week of January 4. The reason we have these events on separate weeks is to allow staff like our informatics team to participate in both events. They play an important role by supporting our end-users and our providers.

**Foreign System Interface Meetings:** While Cerner is a very robust and highly integrated electronic health record, we will interface it to other non-Cerner applications. Some of the systems we will interface to include 7Medical PACS system, LabCorp reference lab, OneContent archiving system. We have conducted kick-off calls with some of these vendors and will continue the kick-off calls with the remaining vendors in

*Continued on page 2*

**From where I sit** | How Cerner will benefit NIHD

## *Jennifer Dixon*

"I am excited for what Cerner will bring to our table. I think that the patients will appreciate having a more robust portal that will have both inpatient and outpatient results/notes. This will be great tool for patients who need to follow up with providers out of the area. They will not have to repeat unnecessary tests because they will be able to log in and show those out-of -town providers current results."

## *Upcoming SME & SU Schedule*

| | | SMEs | SUs |
|---|---|---|---|
| IT 1 Clinical | Feb. 2-4 | Yes | Yes |
| IT 1 Financial | Feb. 9-11 | Yes (B) | Yes (B) |
| IT 1.5 Clinical | March 2-4 | Yes | Yes |
| IT 1.5 Financial | March 9-11 | Yes (B) | Yes (B) |
| IT 2 Clinical | April 6-8 | Yes | Yes |
| IT 2 Financial | April 13-15 | Yes (B) | Yes (B) |
| Training Dates | April 15-May 14 * | Yes | |
| Go-Live Daily Meetings | May 17-28 | Yes | Yes |
| Go-Live End User Support | May 17-28 | | Yes |

*SME- Subject Matter Experts SU - Super User (B) - Billing * - Specifics to come*

## *Success*

*From page 1*

January. Our goal is to develop the necessary interfaces and have them ready by the March Integration Testing event.

**Order Sets:** An order set is a grouping of orders that physicians commonly place based on diagnosis code. Think of them like a check list. With an order set, physicians aren't completely reliant on their knowledge and memory to place the appropriate orders. Additionally, they don't need to search for and select each order individually. Rather, they are presented with a group of orders whereby, they simply select the ones they want to order. Order sets improve physician efficiency and satisfaction. We have developed 116 order sets which is approximately 95 percent of our total order sets. We will continue to review and refine the order sets over the next two months. Developing order sets is one of the largest single tasks of the project and we are slightly ahead of schedule.

**Integration Test Scripts:** Integration test scripts are used to test real-life patient scenarios. They begin with the patient point of entry to the district health system and end with simulating claims processing. We have three scheduled testing events with the first one beginning on Feb. 2. We have

*Continued on page 3*


## Project Timeline

*Join NIHD on this Journey – There's room for everyone!*

## Success

*From page 1*

developed 34 scenarios for IT1. These scenarios will cover the top 80percent of our patient visits reasons. Cerner is currently reviewing the scripts and will provide guidance for potential tweaks.

**Project Communication:** We continue to provide regularly scheduled updates to the organization that include bi-weekly newsletters to all staff, monthly provider podcasts and written report, monthly management and departmental report, and ad-hoc communication. In January, the communication team will conduct a fun activity and a staff survey. The fun activity was a word search game that all staff can play along. No project knowledge is required to play, so, all staff have an equal chance to submit a completed game for a potential prize. The survey will ask staff if they are receiving the project information they need in the format and media that they want.

### Changes in Scope of Work

**Dragon Medical One** (DMO): Some of our providers currently use Dragon voice recognition. The way it works with Cerner may require some additional licensing or setup fees. We have received a zero-dollar sales order from Cerner. An internal legal review of the sales order is underway.

### Challenges We Are

**COVID-19:** COVID-19 has an impact on the project. The impact includes staff needing to rightly focus their time on patient care as NIHD sees an increase in the number of patients and criticality of patients. The additional focus on patient care can impact staff ability to spend the required time on the project.

**Staff Availability:** Challenges with staff availability is partially attributable to COVID-19 as well as staff project role changes. The ability to accurately and fully transfer project knowledge from outgoing team members to incoming team members becomes increasingly difficult at this stage of the project and going forward.

**Integration Testing:** Normally Cerner would bring 20-30 staff onsite to help with the integration testing event and the Wipfli project manager would also be onsite. Due to COVID-19, we will conduct this event with 100 percent of the Cerner / Wipfli staff supporting remotely. Additionally, we have room occupancy limitations due to the virus. Therefore, many of the NIHD staff will work from their office or home rather than gather together and work from one or two large conference rooms.

Decentralizing the staff for the testing event will impact our ability to run the event as smoothly as if we were all together. Communicating with a large group that is gathered together is much easier and more effective than with a decentralized staffing model. We have a plan and approach to be as effective as possible with the decentralized model. We have meetings scheduled with the SMEs and SUs the week of Jan. 25. During this meeting we will lay out the plan for the testing event and answer all questions.

## UPCOMING EVENTS & ACTIVITIES

1. Integration Testing Rounds 1, 1.5, and 2. Cerner is a highly integrated system. We will perform end to end testing of our most common patient scenarios using integrated test scripts. We will begin our integration testing on February 2 and will complete testing on April 15.

2. End User Training: Along with comprehensive testing of the new system, effective end user training is vitally important to the success of the project. Our Education Coordinator and Cerner are working on the education plan and schedule. We will use a Train the Trainer approach and our trainers have received education and will continue to enhance their knowledge over the next couple of months to prepare them to be effective trainers.

## Word Search Winners

Congratulations to the winners of our recent Sierra Cerner Project Word Search Contest. To pick up your prize, please contact Sarah Yerkes in Rehabilitation Services at ext 3516.

**Stacey Santana – Admissions**
**Cameron Hubbard Shinto – EVS**
**Teresa Grate – IT**
**Teresa Surratt – Rehab**
**Nicole Eddy – Surgery**
**Chris Cauldwell – Surgery**
**Danielle Medeiros – Surgery**
**Nancy Ramirez – Medical Records**
**Tanya Deleo – Admissions**
**Scott Stoll – IT**

## NIHD TRAINING CORNER

with Marjorie Routt

# A few words about End User Training

### Sierra Cerner Project eyes February 22 for unveiling of detailed training schedule for Northern Inyo Healthcare

As we continue through our Cerner implementation, I wanted to take a minute to address our upcoming end-user training.

I'm sure a lot of you are quite excited to get your hands dirty and learn how your current job translates into this new exciting system! Your departmental Super Users and Subject Matter Experts are hard at work learning the ropes and will begin training approximately six weeks before our go-live date of May 17, 2021.

There are still quite a few details to work out, but we are working to land a detailed training schedule soon – our projected date to share that with you all is February 22, 2021. We understand that everyone has busy lives – both work and otherwise – and want to give you the opportunity to plan for your training as much as possible.

We continue to be excited for this new chapter at Northern Inyo Healthcare District and look forward to getting everyone ready to go for Day 1 and beyond!

If you have any questions or concerns, please contact me at Marjorie.Routt@nih.org.


The Sierra Cerner Project

Sierra Cerner Newsletter

*Published every two weeks during the implementation of the Cerner Electronic Medical Record system*

**Communications Team**

*Daryl Duenkel, Wipfli*
*Barbara Laughon*
*Linda Ramos*
*Sarah Yerkes*